Berkshire, Buckinghamshire & Oxfordshire LMCs

THE NHS-PRIVATE INTERFACE

Local Guidance for NHS General Practice & Private Providers

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Executive Summary

If a patient requests a private referral, a GP should honour this if they think it meets the clinical needs of their patient, and without charge, as they would do for any patient. GPs have a right to decline to refer (including privately) if they do not think it is clinically appropriate. A private GP can refer into NHS services; they don't need to ask the patients NHS GP to do so on their behalf.

Any pre-referral work-up should be offered by the NHS GP as they normally would do for any of their NHS patients. However, GPs should not be asked to do any investigations requested by the private specialist. The patient should expect to pay for all aspects of the private care including consultations, investigations, privately issued interventions, and any unplanned or planned follow-up related to that private care in order to clearly separate out private and NHS activities. However, the NHS should never decline emergency care, even if it is the result of private interventions, or decline any care simply because the responsibility is unclear. GPs should liaise with private specialists to coordinate care as they would do for their patients in NHS secondary care. A patient cannot retrospectively ask the NHS to reimburse them for private care costs.

A private specialist may ask a GP to prescribe for them, but a GP should only prescribe what they would normally do for any other NHS patient with the same condition and in accordance with their local CCG formulary. This includes declining to prescribed RED-listed drugs, initiate AMBER-initiation drugs, or drugs subject to a local shared care protocol. If the medicine request falls outside of the local formulary arrangement, the specialist will either have to offer this privately to the patient (including all subsequent monitoring) or transfer the patient into NHS care if the patient requests it.

A private patient has a right to transfer into NHS care at any time. If they do transfer, they are entitled to that which is available locally to any other NHS patient with the same condition – no more, no less - and they should join the relevant NHS service at the same point as if their last episode of private care was delivered in the NHS, facing the same wait times as other NHS patients with the same clinical predicament at that point in the care pathway. In these circumstances, the private specialist should complete a consultant-to-consultant referral into the equivalent NHS clinic (which may be their own NHS clinic) – they should not ask the GP to do the referral for them.

Introduction

Our guidance draws upon four key documents which lay out the principles for managing the interface between the NHS and private care:

- Department of Health (2009). *Guidance on NHS Patients who wish to pay for additional private care*.
- Department of Health (2004): *A Code of Conduct for Private Practice*.
- Thames Valley Priorities Committee Commissioning Policy Statement (2019): *Managing the boundaries of NHS and privately funded healthcare*. Policy No. 67d (TVPC 35).
- BMA Medical Ethics Department (2009). *The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland Guidance*.

The purpose of this BBO LMC document is to apply those key principles to scenarios frequently occurring in NHS General Practice. It is written for NHS GPs and private providers serving patients in Berkshire, Buckinghamshire, and Oxfordshire.

Principles of Care Over the NHS-Private Interface

Patients who are entitled to NHS-funded treatment may opt into or out of NHS care at any stage. Patients may pay for additional private health care while continuing to receive care from the NHS. Patients who have had a private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment.[1]

There are two broad principles governing the interface between the NHS & the Private Sector.

PRINCIPLE 1: THE RIGHT TO NHS CARE FOR ALL PATIENTS

Specifically:

- NHS organisations should not withdraw their usual care because the patient chooses to go private[2]
- The NHS should continue to provide free of charge all care that the patient would have been entitled to had he or she not chosen to have additional private care[3,4]. The NHS care provided is based on the NHS's interpretation of patient's clinical need – not that of the private specialist, or the patient themselves.[5]
- Patients who pay for private care should not be put at any advantage or disadvantage in relation to the NHS care they receive. They are entitled to NHS services on exactly the same basis of clinical need as any other patient[6]
- Where private care is being delivered alongside NHS care, patients should not be unnecessarily subjected to two sets of tests or interventions. If the same diagnostic, monitoring or other procedure is needed for both the NHS element of care and the private element, the NHS should provide this free of charge as part of the patient's NHS entitlement and share the results with the private provider if necessary[7]
- Patients can choose to change their status from private patient to NHS patient, but must not be treated differently from any other NHS patient on doing so[8]. This includes:
    - They should join the waiting list at the same point as if the private consultation, investigation or treatment had occurred in the NHS service.

- Their priority on joining the waiting list, or eligibility for NHS treatment, should be determined by the same criteria applied to other NHS patients.
- On requesting to be transferred from private to NHS, they do not need to have a further assessment within the NHS before receiving their treatment, nor do they need to be referred back to their GP[9]

PRINCIPLE 2: NHS & PRIVATE CARE SHOULD BE SEPARATED AS MUCH AS POSSIBLE

Specifically:

- There should be as clear a separation as possible between private and NHS care[10]. Private care should be carried out at a different time and (wherever possible) place to the NHS care that a patient is receiving[11]
- "Top-up" of single episodes of NHS care with private treatment is permitted, but only when delivered at a separate time and place[12] (and not in General Practice). Where different elements of care or treatment cannot be separated out, supplementing NHS care is unlikely to be possible[13]
- In relation to care which is provided free of charge by the NHS, the patient remains an NHS patient and should be treated in the same way as any other NHS patient. In relation to care which is provided on a private basis, the patient is a private patient[14]
- The patient should bear the full costs of any private services. NHS resources should never be used to subsidise the use of private care[15,16]. Specifically:
  - The patient should meet any additional costs associated with the private element of care, such as additional treatment needed for the management of side effects.
  - The private provider should normally deal with emergency and non-emergency complications resulting from the private element of care.
  - However, the NHS should never refuse to treat patients simply because the cause of the complication is unclear. The NHS should never turn any patient away in an emergency.
- The arrangements put in place to deliver additional private care should be designed to ensure as clear a separation as possible of funding, legal status, liability and accountability between NHS care and any private care that a patient receives[17]

- All doctors have a duty to share information with others providing care and treatment for their patients. This includes NHS doctors providing information to private practitioners[18]
- Transferring between private and NHS care should be carried out in a way which avoids putting patients at any unnecessary risk. The NHS and the private provider should work collaboratively to put in place protocols to ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS and private care at all times. This should include 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[19].

PRINCIPLES OF PRESCRIBING OVER THE INTERFACE

Building on the above two principles, the *Thames Valley Priorities Committee Commissioning Policy* lays out key points around prescribing over the NHS-Private interface. Specifically:

- 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.

Specific Scenarios In General Practice

REFERRING INTO THE PRIVATE HEALTHCARE SECTOR

1. Does an NHS GP have to do a private referral whenever asked by a patient?

No. A GP should do a referral where the patient is entitled to it and, in the view of the GP, the referral is clinically necessary. This is the case whether the referral is through the NHS route or a private referral[20].

If the GP does not consider the treatment to be clinically necessary, then there is no obligation to refer; the patient may then seek treatment without a referral[21].

The GMC no longer requires specialists to accept patients only with a referral. However, the BMA considers a referral good practice, and insurance companies usually require a letter of referral. This can create some conflict between what the patient wants and what the GP feels is clinically necessary. In these circumstances, the GP should be open with the patient about this. They may want to offer the patient a second opinion from another GP. Doctors cannot be compelled to arrange treatment where it is not clinically indicated and GMC guidance states that investigations or treatment must be arranged and provided on the basis of clinical judgement of the patient's needs[22,23].

The quality standard of the referral is the same, whether the patient is being referred privately or through the NHS. A referrer must provide relevant information about the patient's condition and history, and the purpose of transferring care or arranging the investigations and treatment the patient needs[24].

2. Can a GP charge for doing a private referral?

GPs may not charge their NHS patients for private referrals, nor may they charge for the provision of relevant information to other doctors providing care for the patient[25].

Part 5, Regulation 24 of the National Health Service (General Medical Services Contracts) Regulations 2015 (which are replicated in any PMS contract), sets out the basic exclusion in charging NHS patients for care. It states:

the contractor must not, either itself or through any other person, demand or accept from any of its patients a fee or other remuneration for its own benefit or for the benefit of another person in respect of the provision of any treatment whether under the contract or otherwise; or a prescription or repeatable prescription for any drug, medicine or appliance[26].

NB: The above refers to not charging for the care GPs are contracted to do for patients. It does not mean GPs are unable to charge for anything. Indeed, there are some situations where a GP can (and should) charge (such as some certificates, reports, malaria medicines and some immunisations). Further details can be found here.

3. Can a patient seek care for single active condition through both Private and NHS routes simultaneously?

There is no binary answer to this question. It is context-specific. The BMA rightly asserts there is still a substantial lack of clarity in protocols arising from simultaneous NHS and private care[27].

On the one hand, patients have a right to seek a private provider for care, if they choose to pay. They also have an absolute right to NHS care.

On the other hand:

- It generates the possibility of simultaneously requiring the same investigations and interventions through both the private and NHS route. Patients should not be unnecessarily subject to two sets of investigations and interventions. The NHS should provide tests and investigations that the patient is entitled to[28].
- When under the care of a private provider, there should be as clear a separation as possible between private and NHS care[29] - they may run in parallel but must be distinct from each other. Private care should be carried out at a different time and (wherever possible) place to the NHS care that a patient is receiving[30].
- The patient should bear the full cost of any private services and NHS resources should never be used to subsidise the use of private care[31].

And then there is the added need to use the scare resource of GP time wisely, avoiding inappropriate duplication of work.

As such, it is recommended that **elements of care** are separated out as clearly as possible: The patient can have an investigation through either the NHS route or private route, but receiving the investigation from both is not clinically appropriate. They may be offered the same treatment by both the

private route and the NHS route, but they should not receive it from both simultaneously – this makes no sense. The patient necessarily has to choose between private and NHS care as each element of their care unfolds. They can switch between private care and NHS care at any point (see onwards referrals section).

As such, we recommend that the patient make a choice with the GP about whether they wish to initiate a referral to the private route OR the NHS route initially. They can change their minds at any point and switch between the two routes.

If a patient and GP do decide to refer to both NHS and private providers simultaneously, the referrer and patient should be clear about which elements of care will be delivered by each sector. Where different elements of care or treatment cannot be separated out, supplementing NHS care with private care is unlikely to be possible[32] and BBO LMC advises that GPs may therefore decline to do both referrals simultaneously on these grounds.

Where simultaneous NHS and private care generates a clinical contraindication - for example, the private and NHS providers recommending conflicting treatment, or the joint care puts the patient at risk of harm, or the private treatments undermine the effectiveness of the NHS treatment, an NHS clinician may decline to provide NHS treatment[33].

4. Is an NHS GP obliged to provide patient information to private practitioners who request it (for example, when the patient has self-referred)?

Yes. A GPs' primary concern should be for the interests and safety of their patients, with due regard to confidentiality. NHS GPs should provide relevant information on request about the patient's medical history or current condition to other doctors providing care, including doctors working in the private sector. If the GP is aware that treatment is being sought privately and has information that might affect the safety or outcome of the treatment, this should be shared, with the patient's consent. The GP cannot charge for this (see question 2).

Failure to provide relevant information when the patient's consent has been obtained could result in a complaint against the GP – either to the GMC or through the courts – if the patient is harmed as a result.[34]

5. What should the patient be expected to pay for as part of their private care?

The patient must expect to pay the full cost of[35,36]:

- The consultation with the private provider
- Any drugs prescribed
- Any other interventions provided in the course of the private consultation
- Any additional costs associated with the private element of care, such as additional treatment needed for the management of side effects
- The private provider should normally deal with emergency and non-emergency complications resulting from the private element of care. However, the NHS should never refuse to treat patients simply because the cause of the complication is unclear. The NHS should continue to treat any patient in an emergency, regardless of whether or not it was as a complication of private care.

The above is in accordance with the principle of clear separation between NHS and private care laid out above. This is also important for establishing liabilities and indemnity cover.

The private provider should assess the patient's ability to cover these costs and, when this is not possible, agree an appropriate exit strategy (for example, see onward referrals section below). 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[37].

6. *Is a GP obliged to make an NHS referral to any private provider who provides NHS care but outside of the usual locally commissioned services and pathways, on the grounds of patient's 'right to choose' (for example, ADHD and psychological pathways)?*

No. Local commissioners have stated that GPs must make NHS referrals only to providers who have a contract with any CCG or NHS England to provide that particular service. They should not refer to providers who do not have such a contractual arrangement, even if that provider purports to provide NHS care. GPs should also be mindful to protect equity of access to care, which sometimes means not making NHS referrals to non-contracted providers simply to 'jump the queue'.

The specific advice from local commissioners on this issue – here, regarding referrals in Oxfordshire for ADHD – is as follows[38]:

Patient choice (as explained in the NHS England Guidance on Choice in Mental Health Care[1]) operates in this context and a patient's legal rights as stated below:

The legal rights to choice of mental health provider and team apply when:

- *the patient has an elective referral for a first outpatient appointment*
- *the patient is referred by a GP*
- *the referral is clinically appropriate*
- *the service and team are led by a consultant or a mental healthcare professional*
- *the provider has a commissioning contract with any Clinical Commissioning Group (CCG) or NHS England for the required service.*

Commissioners are required to provide services that meet the reasonable needs of the populations for which they are responsible. They have finite resources and need to make decisions to ensure the best possible outcome for ***all*** *of the patients for whom they have commissioning responsibility so may put in place arrangements such as single points of access (SPA), prior approval schemes or requirements for patients to make individual funding requests (IFR) for certain treatments which are not routinely funded.* ***Where such arrangements are in place, GPs making choice referrals, should comply with their requirements rather than making a direct referral to a provider.***

Oxfordshire CCG commissions the entire MH secondary care pathway including ADHD and psychological pathways from [Oxford Health NHS Foundation Trust]. The type of contract arrangement we have means they effectively operate as ***the single point of access for all secondary care MH referrals within Oxfordshire.***

On triage of the referral, the Trust will allocate appointments according to clinical need eg urgent referrals will be seen before routine. They may subcontract the referrals to an appropriate provider with the permission of the commissioners, having assured themselves that the quality and service provided is suitable to the patient's needs and that the provider holds an NHS services contract but this is completely at the discretion of [Oxford Health] and not a matter of patient choice.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/02/choice-in-mental-health-care-v2.pdf

This approach ensures patients triaged by [Oxford Health] will be dealt with according to clinical need and urgency, ensuring equity amongst those on waiting lists.

If a GP feels that a patient requires a particular service which is not provided for by the local pathway ie there are additional aspects with which the local pathway would not deal, then they need to make an application to the OCCG via the IFR route detailing why the patient will benefit more than those who would remain within the local pathway (also known as the exceptional capacity to benefit). This would not include jumping a non-urgent waiting list as a sole feature.
As such we would kindly remind colleagues to ensure ***all secondary care MH referrals including ADHD and psychological pathways are made directly to OHFT.***

The commissioners also justify this position on grounds of equitable access to healthcare:

…access to healthcare should not be allocated unfairly or inequitably and that all patients whatever their personal circumstances should have an equal ability to access care based on their need. Individual requests should not be made to the CCG if the patient has the same condition as others unless their clinical circumstances are likely to mean they would benefit more than others. This includes requests to avoid long waiting lists by referral to private providers.

[The Thames Valley Ethical Framework] *states "As far as possible, it will respect the wishes of patients to choose between different clinically and cost-effective treatment options, subject to the support of the clinical evidence.*

This approach leads to three important principles:

- *In the absence of evidence of health need, treatment will not generally be given solely because a patient requests it.*
- *A treatment of little benefit will not be provided simply because it is the only treatment available.*
- *Treatment which effectively treats "lifetime" or long-term chronic conditions will be considered equally to urgent and life prolonging treatments.*

7. What tests/investigations should a GP do prior to referring a patient to a private provider?

The GP should offer to do tests that they would normally do for any pre-referral work-up for an NHS patient under their care - for example, providing an FBC and USS for a patient in advance of a private referral for menorrhagia, or arranging an ECG and electrolytes prior to referring to a cardiologist privately for palpitations. This is in accordance with the principle of the right to NHS care. It also assumes the patient is content to wait for those to be done (as per any other NHS patient) before the referral is initiated. If the patient does not want to wait, then they may elect to have those tests done privately through their specialist – and therefore pay for it.

However, once referred to the private provider, there should be a clear separation of private and NHS care, and any additional investigations deemed necessary by that private provider must be paid for by the patient. As above, NHS resources should never be used to subsidise the use of private care[39].

8. Does a GP have to do any additional investigations requested by a private specialist?

The additional investigations should be done by the person who has overall clinical responsibility for the patient. Following referral to a private specialist, it is the specialist who has clinical responsibility for that episode of care, and therefore the specialist should organise these. Private consultants should not ask GPs to arrange any tests that they feel are needed, either to make a diagnosis and recommend a course of treatment. Any additional investigations deemed necessary by that private provider must be paid for by the patient.

There should be a clear separation of private and NHS care – a patient or private provider cannot 'pick and mix' NHS and private treatment within the same episode of care. NHS resources should never be used to subsidise the use of private care[40].

Furthermore, GPs are not permitted to provide private services for their patients, which means the GP cannot organise these tests privately for the patient themselves.

GPs must treat all their patients the same and according to NHS expectations on standards of care – no more, no less. As such, the operating procedures across the primary-secondary care interface are the same whether the specialist is a private provider or NHS. Specialists can find more information on the primary-secondary care interface operating procedures here:

www.bbolmc.co.uk/trusts. Once a patient is under the case of a specialist, if a specialist feels that further investigations are necessary, those should be arranged by that specialist. If the patient wants those investigations done in the NHS, then the specialist should refer to the relevant NHS clinic to have those done and not delegate to GP to do so (see onward referrals section below).

The exception is where a the GP would normally do those tests for the patient if that patient were receiving NHS care. For example, if the private specialist initiated an ACE-inhibitor and advised the patient that this required routine renal function monitoring, that GP should do the renal function monitoring as per their usual NHS practice.

9. A patient is under specialist care for a condition and has both private and NHS secondary care involvement. Who is responsible for organising tests requested by the private arm of their care?

The specialists are normally responsible for organising these because they are the person who has overall clinical responsibility for the patient in that episode of care.

As said above, concurrent NHS and Private care creates complex conflicts, not least between the right to NHS care at any stage, the need to separate private/NHS care, and the principle that patients should not be unnecessarily subjected to two sets of tests or interventions.

That said, sometimes private care is provided by an NHS Trust or Foundation Trust, as a service provided by their organisation, or by individual consultants who have agreed this with their employing Trust. For example, a patient may be receiving cancer care in their NHS Trust, but pay the cost of imaging or non-NHS-funded therapies through the private route.

In these circumstances, if the same diagnostic, monitoring or other procedure is needed for both the NHS element of care and the private element, the NHS should provide this free of charge as part of the patient's NHS entitlement and share the results with the private provider if necessary.

This would not normally involve the GP as it is an issue that occurs within specialist care. It should be an arrangement between the NHS and private arms of the patient's specialist care. It does *not* mandate the private provider to ask the GP to organise their requested investigations through the NHS on their behalf. Rather, it should be arranged by the private provider in dialogue with their NHS Trust with which they have a relationship. If no such relationship exists, and the patient requests the recommended investigations

on the NHS, then the private provider should refer into the appropriate NHS specialist setting as per onward referrals section below.

10. If a patient is under both private and NHS care for the same or related condition, who is responsible for ensuring communication between the two, such as providing outcomes of their respective investigations or treatment interventions?

It is the responsibility of the clinician organising the tests/intervention to communicate those results with others involved in the patient's care, including across the NHS/private interface. This would normally be the specialist. However, where a GP has done their own relevant investigations and interventions, the GP should communicate those with others who need to know as is the usual case.

The NHS and the private provider should work collaboratively to put in place protocols to ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS and private care at all times. This should include 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[41].

11. Are NHS GPs obliged to complete medical insurance claim forms for their patients?

There is no obligation on NHS GPs or hospital doctors to complete medical insurance claim forms and, if they decide to do so, they may charge the patient. In most cases the doctor who has provided the treatment is in a better position to provide the information needed[42].

TREATMENTS AND PRESCRIBING OVER THE INTERFACE

The private provider will want to make reference to the GP's local CCG formulary when making prescribing decisions which they anticipate will involve the patient's NHS GP:

The Berkshire West Formulary can be found here: http://www.westberksformulary.nhs.uk/

The Berkshire East & Frimley Formulary can be found here: http://www.frimleyhealthformulary.nhs.uk/

The Buckinghamshire Formulary can be found here: http://www.bucksformulary.nhs.uk/

The Milton Keynes Formulary can be found here: https://formularymk.nhs.uk/

The Oxfordshire Formulary can be found here: http://www.oxfordshireformulary.nhs.uk/

12. Can a private consultant expect a patient's GP to prescribe a drug to their patient?

Yes, in most circumstances. The private consultant can anticipate that the GP will prescribe a recommended drug, providing *all* of the following criteria are met[43]:

1. The drug is available on the NHS in the GPs' local area
2. The drug is approved for GP prescribing in the local CCG formulary for the condition for which it is being recommended
3. The GP considers is clinically necessary (because the prescriber accepts clinical responsibility for their prescription)

Private consultants are advised to[44]:

- Check the relevant local formulary guidelines (links above) to check that the medicine can be prescribed by the GP. The specialist should avoid simply informing patients that their GP will prescribe the recommended medication without first checking this.
- recommend patients check with their GP that he or she is happy to prescribe, being sensitive to the objections the GP may have (outlined in previous paragraph)
- communicate directly with the GP themselves, as with NHS referrals.

13. Can a GP decline to prescribe a medicine recommended by a private consultant?

Yes, under some circumstances (as per previous question).

The clinical responsibility for the medicine for a patient, including dosing and monitoring, lies with the prescriber. In the case where a GP has been asked to prescribe a medicine recommended by a private consultant (as with any consultant), they must be clinically comfortable with this.

Reasons why a GP may reasonably decline to not prescribe a medicine recommended by a private consultant include any of the following:

- The GP does not feel able to accept personal responsibility for prescribing and monitoring on clinical grounds

- The drug is not available on the NHS in the GPs' local area
- The drug is not approved for GP prescribing in the local CCG formulary for the condition for which it is being recommended

14. What if the private provider recommends a drug that would normally only be prescribed by secondary care in the GP's local area (CCG footprint)?

In these circumstances, the drug must be prescribed by the private specialist and the patient carries all associated costs. (But see below on transferring to NHS care)

This is because GPs must provide all their patients with the same standard of locally-agreed NHS care – no more, no less. A GP can decline to prescribe the drug if doing so falls outside of their usual NHS practice[45].

The private specialist will therefore want to check the usual NHS practice for the recommended drug on the relevant CCG's formulary prior to recommendation (contact details at the top of this section).

This scenario usually applies to the following classes of drugs in the GP's local CCG formulary:

- RED: prescribing in secondary care only
- AMBER INITIATION: commenced in secondary care, with on-going prescribing in primary care

If a recommended drug is RED-listed in the GP's local CCG formulary, the GP may decline to prescribe it because it falls outside of their usual NHS care for their patients. In this circumstance, the private provider must prescribe the drug for the duration of the course, and the patient must bear all the costs associated with this (including prescriptions, monitoring, and follow-up).

Similarly, if the drug is AMBER INITIATED in the GP's local CCG formulary, the GP may decline to initiate the medicine and this will therefore fall upon the private provider to do. For these drugs, the private provider may ask the GP to continue prescribing once the patient is stabilised as per locally agreed NHS protocols laid out in the relevant CCG's formulary.

Transfer to NHS: The patient always has a right to transfer between private and NHS care. If paying privately for the RED or AMBER-INITIATED drug and its associated monitoring is not acceptable to the patient, they may

request that the private specialist refer them into the relevant NHS clinic (which may be the specialist's own NHS clinic) using a consultant-to-consultant referral in order to receive that treatment. The referral is the responsibility of the specialist; GPs should not be asked to do this (see onward referrals, below).

15. Can a private provider ask a GP to prescribe a drug that is subject to a shared care protocol in the GP's local area (CCG footprint)?

The GP should not prescribe the drug where there is no meaningful expectation of shared care, because a) the GP would be providing care for this patient above and beyond their usual practice for NHS patients; and, b) the drug is only NHS-funded locally if prescribed under a locally-agreed shared care protocol.

Where meaningful shared care with the private specialist *is* offered, the GP has *a right to decline* to prescribe the drug but should liaise with their CCG's *Medicines Optimisation Team* as part of making this decision (see 'Further Explanation' below).

Where the GP declines, the drug should be prescribed by the private specialist and the patient will have to pay all associated costs, including on-going monitoring and follow-up.

Further Explanation:

The circumstance of GP prescribing across the NHS-Private interface a drug that is subject to a local SHARED CARE PROTOCOL (SCP) is more nuanced than for red or amber-initiated drugs.

On the one hand:

- A private patient has a right to NHS care to the same standard as any other patient. As SCP drugs are usually prescribed by a GP, with on-going consultant oversight, there is a reasonable expectation that a GP will honour shared care to the same degree with a private specialist

On the other hand:

- The GP is technically being asked to prescribe outside of their usual practice. This is because SCPs are local agreements between specific, named NHS services and GPs in the local area. SCPs lay out the responsibilities of the named parties, and the thresholds and avenues for escalation to NHS services when required. All SCPs need to be approved by the CCG's *Medicines Optimisation Team*. A GP taking responsibility for prescribing an SCP-listed drug outside of the terms of

a locally-agreed SCP (for example, under a bespoke shared care agreement with the private provider), might expose the GP to breaching their own contractual arrangements with their CCG, and the GP will therefore likely decline

- Even where a GP is invited to prescribe under an existing local SCP arrangement with the relevant NHS service, they may decline to do so in a number of nationally-agreed situations (see SCP section here: https://www.bbolmc.co.uk/trusts)

Given the above complexities, it is recommended that if a GP receives a request from a private specialist to prescribe a drug subject to a local SCP, the GP should liaise with their local Medicines Optimisation Team who will advise on prescribing and ongoing monitoring of the drug regime recommended by the private consultant. If an acceptable protocol cannot be agreed, then the drug is not NHS-funded, and the GP should decline. The private consultant will then retain complete responsibility, at the patient's expense, for prescribing and monitoring their progress on the recommended drug regime[46].

Transfer to NHS: The patient always has a right to transfer between private and NHS care. If paying privately for the SCP drug and its associated monitoring is not acceptable to the patient, they may request that the private specialist refer them into the relevant NHS clinic (which may be the specialist's own NHS clinic) using a consultant-to-consultant referral in order to receive that treatment. The referral is the responsibility of the specialist; GPs should not be asked to do this (see onward referrals, below). The specialist should not create the patient expectation that the GP will prescribe the drug because they may still decline to do so in a number of nationally-agreed situations (see SCP section here: https://www.bbolmc.co.uk/trusts). *It is advised that the private specialist liaise with the GP so that they may counsel their patient appropriately before a decision is made to transfer to the NHS.*

16. What if the private provider recommends a treatment that is not normally funded by the local NHS for patients with the same condition (i.e. non-formulary drugs)?

If the patient still wishes to have that treatment:

- 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[47].

Alternatively, an NHS clinician may submit on the patient's behalf an *Individual Funding Request* (IFR) to the relevant commissioner (usually the patient's CCG, though some treatments are funded by NHS England directly rather than CCGs). Funding may be approved if the individual clinical circumstances provide grounds for making an exception. For example, where the patient's clinical circumstances are clearly different from other patients with the same condition, or there is a reason why the patient will respond to the treatment for favourably than other patients with the same condition. 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 treatment.

Approved IFRs are not paid for out of a dedicated budget. Rather, the funding is taken away from existing service funding. There should be no expectation that and IFR must or should be approved. Nor is there an obligation on an NHS clinician to submit an IFR on behalf of a patient if the NHS clinician does not believe there are exceptional circumstances as laid out above.

17. Can a GP offer to prescribe a drug as a private prescription for a patient where the private specialist has recommended a drug that is not funded on the NHS?

No[48].

First, this would mean the GP was providing an enhanced service to selected patients but not others. The GP's duty is to provide the NHS standard of care – no more, no less.

Second, Part 5, Regulation 24 of the National Health Service (General Medical Services Contracts) Regulations 2015 (which are replicated in any PMS contract), sets out the basic exclusion in charging NHS patients for care. It states:

> *the contractor must not, either itself or through any other person, demand or accept from any of its patients a fee or other remuneration for its own benefit or for the benefit of another person in respect of the provision of*

any treatment whether under the contract or otherwise; or a prescription or repeatable prescription for any drug, medicine or appliance[49].

(NB: The above refers to not charging for the care GPs are contracted to do for patients. It does not mean GPs are unable to charge for anything. Indeed, there are some situations where a GP can (and should) charge (such as some certificates, reports, malaria medicines and some immunisations). Further details can be found here.)

When a patient wishes to pay privately for an unfunded 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[50].

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[51].

18. Can a patient claim back from the NHS costs associated with private care if the patient chose to go through the private route for a condition that would have been supported in a similar way by the NHS?

No. The CCG cannot accept requests for reimbursement (retrospective funding) of any drugs prescribed or treatments received whilst in private practice[52].

ONWARD REFERRALS

19. If the patient is under the care of a specialist, and seeks onward referral (including either private-to-NHS, private-to-private, or NHS-to-private) who should do the referral?

- If the referral is for the same or related condition to that being consulted for, the specialist should do the onward referral. It should not go back to the GP to do. Insisting on a separate referral from the GP can seem to the patient to be unnecessarily bureaucratic as well as adding to the workload of GPs. In such cases doctors can respond factually. There is no requirement for the patient to be referred back to the GP.[53]

- It the referral is for an unrelated condition, the specialist can advise the patient to see their GP for assessment the patient's need in the usual way. Onward referral would be at GP discretion, as is usually the case. This does not stop a private specialist doing their own private referral for an unrelated condition if they choose to do so.

- If the patient has requested a second opinion the private specialist should liaise with the patient's GP to facilitate a referral for this – either via the NHS or private route (at the patient's discretion). This is because the NHS accepts a patient's right to have a second opinion. It also reduces conflicts of interest if the referral comes from an independent referrer.

The above are applicable regardless of whether the patient is seeking to stay within the private sector, transferring from private sector to NHS sector, or transferring form NHS to private sector.

Patients have a right to switch between NHS and private care. They must not be treated differently from any other NHS patient on doing so (see principle 1, above). Specifically[54]:

- They should join the waiting list at the same point as if the private consultation or treatment were an NHS service. So, for example, if the consultant wished to follow-up the patient in their NHS clinic, the consultant would refer to their own clinic, the wait time for that follow-up would be the same as for other NHS patients awaiting a follow-up for that condition. If the consultants has referred to a different consultant's NHS clinic, the wait time will be the same as for any NHS consultant-to-consultant referral.
- As the patient is already under the care of the specialist, there should be no need to seek GP referral. This will simply put the patient 'at the back of the queue'.
- The NHS Standard Hospital Contract makes it clear that the responsibility for onward referral for the same or directly related condition lies with the specialist using a consultant-to-consultant, not the GP[55]. This is also in line with BMA Medical Ethics Guidance and explicated stated by CCGs with regards private consultants referring into NHS clinics:

This is a consultant-to-consultant referral and so does not require a GP to be involved in the process and so is wholly owned by the private consultant…. Patients do not need to have a further assessment….within

the NHS before receiving their treatment, nor do they need to be referred back to their general practitioner (GP) [56].

Some NHS Trusts ask private consultants to seek a GP referral to transfer the patient into the relevant NHS clinic. This may be because the referral activity is more easily captured in the Trust's existing audit trails, and it sometimes attracts a more favourable referral tariff (less so now most Trusts are on block contracts). However, putting additional administrative burden on the GP with no additional clinical benefit for the patient is an inappropriate use of limited GP resource and restricts access for other patients. As such, a GP may reasonably decline to do so.

20. Can private GPs refer patients for NHS diagnostic services and treatment?

Yes. Provided patients are entitled to NHS treatment, they may opt into or out of NHS care at any stage. Private GPs are entitled to make referrals to NHS facilities, if that is the patient's wish, and the referral should be treated in the same way as if the referral came from within the NHS[57]. This does not need to go through the patient's NHS GP.

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