



Department of  
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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

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MÄNNYSTRIE O

**Poustie, Resydènter Heisin  
an Fowk Siccar**

# Guidance on HSC patients who wish to pay for additional private care

November 2009

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# Executive summary

The key points which Health and Social Care (HSC) organisations should take from this guidance are:

- HSC organisations should not withdraw publically funded care simply because a patient chooses to buy additional private care.
- Any additional private care must be delivered separately from publically funded care.
- The HSC must never charge for publically funded care (except where there is specific legislation in place to allow charges) and the HSC should never subsidise private care.
- The HSC 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.
- HSC Trusts should have clear policies in place, in line with these principles, to ensure effective implementation of this guidance in their organisations. This includes protocols for working with other publically funded or private providers where the HSC Trust has chosen not to provide additional private care.
- The Health and Social Care Board (the Board) and HSC Trusts should work together to ensure that the guidance is being implemented properly in their local areas.

## 1. Introduction

- 1.1 This document provides new guidance on how to proceed in situations where HSC patients want to buy additional secondary care services that the HSC does not fund. It has been published in response to a review commissioned by the Secretary of State for Health and conducted by Professor Mike Richards, the National Cancer Director. Professor Richards' report, published on 4 November 2008, showed that there was a great deal of confusion about the rules in this area. Existing guidance was being interpreted differently in different places, and many patients were not clear whether they would still be entitled to publically funded care if they purchased additional private drugs.
- 1.2 Professor Richards recommended that:
  - The Department of Health should make clear that no patients should lose their entitlement to NHS care they would have otherwise received, simply because they opt to purchase additional care for their condition;
  - Revised guidance should be issued as soon as possible to make this clear and to promote greater consistency across the NHS in England; and
  - The guidance should set out mechanisms to ensure that these cases are handled in a way that supports good clinical practice and is fully consistent with the fundamental principles of the NHS.
- 1.3 This document responds to those recommendations for Northern Ireland, outlining guidance on HSC patients who receive private care and setting out a series of important safeguards.
- 1.4 This guidance comes into operation on XXXX. It does not apply retrospectively.

# Revised guidance on HSC patients receiving private care

## 2. Principles

- 2.1 This guidance is grounded in the fundamental principles of the HSC and any decisions about a course of action under this guidance should be taken in accordance with those principles. The fact that some publically funded patients also receive private care separately should never be used as a means of downgrading the level of service that the HSC offers.
- 2.2 As affirmed by the Statement of Common Principles, which was agreed by the three devolved Administrations in response to the publication in England of the NHS Constitution:
  - the HSC provides a comprehensive service, available to all; and
  - access to HSC services is based on clinical need, not an individual's ability to pay.
- 2.3 As overriding rules, it is essential that:
  - the HSC should never subsidise private care with public money; and
  - patients should never be charged for their publically funded care, or be allowed to pay towards an HSC service (except where specific legislation is in place to allow this).
- 2.4 To avoid these risks, there should be as clear a separation as possible between private and publically funded care.

## 3. Scope

- 3.1 The general principles set out in Section 2 above apply to all publically funded care, wherever it is delivered.
- 3.2 However, this guidance (from Section 4 onwards) applies only to all secondary and specialist healthcare (care normally provided in a hospital setting) in Northern Ireland. It supersedes paragraph 2.13, bullet point 1 of the *Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants (November 2003)*<sup>1</sup>, and all other previous guidance on the same subject.
- 3.3 This guidance also applies to HSC Trusts and all providers of services to publically funded patients, in so far as they provide or commission the provision of secondary and specialist healthcare.
- 3.4 The boards of all provider organisations covered by this guidance are responsible for ensuring their organisations comply with it.

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<sup>1</sup> <http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

3.5 The guidance should be read alongside the legislative framework, including equality duties, and organisations should comply with their legal obligations when making a decision.

## 4. Revised guidance

4.1 This guidance establishes that, where a patient opts to pay for private care, their entitlement to publically funded services remains and may not be withdrawn.

4.2 Patients may pay for additional private healthcare while continuing to receive care from the HSC. However, in order to ensure that there is no risk of the HSC subsidising private care:

- It should always be clear whether an individual procedure or treatment is privately or publically funded.
- Private and publically funded care should be kept as clearly separate as possible.
- Private care should be carried out at a different time to the publically funded care that a patient is receiving.
- Private care should be carried out in a different place to publically funded care, as separate from other HSC patients as possible. A different place would include the facilities of a private healthcare provider, or part of a HSC organisation which has been permanently or temporarily designated for private care, such a private wing, amenity beds or a private room. Trusts may also want to consider using the services of a home healthcare provider where this is clinically appropriate. Putting in place arrangements for separation does not necessarily mean running a separate clinic or ward. As is the case now, specialist equipment such as scanners may be temporarily designated for private use as long as there is no detrimental effect to publically funded patients.

4.3 Departing from these principles of separation should only be considered where there are overriding concerns of patient safety, rather than on the basis of convenience. Such decisions should usually be agreed in advance with the Medical Director or equivalent. Where a decision has to be made without gaining prior approval from the Medical Director on the grounds of clinical urgency, the Medical Director should be informed as soon as possible afterwards. A record should be kept of all decisions to depart from these principles.

### ***Case study for illustrative purposes***

Patient A is on a bone marrow transplantation unit in specialist isolation care. He wishes to pay for an unfunded drug in addition to his publically funded treatment but his doctor judges that it would be clinically unsafe to move him from the specialist unit to receive this private care. His doctor discusses his case with the Trust's Medical Director and they agree that the serious safety risks to the patient in moving him justify departing from the principles of separation in this instance. The Medical Director and the doctor record their discussion and the decision they have reached. Patient A is allowed to have the unfunded drug delivered privately in the specialist unit. Patient A has to pay for the full cost of his private treatment.

- 4.4 In relation to care which is provided free of charge by the HSC, the patient remains an HSC patient and should be treated in the same way as any other HSC patient. In relation to care which is provided on a private basis, the patient is a private patient. This guidance should therefore be read in conjunction with the *Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants (November 2003)*<sup>2</sup> which sets out how HSC doctors are allowed to provide private care.
- 4.5 Doctors, working with HSC managers, should exhaust all reasonable avenues for securing public funding before suggesting a patient's only option is to pay for care privately. In these situations, which are likely to be exceptional, doctors should consider:
- Whether NICE has issued a positive technology appraisal for the treatment of the relevant indication and this has been endorsed by the Department as applicable to Northern Ireland;
  - If not, whether there are local commissioning guidelines that would be relevant; in the case of cancer drugs, advice should be sought from the Northern Ireland Cancer Network (NICaN) Oncology & Haematology Drugs and Therapeutics Committee;
  - If not, whether there are specific aspects of the patient's case which justify an application to the Board for exceptional funding. If an application to this process is made and is successful, the treatment will be publically funded.
  - Only once these avenues have been explored should a doctor suggest that the patient's only option is to pay privately for a treatment.
- 4.6 Patients have a right to expect local decisions on funding of drugs and treatments to be made rationally following a proper consideration of the evidence. The Board should ensure that it has robust, transparent processes in place to make such decisions, including decisions on exceptional funding.
- 4.7 The Board should particularly bear in mind the need for timely decisions, especially when patients are seeking funding for end of life treatments. In line with the founding principles of publically funded treatment based on clinical need and not ability to pay, the Board must never take a patient's financial circumstances or willingness to pay into account when making decisions on funding.
- 4.8 In their system oversight role, the Board should ensure that, in any separate provision of private and publically funded care, the fundamental principles of the HSC are not undermined.
- 4.9 Clinical networks, such as NICaN, can play an important role in ensuring consistency and best practice in relation to issues such as pathways, clinical governance, standards and charging.
- 4.10 Any complaints that a patient's publically funded care has been "withdrawn" as a result of choosing to have private care separately should be investigated as quickly as possible through the Trusts' complaints procedure.

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<sup>2</sup><http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

**Case studies for illustrative purposes**

- a. Patient B chooses to pay for an unfunded cancer drug in addition to publically funded chemotherapy treatment she has been receiving. Under agreed clinical governance protocols, she attends an appointment for chemotherapy in the morning in her Trust's chemotherapy suite and attends a separate appointment later that day in the same Trust's private wing, where she is given the unfunded drug. As well as the cost of the drug itself, the charge to Patient B includes the cost of any staff involved in the provision of the drug and any scans or blood tests only needed as a result of taking the unfunded cancer drug. **Patient B is allowed to have additional private care because the publically funded element of care and the private element of care can be delivered separately.**
- b. Patient C chooses to pay for an unfunded cancer drug which, in order to comply with the licensed dosing schedules for the drug, needs to be given concurrently (at roughly the same time) as publically funded chemotherapy. Under agreed clinical governance protocols, he attends an appointment for publically funded chemotherapy at 3pm in the Trust's chemotherapy suite and attends a separate private appointment at 3.45pm in a room designated for private care near to the chemotherapy suite in the same Trust, where he is given the unfunded drug. As well as the cost of the drug itself, the charge to Patient C includes the cost of any staff involved in the provision of the drug and any scans or blood tests only needed as a result of taking the unfunded cancer drug. **Patient C is allowed to have additional private care because the publically funded element of care and the private element of care can be delivered separately.**
- c. Patient D has a hip replacement operation on the NHS, and following the operation, she is offered publically funded physiotherapy to help her recover. However, there is a private clinic offering physiotherapy next door to Patient D's place of work. For reasons of convenience, Patient D chooses to have private physiotherapy after her publically funded operation whilst still receiving other publically funded follow up care. **Patient D is allowed to have additional private care because the publically funded element of care and the private element of care can be delivered separately.**
- d. Patient E needs a cataract operation. This procedure normally involves removal of the crystalline lens from the eye and replacement with an artificial lens with a single focus. After cataract surgery, patients normally have to wear glasses for some purposes, usually for close work. Patient E asks his HSC Trust to insert a multifocal lens at the time of surgery as this may reduce the need for him to wear glasses. The multifocal lens is not routinely available in the HSC. Patient E is willing to pay for the cost of the multifocal lens but wants the HSC to provide the surgery involved free of charge as part of the cataract operation. The Trust informs him that it is not possible to pay for the multifocal lens while carrying out the publically funded surgery as it is not possible to separate the private element from the publically funded element of care. The Trust informs him that he can have the single focus lens free of charge or the multifocal lens as an entirely private operation. **Patient E is not allowed to have additional private care because the publically funded element of care and the private element of care cannot be delivered separately.**

## 5. Roles and responsibilities of doctors in relation to this guidance

- 5.1 Effective communication with patients and patient representatives about treatment options should be maintained at all times. The necessary information should be provided for patients to make an informed decision about their care, including high quality written information. In line with current best practice, doctors should consider signposting patients to other sources of helpful information, such as relevant national or local charities or patient groups.
- 5.2 HSC doctors who carry out private care should strive to avoid any actual or perceived conflict of interest between their publically funded and private work. Where they feel a conflict of interest might exist, doctors should comply with existing GMC guidance (*Consent: patients and doctors making decisions together*)<sup>3</sup> which states that:
- “You must give patients the information they want or need about any conflicts of interest that you, or your organisation, may have”.
- 5.3 Doctors should comply with existing GMC guidance (*Consent: patients and doctors making decisions together*)<sup>4</sup> which states that:
- “You must give patients the information they want or need about any treatments that you believe have greater potential benefit for the patient than those you or your organisation can offer”.
- 5.4 This guidance also makes clear that clinicians should not make assumptions about the information a patient may want or need. This includes deciding whether to tell a patient about all available treatment options based on an assumption of their financial circumstances.
- 5.5 There is a difference between providing information to patients on all of the treatment options available to them, some of which may only be available privately, and advertising private practice to HSC patients. Doctors should continue to comply with paragraph 2.9 of the *Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants (November 2003)*<sup>5</sup>, which states:
- “In the course of their HPSS duties and responsibilities, consultants should not initiate discussions about providing private services for HPSS patients, nor should they ask other HPSS staff to initiate such discussions on their behalf”
- 5.6 However, if a patient seeks information on how to access a private treatment option, the *Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants (November 2003)* makes clear that HSC doctors should provide them with full and accurate information about the private services they or their HSC organisation can provide.

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<sup>3</sup>[http://www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance/sharing\\_information\\_and\\_discussing\\_treatment\\_options.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/sharing_information_and_discussing_treatment_options.asp)

<sup>4</sup>[http://www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance/sharing\\_information\\_and\\_discussing\\_treatment\\_options.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/sharing_information_and_discussing_treatment_options.asp)

<sup>5</sup><http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

- 5.7 As good practice, a brief record should be kept of all discussions with patients about care not routinely publically funded in the patient's medical notes.
- 5.8 The patient (or, where appropriate, the patient's 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<sup>6</sup>. The information provided to the patient should be recorded on the consent form.
- 5.9 When decisions involve a child or young person, doctors should follow the good practice guidance set out in the GMC guidance, *0-18 years: guidance for all doctors*, 2007.<sup>7</sup>
- 5.10 When advising patients or patients' representatives on additional private care, doctors should respect the patient's right to seek a second opinion, as set out in the GMC's *Good Medical Practice guidance 2006*.<sup>8</sup>
- 5.11 HSC doctors who have regular conversations with patients approaching the end of their life should take advantage of the training opportunities available to them on how to handle these conversations in a balanced and sensitive way.
- 5.12 It would be good practice for the outcomes of cases involving the administration of unfunded treatments to be discussed at multi-disciplinary clinical governance meetings.
- 5.13 Doctors should contribute information to relevant national audits.

## 6. Safeguards for the HSC

- 6.1 To help protect the essential principles of the HSC, the following specific safeguards should also be applied when making decisions:
  - As with any other patient who changes between publically funded and private status, patients who pay for private care in these circumstances should not be put at any advantage or disadvantage in relation to the publically funded care they receive. They are entitled to HSC services on exactly the same basis of clinical need as any other patient.
  - The patient should bear the full costs of any private services. HSC resources should never be used to subsidise the use of private care.
  - 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 publically funded care and any private care that a patient receives.

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<sup>6</sup>[http://www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance/sharing\\_information\\_and\\_discussing\\_treatment\\_options.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/sharing_information_and_discussing_treatment_options.asp)

<sup>7</sup>[http://www.gmc-uk.org/guidance/ethical\\_guidance/children\\_guidance/contents.asp](http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance/contents.asp)

<sup>8</sup>[http://www.gmc-uk.org/guidance/good\\_medical\\_practice/index.asp](http://www.gmc-uk.org/guidance/good_medical_practice/index.asp)

- As is the case already, any HSC Trust or individual doctor who does not wish to carry out any element of private practice is not compelled to do so.

6.2 HSC consultants must manage any private practice, including private practice described in this guidance, as set out in the *Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants (November 2003)*<sup>9</sup>, and in the *Consultant Terms and Conditions of Service (Northern Ireland) 2004*<sup>10</sup> or any future versions of these documents.

6.3 In particular, paragraphs 3.7 & 3.8 of the *Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants (November 2003)* continue to apply for the provision of any private care in HSC facilities:

“HPSS consultants may not use HPSS staff for the provision of private services without the agreement of their HPSS employer.”

“The consultant responsible for admitting a private patient to HPSS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient’s private status.”

## 7. Clinical governance

7.1 Any situations where patients receive additional private care alongside publically funded care should be handled with the highest standards of professional practice and clinical governance.

7.2 Transferring between private and publically funded care should be carried out in a way which avoids putting patients at any unnecessary risk. The HSC and the private provider (which may be an HSC organisation) should work collaboratively to put in place protocols to ensure effective risk management, timely sharing of information, continuity of care and coordination between publically funded 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 publically funded care, and the clinician in charge of the private care.

7.3 As when patients are transferred from one HSC organisation to another, it should always be clear which clinician and which organisation are responsible for the assessment of the patient, the delivery of any care and the delivery of any follow up care.

## 8. Charges for private care by HSC providers

8.1 Charges for any element of care provided by a consultant acting in a private capacity and using HSC facilities should be set in accordance with paragraph 3.4 of the *Code of*

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<sup>9</sup><http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

<sup>10</sup><http://www.dhsspsni.gov.uk/consultants-terms-conditions-of-service-revised-may-2008.pdf>

*Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants (November 2003)*<sup>11</sup>, which states:

“Where the employer has agreed that a consultant may use HPSS 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 HPSS equipment that might have been used.”

8.2 Additional private care may be provided by the HSC Trust, as a service provided by their organisation, or by individual consultants who have agreed this with their employer. In either case, in developing charges for publically funded patients who are having additional private care, HSC organisations and staff should use the following principles:

- The HSC should not subsidise the private element of care
- 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.
- Any care which would normally have provided in the course of publically funded treatment should continue to be offered free of charge.
- Where the same diagnostic, monitoring or other procedure is needed for both the publically funded element of care and the private element, the HSC should provide this free of charge as part of the patient’s publically funded treatment entitlement and share the results with the private provider if necessary. Patients should not be unnecessarily subjected to two sets of tests or interventions.
- The private provider should normally deal with non-emergency complications resulting from the private element of care.
- The HSC should never refuse to treat patients simply because the cause of the complication is unclear.
- The HSC should continue to treat any patient in an emergency.

8.3 Detailed guidance on the management of private practice in health service hospitals can be found on the DHSSPS website at:  
[http://www.dhsspsni.gov.uk/management\\_of\\_private\\_practice\\_in\\_health\\_service\\_hospitals\\_in\\_northern\\_ireland\\_november\\_2007.pdf](http://www.dhsspsni.gov.uk/management_of_private_practice_in_health_service_hospitals_in_northern_ireland_november_2007.pdf)

8.4 HSC provider organisations continue to be responsible for recovering all appropriate charges from private patients.

8.5 The patient’s agreement to the likely costs should be sought in advance of any private care being provided, preferably in writing.

8.6 It is important that the HSC should not be seen to be profiting unreasonably from patients in these circumstances.

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<sup>11</sup> <http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

- 8.7 HSC Trusts should ensure they comply with all relevant legislation regarding income generated from providing private healthcare.

### 9. Indemnity arrangements

- 9.1 This guidance does not change the current position in relation to indemnity arrangements for HSC organisations and healthcare professionals wishing to provide private care.
- 9.2 Where healthcare professionals choose to provide additional private care in a private capacity, and agree with their HSC employer that they may use HSC facilities for this purpose, they should continue to have appropriate private indemnity cover in place for themselves. If the agreement to use HSC facilities includes the use of additional HSC staff as part of the facilities provision, those additional HSC staff will be covered by the HSC employer's indemnity.
- 9.3 Where the Trust decides to provide additional private care as one of the services it offers as an organisation, healthcare professionals will be covered by their employer's indemnity as they will be providing private care in the course of their HSC employment.
- 9.4 Doctors having conversations about private treatment options with HSC patients in the course of their HSC duties will be covered by their employer's indemnity.

### 10. Wider policy on private practice in the HSC

- 10.1 Previous guidance on HSC work taking precedence over private work continues to apply. It remains the primary purpose of any HSC organisation to provide publically funded care.
- 10.2 Any income generated under this guidance should be treated in the same way as any other income generated by the HSC acting in a private capacity.

## ***Definitions***

In this guidance:

- “Private care” refers to privately funded care (whether provided as a private service by a HSC body or by the independent sector);
- “HSC patient” refers to any person in receipt of services funded by the HSC;
- “Private patient” refers to any person in receipt of privately funded services;
- “Patient representative” refers to any person legally able to act on the behalf of the patient in question;
- A “HSC consultant” is a consultant involved in the provision of HSC care at the time in question;
- A “HSC doctor” is a doctor involved in the provision of publically funded care at the time in question; and
- A “healthcare professional” is a member of a profession concerned with the physical or mental health of individuals.

References to any publications also apply to future versions of those publications.