East Surrey CCG
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NHS PRESCRIBING RECOMMENDED DURING OR AFTER AN EPISODE OF PRIVATE CARE

Version	**3.2**
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Ratified by	**Individual Clinical Commissioning Groups**
Available on	**Surrey Prescribing Advisory Database (PAD): http://pad.res360.net/**
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Equality Analysis

Equality analysis is a way of considering the effect on different groups protected from discrimination by the Equality Act, such as people of different ages. There are two reasons for this:

- to consider if there are any unintended consequences for some groups
- to consider if the policy will be fully effective for all target groups

Name of Policy: NHS Prescribing Recommended During Or After An Episode Of Private Care	**Policy Ref:**	**Is this New?** [ ] **Or Existing?** [✓]
Assessment conducted by (name, role): Rachel Mackay – Head of Medicines Management		**Date of Analysis:** 17/05/2017
Directorate: Nursing, Quality and Safeguarding	**Director's signature:** 	

Who is intended to <u>follow</u> this policy? Explain the aim of the policy as applied to this group.

GP and Private Providers will be expected to follow these recommendations. The aim of the document is to advise NHS prescribers that they are not obliged to issue NHS prescriptions for recommended treatment after an episode of private care if this is outside their normal practice and expertise or does not follow national or local guidance, but may substitute with a clinically appropriate alternative.

An equality analysis has been undertaken due to the patient information leaflet included in the documents as a template for GP practices to use.

Who is intended to <u>benefit from</u> this policy? Explain the aim of the policy as applied to this group.

Patients and Guildford & Waverley CCG will benefit from the recommendations supporting equitable provision of care to all groups after an episode of private care.

1. **Evidence considered**. No data or information has been used to inform this equality analysis. There is broad understanding that patients with Learning Disabilities and people with other communication problems e.g. aphasia do benefit from receiving written information in an easy read format.

2. **Consultation.** *Have you consulted people from protected groups? What were their views?*

No

3. **Promoting equality.** *Does this policy have a positive impact on equality?*

Yes

4. **Identifying the adverse impact of policies**

In the boxes below, identify any issues in the policy where equality characteristics

require consideration for either those abiding by the policy or those the policy is aimed to benefit, based upon your research. *If no adverse impact predicted, state 'No adverse impact predicted from this policy'.*
a) People from different age groups: No negative impact anticipated
b) Disabled people: People with Learning Disabilities would require patient information in an easy read format and the CCG can make that available.
c) Women and men: No negative impact anticipated
d) Religious people or those with strongly help philosophical beliefs: No negative impact anticipated
e) Black and minority ethnic (BME) people: No negative impact anticipated
f) Transgender people: No negative impact anticipated
g) Lesbians, gay men and bisexual people: No negative impact anticipated
h) Women who are pregnant or on maternity leave: No negative impact anticipated
i) People who are married or in a civil partnership: No negative impact anticipated
5. Monitoring: Any negative impact would be monitored through the usual complaints processes.

Contents

Executive Summary

- **The NHS provides a comprehensive service, available to all. Access to NHS services is based on clinical need, not an individual's ability to pay.**
- **The responsibility for prescribing remains with the clinician who has clinical responsibility for a particular aspect of the patient's care.**
- **The NHS prescriber is not obliged to issue NHS prescriptions for recommended treatment if this is outside their normal practice and expertise or does not follow national or local guidance.**
- **If the recommendation does not follow local or national guidance, the NHS prescriber should not prescribe but may substitute with a clinically appropriate alternative.**

1. Background

1.1. Patient choice is at the heart of the NHS. It is recognised that patients are entitled to choose between NHS and private treatment.

1.2. NHS prescribers are often requested to issue NHS prescriptions for a patient following a private consultation or private treatment.

1.3. Such requests can cause a predicament for NHS prescribers about whether it is appropriate to issue NHS prescriptions and there may be concerns about equity of care.

2. Purpose and Scope

2.1. This policy is to support primary care NHS prescribers (GP and other independent prescribers) in decision making following a request to issue NHS prescriptions when a patient returns to NHS care after an episode of private care.

2.2. This policy is to support private specialists when requesting primary care NHS prescribing following an episode of private care.

2.3. It provides guidance to manage the interface between NHS and private treatment at a practical level where private treatment is a substitute for treatment within the NHS.

2.4. It does not cover situations when private treatment is delivered in addition to NHS care, where single episodes of NHS care are supplemented with privately purchased treatments, also referred to as 'top up' payments.[1]

2.5. The Surrey Interface Prescribing Policy (Appendix to Service Level Agreements) forms part of the contractual requirements for provider organisations. Any request for a primary care NHS prescriber to prescribe should be in line with this policy whether this originates from a NHS or private prescriber.[2]

3. Principles

3.1. This policy acknowledges the principles that guide the NHS as set out in the NHS Constitution[3] including:

- The NHS provides a comprehensive service available to all.
- Access to NHS services is based on clinical need, not an individual's ability to pay.
- Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.

3.2. Patients who are entitled to NHS-funded treatment may opt into or out of NHS care at any stage.[1]

3.3. Patients should never be charged for their NHS care, or be allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.[4]

3.4. The NHS is permitted to charge NHS patients only in specific situations such as:

- Where specific legislation allows charges e.g. prescription charges, eye tests.
- When certain treatments are not classed as NHS care if they fall outside national guidelines or local agreements e.g. proposed fertility treatment not meeting NICE criteria.

3.5. The NHS should never subsidise private care with public money; this would breach core NHS principles.[4]

3.6. Patients who have chosen private care may transfer to NHS care for subsequent treatment.

3.7. The transfer to NHS care entitles the patient to NHS services on exactly the same basis of clinical need as any other patient[5] and should not be put them at any advantage or disadvantage in relation to NHS care they receive. For example they should be placed directly onto the NHS waiting list at the same position as if their original consultation had been within the NHS.[1]

4. Clinical Governance

4.1. The responsibility for prescribing lies with the clinician who has clinical responsibility for a particular aspect of the patient's care until another clinician accepts clinical responsibility for this. Each prescriber is responsible for the prescriptions they sign.[6]

4.2. The transfer between private and NHS care should be carried out in a way which avoids putting the patient at any unnecessary risk.

4.3. It is well established that effective communication is important for safe and effective patient care and is likely to reduce errors.[1,4]

4.4. There should be as clear a separation as possible between private and NHS care[4] (see Box1) It is not normally appropriate for patients to move repeatedly between the care of an NHS specialist and private sector for the clinical management of the same condition.

4.5. The NHS prescriber and private specialist should enact existing guidance to ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS and private care at all times.

4.6. If different clinicians are involved in each element of care, these protocols should include arrangements for the safe and effective handover of the patient between the clinician in charge of the NHS care, and the clinician in charge of the private care.[4]

4.7. 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. [4]

Box 1- What does 'a clear a separation as possible' mean?

The guidelines state you should receive your private care at a different time and place from your NHS care whenever possible.

This means private care should ideally be provided in a separate building to NHS care or, if an NHS organisation also provides private care:

- in a private room
- in a different part of the building, or
- at a clinic run after NHS hours

Occasionally, a patient's doctor may agree they can receive their NHS and private treatment in the same place – for example, if the doctor decides the patient is too ill to be moved

5. Responsibilities

5.1 Responsibilities of NHS Prescriber when making a private referral

- To make the patient aware that they may not always be able to prescribe the treatment recommended by the private specialist following an episode of private care. The patient information sheet should be given to the patient when the referral is made (Appendix B).

- Inform the patient that, if the practice is able to prescribe, it will be processed in line with the usual practice policy, e.g. allow at least two full working days for prescriptions to be processed taking into account weekends and bank holidays, once advice and sufficient information has been received from the private sector clinician. In situations where urgent treatment is required, a private prescription should be issued by the private sector clinician and should be dispensed accordingly. The potential prohibitive cost of the private prescription will not be considered as a reason to preferentially expedite a prescription request.

- To make the private specialist aware that there may sometimes be circumstances when the request to prescribe will be declined. The MCG recommend the statement in Appendix C is included in private referral letters.

5.2 Responsibilities of Private Specialist while the patient is under their care

- To prescribe any immediately required or short term medication needed as part of the treatment the patient is receiving whilst under their care.

5.3 Responsibilities of Private Specialist when requesting transfer of care to NHS Prescriber

- To advise the NHS prescriber of the end of an episode of private care.

- To make appropriate requests for prescribing in primary care in line with national and local guidance.

- To provide sufficient written information about the diagnosis, treatment plan, recommended medication and patient advice given (such as side effects and risks/benefits of treatment) for the NHS prescriber to make an informed decision about taking on the prescribing. This transfer of care should be undertaken in a timely manner.

- To be aware of the concerns the NHS prescriber may have about being asked to accept clinical, legal, financial and ethical responsibility for medication they have not initiated.

- To manage patient expectations by being clear that that the letter to the NHS prescriber constitutes a request to prescribe and being careful to avoid giving the patient the impression that the NHS prescriber will always prescribe the recommended medication.

5.4 Responsibilities of NHS Prescriber when requested to prescribe by Private Specialist

- It should be noted that the principles are similar whether the prescribing request originates from a private specialist or a NHS specialist. (such as adhering to the traffic light status of a drug).

- It is for the individual NHS prescriber, in the light of their own experience and expertise, to decide whether to accept clinical responsibility for prescribing recommended by another clinician.

- The NHS prescriber should be in agreement that the recommended medication is clinically necessary and the medication should be something an NHS prescriber would generally prescribe.

- NHS prescribers are advised to contact the private specialist directly if they have a concern or require clarification to reach a position where a safe, cost-effective and appropriate outcome is achieved, whilst being mindful of the need to keep the patient fully informed.
- If the recommended medication does not follow national or local guidance, the NHS prescriber should not prescribe but may substitute a clinically appropriate alternative in line with national or local guidance.
- The NHS prescriber is not obliged to issue a NHS prescription and in certain circumstances may decline to do this.
- If declining the request to prescribe, the NHS prescriber is responsible for promptly informing the private specialist and the patient of their decision.
- For further advice about or to discuss a prescribing request, the NHS prescriber should contact the Clinical Commissioning Group Medicines Optimisation Team.
- If a patient wishes to complain about a prescribing decision, this should be addressed as far as possible by the practice. If it is not possible to resolve the matter in this way, the patient should be advised to seek advice and, if necessary, to follow the complaints procedure outlined by the Clinical Commissioning Group.

6. References

1. British Medical Association. The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland. May 2009
   Accessed online 9 November 2016
   http://www.bma.org.uk/images/interfaceguidanceethicsmay2009_tcm41-186819.pdf
2. Surrey Prescribing Advisory Database (PAD)
   http://pad.res360.net/PAD/Search/DrugCondition/749
   or contact the individual Clinical Commissioning Group for a copy of their policy.
3. Department of Health. The NHS Constitution. 27 July 2015
   Accessed online 9 November 2016
   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
4. Department of Health. Guidance on NHS patients who wish to pay for private additional care. 23 March 2009.
   Accessed online 9 November 2016
   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/404423/patients-add-priv-care.pdf
5. Department of Health. A code of conduct for private practice. January 2004
   Accessed online 9 November 2016
   http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/DH_085195.pdf
6. General Medical Council. Good practice in prescribing and managing medicines and devices (2013)
   Accessed online 9 November 2016
   http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

Appendix A – Case Studies

These examples illustrate some recommendations that may be received by primary care NHS prescribers and highlight factors to be considered when deciding whether to accept clinical responsibility. It should be noted that the principles are similar whether the request originates from a private specialist or a NHS specialist.

The Surrey Prescribing Advisory Database (PAD) provides guidance on the use of medicines across the interface between primary and secondary care and categorises individual drugs to assist in defining where clinical responsibility should lie: http://pad.res360.net/

Recommendation does not follow evidence base and current national/local guidance	
Patient A had a private health assessment which resulted in rosuvastatin being initiated for primary prevention of cardiovascular disease. The patient returns to their NHS GP and requests a prescription for rosuvastatin.	The drug recommended by the private provider is more expensive, but without good evidence that it is more effective when compared to drugs locally prescribed for the same condition in the NHS. The GP is being asked to accept the legal, financial and ethical responsibility for this medication when local and national policy does not recommend rosuvastatin for primary prevention. The patient may wish to obtain rosuvastatin from the private provider or by privately consulting a GP in another practice.
Recommendation is for a drug for specialist use (red drug)	
Patient B is recommended strontium ranelate for osteoporosis by her private specialist. She has previously not tolerated bisphosphonates.	It is now recognised that the use of strontium ranelate is associated with increased cardiovascular risk and this is now reflected in its product licence. Strontium is now classified as a red drug locally (for specialist use in secondary or tertiary care; prescribing is to be initiated and continued by the specialist).
Patient C has metastatic breast cancer. Her private specialist has initiated fulvestrant for metastatic breast cancer and requests the NHS GP to continue the treatment.	The NHS GP may not have the expertise to accept responsibility for the prescription, particularly as the drug is not normally prescribed by primary care prescribers. Fulvestrant is classified as a red drug locally (for specialist use in secondary or tertiary care; prescribing to be initiated and continued by the specialist).
Recommendation is 'considered as not suitable for routine prescribing' (black status)	
Patient D is recommended solifenacin by a private urologist who writes a letter to the NHS GP requesting they prescribe this treatment. This patient has not previously been prescribed any medication for urinary incontinence.	The prescribing of solifenacin is not routinely supported locally and is not included as a treatment option within the agreed overactive bladder treatment pathway. The NHS GP may offer the patient a clinically acceptable alternative, such as an alternative antimuscarinic included in the local treatment pathway. If the patient is not prepared to accept this, they should be advised to obtain solifenacin from the private specialist or privately from a GP in another practice. It would be against the terms of service for their own GP (or another GP in the same practice) to issue a private prescription for their NHS patient in these circumstances.

Recommendation is part of the package of care	
Patient E has sought IVF treatment in the private sector and asks their GP to issue NHS prescriptions for the drugs recommended by the private specialist.	IVF treatment is a specialised treatment requiring a package of care including interventions such as embryo transfer as well as drugs. Therefore drug treatments are included in the cost of the package and are not funded as a separate element by NHS primary care prescribers.
Patient F needs to use low-molecular weight heparins (LMWH) instead of warfarin pre-operatively. The private surgeon has requested the GP to prescribe on the NHS for this patient.	Low molecular weight heparins are often prescribed prior to surgery but treatment is regarded as a package of care within the NHS so should be prescribed by the acute trust. Private patients should not receive care that is different to that of NHS patients and, on that principle, the pre-operative LMWH should form part of the patient's private package of care.
Patient G has an appointment for a colonoscopy. His private specialist requests his NHS GP to provide a prescription for a stimulant laxative for bowel evacuation prior to the procedure.	Medication used as preparation for a procedure is part of the package of care. The private specialist is clinically responsible for the procedure and this includes prescribing of the laxative for use prior to the colonscopy. The same principle applies whether the procedure is provided by the NHS or a private provider.
Recommendation is unlicensed	
Patient H has recurrent aphthous ulceration and has consulted a private specialist. The recommended treatment is doxycycline application whereby 100mg doxycycline is stirred into water and the is patient advised to rinse around the mouth for 2-3 minutes 4 times daily for 3 days.	This scenario would need questioning regarding any previous treatment. Unlicensed use of medicines becomes necessary if the clinical need cannot be met by licensed medicines; such use should be supported by appropriate evidence and experience. Professional guidance for prescribers on the use of unlicensed medicines and licensed medicines for unlicensed indications should be considered.
Treatment choice is second line	
Patient I has been recommended levocetirizine for symptoms of hayfever following a private consultation.	Local guidance is that levocetirizine is not recommended first line as there is little evidence that it confers any additional benefit over the more established non-sedating antihistamines and it is more costly. Consider whether first line treatment options (loratadine , cetirizine) been previously prescribed or purchased by the patient.

Appendix B – Information for Patients

East Surrey CCG
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NHS prescribing following private assessment or treatment in the private healthcare sector

Your GP (family doctor) can prescribe some medicines on the NHS on advice from a clinician in the private sector.

However, there are a number of circumstances when your GP may refuse the request, or offer to prescribe an alternative medicine. Your GP may decide not to prescribe if:

1) A full diagnosis, with appropriate test results, has not been provided by the consultant in the private sector.

2) He or she feels the medicine is not clinically necessary.

3) The medication is an unlicensed medicine.

4) The medication is prescribed outside of its licensed indications.

5) The medication needs special monitoring and he or she feels they do not have the facilities or expertise to do this.

6) The use of a more cost effective medicine has been agreed locally.

If your GP is able to prescribe for you, please allow **at least** two *(amend as appropriate per practice policy)* full working days for prescriptions to be processed taking into account weekends and bank holidays. If your prescription is urgent, your private sector clinician should provide you with a prescription that you may have dispensed privately to ensure you receive timely treatment.

Further information is available on the NHS Choices website: 'If I pay for private treatment, how will my NHS care be affected?'
http://www.nhs.uk/chq/Pages/2572.aspx?CategoryID=96

If you have further queries or would like to discuss your options, please speak with your GP or healthcare professional at your practice.

Appendix C – Statement to Include in Referral Letters

It is suggested that the following statement is included in all referral letters whether to a NHS or private specialist. Practices may adapt this as appropriate.

NHS prescribing in primary care following a referral

Any recommendation for NHS prescribing in primary care should be in line with:

1. **National guidance**
2. **Local guidance available from the individual Clinical Commissioning Group and on the Surrey Prescribing Advisory Database (PAD): http://pad.res360.net/**
3. **The Surrey Interface Prescribing Policy (Appendix to Service Level Agreements): http://pad.res360.net/Search/DrugCondition/749**

NHS prescribers in primary care prescribe in line with locally agreed prescribing guidance and drug choices based on published evidence and cost effectiveness of equivalent preparations. Please refer to the Surrey Prescribing Advisory Database (PAD) which provides guidance and information about medicines use in Surrey. It can be accessed by healthcare professionals in primary and secondary care and by patients: http://pad.res360.net/

If the recommended medication does not follow national or local guidance, the NHS prescriber may not agree to prescribe (in which case prescribing remains with the specialist) or the GP may substitute a clinically appropriate alternative. The specialist should be aware of these possibilities when discussing proposed treatment with the patient.