# Private Patients Policy and Procedures

| | |
|---|---|
| **Summary statement: How does the document support patient care?** | The document describes the basis upon which private patients can expect to pay for health care provision received in the trust. |
| **Staff/stakeholders involved in development:**<br>*Job titles only* | Private Patient Business Manager Director of Finance Commercial Director All Trust Consultants Senior Clinical Managers |
| **Division:** | Specialist |
| **Department:** | Corporate |
| **Responsible Person:** | Chief Operating Officer |
| **Author:** | Deputy Director of Operations - Specialist |
| **For use by:** | All staff involved in the treatment of private patients |
| **Purpose:** | The purpose of this document is to outline the key principles and standards governing private practice within University Hospitals Sussex NHS Trust (UHS) in the context of local and national guidance. |
| **This document supports:**<br>*Standards and legislation* | Policy Standards<br>• The provision of clear standards for all staff in the management of private patients in University Hospitals NHS Foundation Trust consistent with Department of Health Guidelines<br>• To communicate arrangements effectively<br>• To protect the services for private patients whilst not disadvantaging NHS patients<br>• To ensure no conflict of interest<br>• Supports<br>Trust policy<br>Policy<br>Legislation<br>• The Department of Health & Social Security Management of Private Practice in Health Service Hospitals in England & Wales 'Green Book' 1986 |

| | |
|---|---|
| | • The Department of Health (DOH) 'A Code of Conduct for Private Practice' Recommended Standards of Practice for NHS Consultants 2004<br>Data Protection Act 2018 |
| **Key related documents:** | Consultant Contract<br>A code of conduct for private practice: guidance for NHS medical staff: Department of Health - Publications.<br>The interface between NHS & Private Treatment: a practical guide for doctors in England, Wales & Northern Ireland; guidance from BMA Medical Ethics Department 2009<br>Job Plan Guidance for Consultants & SAS doctors October 2012, Commissioning Policy defining the boundaries between NHS & Private Healthcare 2013<br>Private Patient Standard Operating Procedures<br>Policy & Procedure for the Introduction of New Clinical Techniques & Change in Practice<br>Policy for the Management, Analysis & Learning from clinical Incidents & Events<br>Risk Management Strategy<br>Policy for Management of Complaints, Concerns and Comments.<br>The Management of Children and Young People with Surgical Problems |
| **Approved by:**<br>*Divisional Governance/Management Group* | Specialist Divisional Group |
| **Approval date:** | April 2024 |
| **Ratified by Board of Directors/ Committee of the Board of Directors** | Trust Management Committee |
| **Ratification Date:** | 23rd May 2024 |
| **Review date:** | 23rd May 2026 |
| **If you require this document in another format such as Braille, large print, audio or another language please contact the Trust's Communications Team** | |
| **Reference Number:** | UHSFN009 |

| Version | Date | Author | Status | Comment |
|---|---|---|---|---|
| 1.0 | April 2021 | Assistant Director of Finance – Financial Services | Archived | Reviewed and implemented as a UHSussex policy |
| 2.0 | April 2024 | Deputy Director of Finance – Operational Finance and Private Patients & Overseas Visitors manager | LIVE | Brighton and Worthing separate policies now merged into this one single policy. |
| | | | | |

# Contents

## 1. Introduction

1.1. University Hospitals Sussex Trust ("The Trust") welcomes private patients and uses the income generated from this work for the benefit of all patients within the Trust. There is no differentiation between how staff should behave towards NHS and private patients in terms of responsibility of clinical care, policies and procedures. The Trust is determined to work in partnership with consultant medical colleagues to ensure that their private practice can thrive within The Trust.

The Policy aims to:

- Ensure that patients receive safe and coordinated care.
- Ensure that private care as a treatment choice is understood.
- Promote private practice, recognising that it provides income to the Trust to improve NHS care.
- Ensure that the boundaries between NHS work and private practice are clear and transparent.
- Provide a service that can be audited to demonstrate that the Trust captures the details of all private patients and that the income for their investigations and treatment is received.

1.2. The Trust recognises that, to ensure success, it needs to provide excellent standards of service for consultants and value for money for their private patients and other customers including private medical insurers.

1.3. The Trust recognises that, to ensure success, it needs to provide excellent standards of service for consultants and value for money for their private patients and other customers including private medical insurers.

1.4. The philosophy of care is to provide private patient services within an environment designed to provide the highest standards of care, across the Trust.

1.5. Private practice in the NHS is governed by sections 62 and 66 of the NHS Act 1977, and section 65 of the Act, as amended by the NHS and Community Care Act 1990.

1.6. The Act states that "*Private patients are those who give an undertaking (or to whom one is given) to pay charges for accommodation and services as the Trust may determine and who receive the advantages of choosing both a practitioner and the time for their private treatment. A private patient can be a UK resident or an overseas visitor".*

1.7. This policy is based on, and supplements the NHS Act 1977 and the Department of Health publications, the Management of Private Practice in Health Service Hospitals in England and Wales (commonly called "the green book"), a Code of Conduct for Private Practice 2004 (guidance for NHS medical staff), Guidance on NHS patients who wish to pay for additional private care and the NHS Finance Manual

## 2. General and Key Principles

2.1 This policy sets out the organisational arrangements and framework for the treatment of patients who have elected to pay for their care and choose their own consultant – the Private Patients. All patients must receive the same high standard of clinical care and therefore staff are required to treat patients in the hospital with no distinction being made between private and NHS patients and to be consistent in the application of the policy.

2.2 The Trust wishes to promote and support Private Practice within the Trust, recognizing that it provides a source of income to provide improved care and facilities for all patients in the Trust.

2.3 The Trust's primary responsibility is to cater for a patient's clinical needs. Where there is any doubt regarding a patient's status but clinical imperative dictates that the patient receives treatment, then care for the patient takes precedence with any requisite and administrative and/or commercial arrangements completed as soon as possible.

2.4 The provision of services for private patients must not prejudice the interest of NHS patients. The Trust and Consultants should work in partnership to avoid any conflict of interest between Private Practice and NHS services.

2.5 Consultants work as an independent contractor and not as an employee, agent or servant of the Trust. Consultants are responsible for their own actions and those of any of their own employees whilst on the Trust's premises. Consultants must maintain adequate indemnity cover for the duration of their Private Practice commitments.

2.6 Junior Doctors and other Trust staff have a responsibility to all Trust Patients whether NHS or Private.

2.7 The delivery of private practice in the Trust must reflect the Department of Health's guidance 'A Code of Conduct for Private Practice' and other regulatory guidance.

2.8 All Trust policies and procedures including those relating to Clinical Governance, Information Governance (including medical records) and Patient Safety will apply equally to private and NHS patients.

## 3. Definitions

3.1 "Trust" means University Hospitals Sussex NHS Foundation Trust

3.2 "Private Healthcare" refers to privately funded care (whether provided as a private service by an NHS body or by the independent sector).

3.3 "Private Patient" refers to any person in receipt of privately funded services.

3.4 "NHS Patient" refers to any person in receipt of services funded by the NHS.

3.5 "Patient Representative" refers to any person legally able to act on the behalf of the patient in question.

3.6 "Careflow" refers to the patient's administration system used by the trust. "ITU" refers to the Intensive Care Unit

## 4. Responsibilities, Accountabilities and Duties

4.1 **Health Service Hospitals** - Private patients may be admitted to, and private non-resident patients treated at, an NHS hospital only if the hospital has been authorised by the Secretary of State to make accommodation and services available to them.

4.2 **The Chief Executive and Trust Management Board** - The Chief Executive and the Trust Board have overall responsibility for ensuring that there are proper arrangements in place for the treatment of private patients, including the admission and identification of private patients and the recovery of charges.

4.3 **The Chief Finance Officer** - The role of the Chief Finance Officer is to:

4.3.1 To ensure that the private patient practice generates a level of income that exceeds costs.

4.3.2 To ensure that NHS facilities, staff and services are only used for private practice with the agreement of the Trust.

4.3.3 To ensure that proper procedures are in place for clinicians, medical secretaries, nursing staff and staff of clinical support departments to identify all private activity in order for all appropriate charges to be recovered.

4.3.4 To ensure that capacity and resource are effectively utilised; and

4.3.5 To ensure that all income due in respect of the treatment of private patients is recovered.

4.4 **The Consultants** - Consultants have the prime responsibility of ensuring that the private status of any patient admitted by them to the hospital is accurately recorded and that the Trust's capacity and resources are effectively used. Consultants will be responsible for managing and directing care on behalf of their private patients. The responsibilities which are set out in the Department of Health publication, "A Code of Conduct for Private Practice" include:

4.4.1 Ensuring that the Private Patients' Manager and all other staff concerned with Private Patients' admissions are informed of admissions and treatment so that all private patients are charged for the treatment and services provided by the Trust. Should a patient's planned treatment alter, it is the Consultant's responsibility to advise appropriate OPCS codes by making it clear in the patients notes and to facilitate the correct capture of income and to ensure that any required pre-authorisation for insured patients is provided by the insurance company before any deviation from authorised treatment takes place.

4.4.2 Providing private patients with information about the facilities available, charges for treatment and invoicing procedures. This will include providing information about outpatient appointments, surgical appliances, overnight stay, all pathology and diagnostic tests as well as therapy treatment where applicable. The patient must be informed that the Trust's costs and the consultants' fees will be invoiced separately.

4.4.3 Making the best use of the Trust resources by booking private patients in a timely manner to ensure no clinics or theatre sessions overrun as a result of the inclusion of private patients.

4.4.4 Ensuring that early private consultations do not lead to earlier NHS admissions.

4.4.5 Ensuring that the standards of care are the same for all patients and working within the governance and operational procedures set out in this policy.

4.4.6 Following good working practices including daily and post operative visits to their patients. Patients are admitted under the care of a named consultant who bears full clinical responsibility for the patient at all times and who must provide contact telephone numbers and addresses to the Private Patient Team. All consultants must meet all of the standards in 'Good Medical Practice' (GMC 2006).

4.4.7 Confirming the TTOs to be provided to their patient and sending a discharge

letter to the referring General Practitioner within 3 days post discharge.

4.4.8 Informing staff and formally recording this in the patient's record where there is a transfer of clinical responsibility from the admitting consultant to another consultant.

4.4.9 Ensuring, that elective private practice work is not undertaken when on-call for the NHS or to undertake on-call for the private sector when working for the NHS, except when the express approval of the Trust has been given. In certain circumstances the Trust may allow some practice to be undertaken alongside a consultant's NHS duties, provided that the Trust is satisfied that there will be no disruption to NHS services.

4.4.10 Formally agreeing during job planning to ensure that any time used for private patients during paid NHS sessions will be identified and appropriate measures taken to ensure that the NHS service is not compromised. The time spent on private practice during NHS sessions will be" paid back" within the Consultant's job plan.

4.4.11 Ensuring that NHS consultations are not used to discuss private treatment with patients and that NHS patients' lists are not used to promote private practice.

4.4.12 Making use of NHS facilities for the provision of fee-paying services either in their own time, in annual or unpaid leave or in NHS time where work involves minimal disruption and is agreed in advance.

4.4.13 Ensuring that fixed NHS commitments take precedence over private work and that NHS sessions are not disrupted regularly by private sessions. Where this results from changes to the scheduling of NHS work, the Trust will allow a reasonable period (6 months where the changes to NHS work would affect the scheduling of private commitments) for consultants to rearrange any existing private sessions.

4.4.14 Maintaining a high-quality service to patients, subject to clinical considerations (for example providing patients with the opportunity to be treated by other NHS colleagues or NHS Trust where this will maintain or improve the quality of care, such as reducing waiting times).

4.5 **All Other Staff** - The identification of private patients before admission is essential, and primary responsibility for this rests with the Consultants. On admission all private treatment undertaken in the Trust must be recorded to facilitate continuity of medical care and to ensure accurate management information. Medical staff are responsible for:

4.5.1 Accurately and promptly recoding admissions and discharges of private patients and in the recording of all treatment given – this information must be recorded on Careflow (the Patients' Administration System).

4.5.2 Notifying the Private Patients Department of any private inpatients on their ward or department.

4.5.3 Notifying the Private Patients Department of any private patient emergency admissions from other providers.

4.5.4 Notifying the Private Patients Department of any private patient emergency admissions outside of normal working hours.

4.6 **Private Patient Manager** – The Private Patient Office (PPO) has bases on several campuses and provides support and advice to Directorates. The local office

maintains a database of private patient activity and income, generates invoices, takes and chases payments and liaises with patients as required. The PPO office will also conduct negotiations annually with private health insurers in order to agree the annual tariff. The tariff will be simple, competitive in relation to other providers and will include an element of profit for the Trust.

The local Private Patient Manager has direct responsibility for managing the private patient practice which includes:

4.6.1 Advising patients who have elected to be treated privately before admission and checking that all information required (personal details, "undertaking to pay" documentation and deposits) has been obtained for each patient admitted.

4.6.2 Co-ordinating the administration of all private patient activity within the Trust (See Appendix 1 – process map of booking process).

4.6.3 Working closely with consultants, their private secretaries, ward staff, theatre staff and diagnostic department staff in order to ensure that effective communication takes place in respect of all private patient activity.

4.6.4 Working with the services to ensure that the patient is escorted to their accommodation on arrival and advising the Clinician responsible of the patient's arrival.

4.6.5 Identifying all services provided to private patients.

4.6.6 Processing the relevant documentation to arrive at the correct charge for the treatment provided and collecting the sums due at the earliest opportunity. This includes liaising with the private medical insurance companies to ensure income is recovered.

4.6.7 Ensuring that adequate reporting and controls are in place to identify all chargeable patients in a timely manner and at the point of service delivery.

4.6.8 Maximising the non-recovery of charges and discouraging bad debts; and

4.6.9 Maximising the Trust's private patient income by actively promoting service delivery.

4.7 **Services** - Private patients bring additional income to directorates. Simple but robust systems must be in place at directorate level to enable consultants to see and treat private patients in a timely manner, in an appropriate environment and with appropriate support.

4.7.1 Directorate systems should facilitate the capture of all private patient activity and the provision of prompt and accurate information about the services and care provided to individual private patients in order that invoices can be raised and dispatched in a timely manner by the Private Patient Office. This will include length of stay, diagnostic tests, prostheses used, and OPCS code(s).

4.7.2 Directorate management teams should have a clear view of how they see private patient activity contributing to directorate income and this view should be communicated to the directorate.

4.7.3 Each directorate will where possible have a nominated Private Patient Lead who co-ordinates the administration of all private patient activity in the directorate. The Lead will be the primary point of contact for consultants wishing to undertake private work and the link between the directorate and the Private Patient Office and other departments as required e.g., theatres.

## 5. Philosophy of care – private patients

5.1. The Trust welcomes private patients and uses the income generated from this work for the benefit of all patients within the Trust. The Trust provides private patient care across all hospital sites for a range of medical needs.
5.2. Private healthcare is all about choice and the provision of private patient healthcare by the Trust allows those who elect to pay for their care to choose their own consultant, enjoy a more convenient time for treatment and avoid the NHS waiting list.
5.3. Use of Health Service Facilities for Private Patients may only be used for private practice by consultants when they are registered with the Trust and have entered into an agreement with the Trust to use the facilities and comply with this policy. Entitlement to use Trust facilities is at the Trust's discretion and this entitlement can be withdrawn if a consultant consistently fails to comply with the policy. There are seven overriding principles which must be observed when using health care facilities in the Trust for private patients:
5.4. The provision of accommodation and services for private patients must not disadvantage NHS patients.
5.5. Subject to clinical considerations, earlier private consultation should not lead to earlier NHS admission or to earlier access to NHS diagnostic procedures; this decision must be based on clinical need.
5.6. Common waiting lists should be used for urgent and seriously ill patients and for highly specialised diagnosis and treatment subject to clinical priority. The agreement of the principal lead clinician / medical manager and the service manager or designate should be sought with the Medical Director as the final arbiter. Where a decision has to be made without gaining prior approval from the service manager or designate on the grounds of clinical urgency, the service manager or designate should be informed as soon as possible afterwards and a record kept of this decision. The same criteria should be used for all diagnoses irrespective of whether the patients are private or NHS.
5.7. After admission, access by all patients to diagnostic and treatment facilities should be governed by clinical considerations. This does not exclude earlier access by private patients to facilities especially arranged for them if these are provided without prejudice to NHS patients and without extra cost to the NHS.
5.8. Private practice can be undertaken in any scheduled operating, endoscopy, or diagnostic sessions, with the prior agreement of the service manager or designate. This is provided that this activity does not compromise the provision of services to NHS patients, and, for example, private patients do not take precedence over NHS patients on surgical lists, endoscopy, or diagnostic imaging sessions. The principle is that the Trust will permit Consultants to "add" private patients to their NHS scheduled lists if there is surplus capacity to do so.
5.9. Standards of clinical care and services provided by the Trust should be the same for all patients. This does not affect the provision, on separate payment, of extra amenities, or the custom of day-to-day care of private patients usually being undertaken by the consultant engaged by them.

## 6. Management of potential conflict with NHS Care

The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS Services. Medical practitioners should ensure that they have arrangements in place; such that there can be no significant risk of private commitments disrupting NHS commitments. by causing NHS activities to begin late, or to be cancelled**,** unless the situation arises from an obvious clinical priority. Where possible all Private Patient work should be undertaken either at weekend or weekday evenings so as not to impact any NHS lists. In this instance email communication detailing the circumstances and decision-making rationale is required to provide a clear audit trail. Emails must include the Chief of Service / Clinical Director/ Operational Manager and Private Patient Manager.

## 7. Green Book Key Principles

7.1 When NHS paid sessions are used for treating private patients, the following arrangement will apply to ensure that the time is 'paid back to the NHS' in a like-for-like manner. For example, if the consultant utilises an NHS operating session (or part thereof) for the treatment of a private patient, the consultant will provide an additional operating session at a time when he is not already contracted to the NHS. It would be expected that this time would be repaid within one month of the private session and no further private operating would be permitted beyond this period until the time had been repaid. To ensure compliance the Clinical Service Manager will record all private patient activity.

7.2 There should be no real conflict of interest between private work and NHS work.

7.3 Work outside NHS employment should not adversely affect NHS employment or in any way hinder or conflict with the interests of the NHS employer, or other NHS employers or NHS employees.

7.4 NHS facilities, staff and services may only be used for private practice with advanced agreement of the Trust.

## 8. Finance Manual Principles

8.1. The Private Patient activity should provide a level of income that exceeds total costs, to ensure that commercial activities are not being subsidised by NHS funds, and thus diverting funds away from NHS patients care.
8.2. For any private practice undertaken in contracted hours there will be no double payment. Any time used for private practice in NHS time should be paid back to the Trust with reasonable notice.
8.3. Each Consultant or clinician has an obligation to the Trust to ensure that any patients seen as 'private' within the organisation are identified as such and that before any treatment is carried out the appropriate 'Undertaking to Pay' form is completed. This will enable the Trust to be remunerated for the use of its facilities, associated treatment costs, and provide reassurance that the patient understands their financial obligations as a private patient.
8.4. If a consultant or other clinician decides to waiver their fee for a private patient, hospital charges will still be due. Non-payment of Trust monies may be referred to debt collection agencies. Where the Trust invoices on behalf of the consultant this will be on the basis of sharing the risk for non-payment.
8.5. In those instances where the Trust invoices private patient consultant fees the

consultant will only be paid when the Trust receives payment and will be liable to reimburse the trust should at a future point the fees be recouped by an insurance company. It is the consultant's responsibility to maintain their own records and to bring to the attention of the private patient manager any concerns they may have regarding missing or delayed payments within 4 months.

## 9. Access to NHS Facilities and Referral of Private Patients to NHS Lists

A key principle of this policy is that NHS care should not subsidise private care, and private and NHS care should be kept separate as clearly as is possible**.** Except for emergencies, patients may gain access to NHS hospital services as NHS patients only by referral to a consultant serving on the staff at that hospital. Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient. A private patient may change their status from private to NHS status before, during or after admission provided that the following conditions are adhered to:

9.1. The intention to change status from private to NHS must be confirmed in writing to the Private Patients Department and be signed by the Consultant supporting the change of status. The patient will be responsible for all costs of treatment up until the date of the approved written request. The change of status is recorded in the patient's notes.
9.2. Private patients changing to NHS status must take their place appropriate to their clinical need on any waiting list for hospital elective admissions and diagnostic procedure. Urgent patients will be placed on the waiting list in line with clinical criteria. This ensures that no patient transferring from private to NHS status would gain any advantage over NHS patients through change of status.
9.3. A private inpatient can change their status during the course of their stay in hospital. Transfer of status is only allowed once during the treatment of one condition.
9.4. A private patient transferring from another hospital will continue to be regarded as a private patient for the duration of their stay.
9.5. Any patient changing their status after having been provided with private services should not receive an unfair advantage over other patients.
9.6. A transfer to critical care does not change the status of a patient. If the patient wishes to change to an NHS patient notice must be given in writing/email, in accordance with normal practice. This is particularly relevant where a patient has transferred from a private hospital to critical care. Unless the consultant has confirmed in writing before the transfer that the patient is to be treated as an NHS patient the patient will be treated and charged as a private patient in critical care. **Consultants must make patients aware of this during their pre- operative assessment**; **prior surgery**.
9.7. There are no facilities in A&E Departments for private care. Patients are treated and transferred to a ward according to their clinical need. **Private care commences on admission to a ward if available.**

## 10. Patients Opting for Additional Private Care

Patients may opt for additional healthcare while continuing to receive care from the NHS. However, to ensure that there is no risk for the NHS subsidising private care the following principles should be applied:

10.1. It should always be clear whether an individual procedure or treatment is privately funded, or NHS funded.
10.2. Private care should be carried out at a different time to the NHS care that a patient is receiving; and

10.3. Private care should be carried out in a different place to NHS care, as separate from other NHS patients as far as possible.

10.4. These principles and some case studies illustrating the principles are set out in detail in the Department of Health Document, “Guidance on NHS patients who wish to pay for additional care”.

## 11. Identification of Private Patients

Patients identified as being “private” (or a patient representative) should be asked to sign an “undertaking to pay” form at the earliest opportunity. The signature must be obtained and witnessed by the member of staff attending the patient at the time of arrival. At this stage the Clinician should already have been informed and accepted care of the patient. Where the patient is uninsured payment for the estimated cost of the treatment must be received by the Trust in advance of the treatment.

11.1. Before admitting a private patient, the Trust should always be satisfied of the patient’s ability to pay. If the patient is covered by insurance, the adequacy of the insurance cover must be checked and if the insurance cover is inadequate, full payment must be requested for the uninsured element of the cost of the hospital charges. The patient must also sign an “undertaking to pay” form to cover these and any additional expenses incurred. Treatment cannot proceed until this payment has been received in full by the Trust.

## 12. Training Implications

12.1. The principles outlined in this policy are based upon the NHS publication code of conduct for private practice (guidance for NHS staff) which is mandatory reading for all consultants who undertake private practice in the NHS. A copy of this policy document is issued to Trust consultants who undertake private work at the Trust and all those departments providing treatment to private patients.

12.2. The Trust training needs analysis is reviewed yearly by the Private Patients Manager and specific training provided to departments or staff where there is evidence of poor performance.

## 13. Monitoring

13.1. The Private Patient Manager is responsible for continually monitoring the appropriate implementation of the Private Patient Policy.

13.2. This is supported with a range of information sources such as meetings, audits, and other relevant reports.

| Measurable Policy Objective | Monitoring/Audit Method | Frequency | Responsibility for performing monitoring | Where is monitoring reported and which groups will be responsible for progressing and reviewing actions |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Compliance with policies and procedures and completeness of income | Internal Audit | Annual | South Coast Audit | Chief Finance Officer/Audit Committee |
| Completeness of income | External Audit | Annual | Audit Commission | Chief Finance Officer/Audit Committee |
| Accuracy of Data Quality/Clinical Coding | External Audit | Annual | Audit Commission | Chief Finance Officer/Audit Committee |
| Completeness of income | Performance Reports | Monthly | Divisional Analysis | Divisional Management |

## 14. References

### 1 Due Regard Assessment

As an NHS organisation, University Hospitals Sussex Trust is under a statutory duty to set out arrangements to assess and consult on whether this policy and function impact on equality with regard to the protected characteristics described in the due regard assessment.

An initial screening reveals that this policy does not discriminate against any groups on the basis of age, disability, gender, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, or sexual orientation, including lesbian, gay and bisexual people.

### 2 Linked to Other Trust Policies

Standing Orders, Standing Financial Instructions and Scheme of Delegation

### 3 Associated Documentation

'Management of Private Practice in Health Service Hospitals in England and Wales' ('the Green Book') published in 1986.

A code of conduct for private practice: recommended standards of practice for NHS consultants
-
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPo licyAndGuidance/DH_085197

Guidance on NHS patients who wish to pay for additional private care - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPo licyAndGuidance/DH_096428

Consultant - Terms and Conditions of Service - http://www.nhsemployers.org/SiteCollectionDocuments/Consultant_Contract_V8_Revised_Terms_and_Conditions_220808_aw.pdf

4 **National Health Service Act 1977 –**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4072792

NHS and Community Care Act 1990. - http://www.legislation.gov.uk/ukpga/1990/19/contents

The NHS Finance Manual - http://www.info.doh.gov.uk/doh/finman.nsf

## 15. Appendices

Appendix 1 – Inpatients and Day Cases
Appendix 2 - Outpatients
Appendix 3 – The private patients department
Appendix 4 – Financial matters
Appendix 5 - Interpretation of the Principles Governing Transfers between NHS and Private Healthcare
Appendix 6 – Due regard assessment tool
Appendix 7 – Dissemination, implementation and access plan

# Appendix 1 - Inpatients and Day Cases

## A Booked Admissions onto a Specialty Ward

### Booking of patient

A1.1 The Private Patients Team is contacted by the Consultant's private secretary with a completed booking form to alert them to the intention to treat a private patient and establish bed availability according to the admissions diary. The Private Patient Team then liaise with the service. If there is an available bed the admission date is agreed with the Consultant's secretary and noted in the admissions diary. If there is no available bed but the date of the admission is imminent the patient will also be contacted.

A1.2 Where the patient is insured the details of the insurance are forwarded to the Private Patients' team to check with the insurance company and to secure a pre-authorisation code for the treatment and admission. Where the patient is uninsured the Private Patients team will contact the patient and request an advance payment for the estimated cost of the treatment.

A1.3 If a patient requires a procedure involving Theatres, it is the responsibility of the Administration Clerk and the Private Patients co-ordinator to work together to ensure that a theatre slot and recovery bed is available.

A1.4 Details of the patient are registered on the Patient Access System (PAS) by the Private Patients team where no previous hospital registration exists.

A1.5 The Private Patients team will document a waiting list request detailing the To Come In ("TCI") date, consultant, any remarks and the estimated cost of treatment, as at this point insurance circumstances are unknown. The patient's label is attached.

A1.6 The patient is sent a letter by the Private Patients team confirming admission date, detailing pre-admission preparation and estimated cost of the treatment together with the Private Residential Patient Admission Form, map and leaflets relevant to the procedure.

A1.7 The patient is required to complete and sign the Private Residential Patient Admission Form ("undertaking to pay" – Appendix 6). This must be completed by all patients and represents their agreement to pay for all costs of treatment that are not covered by an insurance company.

A1.8 The Private Residential Patient Admission Form and Credit Application is returned to the Private Patients Manager/Co-ordinator.

A1.8 If the patient is insured the insurance company is contacted to confirm that the patient is entitled to private treatment. The insurance company will provide a pre-authorisation code which effectively guarantees payment for the treatment proposed. Any queries about the adequacy of the insurance cover are raised with the patient.

A1.9 If the patient is not insured (a "self-payer") they are required to pay the estimated cost of their treatment prior to admission and return the payment with the signed Private Residential Patient Admission Form. The cost is estimated by the Private Patients Manager/Co-ordinator based on the advice of the booking request received from the consultant regarding the length of stay, possible additional treatments and tests to be performed.

A1.10 A copy of the Private Residential Patient Admission Form is filed awaiting admission of the patient. The Private Patients team will arrange for the patient's case notes to be sent to the ward.

## B Admission of patient onto ward

B1.1 The Private Patients team carry out a daily check of the movement of patients and bed occupancy for the forthcoming week.

B1.2 On arrival on the ward, the patient's details are checked by the nurse or ward receptionist to source documents and any missing information or documentation is obtained and entered onto the Careflow PAS.

B1.3 Treatment is carried out and the consultant signs the patients claim form and enters coding details of the treatment in the notes (OPCS codes).

B1.4 The Daily Bed State is updated by ward clerks daily for the bed state across the Trust and the discharge details are entered onto Careflow PAS.

B1.5 When the patient is discharged, the Private Patients team review the case notes to ensure all treatments (blood tests, scans etc) are included on the Private Patient database which is used for preparing the invoice. A copy of the Private Residential Patient Admission Form is attached to the original Private Patients Return Form and returned to the Private Patient's office to invoice. The Private Patients team must ensure the coding details on the claim form correspond to the code(s) on the invoice.

B1.6 The Private Patients team forward the case notes to Clinical Coding who in turn send them to the Consultants Secretary prior to filing in the library. The location of the notes is recorded on Careflow PAS (in the tracking notes field).

B1.7 The Private Residential Patient Admission Forms and Credit Application forms held in the Current Inpatient Accounts file are regularly reviewed by the Private Patients Manager to ensure all treatments are invoiced.

B1.8 Waiting list requests are retained for six months from the end of treatment, and then destroyed/deleted.

## C Emergency Admissions (onto a Specialty Ward)

C1.1 An emergency admission via Accident and Emergency (A&E) is notified to the Private Patients team by either the admitting Consultant or A&E staff. If the notification is from the A&E staff, the patient is deemed to be the responsibility of the on call consultant. Emergency admissions from other departments other than A&E arise as a result of a direct request from the Consultant. The Private Patients team are responsible for locating a consultant with PP privileges and the team check the availability of a bed on wards by consulting the ward staff and clinical site managers.

C1.2 The patient is transferred to a ward (once a bed is available), where they are visited by a member of the Private Patients team who advise them about private patients within the Trust. The Private Patients team obtain all necessary details concerning the patient and arrange for the case notes to be sent to the ward.

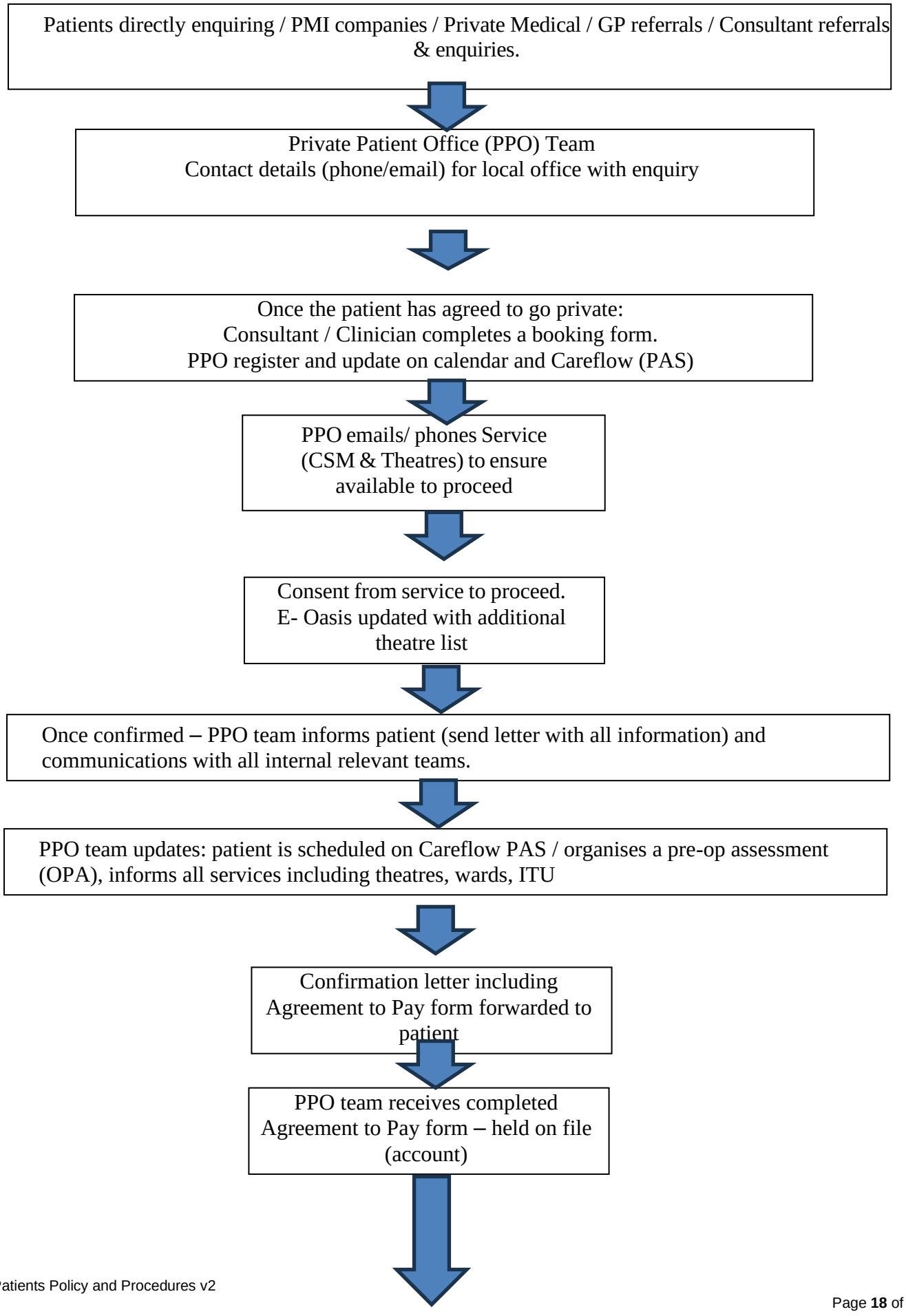
C1.3 An advance deposit is required prior to treatment if the patient is not insured (discretion is used with regard to the amount of the deposit if the patient has difficulty in paying). The amount will vary according to the length of stay and treatment to be provided. If the patient is too ill to be approached a relative or carer will be asked for the payment. The payment will be forwarded to the Private Patients team with the Private Residential Patient Admission Form and Credit Application. A receipt is retained in the current inpatient accounts file until the itemised account is available following discharge. The receipt and invoice are sent to the patient.

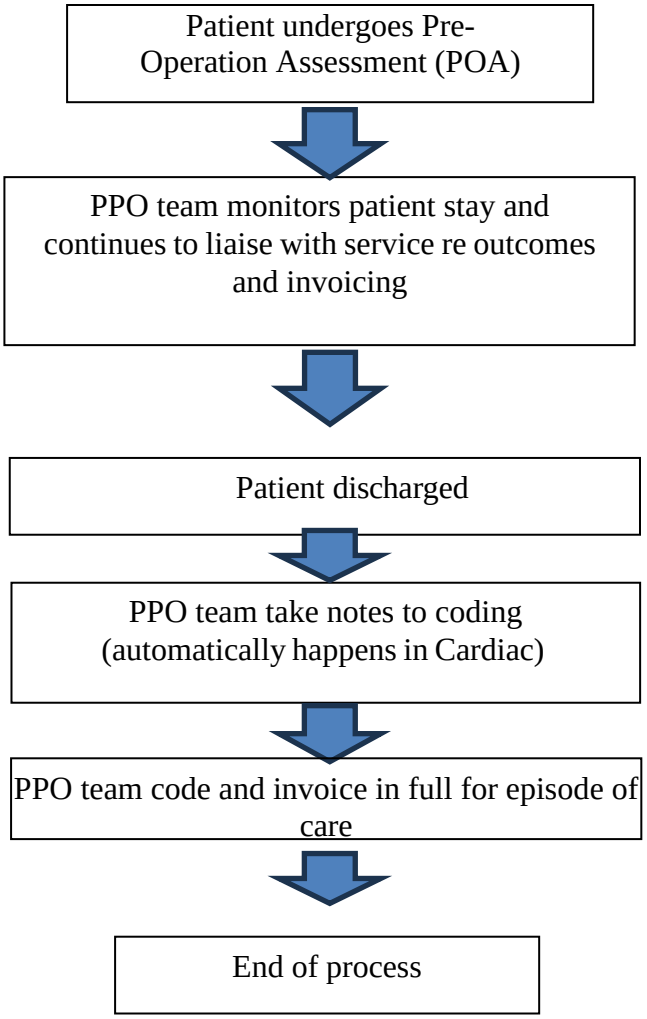
C1.5 Procedures are followed as for booked admissions (see paragraphs 1.1.1 to 1.1.19).

**D** **Day cases** - Day cases are treated as inpatients and follow the procedures outlined in above.

The processes described above are shown in the flowcharts overleaf.

**Processes (inpatients/ day CASE)**




Patient undergoes Pre-Operation Assessment (POA)
PPO team monitors patient stay and continues to liaise with service re outcomes and invoicing
Patient discharged
PPO team take notes to coding (automatically happens in Cardiac)
PPO team code and invoice in full for episode of care
End of process

## Appendix 2 - Outpatients

### E Outpatients

**E1.1** The outpatient clinic is contacted by the Consultant or the Consultants private secretary to book a private patient attendance. This includes any tests to be performed (i.e. blood, diagnostics) which must be as a result of a referral from the Consultant. A date is entered on the clinic list. The Consultants private secretary will notify the patient once an appointment has been booked.

**E1.2** On arrival at the clinic, the patient is required to sign the Private Non- Residential Patient Form (“undertaking to pay”). Each department has a different form to cover departmental variations (master copies of all these forms are held in the Private Patients office).

**E1.3** The case notes are sent to Clinical Coding and then to the PP office and returned to the library for filing.

## Appendix 3 - The Private Patients Department

### F Inpatient Bookings

**F1.1** When booking in-patients for treatment, the Private Patients team consult with the Ward Manager to ensure staff are available to provide the care the patient requires.

### G Weekly Preparation of Advance Admissions

**G1.1** The booked admissions form is finalised every Friday for the following week. The Private Patients team must ensure that all forms have been received from the patient to confirm they are to come in on the expected day. If forms have not been received, the patient must be contacted to confirm the booking and to forward (or bring) the necessary paperwork. Patients **should not** be operated on if the form has not been signed.

**G1.2** The Private Patients team obtains the patients case notes. In addition, a booked admissions sheet is printed by the Private Patients team detailing the patient number, name, procedure, consultant, date and time of admission, with any additional comments. The booked admissions sheets are passed to the ward as confirmation of the bookings in the ward diary.

### H Monthly Procedures

**H1.1** At the end of the month, the Private Patients Manager produces a summary of private patient activity according to specialty, ward, bed days and NHS occupancy of private beds.

**H1.2** Reports are distributed to the Assistant Director of Finance (Financial Services), the Divisional Associate Directors.

### J Record Keeping

**J1.1** Records will be maintained by the Private Patients' Department in such a way that the following information can be accessed quickly and accurately:

- Patients' name, address, and telephone number.
- Completed undertaking to pay form.
- Health insurance details for insured patients.
- Name of consultant.
- Emails relating to episodes of care.
- Details of treatment received admission and discharge dates; and
- Invoices raised and settlement dates.

## K. Complaints

**K1.1** Complaints from patients concerning “hotel services” (i.e. décor, cleanliness, food) are dealt with by the local PP office and escalated if necessary to the Trusts complaints department if not resolved.

**K.2** Medical complaints are dealt with by the nurses and doctors and taken to the Patients Advocate if necessary.

**K1.3** Other complaints (i.e. charges) are referred to the Patient Advice and Liaison Service (PALS). The Private Patients Manager may be required to produce a report for the PALS team in response to the complaint.

## L Extended Treatment

**L1.1** If a patient’s condition requires them to stay in hospital longer than the pre-authorised length of stay then the Consultant, at the point of knowing, must inform the Private Patient Team and provide them with a medical report to gain authorisation for an extension. If this extended length of stay involves further treatment the insurance company must provide pre- authorisation before the treatment can be given.

## M Daily Ward Rounds

**M1.1** Staff from the Private Patient Department undertake a daily ward round to record the bed state and to provide support to private patients. This ensures that the Private Patient team is able to deal with queries about extended stays, discharge and admission arrangements quickly and efficiently. It also ensures that the Private Patient team work with the clinical site team to help the movement of NHS patients for pre-booked private beds and assist with a transfer, if appropriate. Where beds are not available the matter is escalated to the Consultant to submit an additional request for a transfer based on clinical need.

## Appendix 4 - Financial Matters

### N Private Patient Charges

**N1.1** Charges will be reviewed at regular intervals (minimum annually). The Private Patients' Manager will conduct negotiations annually with private medical insurers in order to reach agreement for direct settlement of invoices.

**N1.2** Pricing must be fair and must recover full costs, including overheads, depreciation of assets and an appropriate return on capital employed.

### P Costs of Theatre Consumables and Prostheses

**P1.1** Some items are included in the price of treatment. The price charged for prostheses and implants will vary according to the size of the prostheses/implant and the manufacturer. These details together with the serial number of the product and the date are noted in the patient's case notes. The item price can be found on the manufacturer's price list but any agreed mark up and VAT must also be included.

**P1.2** The Private Patients team will regularly check the prices with manufacturers and NHS Supplies.

**P1.3** Prostheses and any fitting costs are recharged to the patient's invoice.

**P1.4** Artificial limbs are administered centrally by the Department of Health and are provided free to any amputee who normally qualifies for free treatment under the NHS regardless of whether the amputation was performed privately. The supply and payment of privately purchased prostheses should be carried out directly with the manufacturer.

### Q High Value Consumables

**Q1.1** High value consumables (especially drugs used in chemotherapy treatment) must be pre-authorised by the patients Consultant.

### R Drugs

**R1.1** Daily charges must include an element to cover the cost of drugs. The volume of drugs administered can be affected by the patient's weight, which can alter the cost of the treatment. The drugs charge could therefore vary from patient to patient.

### S Fixed Price Packages

**S1.1** The Trust offers set price packages for a small number of "standard" procedures. The package price includes a fixed length of stay, procedures, nursing, drugs and dressing, and accommodation. Full payment is required for all fixed price packages prior to admission.

**S1.2** For other procedures not included in the "standard" fixed price packages, the price will be worked out on an individual basis. The Consultant will advise the Private Patients team about the length of stay, age and the possible

medical complications which may affect recovery in order to determine an estimated price for the patient. It is important that this estimate is as accurate as possible because it is very difficult to explain to a patient at a later date why the price has had to be increased. The Consultant is responsible for providing the base information that is used in the pricing.

**T Cancellations**

**T1.1** If a patient cancels on the day of the treatment a charge will be made to the patient to cover the cost of administration and disruption caused to the Trust because of the resulting rescheduling of patient care.

**U Maternity**

**T1.1** A mother and baby in maternity ward should be counted as one patient. If the mother is discharged and the baby continues to receive hospital care, the baby should be treated as an NHS patient unless the parents wish the baby to be treated privately. In this instance a new undertaking to pay form must be signed.

**T1.2** Maternity tends not to be covered by insurance companies as the patient is not considered “ill and requiring treatment”. However, caesarean sections can be covered as they are classified as procedures.

**U Use of Private Ambulances**

**U1.1** Private patients are required to meet the full costs for private transport including ambulances.

**V Invoicing and Collection of Payment**

**V1.1** The Private Patients Manager is responsible for ensuring procedures are in place to record and invoice all patient activity and collect all income due for treatment provided.

**V1.2** On discharge an invoice will be raised by the PPO and submitted to the patient for payment.

**V1.3** The Private Patients Manager/Co-ordinator regularly checks that all in-patients have been recorded and billed by reviewing the Private Residential Patient Admission Form and Credit Applications held on the Current Inpatient Accounts file.

**V1.4** The Private Patients Manager/Co-ordinator checks weekly that all activity (inpatient and outpatient) has been invoiced. Print outs are obtained from the Management Information System and PAS listing all private patients for all departments. Patients listed are checked against invoices raised to ensure all have been billed. This is a compensatory control. It is the consultant’s responsibility to ensure that the private patient activity is identified and notified to the Private Patient Department.

**V1.5** Consultants are responsible for billing their services directly to the patient unless agreed with the PPO.

**V1.6** An invoice is raised for the cost of treatment. Where the cost of the treatment exceeds the initial deposit, an invoice is raised for the additional cost of the treatment. If the cost of the treatment is less than the initial deposit a credit note is raised for the difference and a refund made to the patient.

**V1.7** Aged debt reports which show unpaid invoices are monitored weekly/monthly. Reminder letters are sent out to all those patients where the invoice remains unpaid for more than 30 days. A second reminder is sent out after 30 days, and a third and final reminder after another 30 days.

**V1.8** Where the invoice remains unpaid and all other avenues have been exhausted the debt is placed in the hands of an external debt collection agency for follow up.

**V1.9** If the debt collection agency is unable to collect the debt and no further action can be taken to recover the debt a decision will be taken to write off the debt. In these circumstances the Losses and Compensations policy is followed. The value of the write off is charged to the budget where the revenue from the private patient income was originally credited.

## W Indemnity Arrangements

**W1.1** Where healthcare professionals choose to provide additional private care in a private capacity and agree with the Trust that they may use Trust facilities for this purpose, they should continue to have appropriate private indemnity cover in place for themselves. If the agreement to use Trust facilities includes the use of additional NHS staff as part of the facilities provision, those additional NHS staff will be covered by the Trust's indemnity arrangements.

**W1.2** Where the Trust provides additional private care as one of the services it offers as an organisation and the work is included in job plans, healthcare professionals are covered by the Trust's indemnity as they are providing private care in the course of their NHS employment**.**

**W1.3** All healthcare professionals providing private healthcare are required to confirm to the Trust that they have the requisite indemnity cover in place before they may undertake any private healthcare. The form is included as appendix 8.

## X Payment of Staff

**X1.1** All staff providing services to private patients on behalf of the Trust other than Consultants (who are charging the patient or the insurance company direct for their services) will be paid in accordance with their normal NHS terms and conditions except where alternative contractual arrangements have been made and where the staff concerned are not working directly for the Trust. Specifically:

- Staff employed by the Trust to undertake private patient work, within normal working hours, will not receive additional pay.
- Staff employed by the Trust to undertake additional work outside of their normal working hours will receive additional pay in accordance with normal, NHS terms and conditions of employment.
- Consultants must not offer personal financial incentives to staff or

make payments directly to staff for work carried out on Trust premises unless they are working for the Consultant on a proper contractual basis and therefore not employed by the Trust.

- Consultants must not offer personal financial incentives to staff.

# Appendix 5

## AC Interpretation of the Principles Governing Transfers between NHS and Private Healthcare

AC1.**1** The Green Book and the Code of Conduct for Private Practice were quite clear about the process for patients who opted to transfer from Private to NHS status. The introduction of top up drugs has muddied the waters. Under the paper Guidance on NHS Patients who wish to pay for additional private care a key principle underlying transfer has been withdrawn. The principle that a patient could not be both a private and an NHS patient for the treatment of one condition during a single visit to an NHS organisation is no longer applicable.

AC1.2 The new guidance is about allowing patients to pay for additional private healthcare while continuing to receive care from the NHS. It is not about allowing patients to pick and choose the parts that they want to pay for privately which would contradict the fundamental principle that the NHS should never subsidise private care with public money, which would breach core NHS principles.

AC1.3 A patient who has been admitted as a private patient will remain a private patient for the whole episode - all blood tests, imaging, drugs inpatient care etc will be private. Therefore, if a patient who chooses to opt for private care, as an outpatient or day case receiving chemotherapy or radiotherapy has a reaction to medication and needs admitting, the inpatient episode will be charged for as private.

AC1.4 Patients cannot:

- Pay the consultant for care using NHS facilities for free. These episodes must be considered private.
- Choose to have the high-cost care under the NHS and low cost as a private patient for the same episode.
- Have a referral from a private consultation for an imaging procedure etc. as NHS, unless an emergency or a clinical priority; and
- Be treated privately at the expense of an NHS patient.

## Appendix 6 - Due Regard Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the document/guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Age | No | |
| | • Disability | No | |
| | • Gender (Sex) | No | |
| | • Gender Identity | No | |
| | • Marriage and civil partnership | No | |
| | • Pregnancy and maternity | No | |
| | • Race (ethnicity, nationality, colour) | No | |
| | • Religion or Belief | No | |
| | • Sexual orientation, including lesbian, gay and bisexual people | No | |
| **2.** | **Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?** | No | |
| **3.** | **If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?** | N/a | |
| **4.** | **Is the impact of the document likely to be negative?** | No | |
| **5.** | **If so, can the impact be avoided?** | N/a | |
| **6.** | **What alternative is there to achieving the intent of the document without the impact?** | N/a | |
| **7.** | **Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?** | N/a | |
| **8.** | **Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?** | Yes | |

If you have identified a potential discriminatory impact of this policy, please refer it to **[Insert Name]**, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact **uhsussex.equality@nhs.net (01273 664685).**

## Appendix 7 - Dissemination, Implementation and Access Plan

To be completed and attached to any policy when submitted to Corporate Governance for consideration and TMB approval.

| | Dissemination Plan | Comments |
|---|---|---|
| **1.** | **Identify:** | |
| | **Which members of staff or staff groups will be affected by this policy?** | Clinical, Nursing, Theatre, Operational, Administration Staff will be affected |
| | **How will you confirm that they have received the policy and understood its implications?** | The document will be shared with all Divisions to cascade down to appropriate groups |
| | **How have you linked the dissemination of the policy with induction training, continuous professional development and clinical supervision as appropriate?** | As above. In addition, clinical staff are reminded of the policy if starting Private Patient work |
| 2. | **How and where will staff access the document (at operational level)?** | Intranet and well as shared around the Divisions |

| | | Yes/No | Comments |
|---|---|---|---|
| **3.** | **Have you made any plans to remove old versions of the policy or related documents from circulation?** | Yes | Will be removed once latest version circulated |
| **4.** | **Have you ensured staff are aware the document is logged on the organisation's register?** | Yes | Staff will be made aware through communications |