RCN response to the draft DH document ‘Guidance on NHS patients who wish to pay for additional private care’

Introduction
The Royal College of Nursing (RCN) is the UK’s largest professional association and trade union for nurses, with over 390,000 members. The RCN works locally, nationally and internationally to promote high standards of care and the interests of patients and nurses, and of nursing as a profession.

This document contains the RCN response to the Department of Health consultation on the guidance published in response to a review commissioned by the Secretary of State for Health and conducted by Professor Mike Richards, the National Clinical Director for Cancer.

The RCN contributed to the consultation which led to Professor Richards’ report and recommended that top up payments be permitted but only for a limited period whilst the implications of such a policy were investigated in more detail. The RCN also recommended that:

- Primary Care Trust (PCT) ‘exemption’ request processes for unapproved drugs and treatments needs to be urgently reviewed and mandatory national guidance drawn up which enshrines effective clinical engagement, improves public accountability and which addresses the gross inequalities in entitlement the current system produces.

- The work and the remit of the National Institute for Clinical Excellence (NICE) need to be publicly explored and a new consensus obtained for the use of economic modelling in the allocation of NHS resources. Attention should be paid in the meantime to enhancing transparency of decision making and speeding up authorisations processes.

- In summary it is the RCN’s clear view that the whole purpose and use of co-payments and top up payments where they exist should be reviewed with a view to establishing what is and what is not funded by the NHS.

Whilst we are disappointed not to see more response from the Department of Health on the wider point around the use of top up payments, we have consulted with our membership and responded to the questions raised by the guidance:

1. Whether or not the principle of separateness are clear;
2. Are sufficient safeguards in place; and
3. Should there be more assurance mechanisms in place to ensure the guidance is followed and does not lead to any unintended consequences?
Is the principle of separateness of care clear?

Whilst we might agree with the principle of separateness of care and the clarity of the guidance, there are some practical issues which might prevent many providers from complying with this aspect of the guidance which we have highlighted below. The overriding principle should be of maintaining and improving patient safety.

Should there be more assurance mechanisms in place to ensure the guidance is followed and does not lead to any unintended consequences?

The RCN has already called for more analysis of the impact of the decision to allow top up payments in cancer care. In one sense it is difficult to answer the question as this policy change is unprecedented and is occurring in an emerging healthcare market, the regulation of which is going through fundamental change.

Our concerns at the pace of this change and how difficult it is to assess the effects of national implementation before a proper consideration of the impact has been echoed again in this consultation by our membership.

“Whilst the Secretary of State has tried to minimise risk, implementation of the proposed guidance may prove logistically difficult and there would always be patients falling into ‘grey areas’…there is a case for a pilot scheme to identify the as yet unknown pitfalls” – Nurse Manager

a) Provider level impacts

We welcome the statement that “the fact that some NHS patients also receive private care separately should never be used as a means of downgrading the level of service that the NHS offers”.

However, our members have raised questions about the practicality of preventing such impacts and indeed assessing whether or not this principle is even applied consistently in practice.

Some providers may wish to increase the provision of private facilities in order to comply with this guidance and in doing so commit organisational capital and capacity to do so. Although the impact might be small, there is still an impact on existing models of provision as a result of the guidance. Again in the absence of any data, the impact on the amount of private income generated is difficult to estimate and as such so is the potential impact on NHS Foundation Trust private income caps.

Currently the system for classifying facilities as NHS or Private is unclear. Existing guidance states that NHS facilities may not be used for Private care without the agreement of the NHS employer. Clearly this is guidance for individual medical staff involved in private practice but seems to suggest that the designation of clinical or administrative facilities as private or NHS is a matter for each employer’s (provider’s) discretion.
The guidance goes on to state that the employer (provider) will make whatever charges are reasonable suggesting the main focus of current guidance is quantifying how much it costs to use the facilities.

If this guidance does not make more explicit what is meant by the separate care principle in respect of what is an NHS or Private facility and how such distinctions are made, then there is a risk of services or resources being reclassified on an ad hoc basis and thus confusing the issue of separateness. Our members have asked for clear rules to be applied to ensure that charges are applied for nursing care, scans, blood tests and other costs associated with additional private care. Guidance should clearly describe a process for how changes in the classification of facilities may be made and how the frequency and impact of such changes should be monitored and reported.

**b) Commissioner level impacts**
The guidance proposes that patients be made aware of PCT exception processes where a drug or treatment is not available under normal NHS funding.

In gathering evidence for our response to the Professor Richards review we were concerned to find that the processes PCTs use to assess such exception requests varied immensely. There was little evaluation of the rigour of the different approaches or the impact on equity of access. Increasing the likelihood of such requests must be preceded by clear national guidance to PCTs on the best practice principles for such exception processes and SHAs mandated to monitor the application of such principles in practice.

**c) Service level impacts**
At the service level there may also be impacts on NHS service provision. For example if a patient were to experience adverse reactions or a need for additional symptom control as a result of receiving the privately funded treatment, would the patient need to be moved backwards and forwards between the private and NHS facilities to receive any additional care required?

It is clear that multiple patient movements would be undesirable in terms of the patient’s comfort, dignity and infection prevention and control reasons. It also immediately raises the possibility that NHS clinicians would be spending time on additional patient care needs that may not have existed had the patient not received the additional privately funded treatments.

“I think that the introduction of this system will bring about an increase in management and administration, particularly around the interaction of clinical teams; dealing with complaints; and litigation. Pilots to assess this in practice and monitor public opinion should be introduced before the final decision [to implement nationally]” – Clinical Risk Manager

Finally, separation of NHS and private treatment may prove a problem for hospitals that have made a strategic decision not to have any private healthcare provision on their site/campus. Some cancer patients may therefore have to travel long distances to receive different treatments – increasing actual costs both to the patient and to the provider.
Again at the service level, there must be every effort to ensure that patient safety is not compromised by multiple episodes of care or trying to fit together incongruent systems or working practices.

d) Workforce impacts
Whilst it may be possible to establish separate facilities in some cases, it is not always possible (or desirable) to have completely separate clinical teams between the privately and publicly funded services. In some specialisms where there is already a limited workforce pool to draw from there will necessarily be a movement of staff between one establishment and another on either a temporary or permanent basis.

Whilst it is difficult to estimate the impact of this policy in real terms, it is possible that more clinician time will be spent moving between the NHS and private facilities or simply that there will be a shortfall in the workforce as clinicians spend more time in private facilities.

e) Individual staff impacts
As far as staff are concerned, our members have raised concerns about potential conflicts of interest and an increase in the need for concise, accessible and balanced information on the options available to patients. The RCN is concerned that NHS staff could find themselves compromised by advising on privately funded care, especially when a member of the NHS care team has private practice interests. Therefore NHS staff should declare all private interests which could potentially result in personal gain as a consequence of their position.

The BMA believes that in the case of treatments which are not routinely funded by the NHS they should be given the choice of a private care option including the availability and price of private treatment.¹

The guidance does offer some welcome clarity around those processes (in particular paragraph 4.4); however, this could put pressure on patients to seek private treatment, particularly where the patient is very sick and potentially vulnerable.

What is not covered so well in the guidance are cases where clinicians might be aware of a very new treatment that has not yet be considered for funding by the NHS and may feel a duty to inform patients of the existence of such information.

The RCN believes that this situation will need very careful handling and should not be left to local policy and practice. The guidance could be expanded to include some core principles to inform the approach to this situation. For example:

- Clinicians are satisfied that the new treatment is actually efficacious and evidence based (even if this is only acknowledged in other countries)
- Clinicians have to hand balanced outcome information and full costing information; and

Clinicians have considered the above and have discussed bringing this fact to patients attention with peers and colleagues before raising it with patients.

Addressing the information needs of patients and patients’ representatives should not be seen as a distraction from the core business of patient care; however thought will have to be given on how to support the workforce in addressing any impacts of this policy on requests for more information about treatment options both privately and publicly funded.

“As the patient’s advocate, Nurses will necessarily spend additional time attempting to solve confusions, answer questions and to contact other partners in care on behalf of the patients.” – Registered Nurse

f) Patient impacts
For patients (and perhaps for many staff), the terminology of charging would need to be clarified. Would charging cover an ‘episode of care’ not available on the NHS and is there a danger than the terminology will confuse the public? Treatment may be provided in a separate ward, a separate hospital or in a home care setting. A standardised terminology should be an essential feature of the guidance to avoid confusion where patients can chose from a range of providers in one geographical area.

The guidance should also address questions that may be raised by patients unable to afford privately funded care who ask why a patient is getting access to a potentially beneficial drug that they themselves do not have access to.

Whilst many may feel comfortable will this, this will inevitably increase any sense of there being two different levels of care available – one for those with money and another for those without regardless of whether or not the private treatment will be effective for the individual concerned.

“I do feel that it will encourage patients to spend [their] savings on treatment which could be futile or inappropriate for their condition…”
– Nurse Manager

Are sufficient safeguards in place?
We welcome the role of the SHA in ensuring that, in any separate provision of private and NHS care, the fundamental principles of the NHS are not undermined.

The RCN would expect the Department of Health to require SHAs to report on all developments in this area of policy and standardise data collection on any impacts. We would suggest in particular that the SHA monitors closely any impacts on patient satisfaction (including complaints/litigation), any changes in transaction costs, trends in workforce movements and service provision or commissioning changes as a result of this policy.

It is essential to ensure that safe, evidence based care is provided to patients with the appropriate probity and governance arrangements that is afforded to NHS patients. The issue of clinical safety is paramount and careful thought must be given to how
near misses and risks will be reported across the NHS and Private care divide in a way which is helpful. The guidance should explicitly confirm the above and state that the results of this monitoring should be available for public scrutiny and analysed by credible and independent bodies.

Finally, the guidance could make greater reference to existing professional regulatory mechanisms (asides from the GMC) where they are helpful for staff in understanding their obligations and duties in respect of advising on care options. For example, the ‘Code of Practice for the promotion of NHS-funded services’ and the ‘NMC Code: Standards of conduct, performance and ethics for nurses and midwives’.

**Future impacts**

In terms of future impacts of other policies on this issue, the rolling out of Individual Health Budgets, cross border patient mobility and other forms of individual commissioning arrangements may increase tensions across NHS and privately funded care. A commitment should be given to keep the guidance under review based on a broad understanding of the issues being encountered at the service, organisational and national level. The RCN believe that a more detailed review should be undertaken within 6 months of publication and also within 18 months of publication.

**Conclusion**

The implementation of this guidance will only be the first step in a long journey towards resolving the deeply complicated debate on top up payments which has very significant implications for patients and health professionals in the NHS and beyond. The Government needs to work with health professionals and patients to ensure that this does not result in a two tier NHS. There remain significant practical issues about how this principle is translated into practice, which could have a big impact on the work of nurses and how patients are cared for. For example, practical difficulties remain on how patients who choose to pay privately can be moved into private facilities and how the additional costs will be priced. We will be monitoring the implementation of this guidance at the local level and are committed to working with the Department of Health to ensure the best possible outcome.

For further information please contact the Policy Unit on 0207 647 3723 or e mail policycontacts@rcn.org.uk.

Royal College of Nursing
January 2009

---

2 Deptment of Health (2008) *Code of Practice for the promotion of NHS-funded services*
3 http://www.nmc-uk.org/aSection.aspx?SectionID=45
4 Patients already have a right to travel to other EU countries for healthcare, subject to certain conditions, under existing European Court of Justice case law. The EU Patient Mobility Directive aims to codify this case law. The entitlement derived from the case law is in addition to long-standing EU rules (Regulation 1408/71) which allow:
   - UK citizens who go on a temporary visit to another EEA country to get state-provided healthcare that becomes necessary during a visit, paid for by the UK, via the European Insurance Card (EHIC)
   - UK citizens to go to another EEA country for planned public sector treatment provided they have prior approval from a local commissioner