**Responding to Private Healthcare Requests**

As NHS waiting lists rise, more patients are seeking private healthcare, and there have been a growing number of requests from private providers to general practice. Avon LMC has received many practice queries relating to this, so guidance has been developed to help you navigate this private interface.

**Please note: this guidance applies to patient self-funded private providers and not private providers commissioned on an NHS Right to Choose pathway.**

Private providers may make requests in the following areas:

* Referrals
* Requests for information
* Investigations
* Prescribing
* Monitoring

**General NHS Principles for Private Healthcare**

Right to Choose

Any patient has the right to choose private care if they wish to. Their right to NHS care remains throughout and is unaffected. The NHS care provided is based on the NHS’s interpretation of clinical need – not that of the private specialist, or the patient themselves.

Equity

NHS GPs should treat all patients equitably – regardless of whether they choose private or NHS care. This means a GP should not do for a patient seeking to go private that which they would not do for a patient receiving exclusively NHS care. This includes (but not limited to) communication with specialists, decisions on referrals, pre-referral tests, prescribing, shared care, and follow-ups. Patients who pay for private care should not be put at any advantage or disadvantage in relation to the NHS care they receive.

Principles of Separation

When a patient chooses to go private, they should anticipate that they will receive the full episode of care from that private provider and have to pay for those episodes of care in their entirety.

**Referrals**

Referral letters to Private Providers

Referral letters to private providers may be required for:

* Sharing of medical information
* Evidence for Private Insurer

Information sharing prior to any referral is classed as a transfer of care and therefore contractual work. The patient or the private company cannot be charged for this referral if the GP feels it is clinically appropriate.

However, a practice is entitled to charge for a private referral if a patient or provider is requesting work outside a normal NHS referral. This may include (but not restricted to) expediting a routine referral letter or completion of a specific referral proforma.

Onward referrals to the NHS

The 2024 BNSSG access policy states that NHS specialists must accept referrals from private providers as long as the patient is eligible for NHS treatment.

This is highlighted in bullet point 5 of the workload transfer template letter found here:



**Requests for Information**

There has been a proliferation of private on-line providers prescribing treatments for conditions such as obesity and menopause. Many providers are requesting that practices undertake a review of a patient’s notes to check there are no contraindications to their prescribing. This, by default, means that a practice takes shared responsibility for prescribing initiated by other organisations.

[GMC](https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices/about-this-guidance) regulations state that medicines must only be prescribed if there is sufficient knowledge to prescribe safely, which includes access to a patient’s medical records and verification of information through examination.

Avon LMC supports practices to pushback requests for medical information from private providers, which is non-contractual work a GP could be liable for. We recommend that private providers encourage patients to share their on-line records with them to obtain a full medical history, including observations. A [template letter](https://mcusercontent.com/bd37c271140654db83f395e52/files/056d7e0e-094e-e66d-49da-65a9c6fb3f76/Template_letter_to_decline_information_sharing_requests_private_providers.rtf) for providers has been developed for this purpose which is embedded in EMIS.

We also advise that any medications prescribed outside the practice are added to a patient’s medication screen as an external prescription, so that drug interactions and safety alerts can be triggered.

Separate from requests for information, if a GP receives information that their patient has been started on a treatment which is contraindicated, (eg: GLP-1 in a patient with an eating disorder) it is a [GMC](https://www.gmc-uk.org/professional-standards/the-professional-standards/cosmetic-interventions/safety-and-quality) obligation to act on this, in the interests of patient safety.

**Investigations**

Any investigations a GP would perform in advance of an NHS referral should be requested as normal. If the patient is not eligible for NHS treatment, a GP is not required to perform pre-referral tests, unless this is important to exclude any pathology. An example of this would be a patient requesting investigations for infertility, but not eligible for NHS treatment. Depending on the clinical presentation, it may be reasonable to request thyroid or hormone blood tests, but the full screening investigations performed before an NHS referral are not required.

Investigations at the request of private providers falls outside the scope of NHS primary medical services and practices are not obliged to fulfil these requests. A GP may wish to do them if clinically appropriate and they are able to interpret and manage them, but this work is not funded and falls outside the core GP contract.

Patients will often access investigations privately, without necessarily seeing a private specialist. The interpretation of these should fall upon the private provider, but a GP should weigh up the risk of patient harm if there is a delay in escalation for red flag test results (eg: a raised PSA or CA125)

**Prescribing**

When a practice is faced with a prescribing request from a private provider, there are several considerations:

* Is it included in the BNSSG ICB [formulary?](https://remedy.bnssg.icb.nhs.uk/formulary-adult/)
* What is the [traffic light status](https://remedy.bnssg.icb.nhs.uk/formulary-adult/formulary-process-and-paperwork/the-traffic-light-system-and-classification-of-medicines/#:~:text=Medicines%20in%20the%20Joint%20Formulary,the%20colour%20of%20their%20category.) of the medication?
* Do I know enough about this medicine to take on the prescribing?
* Can the medicine be purchased over the counter?

Non-Formulary Medication

This should be continued by the private provider in the vast majority of cases.

Green Traffic Light Status Medication

If the private provider has started a patient on a green medication, and it is clinically indicated, it is reasonable for the GP to continue prescribing this. eg: lymecycline for acne. However, there is an expectation for the private provider to prescribe the first 28 days of treatment, as per the first bullet point of the prescribing workload transfer letter found here, and embedded in EMIS:



Amber: Specialist-Initiated or Specialist-Recommended Traffic Light Status Medication

Ongoing maintenance of these medications should be made on a case-by-case basis, with the decision depending on the medical condition and the follow-up required. However, as with green medications, the first 28 days of treatment should be started by the private provider.

Amber: Shared Care Traffic Light Status Medication

Avon LMC has previously shared principles for Shared Care Prescribing as follows:



We advise against engaging in shared care prescribing with private providers for the following reasons:

* It is challenging to ensure quality assurance and governance of the private provider
* Enduring care by the private provider relies on a patient self-funding which is not always guaranteed
* It creates a two-tiered system if patients with the resources to fund private referrals can access long-term medication faster than the NHS route
* General practice does not have the capacity to meet the additional demand from the private sector
* It is usually an unfunded, non-core contractual activity

The template letter for declining private share care can be found in EMIS documents and also found here:



Individual Practice Policies for Shared Care Prescribing with Private Providers

Avon LMC has noted that some practices will have individual policies for accepting shared care prescribing with private providers and may agree to this work for some conditions but not others. It is important for these practices to have a consistent framework when making these decisions, so that individual policies can be justified.

Some valid reasons for sharing care with some private prescribers and not others could be:

* Lack of GP expertise in the condition or medication to prescribe safely
* Lack of confidence in the quality assurance/governance of a provider
* Lack of capacity if there is high demand for a condition

**Monitoring**

A private provider may discharge a patient and request that the practice is responsible for long-term monitoring. What a practice does depends on whether the monitoring is mandated within the GP contract. Therefore, it is mandatory to perform annual monitoring for long-term conditions management included in QOF (eg: heart failure or asthma) but the practice is not obliged to provide ongoing monitoring for conditions sitting outside the GP contract (eg: post-operative monitoring for private Bariatric Surgery)

If ongoing specialist care/monitoring is required for conditions sitting outside the GP contract, the patient must be referred to the NHS specialist.

***Case Study:***

*1. A patient presents with breathlessness and the GP requests some blood tests including a BNP. The BNP is elevated, and the patient wishes to see a private heart failure specialist.*

*It is reasonable to provide the patient with the BNSSG ICB Standard Referral letter, but the practice cannot charge for this unless a specific referral proforma is requested.*

*2. The private cardiologist assesses the patient and requests that the GP performs an ECG and make an onward referral to the genetics clinic to exclude HOCM.*

*The GP is under no obligation to perform an ECG for another provider, and the cardiologist should make their own onward NHS genetics referral.*

*3. The private cardiologist starts the patient on ramipril and asks the GP to continue prescribing and repeat the renal function after two weeks.*

*The ramipril is green on traffic light status and is clinically indicated, so it is reasonable to continue prescribing this and perform annual monitoring under QOF. However, the cardiologist should prescribe for the first 28 days, and request/interpret the renal function after two weeks.*

*4. After a few months, the patient needs further heart failure treatment, and the private cardiologist starts Entresto which is amber shared care for one month, as well as requiring enduring 6-monthly monitoring.*

*As there is no guarantee of the patient continuing to self-fund their specialist care, the private cardiologist should make an onward referral to an NHS heart failure service and continue prescribing and monitoring the patient until they are seen by them. Some practices may choose to prescribe the Entresto if they are doing this for their NHS patients, but there is no obligation to share care with a private provider.*

*5. The private cardiologist advises the patient to lose weight as it will help the heart failure. The patient consults with a private on-line provider who wishes to prescribe Ozempic but writes back to the GP asking for any contraindications before starting treatment.*

*The GP should advise the patient to download the NHS app to gain on-line access to their medical records and write back to the on-line private provider using the LMC template letter.*

**References**

<https://www.gov.uk/government/publications/nhs-patients-who-wish-to-pay-for-additional-private-care>

<https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/general-practice-responsibility-in-responding-to-private-healthcare>

<https://www.bbolmc.co.uk/private>

<https://www.somersetlmc.co.uk/followupofpatientsreceivingprivatecare>

<https://www.sheffield-lmc.org.uk/website/IGP217/files/Shared%20Care%20Requests%20from%20Private%20Providers%20Apr24.pdf>