

Guidelines

Anaesthetic practice in the independent sector 2018



Association
of Anaesthetists

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Anaesthetic practice in the independent sector 2018

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Declaration of interests

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Introduction

The Association released the first 'Independent Practice' guideline in 2008 and much has changed since then. The guideline was intended to provide advice and guidance to consultants involved in independent practice. Working in an independent hospital provides different challenges to working within an NHS hospital, regardless of the funding for the individual patient involved.

Since the last guideline there has been a rapid growth in NHS-funded patients within the independent sector. The term 'private practice' is probably better replaced by 'independent practice' to more accurately reflect current activity. The term 'private practice', historically, often had negative connotations for some as being closely associated with private medical insurance. Now many anaesthetists find themselves delivering clinical care in independent hospitals funded from a variety of sources - NHS, private medical insurance and patient self-pay.

An investigation into private healthcare by the Competition and Markets Authority began in 2012. It will have significant implications for anaesthetists, both financially and organisationally.

The change in demographics of patients undergoing treatment in independent hospitals, in combination with increased regulation, brings new challenges and opportunities to anaesthetic practice. Pre-operative assessment and optimisation, and the anaesthetist as 'peri-operative physician', are areas that are currently often poorly addressed and remunerated within independent hospitals.

Brief history

Before the formation of the NHS in 1948, independent practice was the main source of income for anaesthetists in the UK. With the advent of the NHS, a number of provident societies merged to form the British United Provident Association (BUPA) to preserve freedom of choice in healthcare and to help patients afford choice in terms of where, when and by whom they were treated. BUPA had some 80% of the insurance market in the 1950s, and private practice represented about 6% of acute medical activity, largely concentrated in the major metropolitan centres. At this time, insurers provided patients with a single combined benefit towards anaesthetist's and surgeon's fees, and it was not until 1975, following successful representations by the Association, that this was divided into separate surgical and anaesthetic benefits.

In 1975, the health minister Barbara Castle closed all pay beds in NHS hospitals, and this resulted in a major expansion of independent hospital facilities, rapidly doubling the number of private beds. BUPA purchased its first group of hospitals, and businesses from the USA also invested heavily to establish other hospital providers and hospital groups. This considerably improved the quantity and quality of private facilities available. There has been further expansion in the last decade and this trend looks to continue with other hospital sites planned with new models of working to address the increase in NHS funded work. To year end 2015, the market value of UK private healthcare was around £6.05 billion, with specialist revenue between £1.6-1.8 billion. NHS funded patients make up about 10% of this total (£547 million). Activity relating to patients with private medical insurance accounts for about £4.7 billion and there are roughly 4 million private medical insurance policies (3 million corporate, 1 million individual). About 19% of the market is self-pay. Independent healthcare continues to be a growing market with the volume of self-pay income expected to grow. (BMA Private Practice conference 2017*).

*https://www.laingbuisson.com/wp-content/uploads/2016/10/PrivateAcute_4ed_market_briefing.pdf (accessed 13/05/2018)

Why work in independent practice?

Traditionally, working in 'private practice' was simply seen as a way of increasing income in addition to NHS income and largely involved caring for patients with private medical insurance or self-funding ('self-pay'). Over recent years there has been an increase in NHS funded and self-pay work. There have always been anaesthetists who practice exclusively as independent practitioners but recently there has been an increase in this activity as independent hospitals look towards different models of medical cover, particularly for NHS funded patients. As with any activity, there are pros and cons to undertaking anaesthetic practice within the independent sector. The advantages include additional income (if also undertaking work within an NHS hospital), some increased clinical and managerial freedom and an opportunity to develop closer relationships with colleagues and patients. The disadvantages include the additional time spent in practice, often out-of-hours and antisocial working, and an increased need to be flexible and available. Consultants will normally need to be available/on-call for their patients for a period of time postoperatively and will work more often on their own. If caring for patients with private medical insurance or who are self-funded, the doctor will be required to pay a higher medical indemnity subscription, have more complicated accounts, arrange for the billing of patients and must make sure that their independent practice does not conflict with their NHS contract.

Anyone considering undertaking anaesthetic practice within the independent sector should consider the matter fully before embarking on it. Independent practice income can be variable, and the independent practitioner should always put clinical governance and cooperation with colleagues ahead of financial gain.

Competition and Markets Authority

The Competition and Markets Authority (CMA) replaced its predecessor, the Competition Commission, as the overseer of market competition. In 2012, the CMA conducted an in-depth investigation into the private healthcare market, with a report produced in 2014. A brief timeline follows:

- 2014 CMA investigation and report, main findings
 - Measures to ensure no competing interests for clinicians with hospital incentives
 - Emphasis on introducing clear information for patients in advance of care, particularly focusing on fees and outcomes
 - Private Hospital Information Network (PHIN) appointed
 - Addressing property portfolios and market share, especially in London
- 2015 challenges/appeals to ruling via Competition Appeals Tribunal
 - AXA PPP vs. anaesthetic groups - rejected
 - Anaesthetic groups deemed *not* anti-competitive and involved a huge amount of work by the Association Independent Practice Committee
 - Hospital Corporation of America (HCA) appeal against infrastructure changes
 - Federation of Independent Practitioner Organisations appeal addressing private medical insurers (PMIs) fee structure and anti-competition - rejected. PMIs fee structure unchanged
- 2016 CMA announces intention to bring into force the revised remedies
 - Fee remedy via PHIN
 - Infrastructure remedies

The CMA documentation can be found on the gov.uk website, <https://www.gov.uk/cma-cases/private-healthcare-market-investigation>

The details of the appeal and its findings can be found on the Competition Appeals Tribunal website

Summary of 2014 report:

- The boundaries of the Competition Act with regards to price fixing between independent practitioners must be observed. AXA PPP appealed this finding insisting that groups of consultants working together were anti-competitive. The Association, supported by the anaesthetic groups, assisted the CMA in defeating this appeal at the Competition Appeals Tribunal. It is noteworthy that a formal partnership with partnership agreement etc is a single legal entity and as such may have a single scale of fees
- Patients should receive advanced notification of fees
- PHIN should be established as a resource for patients to obtain information on private hospitals and consultants. In 2017 PHIN is limiting its reporting to hospital level but intends to have consultant level reporting from 2019. As yet, it is unclear how it will collect information on anaesthetists
- There are also remedies concerning incentives to consultants to bring patients to a particular hospital or hospital group in terms of financial interest (which must be declared) or in terms of service provided by the hospital to the consultant, such as subsidised rooms or secretarial support. Significant direct benefits are prohibited outright

The full report and its findings can be found [here](#).

Good practice

Care provided to patients in the independent sector should be to the same standards as for NHS patients. Therefore, all the guidance documents and recommendations that set standards of care for NHS patients should be presumed to be valid for all patients. Guidance documents for anaesthesia are issued by the Association, the General Medical Council (GMC), the Royal College of Anaesthetists (RCoA), the British Medical Association (BMA) and many other organisations. The Care Quality Commission (CQC) has responsibility for monitoring and inspecting all organisations providing care to ensure standards are being met.

The National Institute for Health and Care Excellence (NICE) also produces recommendations, most of which are relevant to the independent sector. The websites of all these bodies are given in the Resources Section. The anaesthetist in independent practice should be well versed in all relevant publications and national guidelines. Active membership of subspecialty societies is strongly recommended in order to maintain current knowledge in the areas of practice conducted in both public and independent sectors.

Practising anaesthesia in independent hospitals commonly involves working in isolation, often being the only anaesthetist in an operating theatre suite or in the whole hospital. The qualifications necessary for appointment to a substantive NHS consultant anaesthetist should be considered those necessary to provide anaesthetic care in any hospital: a GMC acceptable medical qualification; FRCA or equivalent qualification as registered by the RCoA; a Certificate of Completion of Training (CCT) or equivalent; and entry as an anaesthetist in the Specialist Register of the GMC. Some private hospitals only award practising privileges to doctors who hold or who have held a substantive consultant appointment in an NHS hospital; others consider this not to be necessary.

All doctors should undergo regular appraisal and revalidation in line with national recommendations and standards. Processes for appraisal vary locally but if the anaesthetist holds an NHS contract, appraisal is usually undertaken within the NHS hospital. Practice within the independent sector should be addressed and contact between all hospitals recommended during the appraisal process to ensure all areas of practice are covered.

If the anaesthetist works solely in the independent sector, he or she should make arrangements to be appraised by a suitably trained and certified colleague, in line with GMC guidance. The anaesthetist should maintain appropriate continuing professional development and this will be reflected in the appraisal.

Anaesthetists practising in the independent sector should adhere and conform to appropriate clinical governance requirements as determined by the independent hospitals and agreed by the Medical Advisory Committees of these hospitals.

Anaesthetists should only practise in independent hospitals in which they have been awarded Admitting Rights or Practising Privileges. They should conform to the regulations and guidelines adopted by the independent hospital. The independent hospital has the responsibility for ensuring that the Medical Advisory Committee has approved these regulations and guidelines, and that all anaesthetists are informed of the regulations and guidelines relevant to them. The hospital should make the anaesthetist aware of its disciplinary procedures. The anaesthetist should be prepared to share their appraisal documentation with the independent hospital. Some hospitals request a summary, while others request the full appraisal document.

An anaesthetist should only undertake cases in the independent sector for which he or she is appropriately trained, experienced and in ongoing practice. Anaesthetists should keep a logbook of cases done in the independent sector and should be prepared to provide the information contained therein to appropriate supervising bodies.

The anaesthetist has an ongoing clinical responsibility to their patients that continues into the postoperative period. However, this responsibility has limits, and we suggest that the anaesthetist makes the limits clear to the surgeon, other healthcare professionals involved in the patient's care and the independent hospital management. Such limits may be:

- Until postoperative high dependency or intensive care is no longer needed or is handed over to an intensivist or another anaesthetist
- For patients not requiring intensive or high dependency care, the limits of the anaesthetist's care may be when the patient is:
 - Awake and discharged from the recovery room
 - Physiologically stable and satisfactory
 - Free from significant postoperative pain, nausea and vomiting
 - Not receiving intravenous opioid treatment, e.g. patient-controlled analgesia
 - Not receiving neuraxial or peripheral local anaesthetic infusions
 - Free from the short-term effects of peripheral or neuraxial nerve blocks

Any care provided by an anaesthetist beyond these limits may be separately chargeable if the patient has been warned of this before treatment. It is reasonable to expect an anaesthetist to be available for a patient for the period during which the early and predictable complications of surgery may occur. However, we suggest that this period should not normally exceed 24-48 hours and should certainly cease at the discharge of the patient from hospital.

For anaesthetists who work in both the NHS and the independent sector, there will be times when the demands of these two practices will seem to clash. The 2003 Consultant Contract is specific about the conduct expected of an NHS consultant with regard to independent practice. A copy of the contract and specific guidance can be found on the BMA website. The following general points are worthy of consideration:

- Independent practice should not normally be conducted during contracted NHS hours but may on occasion be acceptable provided it causes minimal disruption and has the support of both colleagues and managers
- Scheduled practice in the independent sector should not normally be undertaken when on-call for NHS patients. However, if this practice is performed in the consultant's base NHS hospital, this may be acceptable to colleagues and managers

NHS England has also recently issued guidance about the potential for conflict of interest when considering clinical care. This came into force on 1 June 2017 (*Managing Conflicts of Interest in the NHS. Guidance for staff and organisations*). This guidance covers many potential conflicts but with regards to independent practice it states:

- Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:
 - Where they practise (name of private facility)
 - What they practise (specialty, major procedures)
 - When they practise (identified sessions/time commitment)

*Hospital consultants are already required to provide their employer with this information by virtue of Para. 3 Sch. 9 of the Terms and Conditions - Consultants (England) 2003. <https://www.bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/contracts/consultanttermsandconditions.pdf>

- Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):
 - Seek prior approval from their organisation before taking up private practice
 - Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work**
 - Not accept direct or indirect financial incentives from private providers other than those allowed by CMA guidelines
 - Hospital consultants should not initiate discussions about providing their private professional services for NHS patients, nor should they ask other staff to initiate such discussions on his or her behalf**

**These provisions already apply to hospital consultants by virtue of Paras. 5 and 20, Sch. 9 of the Terms and Conditions - Consultants (England) 2003

This guidance, along with the NHS contract of employment will guide local arrangements for undertaking independent practice in addition to NHS employment. Commonly, additional programmed activities will be offered to the NHS organisation and all work should be included in any agreed job plan.

Getting started in independent practice

Before embarking on independent practice, it would be sensible to get advice from colleagues as well as a chartered accountant. Your colleagues will be able to provide valuable advice about the local independent hospitals and politics. There might be local anaesthetic groups or partnerships or perhaps all local anaesthetists work independently. How you decide to work might depend on local considerations. If you are planning on working independently then get advice from a colleague who is an experienced independent practitioner. If you are planning to join a group practice, then speak to one of the managing partners. A chartered accountant will be able to give advice about your individual tax situation.

Admitting rights

Before you can work in an independent hospital, you will need to obtain what are variously known as admitting rights or practising privileges. All independent hospitals should have a Medical Advisory Committee that comprises consultants of all subspecialties, one of whom will be the chairman. The senior manager of the hospital should grant practising privileges to consultants who meet the standards set by the Medical Advisory Committee. Practising privileges are not awarded by right. The independent hospital will provide you with the necessary application forms on request. It may be a good idea to make an appointment to meet with the senior manager of the hospital before seeking practising privileges. Take advice on this from a colleague who already works in the hospital. An individual hospital's requirements for the award of practising privileges might vary but are likely to include:

- A curriculum vitae
- Documentary evidence of relevant qualifications and completion of subspecialty training
- Evidence of appropriate GMC registration
- Proof of membership of a medical defence organisation (MDO)
- Occupational health requirements such as evidence of hepatitis B immunity

- Proof of recent successful appraisal
- Evidence of a Disclosure and Barring Service check or the application form and appropriate supporting documentation in order to undertake a check

Some of these documents will need to be updated annually, and you should expect the hospital to ask for ongoing evidence that you fulfil their requirements for the maintenance of practising privileges.

Registration with private medical insurers

PMIs have varying requirements for recognition of practitioners and may involve much of the documentation mentioned already. Recognition is a requirement before providing care and hence payment. Recently some PMIs have included a contracted agreement that any newly recognised practitioner's professional charges lie within the organisations schedule of fees. Consultants already recognised by a PMI prior to this requirement may charge a fee above the fee maxima, thereby presenting the patient with a 'shortfall' payment. Consultants not on these terms are being asked by some PMIs to consider signing up to these fee requirements. The argument being that PMIs might direct patients towards practitioners who are fee assured or, in the case of surgeons, towards those who are not only fee assured but who work with fee assured anaesthetists. The Association and many other organisations have challenged this new arrangement and do not agree with the concept of the PMI dictating a maximum fee, insisting that the contract is between the doctor and patient, not between PMI and the doctor.

Chartered accountants

All consultants conducting independent practice should seek and heed advice from an accountant with experience in medical practice conducted in the independent sector. Accountants will provide invaluable advice on billing, banking, taxation and expenses. They might also be very helpful when planning pensions and eventual retirement from both NHS and independent practice. The fee that an accountant charges for work done that relates to independent medical practice is a tax-deductible expense.

Billing

The keeping of accurate records is the key to efficient billing. You should keep a record of the following for every patient you treat:

- Name
- Address
- Telephone numbers
- Date of birth
- Method of remuneration
 - Insurance details (PMI, registration number, authorisation number)
 - Self-pay
 - NHS
- Date of procedure
- The hospital at which the procedure was performed
- Surgeon (if any)
- Procedures performed (both narrative and appropriate codes)
- Any unusual occurrences or circumstances

A logbook or database that contains these details will obviously contain confidential information. Electronic records come under the terms of the Data Protection Act, and appropriate registration and data protection are required. Further information can be found via the Information Commissioner's Office. A secure backup of all data should be kept. Many consultants starting in independent practice choose to do their own billing and keep their own accounts. The consultant should keep precise and careful records of the date and amount billed, and the date and amount received. Commercial software packages are available that will facilitate this process. However, as practice volumes increase, many opt to pay others to do their billing and financial record keeping.

An increasing number of commercial billing services are available. Consultants working in a partnership or group practice often directly employ an office manager to do the billing or have an established arrangement with a commercial billing service. Consultants whose wives, husbands or partners have no income or whose earnings are less than the threshold for higher-rate income tax may benefit financially from paying their partners to do the billing.

Data protection

The GDPR (General Data Protection Regulation) came into force on 25 May 2018. It introduces wide-ranging and significant changes to UK data protection legislation. Further information can be found via the Information Commissioner's Office (<https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/>)

Setting fees

Each consultant should determine their own fees. Agreeing with a group of local consultants to charge the same fee as others can be considered anti-competitive and should be avoided unless trading as a partnership with an established legal identity. If there is doubt about the trading status of a group of anaesthetists, expert legal advice should be sought. The penalties for breaking competition law are severe.

Banking

Take advice from your accountant on how to manage your bank accounts. Most consultants who conduct independent practice maintain a separate bank account that is wholly dedicated to their income and expenditure relating to their independent practice. You should keep a full and accurate record of all payments into this account and all payments made from it.

Tax

Never forget that you will have to pay tax on the money that you have earned, so take advice from your accountant. Many wise anaesthetist's ring-fence 40-50% of their independent practice income in a separate account so that they always have the money available to pay the tax when the demand inevitably arrives twice a year.

Investigations by the Inland Revenue

Every year, a number of doctors are investigated by HM Revenue and Customs. Most are chosen at random, some are chosen because they have drawn attention to themselves in some way. This could include but is not limited to; unusual expenses, late payment of tax demands and late submission of annual tax return. A tax investigation is time-consuming and costly for the individual concerned. It is possible to take out an annual insurance policy to cover the costs of an investigation; this is worth discussing with your accountant. Such policies usually only pay out when the subsequent investigation fails to reveal any inaccuracies on behalf of the consultant.

Billing and financial considerations

Patients cared for within the independent sector have a number of different funding sources:

- Private medical insurance
- Independently funded by the patient - 'self-pay'
- NHS funded - 'Choose and book' etc
- Embassy funded - mainly London
- Military funding
- Solicitors - e.g. third party road accident victims

With the recent increase in NHS funded patients in the independent sector, the proportion of patients funded by private medical insurance has fallen. For privately insured patients we must

be clear about the difference between benefits and fees. Benefits are what insurance companies pay out on behalf of patients according to the terms of their policy contract with them. Fees are what consultants charge patients for their professional services. These two terms should never be confused, and they should not be used interchangeably. Most PMIs make their benefit schedules available to consultants; some, such as the Western Provident Association, make their schedule publicly available. A small number of PMIs do not publish their benefit schedules. Increasingly, over the last decade, the benefit no longer matches the reasonable fees and many patients are left with a shortfall to pay the medical practitioner.

No organisation can set consultants' independent practice fees. If any membership organisation such as the Association were to attempt this, it would attract unwelcome interest from the CMA. It is for the individual consultants to determine their own fees themselves.

It is the Association's view that the individual anaesthetist should be free to set their fees according to a variety of factors that he or she may feel are pertinent. Such factors might include the following but these are not currently recognised by PMIs in general:

- The time taken to provide the service, including pre-operative, intra-operative and postoperative care
- The training, qualifications and experience necessary to provide medical care safely
- The complexity of the medical care provided
- The rarity of the anaesthetic skills necessary to provide safe and effective care
- The risk to the patient of the procedures being performed
- The time of day and day of the week that the service is provided and the degree of surgical urgency
- The risk to the anaesthetist of providing the service

Anaesthetists should review their fees on an annual basis.

Recent guidance from the CMA recommends that efforts are made to inform privately insured and self-pay patients about any fees before consultation and to do so in writing. This is often achieved by email or via practitioner websites. PHIN aims to facilitate this process. It states it is 'an independent, government-mandated source of information about private healthcare, working to empower patients to make better-informed choices of care provider. It is a not-for-profit organisation that exists to make more robust information about private healthcare available than ever before, and to improve data quality and transparency. PHIN's vision is that all patients considering private healthcare will have access to trustworthy, comprehensive information on both quality and price to help them make their decisions.'

There is no national fee structure or advice for anaesthetist remuneration for NHS funded work in the independent sector. Local arrangements are common and the Association is aware of local disputes about such remuneration arrangements. As stated previously, the Association is unable to suggest fee schedules but proposes that local arrangements are negotiated and made clear prior to undertaking NHS work in the independent sector. It is worth noting that in the NHS all consultants, regardless of specialty, are paid identical rates per session. This should be considered when negotiating fees for NHS patients cared for in the independent sector.

The independent sector and NHS funded patients

In recent years, independent hospitals have increased their NHS workload significantly. Growing demand for health services in the UK has resulted in both competition and collaboration between the public and independent sectors.

Access to NHS patients for the independent sector varies across the country and across each home nation. Progressive government policies and initiatives have become more inclusive towards the independent sector, embracing it as part of the solution rather than the problem; the formation of Independent Sector Treatment Centres (ISTCs), patient choice and extended choice have been introduced to improve public sector capacity issues.

Consultants should not assume that non-contracted NHS funded work of any sort is covered by the NHS Litigation Authority (NHSLA) indemnity. Written clarification of indemnity arrangements is essential before undertaking NHS funded work.

Regulation

Regulation of healthcare in England comprises two main elements: regulation of the quality and safety of care offered by healthcare providers, currently undertaken by the CQC, and regulation of the market in healthcare services, currently the responsibility of Monitor (in relation to foundation trusts) and the Department of Health.

- Independent sector standards and regulation:
 - Similarly to the NHS, independent hospitals have a legal obligation to meet minimum standards for quality and safety. Independent regulators of health and social care (the CQC (England), Healthcare Improvement Scotland, Healthcare Inspectorate Wales and the Regulation and Quality Improvement Authority Northern Ireland), work with the independent sector to raise standards
 - Hospitals are inspected at least every two years. These visits can become more frequent if prompted by complaints. Their findings are published within the public domain and follow up visits ensure any actions are followed through
- Market regulation:
 - Monitor, as part of NHS Improvement, ensures market forces work for the benefit of patients by preventing anti-competitive behaviour. It provides hospitals with their NHS provider licence. A national tariff for hospital activity exists across both the public and independent sector. This encourages competition on the basis of quality of service rather than cost. Monitor also ensures commissioners adhere to rules when tendering for services. An appeal panel exists for the independent sector allowing fair opportunities to compete
 - The independent sector, like the NHS, works within the same set tariff and legally has to deliver the same Referral To Treatment waiting times (including diagnostics, inpatient and day-case 18 week pathways). It also participates in the Commissioning for Quality and Innovation national goals in the same way the NHS does and faces the same penalties

From an anaesthetist's perspective, NHS work comes in many forms and includes:

Independent Sector Treatment Centres

ISTCs are purpose built premises, delivering healthcare only for NHS patients. They do not have access to private patients (PMI or self-funding). Their numbers and contracts have declined in recent years. Clinical Commissioning Groups contracts with independent providers allow ISTCs to compete for contracts locally. The rationale behind such centres was to reduce waiting times for patients by separating routine elective surgery and tests from emergency work.

- Medical indemnity: Usually indemnified via the NHS Litigation Authority (NHSLA). However, it is recommended that this is clarified with the local organisation
- Fees: Anaesthetic fees are variable. Increasingly these are less negotiable nationally, with many independent hospital fees dependent on HRG Episodes (HealthCare Resource Group) and BPT (Best Practice Tariff) (for example day-case vs. inpatient care), and negotiated locally

Patient choice and extended choice networks

Choose and Book

Since the advent of electronic booking in 2005, patients have been given the choice of hospital outpatient appointment by their GP. In 2007, this scope was expanded to include any accredited provider, extending NHS patient treatment into the independent hospitals. Therefore patients increased their options to an 'Extended Choice Network'. Successful application through a tender

process results in an agreed Standard Acute Contract. The terms and financial rewards are the same as the NHS. Similarly, the same quality standards need to be met.

- o Medical indemnity: Usually indemnified via NHSLA, e.g. National BMI schemes. It is recommended that this is clarified with the local organisation.
- o Fees: Anaesthetic fees are variable. Increasingly these are less negotiable nationally, with many independent hospital fees dependent on HRG Episodes (HealthCare Resource Group) and BPT (Best Practice Tariff) (for example day-case vs. inpatient care), and negotiated locally.

Trust Capacity work - 'Spot Work'

NHS Foundation Trusts nationally have come under increased pressure, with tighter targets and worsening capacity issues, both for theatre space and bed occupancy. Currently there is a drive both nationally and locally for the independent sector to provide additional capacity.

- **Waiting list initiative:** Displacement of patients from the NHS Trust to the independent provider, usually to meet waiting time targets. Anaesthetists commonly work independently or as a group.
 - o Medical indemnity: **Work may not be indemnified via NHSLA.** It is recommended that this is clarified with the local organisation
 - o Fees: Fees locally agreed, time based or case based (dependent on tariff vs. a proportion of set PMI benefit)
- **Scheduled Trust work:** Displacement of whole theatre teams, or the anaesthetist and surgeon to the local independent hospital (often under current National Consultant Contract T&C), usually to meet waiting time targets and limited on-site theatre capacity.
 - o Medical indemnity: Work usually indemnified via NHSLA
 - o Fees: Fees locally agreed, often time based and linked to National Consultant contract T&C

Medical indemnity considerations

Under NHSLA indemnity, NHS bodies take direct responsibility for costs and damages arising from clinical negligence in which employers are vicariously liable for the acts and omissions of their healthcare professional staff, including locums whether 'internal' or provided by an external agency. An anaesthetist employed by one Trust working in another Trust as part of a formal agreement between the Trusts is also covered by NHSLA indemnity. A consultant undertaking contracted NHS work in a private hospital would also normally be covered by NHSLA, but this must be clarified with the individual independent hospital before undertaking such work. NHS indemnity does not cover the defence of staff involved in disciplinary proceedings conducted by statutory bodies like the GMC, police investigations arising from professional practice or Good Samaritan acts. Clinical negligence means actual or alleged negligence or breach of duty in connection with the provision of clinical services. A Good Samaritan act is the provision of clinical services related to a clinical emergency, accident or disaster when the anaesthetist is not present in his or her professional capacity but as a bystander. NHS indemnity does not normally extend to private practice (PMI-funded or patient self-funded), whether conducted in the independent sector or in NHS hospitals.

It is therefore essential for all anaesthetists, especially those undertaking independent practice, which includes PMI funded and patient self-funded, to be a member of a MDO or have some other form of appropriate insurance cover. This indemnity will cover clinical negligence claims, complaints procedures, Good Samaritan acts, advice on legal and ethical dilemmas arising from professional practice, GMC enquiries, disciplinary procedures, inquests and Fatal Accident Inquiries, and police investigations arising from professional practice. Absence of protection will leave the anaesthetist exposed in the event of a claim, and this may lead to professional and financial ruin.

There are three main MDOs in the UK - the Medical Defence Union, the Medical Protection Society and the Medical and Dental Defence Union of Scotland. All three are mutual companies and do not have legally binding contracts with their subscribers. Their benefits are discretionary on the decision of their boards. In choosing suitable cover, one should carefully consider not just the actual costs but also the detail of the benefits and services offered by the company. The subscriptions for

these three medical organisations are based on a scale according to specialty and income from independent practice, excluding income from medico-legal work and taking into account legitimate independent practice expenses (depending on the MDO). It is also important to note that, in the event of a claim, the MDO will require documentary proof that the full subscription had been paid for indemnity cover. Subscriptions to MDOs are allowable expenses against independent practice earnings. The subscription is based on the coming year's predicted earnings and not the value of the previous year's earnings.

Policies with commercial companies are on a 'claims made' basis. This means that the insured doctor is only covered for claims arising from incidents that both occur and are reported whilst the policy is in force. When the policy expires, so does the cover unless a run-off payment is made. The mutual organisations offer 'occurrence or incident-based' schemes that give protection for claims arising from incidents that occurred during the subscription period no matter when they are reported, even if it is many years after that subscription had ceased. These provide ongoing protection at retirement or death - the latter prevents one's estate being liable for claims. It is worth noting that some of the three main MDOs have introduced the option of taking out 'claims made' indemnity rather than the traditional 'occurrence based'.

It is not possible to cover all aspects of indemnity in the NHS or independent practice in the limited confines of this guidance and some aspects are complex. Readers are advised to consult the relevant defence organisations for further information pertaining to their personal circumstances; see the web addresses given in the Resources section.

Independent practice in subspecialties

Independent medico-legal practice

The 2008 Association Independent Practice guideline addressed independent medico-legal practice. The Association has decided to address this area of work on its website.

Pain medicine

Independent practice in pain medicine should only be undertaken by those with the appropriate training and experience. In most cases this will mean that the consultant holds or has held a substantive NHS consultant post that includes regular work in this subspecialty.

Standards of practice

There should be no difference in the standard of care provided to NHS or private patients. These standards are set out in [The Good Pain Medicine Specialist](#) published by the Faculty of Pain Medicine in 2014. Similarly, clinical pain medicine decision-making and case-mix should be similar for an individual consultant in both public and independent sectors. The only exception to this would be differences in care relating to the form of therapies funded by the NHS and PMIs.

Clinic facilities

Clinics should be held in an environment in which access to adequate and appropriate support facilities is available as set out in [The Good Pain Medicine Specialist](#). This should include adequate facilities for consultation and examination of patients, chaperone facilities, resuscitation equipment and access to appropriate clinical investigations. Facilities for more complex investigations and scans should be available but not necessarily present on site.

Interventions

If any form of intervention is undertaken, suitable sterile conditions, equipment and nursing support must be available, along with recovery facilities if sedation or anaesthesia is given. Major interventions may demand operating theatre facilities with trained nurses. Appropriate radiological imaging modalities are required, such as an image intensifier and ultrasound. Patients should follow a defined and documented pathway of pre-operative assessment, informed consent, procedure, recovery, ward care and discharge.

Mode of practice

When practising in pain medicine, the anaesthetist's mode of practice more resembles that of a surgeon than an anaesthetist. A pain specialist will need to arrange for outpatient consultation facilities to be made available by a private hospital or he or she may rent private consulting rooms. Referrals may come from GPs, consultant colleagues, physiotherapists, osteopaths or chiropractors. When the referral does not come from a GP, it is good practice to notify the patient's GP and ensure they are fully informed about the progress of the treatment. A pain specialist will require secretarial and administrative support.

On-call cover

A consultant will need to be on-call and available for their own patients throughout any hospital admission. They will also need to provide some form of availability at other times for their patients who are undergoing treatment. It is advisable to arrange cross-cover with one or more colleagues in the same specialty. This allows adequate cover for patients during holidays and other absences.

Multidisciplinary work

Although it is less usual for pain consultants in independent practice to run multidisciplinary clinics, referral pathways to the relevant allied health professionals such as physiotherapists, occupational therapists, psychologists and pharmacists should be available in order to provide appropriate standards of care.

Fees

Fees should be set in accordance with the advice set out in 'Billing and financial considerations' above. Most PMIs provide schedules of benefit maxima for pain therapy procedures.

Indemnity

Consultants undertaking independent practice in pain medicine will require full indemnity from their MDO, which should be informed of the exact nature of the consultant's practice, i.e. the relative proportions of the consultant's income that are sourced from pain management and from purely anaesthetic practice.

Intensive care

Responsibility for patients admitted to an Intensive Care Unit (ICU)

When a private patient requires admission to an ICU, their medical management should become the responsibility of one clinician who should be a recognised intensivist. A recognised intensivist is a clinician with appropriate training and experience who holds or has held a substantive consultant's post that includes clinical responsibilities for patients in intensive care. This clinician should be the only consultant to charge the patient for their services. Only if the intensivist requests another consultant, e.g. a cardiologist, to attend the patient should any other consultant charge be made.

Postoperative intensive care as a 'routine' part of anaesthesia

Many major surgical procedures are followed by a short and predictable stay in an ICU, e.g. cardiac bypass or aortic aneurysm surgery. In these circumstances, and if the patient's postoperative treatment and course are uncomplicated, it is common practice for the anaesthetist who has managed the patient before and during surgery to be responsible for the patient while in the ICU. The fee charged by the consultant anaesthetist should include this routine ICU care. However, if intensive care extends beyond this routine postoperative period, usually taken to be a period of no more than 24 hours, responsibility for the patient's ongoing care should become the responsibility of an intensivist, who should be able to make separate charges for the patient's care. If the anaesthetist providing the anaesthetic care is also an intensivist, he or she can make additional charges after the first 24 hours in the ICU provided the patient has been given appropriate warning that this may happen.

Unexpected postoperative ICU admission

In the event of a private patient unexpectedly requiring postoperative ICU management, the patient's medical management should be handed over to an intensivist, who will make appropriate charges.

Standard of care

The same standard of care should be provided to patients in the ICUs of both independent and NHS hospitals. Equipment and beds should comply with existing national standards. Adequate numbers of intensive care trained nursing staff must be available to manage the required patient dependency. Junior medical staff with intensive care training, including airway management skills and resuscitation, must be immediately available. An on-call consultant intensivist without other responsibilities should be available at all times.

Transfer of patients from independent hospitals to NHS ICUs

Many independent hospitals do not have adequate Level 3 ICU facilities, and patients may therefore need to be transferred to an appropriate NHS hospital. The independent hospital should have in place a contractual agreement with a neighbouring NHS ICU to provide transfer of a sick privately funded patient to the NHS ICU or, if full, provide transfer to an ICU where a bed is available.

Patients may elect to continue to be fee-paying or to become an NHS patient if they are entitled to receive free NHS care. If the patient is too sick to make a decision, then they remain a privately funded patient in an NHS hospital until such time as they are competent to express their preference. Under these circumstances, some PMIs will try to claim that, if the patient is entitled to NHS care, they will no longer provide cover after such a transfer. Patients, or their next of kin, should be told that this is not usually the case and they should be advised to contact their relative's PMI to seek confirmation of continued privately funded patient status.

If no retrieval contract has been agreed, it remains the responsibility of the independent hospital to undertake the transfer of the patient. Such transfers must be prearranged in accordance with Intensive Care Society guidelines, with the availability of appropriate monitoring and equipment. Accompanying medical and nursing staff should have suitable training and experience in transporting critically ill patients.

Charging for ICU services

Some elements of ICU management may be charged as individual procedures. For example, the procedure of percutaneous tracheostomy requires both an operator (intensivist) and an anaesthetist, and both may submit accounts for the procedure. Most ICU management is a combination of procedures, ward rounds, therapy adjustments and waiting for these adjustments to work, and availability. This work may be charged as an hourly rate for actual attendance or as a daily rate taking on-call availability into account. A fixed daily charge for each patient covering all procedures may be more practical for billing purposes, and more acceptable to PMIs. As for anaesthetic fees, the actual rate charged is up to the individual, but in calculating the rate it may be helpful to consider the degree of expertise required and the length of training undertaken to become an intensivist.

Accurate records of procedures undertaken and time spent treating patients should be kept in case submitted accounts are questioned by the patients or their healthcare insurance companies.

Charging for ward consultations

Requests for consultation for possible ICU admission should be charged at the rate of a complex outpatient referral, and may be repeated over consecutive days if indicated. Intensivists may also oversee a patient's management in the first few days after discharge from ICU, and may charge for this at a suitable daily attendance rate.

Charging for patient transfers

If a patient is transferred from an independent hospital to a hospital with ICU facilities, the accompanying consultant anaesthetist or intensivist may charge for their services. This may most appropriately be at an hourly rate to include stabilising the patient for transfer, and the time taken to perform the handover.

'Fixed cost' cases and intensive care

Many independent hospitals offer 'fixed cost' packages for uninsured patients. Hospitals offering such packages should have made arrangements in advance to cover unexpected complications,

including unanticipated critical care requirements and transfer to NHS facilities. Such arrangements may include a contingency fund to cover additional medical and hospital fees, or an increased payment for each case to cover such complications.

The 2003 consultant contract

Under the terms of the 2003 consultant contract, independent practice should not be undertaken during NHS time except with the explicit permission of the employing NHS hospital management. It is not considered permissible to be paid twice for the same event. This is a problem for intensivists who may be asked to take over the management of privately funded patients during their normal NHS duties. The agreement between the BMA and the Department of Health relating to the 2003 consultant contract allows for some independent practice to be undertaken alongside a consultant's scheduled NHS duties at the discretion of their NHS employers. This may be taken to cover the situation where an NHS ICU contains the occasional private patient.

Otherwise, the options are:

- Invoice the patient for the intensive care services provided and then pay the fee directly to the hospital. This may cause problems with tax records
- Invoice the patient, keep the fee, then reimburse the hospital in time spent looking after patients
- If the work is undertaken outside of contracted NHS time as defined in the individual's job plan, it is acceptable to invoice the patient and keep the fee
- Arrange for a colleague to undertake the management of the patient, or for this colleague to cover the intensivist's NHS responsibilities in order to avoid such a conflict of interest
- Formalise an agreement with Trust management that allows intensivists to charge for the management of private patients on the basis they are a source of additional income to NHS hospitals and as such a suitable mutually agreeable solution should be possible between clinicians and management

Pre-operative assessment

Within NHS hospitals there has been huge growth in the provision of pre-operative assessment and management by anaesthetists. This has not wholly been mirrored by similar expansions within independent hospitals for privately funded patients. The Association Independent Practice Committee fully supports the notion that care for privately funded patients should reflect advances in practice within NHS funded hospitals. The expansion of anaesthetic-led pre-operative services in the independent sector requires significant time and effort on behalf of the anaesthetic team involved. Some PMIs have been slow to realise the importance and benefits of such pre-operative assessment and management, and have failed to provide appropriate remuneration for this service. The benefit schedules of most PMIs fail to provide appropriate fee codes for such work and, at present, it remains for discussion and remuneration on an individual case-by-case basis after consultation with both patient and PMI. The Association Independent Practice Committee strongly urges the PMIs to embrace the advances in patient care that anaesthetic-led pre-operative services provide and to remunerate anaesthetists accordingly. Until this is agreed nationally then it remains for an individual anaesthetist to negotiate with the patient and PMI and decide whether it is appropriate for the patient to proceed to surgery without a formal pre-operative assessment before the day of surgery.

Single-handed practice vs. group practice

There are many different ways of working within independent practice and one of the biggest considerations is whether to do so as an individual, join an established group, or even start up a new group. Many anaesthetists work as single-handed practitioners while others work within groups or partnerships. Some will decide to undertake only NHS funded work while others will take on patients who are funded via PMIs or are self-funding their care. There are pros and cons of these different ways of working as well as financial considerations.

Many will find that an established group practice or partnership already exists and if their job plan makes them attractive to the established group or they express an interest in becoming part of the group, an invitation to join might be forthcoming after appointment. Within the specialties such as anaesthesia, radiology and pathology, group practice or partnership is particularly attractive as a result of the usually discrete episodes of direct patient responsibility.

For others there are attractions to working as an individual within the independent sector. Both ways of working, along with the pros and cons are discussed below.

Single-handed practice

It is appreciated that there are many aspects of group practice that are favourable but these do not necessarily apply to all anaesthetists practising independently. This is particularly relevant to those working in large metropolitan cities and especially London.

Advantages

- Complete control over when to work, who to work with and where to work
- Complete financial control. Can employ whomever one wants to do administration and secretarial work
- Financial advantages for husband/wives/partners. Either in administration or as anaesthetic partnerships. May provide better options for incorporation as limited companies
- When established, can choose known surgeons with good reputations and low complication rates
- Only responsible for complications arising out of own practice. No requirement to be available to sort out other clinicians' postoperative complications
- Can work as hard or as infrequently as you want. What You Work is What You Earn. Rewards are potentially very high
- Able to set own fees
- Can also choose to work with on-call syndicates if wanted and available
- Independently responsible for the whole care of each patient from pre-assessment through to discharge. Not reliant on others for decisions and management pathways
- Satisfaction of having built a true partnership/friendship with surgeon/s. A relationship where both enjoy working together and rely upon each other's expertise in ensuring the best possible outcome for their patients

Disadvantages

- Potential surgical pressure to perform cases and the impact this can have on relationship with such surgeons in your NHS practice
- Risk of operating outside area of competence/scope of practice
- Need to ensure additional provision for sickness at a financial cost
- Potential for decrease in appropriate work/life balance in the relentless pursuit of greater financial gain
- Fear of loss of practice due to sickness/holiday or other unavailability
- Poor bargaining position in relation to the surgeons with independent hospitals leading to poorer packages/relative income
- Fully self-employed so no work = no income
- May take longer to become established therefore early in career may have an inefficient

practice with low numbers of cases compared to time spent

Group practice or partnership

Working as a group can range from a loosely related group sharing certain duties or facilities, to formal partnerships. The set-up of the group will determine the working practices within that group with particular attention to fee structures in light of recent CMA rulings.

Partnerships vs. chambers

Chambers

This title has been borrowed from the legal profession in the UK. Here, following completion of his or her training, a new barrister must find a seat or 'tenancy' in a set of chambers. Chambers are groups of barristers and tend to comprise between 20 and 60 barristers. The term can equally be used to describe any group of professionals who choose to work together and who share rent and facilities such as the service of secretaries and other support staff. Most chambers offer a system whereby the members contribute to these common expenses by paying a percentage of their gross income. However, there is no profit-sharing as in a partnership (see below), there can be no joint agreement on patient fees and individual members of the group keep the fees they themselves earn beyond what they have to pay towards the chambers expenses.

Partnerships

This title has a much more significant legal meaning under UK law whereby a partnership is a type of business entity in which partners share the profits or losses of the business undertaking in which they have all invested. The shares may be equal (equity partnership) or fractional, based upon the seniority or some other factor that varies only by the consent of all partners. A true partnership must have a legally drafted partnership agreement signed by all partners and there should be regular partnership meetings.

Generally, partners have an obligation of strict liability to third parties injured by the partnership. Partners may have joint liability or joint and several liabilities depending upon circumstances. The liability of limited partners is limited to their investment in the partnership, hence the term Limited Liability Partnership. Without a legally drafted partnership agreement, the group acting as a partnership will be regarded in law as a 'sham' partnership and will not benefit from the legal advantages of a real partnership, such as the ability for all partners to charge the same fee without an accusation of price fixing.

The key to the success of a partnership rests in a sense of mutual trust between partners so that there is a feeling that the work is genuinely being shared equally. One important element in achieving this feeling is the part played by the partnership manager who allocates work according to the agreed partnership rules laid down in the agreement. Partnership administration can be largely left to the salaried partnership manager who acts under the immediate direction of the elected partnership chairperson. Larger partnerships may also choose to appoint a partnership secretary and a treasurer, but the arrangements of the partnership executive are matters to be decided by the members of the partnership with professional advice from their nominated legal and financial advisors.

Since partners are jointly responsible for third party damage, one important item that must be agreed at the onset is the individuals' responsibility for medical indemnity insurance, which should ideally be made an absolute obligation for continued membership of the partnership. Some partnerships take on the responsibility of payment on behalf of the individuals to avoid any inadvertent lapses.

Group practice

Group practice brings many benefits and advantages to patients, independent hospitals, surgeons and anaesthetists, which advocates believe cannot be offered by an individual working alone.

Advantages

- Sharing practice costs and expenses
- Sharing practice accommodation and secretarial assistance
- Sharing administrative responsibilities between group members
- Sharing practice cover and on-call commitments. Can provide an emergency cover rota facilitating the immediate availability of cover 24/7, a service an individual cannot offer
- Sharing specialty expertise, i.e. not everyone in the group needs to be able to cover all specialties. Partners with particular subspecialty expertise can be allocated to the appropriate lists
- Pre-op assessment and postop follow up – due to increased presence of a group members within the independent hospitals covered, communication and assessment facilitated with other hospital staff
- Strength in negotiating with private hospitals, treatment centres and PMIs
- Independence from surgical ties, which can be seen as a strength by a group and a negative by individual practitioners. Dilutes the commitment to one or two surgeons
- Patient information and communication possibly easier to provide via a central administration point. Shared cost of websites, etc
- Changes in NHS job plans can be accommodated more easily as work covered by group

Disadvantages

- Loss of practice and professional autonomy
- Loss of income, if your personal practice becomes very busy or only involves high-value procedures compared to others in the group
- Need to deal with the clinical governance of the group and ensure good communication and consistency among group members

Republic of Ireland

This section is for consultants working in the Republic of Ireland (ROI). The other sections should be read in conjunction as they apply broadly for private practice in the ROI, in particular the appendix about the billing of patients. Specific areas and issues for anaesthesia private practice in the ROI are outlined below.

Hospitals in the ROI are either public or private institutions. To attend a private hospital the patient must have the appropriate health insurance plan for that institution or pay the hospital directly. Patients presenting to public hospitals may have either a medical card, which provides for free medical care, or can be admitted to public hospitals as a public patient for free (under the Health Care Act 1970) or can be admitted as a private patient either from private rooms or elect to go private from public outpatients. Once admitted as a private patient, they are liable for both hospital and professional fees. These are reimbursed by an appropriate health insurance plan or through direct payment by the patient.

In terms of the standards required to practice anaesthesia independently in the ROI, the Medical Council states 'Doctors with general registration may practise independently without supervision but may not represent themselves as being specialists. Doctors with specialist registration may practise independently, without supervision and may represent themselves as specialists.'

The College of Anaesthesiologists of Ireland and the National Clinical Programme in Anaesthesia 'believes that only anaesthetists whose names are included in the Register of Medical Practitioners, Specialists Division (Anaesthesia) of the Irish Medical Council, or who are eligible for inclusion, should practise independently, that is, as consultants.' Most private and public hospitals will only employ an anaesthetist as a consultant if they are on or eligible for the Specialist Register.

The Irish Standing Committee states 'All anaesthetics should be administered by or under the supervision of a consultant anaesthetist.'

Over 95% of consultant anaesthetists in the ROI work in both public and private institutions. A small number work completely in the private sector. Consultants' public contracts vary as to the amount of private practice they can do in public hospitals, as well as to whether they can work 'off-site', away from their public hospital or group of hospitals. Importantly there has been no agreed methodology to determine anaesthetists' public private workload ratio. Any methodology will have to recognise pre-operative assessment, postoperative care, consultations and involvement in intensive or high dependency care. All consultants will have to undergo Garda vetting prior to employment.

Private professional fees are mainly paid through health insurance plans with the consultant choosing either to 'fully participate' or take a non-participating standard (lower) fee and invoice the patient for any difference. This is known as balance billing. However a consultant can elect to have no relationship with an insurer and deal completely with the patient. Most consultant anaesthetists fully participate with all health insurers. Patients can elect to pay consultants and hospitals directly, and are known as private cash paying. These numbers are small outside of aesthetic practice.

The main health insurance companies are VHi Healthcare with a 53% market share, Laya Healthcare and Irish Life Health (22% each), and some other smaller companies mainly covering occupational schemes. In 2015, 46% of the population had some form of private health insurance cover, down from a peak of 51% in 2008.

As in the UK, neither the Association nor the medical representative groups, Irish Hospital Consultants Association and Irish Medical Organisation can negotiate professional fees with health insurers without being in breach of the Competition Authority's regulations. However, individual anaesthetists or recognised groups of anaesthetists within a hospital can negotiate as one entity without being in breach of the Competition Authority.

All consultants should ensure they are covered for medical liability with appropriate insurance cover. The Clinical Indemnity Scheme only covers private practice within the recognised hospital or affiliated institutions. Private patients referred from public hospitals to private ones and who are cared for by the public hospital's doctors in the private institution are usually covered but this should be confirmed with the Clinical Indemnity Scheme in writing before performing anaesthesia. Supplementary insurance such as from the Medical Protection Society (Ireland) is advised for private practice in public hospitals and mandatory for private practice done in private institutions. The exact level of cover should be confirmed with the indemnity company.

It is possible in the ROI to practice as a group of anaesthetists who bill, collect, and distribute monies on an agreed profit sharing basis without becoming a 'partnership', as legally defined. The individual anaesthetists can remain as a sole trader. A more appropriate term would be 'group'. There should be articles of association or a memorandum of agreement for issues such as joining the group, sickness, etc. The group should have a group accountant, a tax number and provide group accounts at the end of each tax year. Incorporation as a company is also possible. In either case, independent accountancy and legal advice should be sought.

Resources

- Medical Council. General Registration-EU/EEA Trained Doctors
- Medical Council. Specialist Registration
- Health Service Executive. Recent Publications
- Association of Anaesthetists. *The Anaesthesia Workforce in the Republic of Ireland*. 2014.
- VHi Healthcare. <https://www.vhi.ie>
- Laya Healthcare. <https://www.layahealthcare.ie>
- Irish Life Health. <http://www.irishlifehealth.ie>

Resources and useful contacts

Association of Anaesthetists	https://www.aagbi.org
Royal College of Anaesthetists	https://www.rcoa.ac.uk
British Medical Association	https://www.bma.org.uk
Faculty of Pain Medicine	https://www.rcoa.ac.uk/faculty-of-pain-medicine
Medical Defence Union	https://www.the-mdu.com
Medical and Dental Defence Union of Scotland	https://www.mddus.com
Medical Protection Society	https://www.medicalprotection.org/uk
General Medical Council	https://www.gmc-uk.org
Care Quality Commission	http://www.cqc.org.uk
Intensive Care Society	http://www.ics.ac.uk
Information Commissioner's Office	https://ico.org.uk
National Institute for Health and Care Excellence	https://www.nice.org.uk
National Patient Safety Agency	http://www.npsa.nhs.uk
NHS Litigation Authority	http://www.nhsla.com
Competition and Markets Authority	https://www.gov.uk/government/organisations/competition-and-markets-authority
Private Healthcare Information Network	https://www.phin.org.uk
Small Claims Court	https://www.gov.uk/make-court-claim-for-money/overview
British Pain Society	https://www.britishpainsociety.org
UK Department of Health	https://www.dh.gov.uk
AXA PPP	https://www.axapphealthcare.co.uk
SimplyHealth	https://www.simplyhealth.co.uk
BUPA	https://www.bupa.co.uk
Cigna	https://www.cigna.co.uk
Aviva	https://www.aviva.co.uk/health-insurance
Western Provident Association	https://www.wpa.org.uk
Health-on-Line	https://www.health-on-line.co.uk
Monitor	https://www.gov.uk/government/organisations/monitor
Federation of Independent Practitioner Organisations	http://www.fipo.org
Disclosure and Barring Service	https://www.gov.uk/government/organisations/disclosure-and-barring-service

Appendix 1 - London

Why is the Greater London area different?

Unlike regional centres or hospitals, the Greater London area can be geographically different and more challenging for the anaesthetist and intensivist. There are hundreds of work locations spread across densely populated areas. Despite this opportunity there is often a lack of high end skilled providers of peri-operative care. The workload is far from predictable due to client demands, surgeon availability and resource sharing. It is rare to have a predictable single speciality, single clinical team delivering care for more than a few hours. This leads to increased travel and timing conflicts as surgery is never exactly time defined. As hospital costs are higher, the theatre resource is densely packed, variable and moveable to capture as much income as possible from each theatre time block.

There are also huge differences between how a doctor is paid for many London based patients. Syndicates and group practices are relatively rare in this area but there are some large and effective groups. In general, these have shared secretarial services with individuals deciding individual charges. They carry no group liability, rarely have profit share and 'membership' is usually by invitation only.

Travel between multiple worksites within a single day is very common in London and given the variability in traffic and public transport, consideration must be given to avoid clinical delays and unplanned double booking of services. Given external communication on the underground trains can be challenging, especially if unexpected train delays combine with variable surgical times, single day multiple site working can be more stressful than rewarding. There is always a potential to be delayed in returning to an NHS session later in the day due to travel or surgery and this should be contingency planned as per other sections of this booklet.

Different funding authorities

Self-funding UK residents

These can be invoiced as per the usual rules of that doctor established above.

Self-funding non-UK residents

Can present a problem due to expectations that the surgeon's fee in some countries includes anaesthesia, so pre-warning or invoicing is essential. Many will not have access to a computer and only have access to the internet via mobile devices. Therefore some will not see, or being able to clearly read, PDF/Word attachments, etc. Payments can be a challenge in terms of currency, exchange rates and conversion fees - i.e. who absorbs these charges - clarity is important to avoid conflict. Receipts will be expected. Cash is offered sometimes but be aware that issuing banks ask for the name and details of the requesting doctor under current rulings. Payment after the procedure can be awkward for anaesthetists as the patient may not have a UK address to serve invoices. Pre-payment, or agreement to pay, is recommended before the event.

Non-UK residents covered by organisations

A country of origin may not clearly dictate what sort or nature of healthcare coverage is guaranteed/agreed for that individual. In some circumstances the individual may not know the extent of the cover either.

Many such clients will have healthcare cover under policies from large organisations such as:

- National Embassies - e.g. Kuwait, America
- Health Offices/attachés to embassies - Saudi, Kuwait, and many others
- Military attachés of countries or embassies - Kuwait
- Student offices - Saudi Cultural office
- Insurers providing cover to section of a population - Saudi Allianz or Saudi Aviva

n.b. clients of these groups will not pay any invoice themselves, before or afterwards.

Many require pre-authorisation in the name of the treating doctor - now including anaesthetists before treatment. This does NOT guarantee payment; some will require a medical report before and indeed afterwards. Schedules of charges are not published; this is a vague, grey area and leads to confusion and distress for clinicians and their administrative staff. Some have moved towards matching a large insurer's schedule of charges.

Payment is not guaranteed, either in amount or time of payment. It is not unusual for payment to arise many months or even years later and yet at an amount that may not match the invoice. Repeated reminders are commonly necessary. Some sole traders prefer to not care for some organisation's patients due to historical issues with recompense. It is advised to know the funding authority prior to agreeing the clinical care - to negotiate or cancel on the day of surgery is deemed unprofessional by many private hospitals. Many large hospitals now have International Patient Affairs offices to assist clinicians, but even these offices struggle.

It should be noted that these large highly funded organisations have non-European style administration and office work flows. If their clients identify invoice issues then those clinicians involved can be excluded from future clients and also remain unpaid for their work already delivered.

Private hospitals

Greater London contains a very large number of hospitals, clinics, offices, and surgeries that require anaesthesia. This is an ongoing challenge for the CQC and the individual anaesthetist. It is an administrative load to maintain distribution, to multiple independent platforms, of appraisal, GMC, indemnity and vaccination data that are required - this is not to be underestimated. Many doctors have practising privileges at many institutions. This is often in contrast to non-large city practice across the UK. Many institutions require demonstration of the Scope of Practice and only allow independent practice that is reflected in the appraisal Scope of Practice - this can of course become a challenge as careers develop and should the clinician leave the NHS to become fully independent.

The CQC has encouraged many clinical areas to have an anaesthetic on-call rota, funded or voluntary. The local regulations govern these; however, potential conflicts exist: scope of practice declaration, content/cover (especially of paediatrics, obstetrics, cardiac, and pain); whilst the rota may not seem onerous in frequency, it is easy to find crossover/overlap issues (probity) between two or more rotas from the NHS and private sector, especially if the doctor has admitting rights at several institutions.

Staffing at so many providers is frequently transient, with large numbers of bank and agency staff covering regular, ad hoc sessions and isolated sites. With the buildings themselves rarely being built for purpose, this can lead to a lack of essential knowledge. Therefore the occasional user should clearly establish local safety procedures, location and access to the difficult airway trolley, sugammadex, professional help (colleague), cardiac arrest trolley and dantrolene/Intralipid® - as these things are rarely known by non-permanent staff.

A number of the hospitals will have high dependency or intensive care facilities on site with separate formal rotas and trained registered medical officers, and frequently there are multiple theatres and suites - this gives easy access to colleague/peer support in a crisis situation but should not be relied upon and anticipated escalation of care should be pre-planned.

VIPs

Occasionally there are clients who describe themselves or are described as very important people (VIP). As such they may demand special treatment, service and follow up. Some are self-pay, some are covered by larger organisations as above, some on special policies within these organisations. Of note, these clients may travel with an entourage of family and friends and, of course, personal medical teams who have ill defined roles in healthcare delivery of the individuals but may affect the traditional relationship UK clinicians have with their patients/clients.

Appendix 2 - Billing guidance

Voluntary code of practice for billing private patients

Introduction

In 2008, the Association produced the *Voluntary Code of Practice for Billing Private Patients* in response to requests from members and in order to guide members in matters relating to invoicing patients for private medical services. This has been updated for 2018 and is included here as an appendix rather than a standalone guideline. This guidance refers only to billing for patients with private medical insurance and self-funding patients. It does not refer to NHS funded work in independent hospitals.

The private health market, particularly around billing, continues to experience huge change. Traditionally fees were payable by patient to anaesthetist directly but as online billing opportunities increased there was pressure for anaesthetists' fees to be paid directly by third parties as part of a treatment 'package' or network. The Association believes it is important that the direct professional and contractual relationship between consultant anaesthetist and private patient be maintained. The guidance provided in this document underlines this relationship.

Summary of recommendations

- An anaesthetic consultant (henceforth 'consultant') sets the fees that they charge their patients. PMIs set benefit levels for their customers. Until recently there was no requirement for any correlation between fees and benefits
- Some PMIs now insist, as part of the process of recognition with the provider, that any new consultant agrees to set their maximum fee to the benefit level or below
- Once a patient has agreed to the fee to be charged by the consultant for a procedure, there exists a contract under which the patient becomes liable for the payment of the fee, regardless of whether or not the patient holds private medical insurance
- Consultants should charge transparent and reasonable fees, and should make every effort to inform their patients of the fees before surgery
- Insured patients should be encouraged to check the benefit levels provided by their particular policy with their PMI before undergoing surgery
- The fee charged should ideally include the totality of the care involved in the planned procedure. Any additional fees should be disclosed to the patient before surgery
- Consultants may send invoices to the patients, their PMI or both. The Association recommends that consultants always send the invoice to the patient. A copy of the invoice may also be sent to insured patients' PMI
- Increasingly PMIs request online billing as part of their terms and conditions of recognition, with no requirement to bill the patient directly. While this has become common practice the contract of care remains between anaesthetist and patient

General comments

- When a consultant anaesthetist offers medical care to a private patient in return for a disclosed fee and the patient agrees to this arrangement, a contract is created in which the patient is wholly responsible for the payment of the consultant's fee
- This contract is not affected by the fact that the patient is a subscriber to a PMI; the patient remains ultimately responsible for payment of the fee but the PMI may pay some or all of the fee to the consultant on behalf of the patient
- There exists no legally enforceable contract between a consultant and a PMI except where both parties enter willingly into such a contract
- Private patients will remain responsible for payment of a consultant's fee under the contract between them unless the consultant agrees to accept that the responsibility for payment should be confined to the PMI or other third party

Before treatment

- Whenever possible, the consultant should inform the patient before treatment of the likely fee or explain how it will be determined. Where, as often happens, patients take the decision to undergo an operation before they have spoken to their anaesthetist, they should be advised to contact the consultant anaesthetist if they wish to be told more about the fee that will be charged
- The scope of the fee quoted by the consultant should be explained. It may for example be a totalled fee for all the planned elements of the expected treatment process, such as:
 - Routine pre-operative evaluation whether performed shortly before surgery or some time in advance;
 - Intra-operative care, including payments to assistants or consultant colleagues for services provided during the treatment;
 - All drugs and equipment used in connection with the procedure;
 - Invasive monitoring lines used before, during or after surgery;
 - The performance of peripheral or neuraxial regional anaesthetic or analgesic techniques supplementary to or in place of general anaesthesia; and
 - Postoperative care, to include high dependency and intensive care, and the management of continuous neuraxial or peripheral analgesic techniques.
- If the fee quoted does not cover the totality of planned care, the consultant should tell the patient and clearly describe the additional fees that may be charged
- The patient should be warned that if the procedure and care differs from that planned, the fee may also vary, but that this variation will be fixed by the same means.* If any specific variations are envisaged these should be described at least in outline and the fee scales explained

*If the fee for the planned procedure is, for instance, 125% of the benefit maximum provided by the patient's PMI, then the fee for the procedure actually performed would be expected to be approximately 125% of the benefit maximum offered by the PMI for the actual procedure performed

- The consultant may choose to provide a separate estimate of high dependency or intensive care fees. This is advisable where it is less likely that these costs may be incurred
- The consultant should recommend that all patients check the benefit levels that are available for the treatment under the policy held with the PMI
- The patient should be told that they are ultimately responsible for the payment of the fee or the payment of any shortfall
- The consultant may wish to ask the patient to sign a financial agreement before the treatment in which the patient guarantees that the consultant's fee will be paid
- If the consultant chooses not to be paid directly by the PMI, the patient should be told as far in advance before the planned treatment as possible
- The consultant should tell the patient if they know they are not recognised for benefits by the patient's PMI
- The consultant should keep a record of the fee quoted to the patient
- It is acceptable for a consultant to request payment of fees in advance of treatment under certain circumstances
- Sometimes fees are negotiated by a third party on behalf of the doctor. The fee set by the consultant anaesthetist may be agreed with the patient by the surgeon or by the surgeon's secretary or other agent. Sometimes it will be by a hospital administrator. Consultant anaesthetists must ensure that their agents have a clear, complete and up-to-date list of their charges and that they make a record of precisely what has been agreed
- Sometimes, particularly in emergencies or where there are linguistic problems, the patient's agreement will be given by an accompanying relative or other agent acting on their behalf. In all these circumstances it is vital to ensure the representative has the authority of the principal they represent. Parents and spouses have ostensible authority to negotiate on behalf of their children and partners; in all other cases the doctor will be wise to ensure there is a binding agreement with someone identifiable
- If separate charges are to be made by the consultant in respect of anaesthetic agents, other drugs or equipment, they should ensure that the patient appreciates this

During treatment

- If the consultant surgeon and anaesthetist plan to use a coding system, e.g. CCSD codes, when billing the patient, they should agree the code or codes relating to the procedure or procedures performed, and should ensure that members of the operating theatre staff are informed of these codes
- In choosing codes, the consultants should agree upon the code or codes that best describe the procedure or procedures performed, bearing in mind that some codes are specifically constructed so as to include the performance of more than one procedure. Consultants should not break up the elements of a single surgical or anaesthetic procedure into its constituent parts in order to maximise the benefit provided to the patient by his PMI

After treatment

- Accounts** should be sent to the patient, the patient's PMI or to both***

**A sample invoice is provided at the end

***The Association recommends that consultants always send the invoice to the patient. A copy of the invoice may also be sent to insured patients' PMIs

- If the consultant agrees to set their fee within the PMI's benefit maxima, they can send an account only to the PMI if they so wish. Alternatively, the consultant can send an account to the patient and a copy to the PMI (or vice versa), making clear that this has been done
- If the consultant's fee is likely to be in excess of the PMI's benefit, they would be wise to send an account to the patient and, if they wish, a copy to the PMI (or vice versa)
- If the patient does not hold private medical insurance or if the consultant does not wish to be paid directly by the PMI, the consultant should send an account to the patient and should ask to be paid directly by the patient. Under these circumstances, the consultant should offer to provide the patient with a receipt so that the patient can claim benefits from their PMI if he has one
- If a consultant uses a billing service, they should consider themselves responsible for the fees charged in the bills sent on their behalf and for the way in which the fees are collected
- Only one invoice (and copy if appropriate) should be sent for each discrete treatment episode
- Consultants are not obliged to put a CCSD code on their accounts, unless they have entered into an agreement with the patient or their PMI to do so, but it may assist the patient if codes are included in the account
- The consultant may include a descriptive narrative of the procedures performed in the account in order to assist correct coding by the PMI but should not do so in order to maximise benefit payment
- The consultant should not normally allocate portions of the fee to particular codes or narratives. The fee should represent the whole amount payable for the entire treatment episode
- The consultant may, if it has been specified as a term of the contract, set a time limit for payment and should detail any penalties or additional payments that will be incurred by late payment

Emergencies

- Emergency treatment is more complex and carries more risk than elective treatment. It also frequently takes longer than elective treatment and is often more disruptive of the consultant's life, being conducted outside routine working hours. Thus the consultant will frequently feel it is appropriate to charge a higher fee
- Some procedures specified by CCSD codes are always performed as emergencies and the PMI's benefit maxima associated with those procedures may take this into account
- Other procedures specified by CCSD codes are commonly performed electively so that benefit maxima are less likely to cover the fees consultants charge for acting in an emergency. Where the consultant charges a higher fee because of some factor particular to the case, such as the fact that it has been performed as an emergency, then this should be made clear to assist the patient in explaining the situation to the PMI
- The consultant should make every effort to warn the patient of the fee in advance of surgery but

this may not be possible in an emergency, in which case the patient, or whoever has contracted on their behalf, will have incurred a liability to meet a fee that is reasonable in the circumstances

- The fee that will be reasonable in the circumstances will take into account the issues mentioned above. If the patient cannot be warned of the fee in advance of surgery, the fee that will be reasonable in the circumstances will be based on the appropriate fee for the equivalent elective procedure, with an additional proportion added to the extent that the factors described arise

Example of an invoice

Dr H Featherstone FRCA
Consultant Anaesthetist

21 Portland Place
London W1B 1PY
Tel: 020 7631 1650
PMI Ref: HF 04786
Provider Ref: 152320

To Mr A Patient
Address

For Professional Services

At the John Snow Hospital on 29/2/2018

Procedure: Ectomy and refashioning
CCSD Code: X2365

£325.00

Terms: payment within 30 days

Either: If you have insurance please forward this to your insurers

Or: A copy of this invoice has been forwarded to your insurers

With compliments

Safer, for everyone

Every anaesthetist aims to keep their patients safe. We aim to safeguard every anaesthetist – by educating, supporting and inspiring them throughout their career.

We represent the life-changing, life-saving profession of anaesthesia by supporting, informing and inspiring a worldwide community of over 11,000 members.

Our work and members span the globe, yet our voice is local and personal. We stay in close contact with our members, look after their day-to-day wellbeing, and act as their champion.

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