NHS
Dorset
Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Policy and Guidance for the Management of Planned Care for Dorset



Supporting people in Dorset to lead healthier lives

Document History				
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Nature of Change**
June 2019	1.1	June 2022		This policy combines the former Framework for Scheduled Care and Hospital Generated Inter-Specialty Referrals Policy. Both documents are available from NHS Dorset CCG on request. The policy also includes the development of a Private and NHS Transfer of Care Policy.

NHS DORSET CLINICAL COMMISSIONING GROUP (CCG)

POLICY AND GUIDANCE FOR THE MANAGEMENT OF PLANNED CARE FOR DORSET

1. INTRODUCTION

This policy and guidance defines roles and responsibilities and establishes a consistent approach to how Dorset patients access services, ensuring national standards are met and waiting time data is accurate and of good quality. The Policy and Guidance for the Management of Planned Care applies to Dorset registered patients and includes:

- NHS Constitution entitlements
- Waiting times including Referral to Treatment entitlements as per October 2015 rules suite and cancer waiting times
- Key national and locally agreed standards.
- Hospital Generated Inter-Specialty Referrals
- Interface between NHS and private care pathways
- Evidence-Based Access Criteria Protocols
- Individual Funding Requests

All NHS and independent sector organisations commissioned by NHS Dorset CCG to provide NHS care are required to develop and publish operational policies in line with this Dorset CCG policy and guidance.

1.2 The term 'planned care' (also often referred to as elective care) relates to services where patients attend health appointments and clinics which have been pre-arranged (planned) at a hospital or other health care location. This applies to those appointments (outpatient, follow up, treatment and surgery) which are not a result of a health accident or emergency and can be arranged in advance of the patient's care.

1.3 The successful management of patients who are waiting for planned care is the responsibility of all staff working within the NHS.

2. THE NHS CONSTITUTION

The NHS Constitution sets out patient and staff rights and responsibilities relating to the NHS through seven key principles which guide the NHS, including access to health services.

2.1 Access to health services

Patients have the right to:

- Receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.
- Access NHS services. Patients will not be refused access on unreasonable grounds.
- Receive care and treatment that is appropriate to them, meets their needs and reflects their preferences.

- In certain circumstances, go to other European Economic Area countries or Switzerland for treatment which would usually be available to through NHS commissioner.
- Not be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.
- Access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

More details can be found in The Handbook to the NHS Constitution

2.2 Patient responsibilities

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used efficiently:

- Please provide accurate information about your health, condition and status.
- Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
- Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

More can be found at https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#patients-and-the-public-your-responsibilities

3. EVIDENCE BASED ACCESS CRITERIAL PROTOCOLS

NHS Dorset CCG has a finite level of financial resources with which to commission healthcare interventions for its population. Consequently, it has to prioritise which interventions that it commissions. In doing so it takes into consideration a number of factors including clinical effectiveness and value for money as well as the availability of alternative interventions and the implications of not commissioning the intervention.

Inevitably there will be some interventions which the CCG has not prioritised for routine commissioning. A series of Criteria Based Access Protocols (CBAPs) have been developed for these interventions which outline under what clinical circumstances an intervention would be made available. Some of these will only be made routinely available where specific clinical criteria are met, whilst in others they will not be made routinely available at all. In both cases consideration may still be given to provision for a specific patient if a case is made and accepted that there are clinical factors that make the patient clinically exceptional. The process for considering requests on the basis of clinical exceptionality is outlined in the CCG's Policy for Individual Patient Treatment.

4. WAITING TIMES

Patients have the right to be seen in a timely manner and within the expectations set out by the Referral to Treatment Rules Suite (2015).

4.1 Referral to Treatment (RTT) Rules Suite

The RTT Rules Suite published in October 2015 aims to set out clearly and succinctly the rules and definitions for referral to treatment times to ensure that each patient's waiting time clock starts and stops fairly and consistently.

A waiting time clock starts when any care professional or service, permitted by an English NHS commissioner to make such referrals, refers a patient to:

- A consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility of care is transferred back to the referring health professional or general practitioner;
- An interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility of care is transferred back to the referring health professional or general practitioner;
- A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

4.2 The RTT rules suite sets out national waiting time rules, definitions, clock stopping conditions, guidance on applying the national rules locally, guidance on reviewing the pathways of patients who have waited longer than 18 weeks before starting their treatment and guidance on clinical expectations to the NHS Constitution right to access services within maximum waiting times.

4.3 It does not attempt to provide detailed guidance on how the rules should apply in every situation, but provides the NHS with a framework to work within to make clinically sound decisions locally about applying the rules, in consultation between clinicians, providers, commissioners and, of course patients.

4.4 For all types of appointment/admission priority will be given to clinically urgent patients. Patients of the same clinical priority will be seen in chronological order from date the referral was received. However, priority access must be given to military personnel and veterans for service related conditions.

RTT_Rules_Suite_October_2015.pdf

5. NATIONAL AND LOCAL OPERATIONAL STANDARDS

5.1 Commissioners and providers in Dorset are committed to putting patients first and ensuring that national operational performance standards are met. Commissioners and providers will provide information on a patient's right to access services and start treatment within the maximum waiting times.

5.2 The National Operational Performance Standards for England are as follows:

National Operational Standards		Standard
Referral to Treatment Times	Patients on an incomplete pathway (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%
Diagnostic Wait Times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%
Cancer Two Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially	93%
Cancer Wait 31 Day	Maximum one month wait from diagnosis to first definitive	96%
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%
	Maximum 31 day wait for subsequent treatment where the treatment is a course of	94%
Cancer Wait 62 Day	Maximum two-month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%
	Maximum 62 day wait from an NHS screening service to first definitive treatment for all cancers	90%
	Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	None set

Cancer standards are covered within the Dorset Cancer Partnership Access Policy.

5.3 In addition to these standards, the following quality measures must be attained. The threshold, method of measurement and consequences of breach are also detailed:

- The Provider shall make information relating to services and waiting times available to NHS patients through the NHS Choice Framework, ensuring the information provided is accurate and up-to-date.
- The Provider shall offer clinical advice and guidance to GPs through the NHS e-

Referral system (eRS) unless otherwise agreed, whether this leads to a referral being made or not. All GP referrals to consultant-led outpatient services must be made via the eRS system. Providers are encouraged to make referrals to other services also available for booking via eRS (e.g. AHP, nurse-led services, diagnostics).

- The Provider and the Commissioners shall work together to ensure that patients are not inconvenienced by insufficient appointments being made available on e-RS to book
- The Provider must ensure contingency plans are in place to deal with patient bookings and the receipt of referrals should the NHS e-Referral system be temporarily unavailable for any reason. A process has been agreed across Dorset for the very occasional times when the service is temporarily unavailable. See Appendix 1
- Providers must have in place a robust system to accept referrals from the Appointments Slot Issue (ASI) where patients have attempted to book an appointment but there were no slots showing on e-RS at the time, as detailed in the Rapid Improvement Guide to Appointment Slot Issues (2017) https://improvement.nhs.uk/resources/rapid-improvement-guide-appointment-slot-issues/
- Referrals should only be rejected if considered clinically inappropriate for that specialty, for example, if, following clinical assessment it is considered that alternative methods to a face to face appointment are more appropriate. Rejections should only happen occasionally and **providers must not reject patients for capacity reason as choice has been made by the patient**. Clear feedback information in NHS e-Referral should be provided to the GP when rejecting a referral to help manage the patient's condition and/or help inform future similar. It is helpful for providers to communicate to the patient (particularly if near to the appointment date) that the appointment has been cancelled. Responsibility for acting on the rejection advice does, however, rest with the referrer in line with how the referrer would act on a response for advice and guidance.

5.4 **Interface between primary and secondary care**

Six new requirements for hospitals were introduced in the 2016/17 NHS Standard Contract to clarify the expectations across the hospital and general practice interface and reduce avoidable extra workload for GPs and help release time. These changes help to address concerns raised in 'Making Time in General Practice' and are acknowledged in the 'General Practice Forward View. Some of these have been updated and additional ones also added in the 2017-2019 NHS Standard Contract, as below.

a) Local access policies

Hospitals cannot adopt blanket policies under which patients who do not attend an outpatient clinic appointment are automatically discharged back to their GP for re-referral. This policy fulfils this element and ensures there is a consistent approach to the management of scheduled care across Dorset.

b) Discharge Summaries

Discharge summaries following inpatient or day case admission must already be sent electronically as structured messages using standardised clinical headings. From 1 October 2018, this requirement also applies to discharge summaries after A&E attendance. From 1 October 2018, transmission of both discharge summaries and clinic letters to general practices must be via direct electronic transmission, not via email.

c) Clinic Letters

Where there is information which the GP needs quickly in order to manage a patient's care, the provider must communicate this by issue of a clinic letter within 10 days of attendance (reducing to within 7 days from 1 April 2018). New guidance requires that as from 1 October 2018, clinic letters must be sent by direct electronic transmission as structured messages using standardised clinical headings.

d) Onward referral of patients

See section 5 on Inter hospital specialty referral.

e) Medication on discharge

Providers to supply patients with medication following discharge from inpatient or day case care. Medication must be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).

f) Medication Following Clinic Attendance

The provider must supply medication following a patient's attendance at clinic, where clinically indicated, for the period required by local protocols or practice, but at least sufficient to meet the patient's immediate needs up to the point at which the clinic letter reaches the GP.

g) Referral Information

The commissioner must seek to ensure that GPs supply the provider with accurate patient contact details and other information required in local referral protocols.

h) GP Feedback

Providers are required to take account of GP feedback and to involve GPs when considering service development and redesign.

i) Communication and Organisation of Care

The provider must organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs. This specifically includes notification to patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example, telephoning the patient.

5.5 Health communities are required to agree local arrangements, where the national guidance allows, to ensure consistency across all commissioned services. In Dorset, 18 weeks RTT, as a minimum, will also be applied to non-Consultant led pathways such as

therapy services.

5.6 It has been agreed that the following local arrangements in Dorset will apply in relation to DNAs and patient cancellations. All DNAs will be clinically reviewed before discharging back to GPs and additional exceptions will be applied for children and vulnerable adults.

DNAs:

- In line with the national strategy 'Making Time in General Practice' (October, 2015) no Trust is able to implement a blanket Did Not Attend (DNA) policy e.g. of discharging patients back to their GP. Clinical review must take place. In line with the October 2015 Rules Suite a DNA is defined as "where a patient fails to attend an appointment/admission without prior notice. Patients who cancel their appointments in advance should not be classed as a DNA and therefore should not have their clocks nullified."
- The referral for all patients who DNA a first outpatient appointment will be clinically reviewed and acted upon accordingly. If at this point there is a decision to not reappoint the patient, both the patient and the GP will be made aware.
- Patients who DNA a hospital appointment will be able to re-book directly with the hospital within two weeks without going back to their GP if deemed appropriate following clinical review. A new 18-week clock would restart from the date the patient contacts the hospital to rearrange the appointment (not the date of their new appointment). The hospital must contact the patient directly within 2 weeks to re-book. The GP should be notified if a new appointment is not able to be made for those deemed to require a further appointment.
- In all instances of DNA for first outpatient appointment the clock will stop and a new one started as detailed above.
- When a patient DNAs a follow up appointment, a new appointment should be offered and the clock continues. If the clinician considers it to be in the patient's best clinical interest to be discharged back to their GP then the clock will stop.

Cancellations:

- Patient-initiated cancellations: If a patient has cancelled or rearranged a mutually agreed appointment twice before, on the third cancellation of an open pathway a clinical review will take place. This is to ensure the patient's clinical risk is managed. A referral back to the GP should always be a clinical decision, based on the individual patient's clinical safety. Patients **may be** referred back to their GP unless they are patients on a cancer pathway/paediatric/military veterans / pensioners requiring NHS care for conditions related to their service. A degree of flexibility is needed for when there are reasonable reasons for the cancellations, e.g. if the patient has experienced bereavements.
- If a patient postpones an appointment when the patient is willing but circumstances don't allow a date to be booked the clock continues ticking as clock pauses no longer accepted in national Model Access Policy.
- Provider-initiated cancellations: If a provider cancels an appointment at any point in the RTT pathway, this has no effect on the RTT waiting time. The RTT clock should continue to tick.

If the treatment is cancelled by the provider after admission because of resource constraints (for example, lack of theatre time due to emergency procedures being carried out), then the RTT clock should continue to tick until the patient ultimately starts their treatment.

- If a patient requests time to think about the offer of a clinical intervention, a week of thinking time can be given and the patient's clock will continue. If the patient either does not communicate in the agreed time or cannot make a decision, they will usually be returned to their GP following clinical review of the individual patient's condition.
- Patients who become unwell with an illness that is expected to last less than two weeks will remain on their current pathway and their clock will continue. Patients who become unwell with a condition expected to last more than two weeks will be referred back to their GP with an explanation of why this has happened. If they require urgent secondary care intervention in another specialty, an onward referral will be made and the GP will be informed why this has happened
- Patients should be offered two dates for appointments with reasonable notice (at least three weeks). If patients cannot commit to one of these dates they **may be** returned to their GP as they are not ready, willing and able.
- Patients opting to participate into research projects will be outside of the 18 weeks to enable them to be treated according to the research protocol.
- Patients who are sent a partial booking letter, but fail to respond within the requested timescale, will be contacted once more, following which their care will be returned to the GP

5.7 If a patient moves in to the county and is already on a care pathway the waiting time clock continues. A new clock does not start.

6. INTER-HOSPITAL GENERATED INTER-SPECIALTY HOSPTIAL REFERRALS

This section relates specifically to NHS care within the same hospital. The exception is where the same condition requires the patient to go to another hospital as part of that same pathway. This does include NHS to private transfer (see section 7.)

6.1 The following should be applied by hospital providers in respect of potential onward referrals:

- Unless otherwise requested by the GP, onward referral within the same provider for a non-urgent condition which is **directly related** to the original complaint or condition should be made without re-referral to the GP;
- Onward referrals should not be made for non-urgent conditions which are **not** directly related to the original complaint or condition. In such cases the patient should be referred to their GP for a review;
- Onward referral for urgent conditions should proceed automatically and without delay where:
    * The referral is for investigation, management or treatment of cancer or a suspected cancer;

- The symptoms or signs suggest a life threatening or clinically urgent condition. It would be expected that such a situation would however be rare in the case of an outpatient referral;
- The onward referral for a non-urgent condition is directly related to the complaint or condition which caused the original referral;
- Failure to refer onwards may result in either hospital admission or re attendance for example through Accident and Emergency;
- Where a GP has specifically given approval for such an onward referral in their original referral letter;
- Diagnostics and investigation, for example where endoscopy is required as part of the patient pathway for the original presenting condition;
- An anaesthetic risk assessment is required.

6.2 Principles

- The GP is the overseer of the patient's care and where a consultant or associate specialist is unsure about referring a patient on within the Trust they should consult with the GP to agree the appropriate course of action
- GPs, including locums, should provide adequate referral information to ensure that patients are directed to the appropriate consultant;
- If an unrelated condition can be managed in primary care then the patient should be referred back to their GP practice (without a recommendation being made to the patient that they need to be referred to see another hospital specialist);
  - Patients with minor symptoms should be sent back to their GP with supporting information (for example patients with dizziness should not be referred routinely on to neurology unless the referral is deemed to be clinically urgent).
  - In the event that a patient mentions a condition during the hospital consultation that is coincidental or not relevant to the initial referral by the GP, the patient should be referred back to their GP with instructions to seek the GPs opinion regarding the management of the secondary condition. The exceptions are outlined in 6.1.
- If a patient is referred for a clinical opinion to exclude a specific cause, such as cardiac involvement in a breathless patient, they should not then be referred onto the respiratory team for further investigation. They should instead be referred back to the GP to determine if the patient can be managed in Primary Care without the need for further specialist support;
- A single episode of care should not generate two first outpatient attendances in different hospitals for the same consultant within the same pathway;

- Provider Trusts must advise the CCG on the source code(s) used for recording interface service referrals;
- If patients self-refer they should be advised to see their GP to initiate a referral, with the following exceptions:
  - Genitourinary medicine;
  - SOS returners.

- In cases where an inter-specialty referral is appropriate the patients GP must be informed of all such referrals by receipt of a copy of the consultant's referral letters.
- If inadequate information is provided on referral, providers must use the 'reject' option on e-Referral.

6.3 Consultant to consultant referral principles

- Internal non-emergency inter-specialty referrals (including accident and emergency to consultant referrals) can only be authorised by the consultant or associate specialist not members of their team such as:
  * Specialist nurses/Accident and Emergency nurses;
  * Junior Doctors; and
  * Allied Health Professionals.

- Where the referrer has sent the patient to the correct specialty but to the wrong consultant the case should be forwarded to the correct clinician without delay. The patient should not be referred back to the original referrer;
- If the patient has been referred to an incorrect specialty and is not deemed to be urgent, all referrals should be passed back to their GP without delay with details for the correct referral outlined.
- Referrals that are not life threatening, cancer or urgent, should not be referred to another specialty. Ongoing referral investigations should be completed and the patient referred back to the GP for potential alternative investigations.

7. INTERFACE BETWEEN PRIVATE AND NHS CARE

7.1 Patients can choose to move between NHS and private status at any point during their treatment without prejudice. This is provided NHS care is delivered in clear episodes which are demonstrably separate from any privately funded care *(Guidance on NHS patients who wish to pay for additional private care, DoH, 2009).* This is to ensure the patient does not combine elements of NHS and private treatment/care within the same episode.

Following a private outpatient appointment, a consultant can refer in to the NHS without the need for it to go via a GP. Providers must ensure that all patients who are referred to them following a private outpatient appointment meet local criteria, e.g. CBAPs.

ALL MSK referrals in Dorset (**both private and NHS**) must go via the MSK triage service, with the exception of red flags. Private MSK referrals for surgery must be sent to the Dorset MSK triage service with a fully completed pro forma. If the pro forma indicates that the patient has had previous interventions prior to the surgical referral, in line with the NHS pathway, MSK triage will forward the referral to the consultant-led service.

Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate. The

RTT clock starts at the point the GP or original referrer's letter arrives in the hospital (Model Access Policy, Jan 2019).

The following entitlements and principles apply:

a. Patients may pay for additional private health care while continuing to receive care from the NHS. It should always be clear whether an individual procedure or treatment is privately funded or NHS funded. *(Guidance on NHS patients who wish to pay for additional private care, DoH, 2009)*

b. Private and NHS care should be kept as clearly separate as possible, e.g. delivered at separate time and place unless clinically inappropriate to do this *(Guidance on NHS patients who wish to pay for additional private care, DoH, 2009).* Co-funded treatment is not supported.

c. Patients who have had a private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment. They should be placed directly onto the NHS waiting list **at the same position as if their original consultation had been within the NHS** (*Code of Conduct for Private Practice, 2004*).

d. Doctors, working with NHS managers, should exhaust all reasonable avenues for securing NHS funding before suggesting a patient's only option is to pay for care privately. *(Guidance on NHS patients who wish to pay for additional private care, DoH, 2009)*

e. Consultants should not spend time during NHS consultations discussing private treatment with patients nor should they use their NHS patient lists to promote their private practice. An exception is where clinically appropriate treatment is not funded by the NHS. Where this is the case, patients should be informed, in order to be able to consider the options open to them, including the option of seeking the treatment privately (*Code of Conduct for Private Practice, 2004)*

f. All doctors have a duty to share information with others providing care and treatment for their patients. This includes NHS doctors providing information to private practitioners

See Appendix 2 for case studies.

7.2 It is expected that the options for onward referral from private healthcare for NHS treatment will be discussed by the private clinician with the patient, including patient choice (in line with the principles outlined in c, d. and e. above). The patient should be made aware that they may not necessarily see the same consultant in the NHS as they did privately.

7.3 Private to NHS referrals should be made using 'consultant to consultant' functionality until functionality exists within eRS to carry out 'any to any' referrals.

8. SAFEGUARDING GUIDANCE – ADULTS/CHILDREN

8.1 Patients have the right to be kept safe and their needs considered and managed whilst in the care of NHS services.

All health staff has a responsibility to safeguard and protect children and adults who use their services.

Each health organisation is required by law to ensure all staff are able to identify the signs of abuse and to respond appropriately.

They need to have systems in place which allow for the sharing of information for the purpose of safeguarding that is in the best interest of the patient whilst minimising risk; and to work closely with other agencies including: social care, police and education to ensure children and adults are safeguarded, protected and their welfare promoted.

8.2 Guidance can be accessed from the following websites:

Children

https://www.dorsetlscb.co.uk/
http://www.bournemouth-poole-lscb.org.uk/

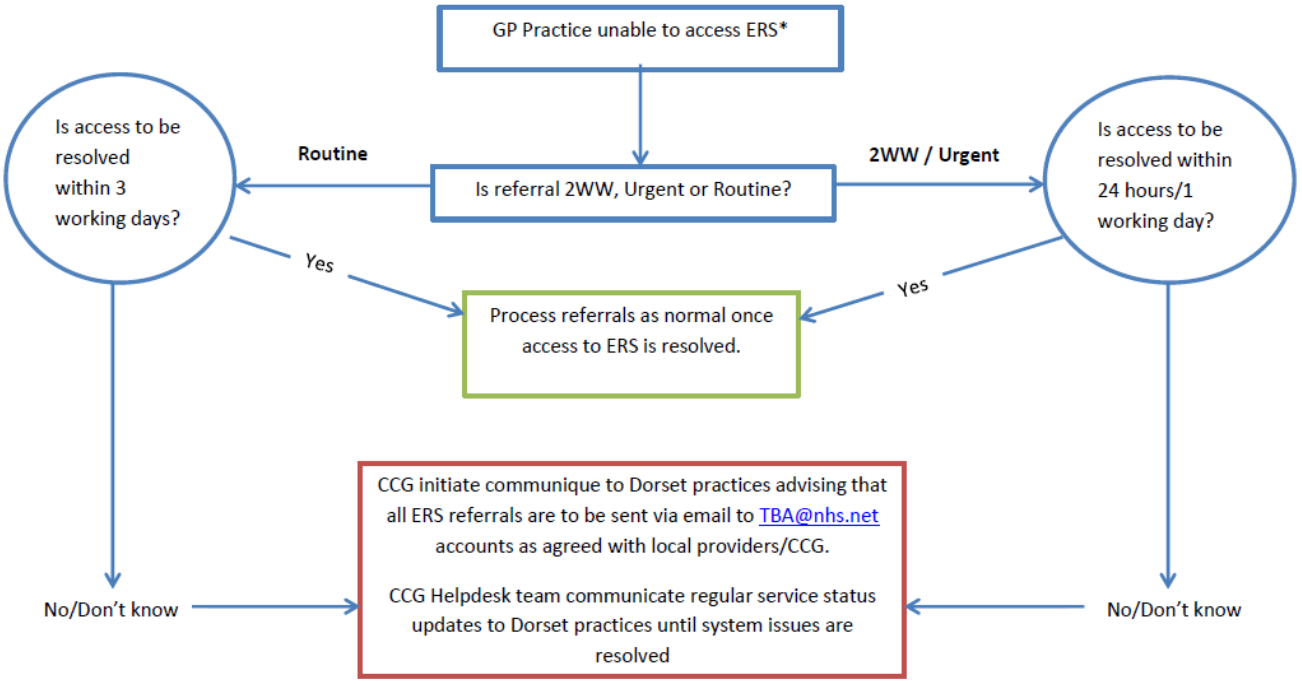
Adults

http://www.bpsafeguardingadultsboard.com/
https://www.dorsetforyou.gov.uk/dorsetsafeguardingadultsboard

9. Date Agreed - Clinical Commissioning Committee - xxxxxxx

10. Review Date- by April 2021.

Dorset CCG e-Referral System Downtime process for GP referrals to Provider



*If smartcard issue that practice RA Manager unable to resolve please contact CCG smartcard support Tel: **01305 368011** Email: smartcard.support@dorsetccg.nhs.uk

* If GP clinical system not connecting to e-RS please use web based e-RS. Contact Dorset CCG e-RS Helpdesk for further assistance if unfamiliar with it Tel: **03332408455/01202 541486** Email: ereferrals@dorsetccg.nhs.uk

30/04/2018 ERS Downtime Process – Dorset CCG – V1

Appendix 1

Appendix 2

Interface Between Private and NHS Care – Case Studies for Guidance

Patients wishing to pay privately for additional treatment not usually funded by the NHS

Case study for illustrative purposes

Patient A is on a bone marrow transplantation unit in specialist isolation care. He wishes to pay for an unfunded drug in addition to his NHS treatment but his doctor judges that it would be clinically unsafe to move him from the specialist unit to receive this private care. His doctor discusses his case with the Trust's Medical Director and they agree that the serious safety risks to the patient in moving him justify departing from the principles of separation in this instance. The Medical Director and the doctor record their discussion and the decision they have reached. **Patient A is allowed to have the unfunded drug delivered privately in the specialist unit. Patient A has to pay for the full cost of his private treatment.**

Receiving private and NHS care at the same time

A patient cannot mix different parts of the same treatment between NHS and private care.

Case studies for illustrative purposes (continued):

c. Patient D has a hip replacement operation on the NHS, and following the operation, she is offered NHS physiotherapy to help her recover. However, there is a private clinic offering physiotherapy next door to Patient D's place of work. For reasons of convenience, Patient D chooses to have private physiotherapy after her NHS operation whilst still receiving other NHS follow up care. **Patient D is allowed to have additional private care because the NHS element of care and the private element of care can be delivered separately.**

d. Patient E needs a cataract operation. This procedure normally involves removal of the crystalline lens from the eye and replacement with an artificial lens with a single focus. After cataract surgery, patients normally have to wear glasses for some purposes, usually for close work. Patient E asks his NHS Trust to insert a multifocal lens at the time of surgery as this may reduce the need for him to wear glasses. The multifocal lens is not routinely available on the NHS. Patient E is willing to pay for the cost of the mulifocal lens but wants the NHS to provide the surgery involved free of charge as part of the cataract operation. The Trust informs him that he can have the single focus lens free of charge on the NHS or the multifocal lens as an entirely private operation. **Patient E is not allowed to have additional private care because the NHS element of care and the private element of care cannot be delivered separately.**

Source: Guidance on NHS patients who wish to pay for additional private care – prepared by Department of Health 23rd March 2009