

Independent Healthcare
Providers Network
NHS CONFEDERATION



Medical Practitioners Assurance Framework

England

Foreword

Chair, Medical Practitioners Assurance Framework Expert Advisory Group

Healthcare is broadly about the prolongation of life, relief of suffering and the enhancement of wellbeing. Understanding how well we do this takes us into the complexities of defining and measuring quality of care. In England, a pragmatic, measurable definition of quality was articulated in 2008 in the Department of Health publication, *High quality care for all*, on the 60th anniversary of the NHS.¹ This described quality using the three domains of effectiveness, safety and patient experience. It has the advantage of being simple, understandable and measurable in each domain. This definition was subsequently enshrined in law through the Health and Social Care Act (2012) and now forms the basis of our regulatory framework.ⁱ

Even with the best intentions things will go wrong from time to time, though responsive and learning systems can reduce this risk. In 2012, The King's Fund set out three lines of defence "in the battle against serious quality failures in healthcare":²

1. The first line of defence is frontline professionals, both clinical and managerial, who deal directly with patients, carers and the public and are responsible for their own professional conduct and continued competence and for the quality of the care that they provide.
2. The second line of defence is the boards and senior leaders of healthcare providers responsible for ensuring the quality of care being delivered by their organisations. They are ultimately accountable when things go wrong.
3. The third line of defence is the structure and systems that are external, usually at a national level, for assuring the public about the quality of care.

In 2013, the newly formed National Quality Board made it clear that "quality is everyone's responsibility. But, [was] equally clear that an effective early warning system for quality should begin within the organisation providing care".³ Sick patients are protected by effective clinical early warning systems. Similarly, healthcare organisations, their patients and their medical practitioners are protected by effective governance.^{4,5,6}

This framework focuses primarily on the first and second lines of defence. Being clear about the respective responsibilities of medical practitioners and the independent providers will reinforce that it is patients who are the priority for care delivered in the independent sector. An example of how the three lines of defence can be applied by independent providers and medical practitioners is included at the end of the framework.

The framework also touches on the governance responsibilities of payors or commissioners of services in the independent sector, and NHS organisations whose medical practitioners also work in the sector.

Oversight of medical practitioners is an area where the independent sector and the NHS should work together to improve clinical governance for the medical profession through transparent, evidential assurance on the quality of an individual medical practitioner's practice.

The independent sector does not operate in isolation, but as part of a wider national health service. Independent sector and NHS providers should work together to improve clinical governance for the medical profession⁷ and, in turn, patient safety. The framework aims to set out some principles for strengthening and building on systems that already exist in the independent healthcare sector, rather than adding more bureaucracy or making the system even more complicated. Individual

i. England and Wales

organisations will have different structures and the framework does not require those structures to be replaced, but rather requires providers to consider the principles and to be able to demonstrate how their individual systems and processes meet the expectations of the framework.

There will be some who feel that this report has not gone far enough. It is focussed on medical oversight. It does not aim to address other issues, but it fires a starting gun for a series of discussions and deliberations to improve care and confidence in the private sector.

For me, the essence of this framework is distilled in the following points which summarise the key expectations that the Medical Practitioners Assurance Framework (MPAF) places on providers. These are not designed to be fully comprehensive nor to be read in isolation from the framework but they are a useful reference. [The blue text throughout the document expands on these key expectations.](#)

1. Have a 'ward-to-board' clinical governance structure with clear lines of accountability (up and down the organisation). [In the document we suggest minimum requirements.]
2. Move towards more consistency in clinical governance for medical practitioners by developing an Independent Healthcare Providers Network (IHPN) practising privileges template documentation in 2019 that updates the Independent Healthcare Advisory Services guidance and supports the development of practising privileges policies.
3. Standardise the following key aspects of practising privileges:
 - dataset required on application **for and renewal of practising privileges**
 - data requested about **scope of practice**
 - how and when there is a **review of practising privileges**
 - approval requirements for medical practitioners to use **new procedures and treatments**.

[More detail on each of these in the document]

In respect of directly employed medical practitioners there should be a consistent approach in using similar or overlapping datasets to those above when considering:

- i the implementation of recruitment processes to ensure the individual is able to meet the skills and capabilities of the role as identified in the job description and person specification
 - ii the policies which will be applicable as regards ongoing performance management, appraisal and review of employed medical practitioners to ensure adherence to the standards expected.
4. Define the role of the Medical Advisory Committee (or other structures in the provider organisation carrying out similar functions) with particular respect to clinical governance of medical professionals, this should be clearly understood by the independent provider, the members of the committee and medical practitioners practising in the organisation. [More detail on each of these in the document.]
 5. Submit, and require medical practitioners working in their organisations to submit data about the quality of their performance to relevant national registries available to the sector and to the Private Healthcare Information Network.
 6. Providers should seek assurance from medical practitioners that they are participating in quality improvement activities on application for, or review of, practising privileges.

7. Where it is widely established as standard practice, formalise arrangements for multi-disciplinary team review, including how relevant clinical data is transferred, and how the teams are reviewed, and outcomes audited.
8. Ensure there is a system in place (via their Responsible Officers) to share relevant governance information about the performance of medical practitioners working in their settings (including activity data) in a timely and straightforward manner. The development of a standard sector wide template to share information may be appropriate here.
9. Require medical practitioners to share as a minimum their summary appraisal outcomes and personal development plan (PDP) to inform the practising privileges review. If this does not provide sufficient information to make a decision, additional relevant information from the whole practice appraisal should be requested by the provider and made available by the medical practitioner.
10. Have a transparent clinical governance framework that is explicit about responsibility for medical performance and how performance issues are identified, managed, escalated and communicated to relevant stakeholders. Corporates with multiple, geographically dispersed providers should appoint a clinician as a national lead for clinical governance. Ideally, this person should be on the executive team and report directly to the Board or relevant board sub-committee. To support the national lead for clinical governance they should consider appointing local or regional designated lead consultants for clinical governance of medical practitioners with clearly defined responsibilities.
11. Have effective processes in place that support speaking up, with a speaking-up/whistle-blowing process as well as Freedom to Speak Up Guardians. Providers should follow the guidance, expectations and best practice set out by the National Guardian's Office and should ensure that medical practitioners' voices can be reflected by processes that support Freedom to Speak up Guardians.

Bruce Keogh
Chair
MPAF Expert Advisory Group

Foreword from the Chief Executive of IHPN

Leading the Independent Healthcare Providers Network (IHPN) is one of the best jobs in UK healthcare. The breadth and quality of independent sector service provision to NHS and private patients is often exceptional and in my many visits to member services every year I speak with staff and patients who are providing and receiving responsive, high quality healthcare in modern settings, helping to give the UK healthcare system its world-class reputation.

However, no sector and no organisation has a right to exist and what is expected of all healthcare providers from the people they serve rightly increases all of the time. For all of us as we learn we improve and as we improve we grow. Healthcare provision is no different.

So as the sector reflects on how it can ensure that more patients are able to choose to receive care in the most appropriate setting and to respond to the legitimate challenges of delivering consistency across the entirety of the UK independent healthcare sector it is right that we look at what can be done to drive continuous improvement.

As part of a major package of work IHPN asked Sir Bruce Keogh, former NHS England Medical Director, to work with the sector on designing a framework that would support improvement and consistency in the oversight of medical practitioners in the independent acute sector. This is one of the key issues identified by the Care Quality Commission (CQC) as an area for improvement and the sector has responded by coming together to learn from each other, identify expected practice and set out clearly where responsibility lies for ensuring the best available care possible for patients.

The Medical Practitioners Assurance Framework (MPAF) is therefore designed to provide a basis from which all independent providers can work; in turn giving confidence to patients and regulators over 'what good looks like' and giving operators some clear structure to their day to day work. The framework is principles based enabling independent providers to apply it in the way that best suits their organisation and is designed to be a 'live' document and a contemporary consensus view of expected practice. It also articulates the need for healthcare providers across the NHS and independent sector to work much more collaboratively, improving communication channels and ensuring that patient safety pathways reflect the pathways that patients themselves increasingly flow through as they live with increasingly complex conditions.

As such, I see this framework as a starting point for the sector. I echo the CQC's own view that the independent acute sector is a learning sector by quoting from the CQC's End of Programme report on independent acute hospitals: "Where we have found problems, providers have been quick to take our findings on board and make improvements."⁸

Healthcare systems across the UK have seen a culture change in recent years, with a shift to a more just, open and transparent culture. However, there is always more to do, and I believe that this framework can play a critical role in raising the bar in medical leadership, driving up overall standards of assurance around medical practitioners across the independent sector and NHS. Most importantly for me is that the MPAF sets out a clear view of how providers and medical practitioners can work together to improve the assurance around clinicians working in both sectors.

David Hare
Chief Executive
Independent Healthcare Providers Network

Development of the Medical Practitioners Assurance Framework

The development of the Medical Practitioners Assurance Framework was commissioned by IHPN. The framework was developed through an expert advisory group of key stakeholders (membership below) that was chaired by Professor Sir Bruce Keogh. Additional IHPN members contributed to the framework through two workshops. The IHPN Paterson Steering Group recommended the framework to the IHPN Board. The framework will be formally reviewed on an annual basis.

Expert Advisory Group	
Professor Sir Bruce Keogh	Chair
Dr Nigel Acheson	Deputy Chief Inspector of Hospitals, Care Quality Commission
Tim Aldrich	Assistant Director of Strategy, General Medical Council
Professor Sir Jonathan Asbridge	Clinical Director, Healthcare at Home
Dr Cliff Bucknall	Medical Director, HCA Healthcare UK
Mehdi Erfan	General Counsel, Ramsay Health Care
Dr Howard Freeman	Clinical Director, Independent Healthcare Providers Network
Dr William Harrop-Griffiths	Council Member, Royal College of Anaesthetists
Dr JJ de Gorter	Then Chief Medical Officer, Spire Healthcare
Mr Richard Packard	Chair, Federation of Independent Practitioner Organisations
Mr Ron Hoile	Medical Director, KIMS Hospital and Responsible Officer, Ramsay Health Care
Judi Ingram	Then Group Clinical Director, Aspen Healthcare
Una Lane	Director of Registration and Revalidation, General Medical Council
Dr Steven Luttrell	Medical Director, BMI Healthcare
Mr Ian Martin	Council Member, Royal College of Surgeons (England)
Professor Carrie MacEwen	President, Academy of Medical Royal Colleges
Professor David Oliver	Council Member, Royal College of Physicians
Catherine Picton	Framework Author
Rachel Power	Chief Executive, The Patients Association
Dr Mike Prentice	Regional Medical Director and Revalidation Lead, NHS England and NHS Improvement
Heidi Smoult	Deputy Chief Inspector of Hospitals, Care Quality Commission
Jason Yiannikou	Deputy Director, Acute Care and Provider Policy Team, Department of Health and Social Care
Disa Young	Director of Regulation, Independent Healthcare Providers Network

Executive summary

The three lines of defence that underpin this framework make the point that the primary accountability of providers and individual medical practitioners is to their patients and to patient safety. Appendix 1 sets out an example of how the three lines of defence can apply to independent providers and medical practitioners.

The framework is also based on the precautionary principle that problems and failings will be prevented or detected early through effective governance systems underpinned by the right professional and personal behaviour.

The framework is focused on all medical practitioners working in independent healthcare settings through practising privileges or on an employed basis.ⁱⁱ Independent healthcare providers need to consider how they will engage with and implement the Medical Practitioners Assurance Framework (MPAF). It has been developed in the context of the English healthcare system, and will be modified, with translation, for use in the devolved nations.

The MPAF is a contemporary consensus view of expected practice rather than a description of best practice in independent healthcare. The framework is divided into four sections:

1. Creating an effective clinical governance structure for medical practitioners
2. Monitoring patient safety, clinical quality and encouraging continuous improvement
3. Supporting whole practice appraisal
4. Raising and responding to concerns

Each section is structured as follows: what the framework is trying to achieve, provider responsibilities and medical practitioner responsibilities. Where interdependencies with other agencies exist, these are described under the different headings.

The framework sets out expected practice as follows. There should be:

- Clinical governance leads at executive and non-executive level.
- A standard approach to application for practising privileges (or employment of medical practitioners) across the sector.
- A standard approach to how practising privileges are reviewed and the frequency at which this occurs.
- A standard approach to the introduction of new procedures and innovative techniques.
- Robust processes to ensure that the recruitment and oversight of medical practitioners are subject to regular and appropriate review in line with legislative changes and recommended practice.
- Clarity on how the Medical Advisory Committee where it exists (or such other structure within a provider that discharges those functions), fits into the overall clinical governance structure.
- A standard system of oversight/monitoring and assurance – including supporting whole practice appraisal and quality improvement activities.
- A standard system for identifying and acting on concerns about any medical practitioner.
- A clear understanding of the responsibilities of individual medical practitioners as set out in each of the following four sections.

ii. The emphasis placed on the practising privileges relationship in the framework reflects how the majority of medical practitioners work in the independent sector. However, the principles in the framework apply equally to employed medical practitioners.

Introduction

Patientsⁱⁱⁱ have a right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in appropriately approved or registered organisations that meet required standards of quality (defined as safe, effective care with a good patient experience).

The responsibility for quality of care rests with the organisation providing services through their employees or through those working in their organisations using other contractual arrangements such as practising privileges (see section 1.4). Ultimately, the executive and non-executive members of the organisation's board are responsible for the quality of care offered by an organisation, which includes a safe and effective governance system for medical practitioners.

Through the development of the MPAF, IHPN is supporting providers to strengthen the assurance processes that support medical practitioners to deliver quality care to patients being treated in their organisations.

The framework also provides the independent sector with an opportunity to reset the expectations that it has of itself in the way it supports patient care through the clinical governance of medical practice.

It is the independent provider's responsibility to put in place clinical governance structures and well-resourced systems which promote and protect the interests of patients and families, to train and support staff and to prioritise patient safety by creating an environment which supports medical practitioners to meet their professional obligations. Good governance for the medical profession can only be delivered with the support of effective clinical governance systems.

Developing, operating and quality assuring clinical governance for medical practitioners is a key responsibility for organisations and their boards. It includes making sure there are clear lines of accountability throughout an organisation with defined structures, systems and standards, and visible leadership.⁹

Independent providers vary in size, structure and spectrum of clinical activity. One size will not fit all. So, any clinical governance framework for medical practitioners working in independent providers needs to be developed within each provider's own organisational governance structures, with regard to the requirements of organisational and professional regulators. A key principle that underpins this framework is that independent providers' Chief Executive Officers and their boards allocate appropriate staffing, facility and system resources for the activities that support effective clinical governance for medical practitioners.

Because one size will not fit all, this framework takes a principles-based approach to outlining provider responsibilities in the following four areas:

1. Creating an effective clinical governance structure for medical practitioners
2. Monitoring patient safety, clinical quality and encouraging continuous improvement
3. Supporting whole practice appraisal
4. Raising and responding to concerns

As noted above, individual organisations have different structures and the framework does not require those structures to be replaced. Instead providers should be able to demonstrate how their individual systems and processes meet the expectations of the MPAF.

iii. Patient is used in the broadest sense and includes, for example, service users, customers and clients.

As in the NHS, medical practitioners must act in accordance with the guidance issued by the General Medical Council (GMC) on clinical, medical and ethical issues, and follow accepted best clinical practice. Medical practitioners working in independent providers therefore have responsibilities in each of the four areas in this framework. These responsibilities are described at the end of each section.

Where clinical governance for medical practitioners spans NHS organisations and other agencies this is highlighted as an interdependency requiring action by multiple organisations.

1. Creating an effective clinical governance structure for medical practitioners

What are we trying to achieve?

Independent providers should have transparent and, as far as possible, consistent approaches to clinical governance for doctors in their organisations that support high quality patient care and are well understood by doctors and independent providers.

"The key to excellent care is organisational support for the right clinicians with the right expertise to do a good job and having systems in place that spot when things are not going well." Professor Sir Bruce Keogh

1.1 This framework presents the opportunity for a multi-organisational commitment to drive continued improvement in clinical governance across the independent healthcare sector, but it will require strong leadership from Chief Executives and Executive Boards.

1.2 In a compelling analysis, the Faculty of Medical Leadership and Management, The King's Fund and the Centre for Creative Leadership note that "Leadership is the most influential factor in shaping organisational culture, so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental. There is clear evidence of the link between leadership and a range of important outcomes within health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care."

They are clear that: "Effective boards ensure a strategy is implemented for nurturing a positive culture; sense problems before they happen and improve organisational functioning; promote staff participation and proactivity; enable and encourage responsible innovation by staff; and engage external stakeholders effectively to develop cooperative relationships across boundaries." In practical terms, the vision and values of organisations are enacted in tandem through board leadership and what they attend to, monitor, reprove or reward; and by listening to staff and patient voices.¹⁰

1.3 The CQC agree and state that being "well led" means that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture". This forms the basis of the Well Led domain in their inspections.¹¹

1.4 Therefore, the organisation's board (or equivalent) should understand that they hold the ultimate responsibility around clinical governance for medical practitioners, and their accountability for the quality of care provided by their medical practitioners (whether employed or working on practising privileges). Independent providers have a range of different corporate structures. Where the term 'board' is used should be taken to apply to the equivalent level decision makers in an independent provider.

1.5 Accountability in an individual facility^{iv} is the responsibility of the Registered Manager who is appointed by the provider to manage regulated activity in an individual facility on their behalf. This is an important role. The registered manager, along with the registered provider, is legally

iv. A facility is the location in which care is provided, which might be an acute hospital, a clinic or a community hospital.

responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) and the Care Quality Commission (Registration) Regulations 2009.¹²

1.6 Independent provider structures are diverse, from large international corporate hospital groups, to single hospital charitable foundations and not-for-profit or specialist providers. Independent providers therefore need to define the structures that support clinical governance for medical practitioners in the context of their own organisations and corporate board structures. However, all independent providers should have a 'ward-to-board' clinical governance structure with clear lines of accountability (up and down the organisation) that as a minimum should:

- Ensure that all board members (or equivalent) are cognisant of their responsibilities for the quality of clinical care. For example, by designating a non-executive board member [ideally with a clinical background] with oversight of clinical governance of medical practitioners.¹³
- Corporates with multiple, geographically dispersed locations should appoint a clinician as a national lead for clinical governance. Ideally, this person should be on the executive team and report directly to the Board or relevant board sub-committee. [This role is in addition to the statutory responsibilities of the organisation's Responsible Officer as defined by legislation.¹⁴ However, the Responsible Officer could also undertake this role depending on the size of the organisation.] To support the national lead for clinical governance they should consider appointing local or regional designated lead consultants for clinical governance of medical practitioners with clearly defined responsibilities.
- Define the roles and responsibilities of key committees in the clinical governance process for medical practitioners, in particular, the Clinical Governance Committee and the Medical Advisory Committee (or equivalents).
- Define the responsibilities of the key roles relating to the clinical governance of medical practitioners, in particular, the Responsible Officer, Registered Manager, Nominated Individual, Fit and Proper Persons: Directors, Medical Director, Clinical Director, Medical Advisory Committee Chair, Medical Appraisal Leads and Matron/Head of Clinical Services
- Specify how information on individual medical practitioners' performance is collected, reviewed and presented to the hospital management team and how compliance is overseen by the board. (See also section 2: Monitoring Patient Safety, Clinical Quality and Encouraging Continuous Improvement)
- Define how to communicate governance structures and assurance processes to medical practitioners, patients and to how members of the public might be meaningfully engaged in governance structures.

1.7 The granting of practising privileges is the process defined with a specific meaning within relevant regulations whereby a medical practitioner is granted permission to work in an independent provider. Whilst medical practitioners with practising privileges are independent self-employed contractors, the independent provider is required to demonstrate that medical practitioners engaged for the purpose of carrying out a CQC regulated activity are 'fit and proper' for the role.¹⁵ Accountability for this sits with the Registered Provider and Registered Manager supported by clinical and professional input from the medical/clinical director (or equivalent).

The Responsible Officer is required to ensure the organisation discharges its legal duties regarding pre-engagement background checks prior to a designated body entering into contracts of employment, or contracts for the provision of services, with medical practitioners.¹⁶

Practising privileges

The granting of practising privileges is a well-established process within the independent sector whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice or within the provision of community services. Practising privileges are a defined exemption from the requirement of medical practitioners to register separately with CQC. CQC's Scope of Registration 2015 sets out that for practising privileges to apply, "it means that all aspects of the consultation must be carried out under the hospital's management and policies".¹⁷

All practitioners granted practising privileges by a provider are independent and self-employed contractors with regards to employment law. However, the regulations define doctors working under practising privileges as employees of the provider for the purposes of the regulations.

1.8 Independent providers should all have detailed practising privileges policies which form the basis for the application, granting, maintenance, restriction, suspension and withdrawal of practising privileges in their organisations and require compliance by all medical practitioners who are engaged under these terms. In 2012, the Independent Healthcare Advisory Services (a predecessor of IHPN) published detailed guidance for the development of a practising privileges policy for consultant medical staff.¹⁸

Equally independent providers should have appropriate policies and procedures in place in respect of recruitment and performance management of any medical practitioners directly employed (including appropriate checks demonstrating that such employees meet with relevant person specification and job requirements for their roles).

This guidance has been used variably across the independent sector however it encourages consistency of approach to practising privileges whilst allowing independent providers to tailor to their own clinical governance structures. Therefore, as the independent sector moves towards more consistency in clinical governance for medical practitioners (irrespective of employment status), this guidance should be updated and inform practising privileges and employment policies across the sector.

1.9 While there will be appropriate variations in practising privileges policies, there are also aspects of the policies where standardisation across the sector will provide much needed transparency and set the expectations that the independent sector has of its medical practitioners. Therefore, the following key aspects of practising privileges should be standardised in all independent providers (irrespective of the employment status of the medical practitioners engaged):

- **Application for practising privileges.** Application for practising privileges should be based on a standard dataset (see Appendix 2) that should be incorporated into all providers' Practising Privileges application forms. The dataset should form part of the update of the IHAS practising privileges policy template outlined in 1.8). When medical practitioners are engaged directly as employees then appropriate recruitment and selection processes, together with policies and procedures for monitoring and managing performance should reflect the dataset.
- **Scope of practice.** Understanding a medical practitioner's scope of expertise and practice is important to ensure individuals adhere to their areas of competence and expertise. At present, this is generally defined by their area of NHS practice, but in some instances there may be legitimate, justifiable differences which should be formally agreed. Furthermore, for medical practitioners no longer working in the NHS or for those who work exclusively in the independent sector or are being recruited from abroad, scrutiny of scope of practice is equally necessary.

Information on a medical practitioner's scope of practice on application or for an annual/biennial review should be requested by all independent providers in a standard format and supported by relevant information from the medical practitioner's annual whole practice appraisal (see also section 3 Supporting whole practice appraisal). Therefore, a template should be developed to request scope of practice information as part of the Practising Privileges dataset. Equally, such information on those directly engaged as employees should be generated and retained together with appropriate employer policies in place to ensure creation, storage and possible exchange of such information (subject to appropriate employer-employee safeguards and compliance with GDPR obligations).

There is an expectation that medical practitioners share their activity and outcomes data with independent providers through the annual appraisal process. There is also an expectation that NHS Responsible Officers share any significant concerns about a medical practitioner with relevant independent providers whenever they arise.

IHPN and its members are overseeing the development of a secure information sharing platform for independent providers that can be used initially to ensure there is full visibility by all relevant organisations of a mandatory dataset about medical practitioners, visibility of all locations where a medical practitioner is employed and holds practising privileges, and scope of practice.

A system for monitoring scope of practice for an individual across all independent and NHS providers should also be developed. Ultimately, making it a professional regulatory requirement for all UK registered doctors to use such a system would create a single reliable view of any given doctor's scope of practice, outcomes and performance. It would also lead to a successful adoption across the NHS and independent sector. (See also 'Interdependency 1').

Interdependency with other agencies 1

At present no single reliable and definitive view of any given doctor's scope of practice, activity, outcomes or performance exists. A consistent approach by professional regulators and professional bodies to defining scope of practice, the level of granularity thereof, and an accessible way of recording and accessing any doctor's scope of practice that can be used by the NHS, the independent sector and private medical insurers will provide a way to improve the governance of medical practice across the board.

IHPN and its members are overseeing the development of a secure system for use by independent providers (and other stakeholders, eg NHS Responsible Officers) to share information about the practice of medical practitioners working in the sector. The system will set out the principles of what/when and with whom information is shared.

The system will allow all providers who grant or are considering granting Practising Privileges (PPs) to view a common, definitive record for each doctor. This will likely include:

- A mandatory dataset that includes: basic demographic/identity information; site specific Disclosure and Barring Service certification; indemnity; ICO; mandatory training, compliance with relevant mandatory training, evidence of Hep B/Hep C/HIV status; qualifications; GMC registration and other licensing bodies.
- All locations where a doctor holds practising privileges.
- A self-declared statement on the scope of practice of all roles to include: clinical codes (where applicable), procedures, volumes and registries where the doctor shares outcome data.

- **Review of practising privileges.** The rigour and process of the practising privileges review^v should be the same across all independent providers. The provider's clinical governance framework should specify where accountability for the review decision sits and define the input necessary from other clinical and professional sources. A review of practising privileges should consider the dataset in Appendix 2.

Where the independent provider does not have the required information necessary to make a decision about renewal, practising privileges should be suspended until that information is available. Collection of 'whole practice' clinical data, cooperation with the appraisal process and sharing of relevant information should be a requirement for maintaining practising privileges.

- **New procedures and treatments.** Independent providers should have robust processes for assessing novel therapies/procedures in place that protect patients, medical practitioners and the organisation without stifling innovation.¹⁹ This also applies to amended therapies/procedures and common procedures new to a particular organisation. Policies need to clearly set out organisational and practitioner responsibilities, clear standards for reviewing the evidence, staff training, patient consent, incident reporting and monitoring of outcomes for any new or innovative procedures.

1.10 Medical Advisory Committees (where they exist) can provide organisations with a resource for medical advice on professional and clinical issues. However, how they fit into an organisation's clinical governance structure should be properly defined by the provider.

The constitution and functions of Medical Advisory Committees are different in different organisations.

This has created a lack of clarity around expectations from both independent providers and committee members. Therefore, the role of the Medical Advisory Committee and any sub-committees (or other structure in the organisation carrying out similar functions) with particular respect to clinical governance of medical practitioners should be clearly defined and understood by the independent provider, the members of the committee and medical practitioners practising in the organisation.

In particular:

- The role, responsibilities and accountability of the Chair should be specified in a role description.
- If the committee is to have a role in advising the independent provider on the granting, extension, renewal and suspension or restrictions of practising privileges this should be transparent and conflicts of interest clearly declared and managed. Management of conflicts of interest should also be extended to providing "second opinions and role in advising on complaints. See Appendix 3.

1.11 What are medical practitioners' responsibilities?

- To practice in accordance with the requirements of the GMC in line with *Good medical practice*.²⁰
- To be personally accountable for their professional and ethical practice and to be prepared to justify their clinical decisions and actions to the independent provider and their peers.
- To ensure their awareness of, and compliance with, their legal and other responsibilities for their patients, including under the Competition and Markets Authority's Private Healthcare Order²¹ and NHS conflict of interest guidance.²²

v. Practising privileges are generally reviewed annually for medical practitioners with no NHS practice and biennially for medical practitioners active in the NHS.

- To demonstrate high standards of professional behaviour whilst working in the independent provider and to expect discussions about professional behaviour to form part of both applications for and review of, practising privileges in any independent provider (see Appendix 2) and part of any recruitment or appraisal process for any directly employed medical practitioner.
- To work in line with the requirements of the provider's practising privileges policy, the policies and systems for clinical governance, audit, complaints handling, records management and all other relevant provider policies.
- To engage with and contribute all necessary data when requested to as part of an annual or biennial review of practising privileges (see Appendix 2) including ensuring that the provider and Responsible Officer has all the information necessary for a robust review of the entire scope of their practice.
- To report incidents, complaints or concerns to the provider and Responsible Officer, whether about their own practice or other clinicians, or wider issues in the hospital, and to take an active part in investigations and share learnings arising.

2. Monitoring patient safety, clinical quality, and encouraging continuous improvement

What are we trying to achieve?

Independent providers and doctors must be assured that they are providing good quality care to their patients. This requires transparent assurance processes in all independent provider organisations that provide insight into medical practice and includes a framework for the publication of activity and results.

"Patients have the right to expect that any treatment they receive is safe and of the highest quality, whether in the NHS or independent sector. This can only be assured if all sectors produce and share accurate, relevant and timely information about their services and the performance of practitioners."

Ian Martin, Council Member, Royal College of Surgeons (England)

2.1 The independent provider should ensure that all medical practitioners working in the organisation read and understand the clinical governance framework, the practising privileges policy as well as the organisation's policies and the standard operating procedures that support safe clinical practice.

2.2 Monitoring for the purpose of assurance should be based on the collection and analysis of data including, but not limited to the defined domains of quality: effectiveness, safety and patient experience. There must be a system in place to regularly review the data and to explore any divergence from the expected norm.^{vi}

2.3 Lessons should be learnt from analysing adverse incidents, near misses, complaints and legal claims. Lessons learnt should be used to continually improve performance and feed back into the clinical governance systems for medical practitioners and more widely. Any concerns about the performance of an individual medical practitioner should be investigated and, if appropriate, addressed quickly and effectively (see also section 4 Raising and responding to concerns).

2.4 Scope of practice should be monitored and systems of control be in place to enable rapid identification of variations from that authorised under existing employer policies or procedures relevant to medical practitioners directly employed or through practising privileges. This might include review of procedures against set codes for surgical procedures or systems that allow booking only for pre-authorised procedures.

2.5 Independent providers should also access and use external data to inform their clinical governance processes. Therefore, independent providers should submit, and require medical practitioners working in their organisations to submit data about the quality of their performance to relevant national registries available to the sector. Providers also have a responsibility to submit medical practitioners' episode data to the Private Healthcare Information Network. See also 'Interdependency 2'.

vi. This is likely to include (but is not limited to) collection and reporting of; activity, outcomes, complications, incidents and complaints, peer review participation, clinical audit, patient feedback.

Interdependency with other agencies 2

Independent providers contribute to patient safety incident reports, to the National Reporting and Learning System central database and its successor DPSIMS, coordinated by NHS Improvement.

Independent providers should submit data to all relevant national datasets, including some national clinical registers. Independent providers are currently piloting their contribution to relevant quality improvement audits and programmes commissioned by the Healthcare Quality Improvement Partnership.

Work is still needed across the healthcare sectors to continue to remove the barriers that prevent the independent sector contributing to single, comparable datasets and accessing this data to assess outcomes and drive up standards. In particular, clarity about charges for independent sector providers to submit data to relevant audits and registries, and how the outcomes of datasets and audits can be accessed by independent providers is needed.

2.6 Peer review reduces the risk of professional isolation and lone practice and the risk of 'creep' in scope of practice. The use of external peer review systems, such as those run by Royal Colleges, should be employed when appropriate. Independent providers should seek demonstrable assurance from medical practitioners that they are participating in quality improvement activities on application for, or review of, practising privileges or engaging in appropriate employer review policies and procedures or employer checking processes as regards recruitment and performance management if directly employed. (See Appendix 2).

2.7 Processes should be in place to support medical practitioners in their professional Duty of Candour and require medical practitioners to support providers in complying with their statutory Duty of Candour. There should also be procedures for reporting adverse incidents, near misses and complaints.

2.8 Multi-disciplinary team working promotes cross-sector working in the interests of patient safety. The use of multi-disciplinary teams (MDT) as part of a patient's care pathway to provide team based clinical decisions based on reviews of clinical documentation such as case notes, test results and diagnostic imaging is accepted as standard practice in many areas. In particular this is the case in patients with complex care needs, for example cancer. Therefore, where this is widely established as standard practice, independent providers should formalise arrangements for multi-disciplinary team working, including how relevant clinical data is transferred, how the teams are reviewed, and outcomes audited. See also 'Interdependency 3'.

2.9 What are medical practitioners' responsibilities?

- To understand and work within with the provider's clinical governance framework for medical practitioners and actively participate in medical and clinical governance activities in independent providers.
- To participate in the systems and processes put in place by independent providers to assure patient safety and to improve patient care.
- To be familiar with all the independent provider's relevant policies and to remain familiar with the provider's team structure, policies, procedures, equipment and processes.
- To accept team responsibility in partnership with the independent provider's wider healthcare team for the package of care provided to the patient.

- To participate in any multi-disciplinary teams that support clinical decision making about their patients' care and/or other quality improvement activities expected by the provider organisation.
- To ensure their awareness of, and compliance with, their legal and other responsibilities for their patients.
- To report incidents, complaints or concerns, in accordance with the provider's policies and procedures, to the provider and Responsible Officer, whether about their own practice or other clinicians, or wider issues in the hospital, and to take an active part in investigations and share learnings arising.
- To accept team responsibility in partnership with the independent provider's wider healthcare team for the package of care provided to the patient.

Interdependency with other agencies 3

Where multi-disciplinary team review is standard practice (for example in complex multi-speciality procedures and cancer care), the NHS and the independent sector have a joint responsibility to ensure that patients receive joined-up multi-disciplinary team care regardless of where their treatment is received. How this happens currently is variable, specifically there are questions around funding of reviews and communication channels between the NHS and independent sector. Patients would benefit from clarification of responsibilities of both the NHS and independent providers in this area as all patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.²⁸

3. Monitoring patient safety, clinical quality, and encouraging continuous improvement

What are we trying to achieve?

Annual whole practice appraisal should cover a doctor's whole scope of practice. Doctors working in the independent sector frequently work in multiple organisations so the effective sharing of information between independent providers and the NHS ensures that a doctor only practises within their area of expertise, wherever they work.

It can enable early identification of doctors whose practice needs attention and allow for governance and support measures to be put in place to ensure a doctor remains up to date and fit to practice.

3.1 All medical practitioners should undertake an annual whole practice appraisal that is focused around the General Medical Council's (GMC's) *Good medical practice*. Annual whole practice appraisals inform the recommendation made by the medical practitioner's Responsible Officer to the GMC when the medical practitioner revalidates.^{vii} Responsible Officers have a statutory duty to ensure that appraisal and revalidation processes take account of information covering a medical practitioner's whole scope of practice and should include all the objective data around each medical practitioner's practice irrespective of where that individual is working.^{viii}

3.2 The Registered Manager who oversees the annual/biennial review should ensure that the person with governance responsibility for the medical practitioner's practice provides feedback to the Responsible Officer in a medical practitioner's designated body (whether independent or NHS) in order to support that medical practitioner's annual whole practice appraisal.^{23,24} Therefore, to facilitate effective information sharing, independent sector Responsible Officers should ensure there is a system in place to share relevant governance information about the performance of medical practitioners working in their settings in a timely and straightforward manner (including scope of practice and activity data); the development of a standard sector wide template in order to better share information efficiently should form part of the work highlighted in section 1.9. See also 'Interdependency 4'.

3.3 The NHS England guidance on information flows and the GMC's information sharing principles are essential references here²⁵ and organisations should have a risk stratification system based on information of note in relation to fitness to practise and scope of practice. Information flows should be directed towards the person with governance responsibility for the medical practitioner in each location where the medical practitioner is working. The term 'information of note' is significant as it allows for the sharing of information at a lower threshold than a major concern, thereby permitting triangulation at an earlier stage. Sharing of information should not only occur when there is a crisis.

vii. Designated Bodies have a legal responsibility under The Medical Profession (Responsible Officer) Regulations 2010 and The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 to support their doctors throughout the revalidation process.

viii. Regulation 11(3) of the Medical Profession (Responsible Officers) Regulations 2010, as amended, and regulation 9(3) of the Medical Profession (Responsible Officers) Regulations (NI) 2010 place a duty on Responsible Officers to ensure that medical practitioners have regular appraisals which obtain and take account of all available information relating to the medical practitioner's fitness to practise in the work carried out for the designated body, and for any other body, during the appraisal period revalidation process.

Interdependency with other agencies 4

Responsible Officers in the NHS have a responsibility to routinely feedback and request information from Responsible Officers in the independent sector to inform whole practice appraisals and vice versa. Where patient safety may be compromised concerns should also be shared promptly with independent sector Responsible Officers and vice versa.

While guidance on information sharing is available from both the GMC²⁶ and NHS England,²⁷ there remains confusion about what and how information can be shared between the sectors and practice varies across the country.

There is a clear need for a more effective dissemination and implementation of the existing guidance and the development of systems and processes to reinforce the importance of NHS organisations and independent providers sharing relevant information about a medical practitioner.²⁸

3.4 Providers must be cognisant that whole practice appraisal is designed to be a formative and confidential process for medical practitioners. When reviewing practising privileges, the relevant sections of the medical practitioner's annual whole practice appraisal should form part of the information reviewed to give a full picture of the medical practitioner's practice. Therefore, independent providers should require medical practitioners to share as a minimum their summary appraisal outcomes and PDP to inform the practising privileges review.²⁹ If this does not provide sufficient information to make a decision, additional relevant information from the whole practice appraisal should be requested by the provider and be made available by the medical practitioner.

3.5 Independent providers should provide their Responsible Officers with sufficient resources to enable them to effectively carry out their statutory responsibilities. This includes ensuring that the Responsible Officer is appropriately trained to undertake their responsibilities, undertakes an annual quality assurance of the provider's revalidation systems and is given support to regularly participate in local Responsible Officer network activities that provide shared learning opportunities and support consistency of approach.³⁰

3.6 What are medical practitioners' responsibilities?

- To notify independent providers and their Responsible Officer of all the organisations or settings where they provide medical services and keep that information up to date.
- To participate in revalidation and to share relevant information from their annual whole practice appraisals with all providers where they practice. The appraisal summary and PDP should contain sufficient information to make a decision (for example when practice is being reviewed/ complaints investigated) but if not, additional information is shared and updated.

4. Raising and responding to concerns

What are we trying to achieve?

Independent providers set the standard of medical practice, behaviour and probity expected of doctors in their organisations over and above the requirements of the professional and systems regulators, and they have a duty to protect patients and safeguard their needs. Providers should have systems in place to give early warning of any failure, or potential failure, in the clinical performance and outcomes, behaviour, conduct and health of doctors working in their organisations and a defined framework for responding to any concerns raised.

“Establishing a formal system for concerns about medical practitioners to be raised between the NHS and independent providers at an early stage, and a framework for providers to act on and communicate those concerns will result in a safer environment for patients.” Mehdi Erfan, General Counsel, Ramsay Health Care

4.1 All concerns regarding a medical practitioner, whether employed or on practising privileges, triggered through whatever route, whether through clinical audit, incidents, complaints (see also 'Interdependency 5') or Responsible Officer networks, should follow the same structured, documented process. Therefore, independent providers should have a transparent clinical governance framework that is explicit about responsibility for medical performance and how performance issues are identified, managed and escalated. NHS England has produced guidelines in this respect³¹ and the GMC's Employer Liaison Service offers a useful support to the management of concerns at a local level.³²

4.2 If it is necessary to restrict, suspend or remove practising privileges due to concerns about a medical practitioner's performance (temporarily or substantively) or where a practitioner withdraws from practising privileges during the course of an investigation, this information should be communicated to all other organisations where the medical practitioner practices (including the NHS) and to the medical practitioner's Responsible Officer. Private medical insurers and NHS commissioners should be informed where restrictive measures are taken. IHPN and private medical insurers are developing a voluntary code on sharing information about medical practitioners for patient safety purposes.

4.3 If independent providers receive information that a medical practitioner working in their organisation is under interim or substantive measures in another provider this should trigger an explicit discussion. Providers need to consider, in the context of their clinical governance framework, whether the medical practitioner's practice causes a significant risk to the quality and safety of patient care in their organisations. It is also important that all independent providers have an adequate speaking-up/whistleblowing process which staff and medical practitioners can access to raise concerns without fear of having their practising privileges withdrawn or their employment affected. There should be no barriers to concerns about patient safety being raised.

4.4 Staff at all levels are the eyes and ears of the organisation. They notice breaches in safety, good and bad behaviours, inappropriate investigations, treatments and interventions, but they don't always find it easy to raise their concerns. Therefore, all independent providers should have effective systems in place to enable staff to speak up and should appoint Freedom to Speak Up

Guardians in place as a further route for this. Independent providers should ensure that medical practitioners' voices can be reflected by processes that support Freedom to Speak up Guardians.

4.5 Responsible Officers should take appropriate action in response to any information of note they receive about the practice of a medical practitioner who works at their organisation. This includes information received from outside their organisation. Therefore, where a Responsible Officer (NHS or independent sector) becomes aware of information about a medical practitioner that could affect the safety or confidence of patients, they should share that information with all places where the medical practitioner is known to be working in a medical capacity in an effective and timely manner.^{ix,33}

4.6 When problems or concerns about a medical practitioner's performance have been investigated, learning should be shared with the wider healthcare team and the medical practitioner supported to improve.

Interdependency with other agencies 5

When dealing with complaints, CQC's assessment framework asks independent providers what arrangements are in place for the independent review of complaints and expects providers to be able to demonstrate what these arrangements are in their policy, and in information materials for private patients. If the patient is funded by the NHS, they are able to access an independent review by the statutory Parliamentary and Health Service Ombudsman.³⁴ However, privately-funded patients treated in an independent hospital or in an NHS private patient unit do not have access to the Ombudsman in England. Instead, if the provider subscribes to the voluntary complaints body, the Independent Sector Complaints Adjudication Service (ISCAS)³⁵ complaints made by privately-funded patients who are dissatisfied with the outcome of a local investigation may be referred by ISCAS to an independent adjudicator. This is an inconsistency in patients' rights in relation to independent redress of complaints.³⁶

4.7 What are medical practitioners' responsibilities?

- To comply with the GMC's *Good medical practice*.³⁷
- To be open and share any issues or concerns raised about their practice even if this does not result in an investigation or measures being taken.
- If measures are implemented by any organisation (whether healthcare providers, the GMC or non-clinical employers/bodies), to immediately inform their Responsible Officer or senior medical officer at all locations in which they work (independent sector and NHS).
- To notify providers (independent or NHS) of any incidents, complaints and any other concerns that are being investigated in other settings in which they work that are relevant to their practice.
- To work collaboratively with all staff and support all colleagues in being able to speak-up if they have any concerns about patient safety in the setting in which they work.
- Where complaints are made by patients to fully participate in the independent providers complaints process, including meeting with patients if necessary, and using complaints as an opportunity to learn and improve.

ix. The Medical Practice Information Transfer Form supports the appropriate transfer of information about a doctor's practice to and from the doctor's Responsible Officer. It can be used to share information with the doctor's Responsible Officer when a concern arises about the doctor's practice in any place where the doctor is practising.

Appendix 1: Three lines of defence

An example of how the three lines of defence can be applied by independent providers and medical practitioners is illustrated below.

	Independent providers	Medical practitioners
Accountability	Accountable to their patients for the regulated activity they offer. Providers are regulated through system regulators such as the Care Quality Commission (CQC). CQC regulate, monitor and inspect services to make sure they meet the fundamental standards of quality and safety.	Medical practitioners (irrespective of their employment status) are accountable to their patients for their behaviour and the quality of care they offer. This accountability is legally enacted through the General Medical Council for ensuring patients are treated in line with published medical standards and guidelines, in keeping with <i>Good medical practice</i> .
First line of defence (frontline professionals)	<ul style="list-style-type: none"> • Clear and understood ward-to-board governance structure. • Clear role descriptions and responsibilities, for example: Medical Director/Clinical Director, Responsible Officer, Registered Manager, Matron/Head of Clinical Services, Medical Advisory Committee Chair, Medical Appraisal Lead. • Polices: including application for and review of Practising Privileges; Consultants Handbook, Appraisal, New Procedures, Research, Managing Performance Concerns, Consent, Clinical Governance, Complaints Handling, Records Management policies. • Meeting training needs of those engaged. • Completion of appraisals/ liaison with others, eg NHS provider Responsible Officers. • Annual/biennial review of Practising Privileges. • Whistleblowing: Freedom to Speak Up processes. • Communication to Patients re. governance and assurance structures/ processes. 	<ul style="list-style-type: none"> • Completion of minimum training standards and professional registration and licensing. • Compliance with Provider policies. • Ongoing professional training (including safeguarding/ resuscitation) and personal development plan (PDP) in order to keep up to date in their chosen field. • Submission to provider of evidence necessary to hold Practising Privileges, eg indemnity /or in relation to directly employed practitioners' evidence of the relevant competencies to meet the person specification and job description for the role.

continued	Independent providers	Medical practitioners
Second line of defence (boards and senior leaders)	<ul style="list-style-type: none"> • Clear role descriptions and responsibilities of the Fit and Proper Persons: Directors and the Nominated Individual. • Provider clinical risk management systems and processes. • Provider clinical audit programme and action on variances to NICE and other guidance. • Scrutiny by Medical Advisory Committees (or equivalent). • Internal Audit (reporting to the Board Audit Committee). • Review of intervention ratios. • Quality improvement activities. • Systems for monitoring scope of practice. • Submission of data to the National Reporting and Learning System (NRLS). • Submission of data to national registries, eg National Joint Registry and action in response to outlier notification. • Monitoring of Patient Reported Outcome Measures (PROMS) data. • Monitoring and analysis of Patient Satisfaction and Complaints. • Submission of activity data to the Private Healthcare Information Network (PHIN) in line with the Competition and Markets Authority (CMA) order. • Communication flows between independent sector and NHS providers/clinical governance leads for medical practitioners. 	<ul style="list-style-type: none"> • Annual whole practice appraisal. • Participation in Provider audit programmes. • Submission of data to relevant national registries. • Participation in discrepancy audits, eg radiology. • Participation with Multi-disciplinary Teams (MDTs) and compliance with national guidance. • Submission of fee information to the Private Healthcare Information Network (PHIN) in line with the Competition and Markets Authority (CMA) order. • NHS Improvement's Getting It Right First Time (GIRFT). • Other appropriate national quality improvement and audit initiatives/ programmes.
Third line of defence (regulators and other external bodies)	<ul style="list-style-type: none"> • The Care Quality Commission, Health Inspectorate Wales, Healthcare Improvement Scotland inspections, Regulation and Quality Improvement Authority and other relevant systems regulators. • Professional regulator (General Medical Council) and accredited registers (eg Joint Council for Cosmetic Practitioners). • Professional leadership bodies (eg Royal College of Surgeons). • PHIN's publication of information under the Competition and Markets Authority (CMA) Order. • Medicines and Healthcare products Regulatory Agency (MHRA) inspections. • Human Fertilisation and Embryology Authority (HFEA) inspections. • United Kingdom Accreditation Service (UKAS) inspection. • NHS England Higher Level Responsible Officer reviews. • External independent audit of risk management systems and performance. • External Review and Audits of Clinical Practice/Outcomes. 	<ul style="list-style-type: none"> • Revalidation by the General Medical Council. • Royal College invited Review Mechanism. • External /national reviews.

Appendix 2: Dataset for Practising Privileges

Dataset to be considered on application for Practising Privileges [independent providers may request more information]:

- Standard dataset and ID check: proof of identity including a recent photograph, basic demographic/identity information, work permit (if necessary), Disclosure and Barring Service certification, ICO registration, evidence of compliance with relevant mandatory training, evidence of Hep B/Hep C/HIV status, CV and references, designated body and Responsible Officer.
- Satisfactory evidence of conduct in previous employment.³
- Current registration with the General Medical Council, entry on the specialist register and any other appropriate professional registrations.
- Valid certificate of adequate insurance cover through an insurance company or medical indemnity cover through a Medical Defence Organisation to an appropriate level.
- All locations where a doctor holds practising privileges or works as a doctor.
- Evidence of participation in annual whole practice appraisal. To include sharing of appraisal summaries and PDPs as a minimum, and relevant information from whole practice appraisals if the summaries and PDPs are not sufficient. Providers should consider a mandatory requirement of at least one whole practice appraisal before medical practitioners practising in the UK can apply for Practising Privileges.
- Description of scope of practice. To include but not limited to: for surgeon's procedure codes, for physician's codes (if feasible), procedures undertaken, volume of work in each area of practice and registries where outcome data is shared.
- Evidence of participation in quality improvement activities.
- Immediacy of availability of attendance, ie minimum availability/travel distance requirements and the requirement to have back-up for known non-availability appropriate to the level of care being delivered.

Dataset to be considered in an annual or biennial review of practising privileges [independent providers may request more information]:

- Updated dataset required on application.
- Review of and compliance with the agreed scope of practice. Including a discussion about required volumes for surgical activity and/or ensure practice is sufficient to maintain competency.
- Review of clinical audit, clinical metrics or clinical outcomes data derived from the organisations clinical governance systems.
- Relevant registry data where appropriate, eg NJR data for orthopaedics.
- Review of adverse events and outcomes.
- Investigated complaints and outcomes.
- Concerns, investigations or changes to practice in other hospitals where the doctor works.
- Concerns, investigations or changes to recognition from an insurer or commissioner.
- Other concerns relating to the doctor's work; including those related to non-technical/soft skills such as situational awareness, coping with stress, etc.
- Consideration of professional behaviour, including: patient is the first concern, commitment to quality and safety, collaborative team working, openness and transparency, fairness, honesty, integrity, insight into strengths and weaknesses, commitment to reflection and learning in line with the General Medical Council's *Good medical practice* guidance.

Appendix 3: Requirements for Medical Advisory Committees

Medical Advisory Committees have no statutory role. Independent providers can choose to use Medical Advisory Committees as part of their governance structures to access medical advice on professional and clinical issues. Not all independent providers use Medical Advisory Committees in this way and the stated expectations in this appendix are also applicable to any other structure in a provider organisation carrying out similar functions.

To work effectively, it is crucial that Medical Advisory Committees (and any sub-committees) are constituted clearly and that both providers and members of the committee are clear about the role and functions of the group.

When operating a Medical Advisory Committee, the following should be considered:

- How the functions of the Medical Advisory Committee are defined in relation to the clinical governance structure of the organisation. Where the Medical Advisory Committee reports to in that structure. That the committee's status as an advisory board is widely understood.
- The appropriate membership of the committee. That the membership has the expertise necessary to undertake the functions the committee is being asked to fulfil. The balance of expertise. The balance between medical practitioner and independent provider members.
- The group's transparent terms of reference that define: functions, individual member responsibilities, nomination of members, decision making, recruitment policy that includes election of the Chair and duration of membership term.
- The role specification and performance review for the Chair of the Medical Advisory Committee.
- A policy for and procedures to manage conflicts of interest. Specifically, whether the Medical Advisory Committee has a role in the granting of practising privileges or reviewing concerns about doctors, giving second opinions and/or advising on complaints, and how conflicts of interest are avoided.
- The Chair of the Medical Advisory Committee should be encouraged to forge an effective relationship with local NHS Trusts, in particular local NHS Medical Directors, in order to maximise the flow of intelligence about and between local providers and medical professionals.

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