



# Medical Practitioners Assurance Framework Refresh

September 2022

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# Foreword

It's now almost three years since IHPN, together with former NHS England National Medical Director Sir Bruch Keogh, launched our Medical Practitioners Assurance Framework (MPAF). The MPAF was designed to help foster a more standardised approach to medical governance in the independent sector and ultimately drive up the quality and safety of care for patients.

Since its launch in 2018, the framework is now firmly embedded in the patient safety and regulatory landscape. CQC uses the framework's principles in assessing how well led an independent service, and it is now also part of the NHS' Standard Contract - requiring all independent sector providers that deliver NHS-funded care to adhere to it.

The sector's ongoing journey to improve the safety and quality of care it delivers has been recognised, with the Government's response to the Paterson inquiry, published in December 2021, noting the "significant work" undertaken by the sector to fulfil the Bishop of Norwich's recommendations, specifically through the implementation of the MPAF.

Of course, the world of healthcare does not stand still – not least with a global pandemic to contend with - and the MPAF was always designed to be a "live document". Since it was published we have been looking at areas where the framework can be further strengthened to ensure the principles remain in-keeping with current best practice around medical governance in the health system.

This is particularly important given that since MPAF was published we've seen the publication of the Bishop of Norwich's independent inquiry report into Ian Paterson, Baroness Cumberlege's Independent Medicines and Medical Devices Safety Review (IMMDS), as well as new initiatives such as the Learn from Patient Safety Events (LFPSE) service and wider regulatory changes in the 2022 Health and Care Act.

In looking to continually improve the MPAF, IHPN conducted an impact review to understand how the framework is being used in the independent sector and how it can be strengthened. Overall, it is clear that independent sector Medical Directors, Registered Managers, and Medical Advisory Committee (MAC) Chairs have embraced the framework, with high levels of awareness and support for the principles contained in it. Critically, it has also led to some tangible changes and improvements in providers' governance processes and frameworks and real enthusiasm to develop the framework's principles even further.

With the support of our colleagues and partners from across the healthcare system, IHPN have now undertaken a refresh of the MPAF so it delivers maximum value to healthcare providers, practitioners, and, ultimately, patients. While its principle-based approach remains, we have updated it to both reflect new or revised guidance or legislation published since 2019, as well as strengthening specific areas such as the importance of patient consent and declaring any conflicts of interest which were key themes in both the Paterson and IMMDS reviews.

With ever greater collaboration between independent and NHS providers as part of the work to put the health system on sustainable footing post covid, it's never been more crucial that the MPAF continues to evolve and accurately reflect the latest medical governance practices. I'd therefore like to personally thank all those who contributed to this refresh, and we look forward to continuing this work and striving to improve the safety and quality of care delivered by independent sector providers to both NHS and private patients.

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**David Hare**

Chief Executive, Independent Healthcare Providers Network

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# Introduction

Patients<sup>1</sup> 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 independent provider delivering services through their employees or through those working in their organisations using other contractual arrangements such as practising privileges (see section 1). Ultimately, the executive and non-executive members of the independent provider's board are accountable for the quality of care provided by the organisation, which includes a safe and effective governance system for medical practitioners.

Responsibility for quality of care also rests with individual medical practitioners who 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.

Through the development of the Medical Practitioners Assurance Framework, IHPN is supporting independent providers to strengthen the assurance processes that support medical practitioners to deliver quality care to patients being treated in their organisations. The framework sets out the standards the sector expects 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 visible leadership<sup>2</sup>.

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 needs to be developed within each independent provider's own organisational governance structures, with regard to the requirements of systems and professional regulators. A key principle that underpins this framework is that the 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 continues to take a principles-based approach to describe independent 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

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<sup>1</sup> Patient is used in the broadest sense and includes, for example, service users, customers and clients.

<sup>2</sup> General Medical Council, Effective clinical governance for the medical profession, [online], accessed August 2022.

Since individual organisations have different structures, the framework does not require those structures to be replaced. Instead, providers should be able to demonstrate how their systems and processes meet the expectations of the MPAF. Medical practitioners working in independent providers also have responsibilities in each of the four areas in this framework. These responsibilities are described at the end of each section.

To further support providers, this new refresh of the MPAF has been reduced in size with any areas of duplication removed and responsibilities and accountabilities strengthened or clarified. The three lines of defence set out by The King's Fund 'In the battle against serious quality failures in healthcare'<sup>3</sup> remain of equal importance but are now golden threads throughout the document itself, rather than held as an appendix. An additional appendix detailing the IHPN Development plan has also been included to provide IHPN member organisations and stakeholders a clear view of the sector's commitment in continuing to improve safety and quality across the sector.

Each section is structured in the following way:

- What the framework is trying to achieve,
- Medical practitioners' responsibilities; and
- An IHPN Development Plan

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<sup>3</sup> The King's Fund (2012), Preparing for the Francis report: How to assure quality in the NHS, [online], accessed August 2022

# Creating an effective clinical governance structure for medical practitioners

### What are we trying to achieve?

Independent providers should have transparent, consistent approaches to the clinical governance of medical practice in their organisations that support high quality patient care, and are well understood by medical practitioners and teams working in independent providers.

- 1.1** This framework presents the opportunity for independent providers together to drive continued improvement in clinical governance across the independent healthcare sector, and it will require strong leadership from Chief Executives, executive boards and clinical leaders.

Leadership is the most influential factor in shaping organisational culture and so ensuring necessary leadership behaviours, strategies and qualities are robustly and positively developed is fundamental to the delivery of good care. The calibre of an organisation's leadership is linked to a range of outcomes within health services that include patient mortality, financial performance, staff well-being and overall quality of care. In practical terms, the vision and values of the organisation are set by board leadership (what they attend to, monitor, reprove or reward) and by how it views staff and patient voices<sup>4</sup>. The value of inclusive and diverse boards is well accepted<sup>5</sup>, guidance and research suggest that organisations are best served by boards drawn from a wide diversity of backgrounds and sectors<sup>6</sup>.

The organisation's board (or equivalent leadership<sup>7</sup>) should understand that they hold the ultimate accountability<sup>8</sup> around clinical governance for medical practitioners, and accountability for the quality of care provided by their medical practitioners (whether employed or working on practising privileges).

- 1.2** The Care Quality Commission "well led" inspection key question is based on the premise that the leadership, management and governance of the organisation is key to assuring the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture<sup>9</sup>. Implementing the MPAF is a key aspect of how independent providers can provide assurance and evidence that they are "well led".

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<sup>4</sup> West M, Loewenthal L, Eckert R et al (2015), Leadership and leadership development in healthcare. The evidence base, The Faculty of Leadership and Management, [online pdf] accessed August 2022

<sup>5</sup> Sealy R (2017), NHS: Women on Boards. 50:50 by 2020, Exeter Business School, NHS Improvement, NHS Employers.

<sup>6</sup> NHS Leadership Academy (2013). The NHS Healthy Board 2013. Principles of good governance, [online pdf] accessed August 2022.

<sup>7</sup> Independent providers have a range of different corporate structures. Where the term 'board' is used it should be taken to apply to the equivalent level decision makers in an independent provider.

<sup>8</sup> Care Quality Commission. Well led: outstanding, [online] accessed August 2022  
<https://www.cqc.org.uk/guidance-providers/healthcare/well-led-outstanding>.

<sup>9</sup> Care Quality Commission (2018), *Key lines of enquiry, prompts and ratings characteristics for healthcare services*, [online pdf], accessed August 2022

- 1.3** In an individual facility<sup>10</sup> accountability sits with the Registered Manager appointed by the independent provider, and registered by the CQC, to manage regulated activity on their behalf. This is an important role. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations<sup>11</sup>.
- 1.4** Independent provider structures are diverse, from large international corporate hospital groups, to single hospital charitable foundations and not for profit or specialist providers, and everything in between. Independent providers therefore need to define their structures that support clinical governance for medical practitioners in the context of their own organisational and corporate board structures.

All independent providers should have a 'ward-to-board' clinical governance structure with clear lines of accountability (up and down the organisation). Minimum requirements for clinical governance structures are outlined in Box 1.

**Box 1.** Minimum requirements for a 'ward-to-board' clinical governance structure in an independent provider

- Ensure that all board members (or equivalent) are aware of their responsibilities for, and the organisation's assurance processes around, the quality of clinical care. For example, by: training non-executive board members in clinical governance; designating a non-executive board member (ideally with a clinical background) with oversight of the clinical governance of medical practitioners<sup>12</sup>; having a standing agenda item on patient safety and the clinical governance of medical practitioners linked to key metrics.
- Corporates with multiple, geographically dispersed locations should appoint a clinician as national clinical 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<sup>13</sup>. However, the Responsible Officer could also undertake this role depending on the size of the organisation. To support the national lead for clinical governance, organisations should also consider appointing local or regional designated lead consultants for the clinical governance of medical practitioners with clearly defined responsibilities.
- Define the roles, responsibilities and reporting arrangements 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 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 Directors, Clinical Director, Medical Advisory Committee Chair, Medical Appraisal Leads and Matron/Head of Clinical Services.
- Specify how information on individual practitioners' performance is collected, reviewed and presented to hospital and clinical management teams, 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 and patients, and how members of the public might be meaningfully engaged in governance structures.

<sup>10</sup> A facility is the location in which care is provided, which might be an acute hospital, clinic or a community hospital.

<sup>11</sup> These regulations include the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) and The Care Quality Commission (Registration) Regulations 2009.

<sup>12</sup> General Medical Council, Effective clinical governance for the medical profession, [online] accessed August 2022.

<sup>13</sup> Legislation.gov.uk (2010 no. 2841) The medical profession (responsible officers) regulations 2010, [online] accessed August 2022.

- 1.5** There are two main ways that medical practitioners are engaged in the independent sector, either through 'practising privileges' or directly employed. The principles of good governance apply equally, and the ultimate responsibility of independent providers for care provided in their facilities remains, regardless of how a medical practitioner is engaged.
- 1.6** The granting of practising privileges is a widely used, well-established process within the independent sector with specific meaning within regulations, whereby a medical practitioner is granted permission to work in an independent provider<sup>14</sup>. Whilst medical practitioners working with practising privileges are independent contractors, the independent provider must demonstrate that medical practitioners carrying out a Care Quality Commission regulated activity are 'fit and proper' for the role<sup>15</sup>. Accountability for this sits with the Registered Provider and the Registered Manager supported by clinical and professional input from the Medical/Clinical Director (or equivalent). Even though medical practitioners are independent contractors with regards to employment law, for the purpose of the regulations, medical practitioners working under practising privileges are defined as employees. All aspects of the medical practitioner's consultation must be carried out under the independent providers management and policies<sup>16</sup>.

The Responsible Officer must ensure that 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<sup>17</sup>.

- 1.7** Independent providers should have practising privileges policies which form the basis for the application, granting, maintenance, restriction, suspension and withdrawal of practising privileges in their organisations that require compliance by all medical practitioners who are engaged under these terms.

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

**Box 2.** Aspects of practising privileges policies that should be standardised in independent providers

- **Application for practising privileges.** Application for practising privileges should be based on a standard dataset (see Appendix 1 and 1.9) which should be incorporated into all providers practising privileges application forms. 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.
- **Review of practising privileges.** The review of practising privileges 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 1. Practising privileges are reviewed biennially for all medical practitioners and more regularly in circumstances where additional scrutiny is required.

<sup>14</sup> Practising privileges are a defined exemption from the requirement of medical practitioners to register separately with the Care Quality Commission.

<sup>15</sup> Care Quality Commission, *Health and Social Care Act 2008 (regulated activities) Regulations 2014 Regulation 19*, [online] accessed August 2022.

<sup>16</sup> Care Quality Commission (2015), *The scope of registration*, [online pdf], accessed August 2022.

<sup>17</sup> Legislation.gov.uk (2010 no. 2841) *The medical profession (responsible officers) regulations 2010*, [online] accessed August 2022.

- 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 (see also 1.9), 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<sup>18,19</sup>. This also applies to amended therapies/procedures and common procedures new to a particular organisation. Policies need to clearly set out independent provider and medical practitioner responsibilities, clear standards for reviewing the evidence, staff training, conflict of interest declarations<sup>20,21</sup>, incident reporting and monitoring of outcomes for any new or innovative procedures.
- **Patient consent.** Independent providers should have clear policies on patient consent outlining which professionals should be involved in the decision-making process with the patient<sup>22,23</sup>. Policies should include the need to provide full information (referencing independent sources where available) on risks, potential benefits and alternatives to the treatment. Policies also need to provide for patients to be given specific time to reflect and make decisions<sup>24</sup> and detail how consent is documented and recorded. Policies should take account of specific guidance around defined procedures<sup>25,26</sup>.

**1.8** 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. Box 2 highlights the key aspects of practising privileges that should be standardised in all independent providers (expectations that should apply irrespective of the employment status of the medical practitioner).

**1.9** Understanding a medical practitioner's scope of expertise and practice ensures that 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. For medical practitioners no longer working in the NHS, 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 should be requested in a standard format (see Appendix 1) by all independent providers both on application for practising privileges or for a practising privileges review. This information should be supported by relevant information from the medical practitioner's annual whole practice appraisal (see Section 3. Supporting whole practice appraisal). 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<sup>26</sup>.

<sup>18</sup> The Bristol Royal Inquiry (2201), *Learning from Bristol: Report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary Inquiry 1984-1995*, [online pdf] accessed August 2022.

<sup>19</sup> 2020 *First do no harm. The report of the Independent Medicines and Medical Devices Safety Review*, [online pdf], accessed August 2022.

<sup>20</sup> General Medical Council (2013), *Financial and commercial arrangements and conflicts of interest*, [online pdf], accessed August 2022.

<sup>21</sup> Independent provider policies on conflict of interest declarations will apply more widely than just new procedures and treatments.

<sup>22</sup> Royal College of Surgeons (2018), *Consent: Supported decision-making*, [online pdf], accessed August 2022.

<sup>23</sup> General Medical Council (2020), *Decision making and consent*, [online pdf], accessed August 2022.

<sup>24</sup> Department of Health and Social Care (2021). *Government response to the independent inquiry report into the issues raised by former surgeon Ian Paterson*. [online pdf], accessed August 2022.

<sup>25</sup> General Medical Council (2016), *Guidance for doctors who offer cosmetic interventions*, accessed August 2022.

<sup>26</sup> Subject to appropriate employer-employee safeguards and compliance with GDPR.



The need to ensure visibility of a suite of information about medical practitioners by all relevant organisations (independent sector, NHS and insurers) remains, including about their scope of practice and all locations where a medical practitioner is employed or holds practising privileges<sup>27</sup>. At present no single, reliable and definitive view of a doctor's scope of practice, activity, outcomes or performance exists. However, a number of national solutions are underway which together may provide the definitive view necessary to improve the governance of medical practice across the board. These include aligning the independent sector to the NHS Digital Staff passport, the Acute Data Alignment Programme (ADAPt), the continued development of the Private Healthcare Information Network data sets and the National Consultant Information Programme (NCIP). See IHPN Development Plan (below and Appendix 2).

- 1.10** Medical Advisory Committees can provide organisations with a resource for medical advice on professional and clinical issues. However, Medical Advisory Committees have no legal status therefore it is for the independent provider to define how a Medical Advisory Committee fits into the organisation's clinical governance structure. The constitution and functions of a Medical Advisory Committee will be different in different independent providers. To avoid any lack of clarity, the role and functions of the Medical Advisory Committee and any sub committees (or other structures carrying out similar functions) should be clearly defined and understood by the independent provider, Responsible Officer, members of the committee and medical practitioners working in the independent provider (See also Appendix 3 Requirements for Medical Advisory Committees).

In particular, attention should be given to:

- The role, responsibilities and accountability of the Chair which should be specified in a role description which includes expectations around culture and behaviours, and relationships with Responsible Officers.
- If the committee is to have a role in advising on the granting, renewal and suspension or restriction 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 advising on complaints.

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## What are medical practitioners' responsibilities?

- To practice in accordance with the requirements of the General Medical Council in line with *Good medical practice*<sup>28</sup>.
- To be personally accountable for their professional and ethical practice, to work within their competence 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 Order<sup>29</sup>, and NHS<sup>30</sup> and GMC<sup>31</sup> Conflicts of Interest guidance.
- To demonstrate high standards of professional behaviour, work collaboratively with independent providers and expect discussions about professional behaviour to form part of both applications for, and renewal of, practising privileges in any independent provider (see Appendix 1) and part of any recruitment or appraisal process for any directly employed medical practitioner.

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<sup>27</sup> Department of Health and Social Care (2021). Government response to the independent inquiry report into the issues raised by former surgeon Ian Paterson, [online], accessed August 2022

<sup>28</sup> General Medical Council (2013), *Good medical practice*, [online], accessed August 2022.

<sup>29</sup> Competition and Markets Authority (2014), *Private healthcare market investigation order 2014 (as amended)*, [online pdf], accessed August 2022.

<sup>30</sup> NHS England (2017), *Managing conflicts of interest in the NHS*, [online], accessed August 2022.

<sup>31</sup> General Medical Council (2013), *Financial and commercial arrangements and conflicts of interests*, [online pdf], accessed August 2022.

- To work in line with the requirements of the provider's practising privileges policy, the policies and systems for clinical governance, audit, consent and decision making, declaration of conflicts of interest, complaints handling, records management and all other relevant provider policies.
- To engage with and contribute all necessary data when requested to as part of a review of practising privileges, including ensuring that the provider has all the information necessary for a robust review of the entire scope of their whole practice.

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## **IHPN Development Plan**

- IHPN will continue to provide leadership across the sector to support MPAF implementation. A suite of support tools (for example, to support standardisation of Practising Privileges Policies) and learning events will be continuously developed and available to IHPN members and more widely.
- Work with other stakeholders to enable national initiatives that deliver a repository of information about medical practitioners' scope of practice that can be viewed by all relevant organisations and patients. This includes the NHS Digital Staff passport, the Acute Date Alignment Programme (ADAPT), the continued development of the Private Healthcare Information Network data sets and the National Consultant Information Programme (NCIP). Linked to MPAF 1.9.
- IHPN will continue to work across the sector and with other stakeholders to share best practice around decision making and consent, and conflicts of interest for medical practitioners. Linked to MPAF 1.8.
- IHPN will work with patient groups to develop a patient-focused summary version of the Medical Practitioners Assurance Framework. This can be used by independent providers and other stakeholder organisations to explain in lay terms the expectations that the independent sector has of itself with regard to patient safety and medical practitioners. Linked to MPAF 1.4.

# Monitoring patient safety and clinical quality, encouraging continuous improvement

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### What are we trying to achieve?

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

- 2.1** The independent provider should ensure that all medical practitioners working in the organisation read and understand their clinical governance framework, practising privileges policy and the organisation's policies and standard operating procedures that support safe clinical practice.
- 2.2** Monitoring of individuals 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 explore any divergence from the expected norm<sup>32</sup>. The independent provider should facilitate individuals to carry out regular audit of their outcome data and subject their results to peer discussion and review.
- 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 feedback into the clinical governance systems for medical practitioners and more widely. Any complaints about the performance of an individual medical practitioner must be investigated and, if appropriate, addressed quickly and effectively (see Section 4. Raising and responding to concerns).
- 2.4** Scope of practice (see also 1.9) should be monitored and systems of control be in place to enable rapid identification of any variations from that authorised under existing employer policies or procedures. 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 (for example, Healthcare Quality Improvement Partnership data) to inform clinical governance processes where possible to do so. Independent providers should submit data about performance to relevant audits and national clinical registries, and require medical practitioners working in their organisations to do so. They must also submit medical practitioner's episode data to the Private Healthcare Information Network and patient safety incident reports to Learn from Patient Safety Events (LFPSE) service<sup>33</sup>. See also IHPN development plan (below and Appendix 2).

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<sup>32</sup> This is likely to (include but is not limited to) collection and reporting of; activity, outcomes, complications, incidents, complaints, peer review participation, clinical audit, patient feedback.

<sup>33</sup> NHS England, Learn from Patient Safety Events Service, [online], accessed August 2022.

- 2.6** Effective 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 peer review and quality improvement activities on application for, or review of, practising privileges (see appendix 2) or if directly employed, this should form part of employer recruitment and performance management processes. Independent providers should also consider arranging or signposting individuals to mentoring schemes for their professional support and development.
- 2.7** Independent providers have a statutory Duty of Candour to be open and transparent with people receiving care or treatment<sup>34</sup>. Medical professionals also have a professional Duty of Candour to be open and honest with patients when something goes wrong<sup>35</sup>. Processes should be in place to support medical practitioners and independent providers in complying with their statutory and professional Duty of Candour. There must also be procedures for reporting adverse incidents, near misses and complaints (see also Section 4. Raising and responding to concerns).
- 2.8** Multidisciplinary team working promotes cross sector working in the interests of patient safety<sup>36</sup>. The use of multi-disciplinary teams (MDTs) as part of a patient’s care pathway to provide team based clinical decisions based on review 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. Where an MDT is required as standard practice, independent providers should formalise arrangements for MDT working, including how relevant clinical data is transferred, how the teams are reviewed, and how outcomes are audited. See also IHPN development plan (below and Appendix 2).

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## What are medical practitioners’ responsibilities?

- To understand and work within 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 including engaging with the review and verification processes for any mandated registries or information organisations (e.g. PHIN)<sup>37</sup>.
- To be familiar with 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.
- Where possible, to make mentoring arrangements to support their professional development, particularly if their practice is different from their NHS practice or if they are transitioning to working exclusively in the independent sector.

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<sup>34</sup> Care Quality Commission, *Regulation 20. Duty of Candour, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20* [online], accessed August 2022.

<sup>35</sup> General Medical Council (2015), *Openness and honesty when things go wrong: The professional duty of candour*, [online], accessed August 2022.

<sup>36</sup> Department of Health and Social Care (2021) *Government response to the independent inquiry report into the issues raised by former surgeon Ian Paterson*. [online], accessed August 2022.

<sup>37</sup> Competition and Markets Authority (2014), *Private healthcare market investigation order 2014 (as amended)*, [online pdf], accessed August 2022.

- To work within General Medical Council<sup>38</sup>, Care Quality Commission<sup>39, 40</sup> and other national guidance<sup>41</sup> for multidisciplinary team working that supports clinical decision making about their patient's care and/or the quality improvement activities expected by provider organisations.
- 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 independent provider, and to take an active part in investigations and share learnings arising.

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## IHPN Development plan

- IHPN will continue to work across healthcare sectors to remove barriers that prevent the independent sector contributing to single, comparable datasets and accessing 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 will be sought. Linked to MPAF 2.5.
- IHPN will continue to identify and share good practice on multidisciplinary team (MDT) working, recognising that whilst much current guidance focuses on cancer patients MDTs take place in other medical settings. At the same time, IHPN will continue to work nationally with NHSEI and the Care Quality Commission on whether it's necessary and appropriate for further national guidance on MDTs to be developed<sup>42</sup>. Linked to MPAF 2.8.

<sup>38</sup> General Medical Council (2013), *Good medical practice*, [online], accessed August 2022.

<sup>39</sup> Care Quality Commission, *Key lines of enquiry, prompts and ratings characteristics for healthcare services*, [online pdf], accessed August 2022.

<sup>40</sup> Care Quality Commission, *Inspection Service Framework: Diagnostic Imaging*, [online pdf], accessed August 2022  
[https://www.cqc.org.uk/sites/default/files/20200515\\_Surgical\\_Core\\_Services\\_framework\\_NHS\\_and\\_IH\\_providers\\_v10.pdf](https://www.cqc.org.uk/sites/default/files/20200515_Surgical_Core_Services_framework_NHS_and_IH_providers_v10.pdf) page 47.

<sup>41</sup> NHS England and NHS Improvement (2020), *Streamlining Multi-Disciplinary Team Meetings, Guidance for Cancer Alliances*, [online pdf], accessed August 2022.

<sup>42</sup> Department of Health and Social Care (2021) *Government response to the independent inquiry report into the issues raised by former surgeon Ian Paterson*. (online), accessed August 2022.

# Supporting whole practice appraisal

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### 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.

Whole practice appraisal, alongside other governance data, 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 must 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<sup>43</sup>. Responsible Officers have a statutory duty to ensure that appraisal and revalidation processes take account of all relevant 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<sup>44</sup>.

The Responsible Officer can, therefore, request information about a doctor's practice from the person with governance responsibility in any place the doctor is working, and that individual has a duty to respond to the request. There is also an expectation that the doctor's Responsible Officer will share information of note with the person with governance responsibility in all places where the doctor is working, for example, if there is an issue of patient safety<sup>45,46</sup>.

**3.2** The Registered Manager who oversees the practising privileges review should ensure that the person with governance responsibility for the doctor's practice provides feedback to the Responsible Officer in a medical practitioner's designated body (whether independent or NHS) in order to support the whole practice appraisal<sup>47,48</sup>. Independent providers can also support medical practitioners by providing governance information about their practice that can be used as part of their annual whole practice appraisal.

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<sup>43</sup> 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.

<sup>44</sup> 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.

<sup>45</sup> ROAN information sheet 37: Sharing appraisal information with employers.

<sup>46</sup> NHS England (2016), *Information flows to support medical governance and responsible officer statutory function*, [online pdf] accessed August 2022.

<sup>47</sup> NHS England, *Designated Bodies (DBs), Executive Boards, their revalidation and medical staffing communities*, [online] accessed August 2022.

<sup>48</sup> General Medical Council, *Information sharing principles*, [online], accessed August 2022.

To facilitate effective information sharing, independent sector Responsible Officers should have systems 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).

- 3.3** The NHS England guidance on information flows and the GMC's information sharing principles are essential references for sharing information about medical practitioners<sup>49</sup>. Organisations should have a risk stratification system based on information of note in relation to fitness to practice and scope of practice. The term information of note allows for the proactive sharing of information at a lower threshold than a major concern, thereby permitting triangulation with other information at an earlier stage. Sharing of information should not only occur when there is a crisis. See also Section 4. Raising and responding to concerns.
- 3.4** Independent providers must be aware 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 practitioners annual whole practice appraisal viewed alongside other governance sources will help to provide insight into the medical practitioner's practice. Therefore, if necessary, independent providers may request medical practitioners share as a minimum their summary appraisal outcomes and PDP to inform the review (5). If this does not provide enough information to make a decision, additional relevant information can be requested from 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, 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<sup>50</sup>.

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## What are medical practitioners' responsibilities?

- To notify independent providers and their Responsible Officers of all the organisations or settings where they practice and provide medical services, and keep that information up to date.
- To participate in the professional standards activities underpinning annual appraisal and revalidation and to share relevant information from these, including declaring any professional performance matters relevant to the work they will be undertaking with all providers where they practice.
- To participate in revalidation and to share relevant<sup>51</sup> information from their whole practice appraisal with all providers where they practice.

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## IHPN Development plan

- Guidance on information sharing about medical practitioners is available from both the General Medical Council and NHS England. However, there remains confusion about what<sup>52</sup> and how information can be shared between the NHS and the independent sector. This means that practice varies across the country. IHPN will work with the General Medical Council, the NHS, independent providers and Private Medical Insurers, to identify and disseminate examples of good practice so that learning can be shared and good practice accelerated.

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<sup>49</sup> NHS England (2016), *Information flows to support medical governance and responsible officer statutory function*, [online pdf] accessed August 2022.

<sup>50</sup> General Medical Council (2019), *Governance handbook* [online pdf], accessed August 2022.

<sup>51</sup> 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.

<sup>52</sup> Department of Health (2003), *Confidentiality: NHS Code of Practice* [online pdf], accessed August 2022.

# Raising and responding to concerns

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### What are we trying to achieve?

Whilst medical regulators and professional bodies set standards of clinical conduct and practice, independent providers set the standards of medical practice, behaviour and probity expected of doctors in their organisations. Independent providers also have a duty to protect patients and safeguard their needs.

Providers must have systems in place to give early warning of any failure, or potential failure, in clinical performance and outcomes, behaviour, conduct and health of doctors working in their organisations.

- 4.1** All concerns regarding a medical practitioner should follow a structured, documented process. This is regardless of whether medical practitioners are employed or on practising privileges, or how the concern is triggered (for example, clinical audit, whistle blowing, incidents, complaints or Responsible Officers). Independent provider clinical governance frameworks must be explicit about responsibility for medical performance and transparent about how performance issues are identified, first responded to and, when necessary, formally managed. NHS England and NHS Resolution's Practitioner Performance Advice Service have produced guidance in this respect<sup>53, 54</sup> and the Practitioner Performance Advice Service<sup>55</sup> and the GMC's Employer Liaison Service<sup>56</sup> offer support to the fair and effective management of concerns locally.
- 4.2** If it is necessary to restrict, exclude<sup>57</sup> suspend or remove practising privileges due to concerns about a medical practitioner's performance<sup>58</sup> (temporarily or substantively) this information must be communicated to all other organisations where the medical practitioner practises (including the NHS) and to the medical practitioner's Responsible Officer. This applies equally where a practitioner withdraws from practising privileges during the course of an investigation. Where required, private medical insurers and the NHS payor should be informed where and in broad terms<sup>59</sup> why restrictive measures have been taken. Regulatory restrictions as applied by the General Medical Council and restrictions on practising privileges are different processes, independent providers need to take independent action as necessary.

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<sup>53</sup> NHS England (2019), *A practical guide for responding to concerns about medical practice*, [online pdf] accessed August 2022.

<sup>54</sup> National Clinical Assessment Service (2010), *How to conduct a local performance investigation*, [online pdf] accessed August 2022.

<sup>55</sup> NHS Resolution, Practitioner Performance Advice Service, [online], accessed August 2022.

<sup>56</sup> General Medical Council, Employer Liaison Service, [online], accessed August 2022.

<sup>57</sup> NHS resolution has a suite of resources to support decision makers across the healthcare system as they consider exclusion as an option in the management of practitioner performance concerns.

<sup>58</sup> NHS Resolution, Maintaining High Professional Standards in the NHS, [online], accessed August 2022.

<sup>59</sup> This should avoid prejudicing any possible third-party investigation.



- 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 with the practitioner. Providers need to consider, in the context of their clinical governance framework, whether the medical practitioners practice causes a significant risk to the quality and safety of patient care in their organisations and take appropriate action. The Practitioner Performance Advice Service can help explore what these actions might be<sup>60</sup>.
- 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 do not always find it easy to raise their concerns. There should be no barriers to concerns about patient safety being raised whether because of clinical or behavioural concerns. As part of a just and learning culture<sup>61</sup> all independent providers must have effective speaking up/whistle blowing systems in place that enable all staff to speak up regardless of their gender, seniority, role or ethnicity. Independent providers should appoint Freedom to Speak Up Guardians (for NHS work it is required by the NHS Standard Contract) as a further route for this. The organisation's culture should enable medical practitioners and other workers voices to be heard without fear of having their practising privileges withdrawn or their employment affected.
- 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 the organisation. 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 the relevant Responsible Officer in all places where the medical practitioner is known to be working in an effective and timely manner<sup>62, 63</sup>. Responsible Officer training and participation in Responsible Officer Networks should encourage collaboration between the NHS and independent sector as part of a community of care where there can potentially be sharing of specialist resources such as case investigators.
- 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. If practice is restored following an investigation, the provision of an appropriate support package for the medical practitioner should be facilitated. The Practitioner Performance Advice and Remediation Service can provide support<sup>64</sup>.
- 4.7** Independent providers must have arrangements in place for the review of complaints that are outlined in their policies and in information available to patients<sup>65, 66</sup>. Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. If a patient is not satisfied by a local complaint review they should have access to complaints escalation and access to an independent review. For NHS patients this is through the Parliamentary and Health Service Ombudsman. For private patients, independent providers should subscribe to a voluntary complaints body, such as the Independent Sector Complaints Adjudication Service (ISCAS)<sup>67</sup> able to refer complaints to an independent adjudicator where required<sup>60</sup>.

<sup>60</sup> NHS Resolution, Practitioner Performance Advice Service, [online], accessed August 2022.

<sup>61</sup> NHS Resolution, Maintaining High Professional Standards in the NHS, [online], accessed August 2022.

<sup>62</sup> The Medical Practice Information Transfer Form (MPIT) supports the appropriate transfer of information about a doctors 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 doctors practice in any place where the doctor is practising.

<sup>63</sup> NHS England (2016), Information flows to support medical governance and responsible officer statutory function, [online pdf] accessed August 2022.

<sup>64</sup> NHS Resolution Practitioner Performance Advice Service; Professional Support and Remediation Plans; guidance and resources for clinical supervisors [online] accessed August 2022.

<sup>65</sup> Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

<sup>66</sup> Department of Health and Social Care (2021), Policy Paper, Government response to the independent inquiry report into the issues raised by former surgeon Ian Paterson, [online] accessed August 2022.

<sup>67</sup> Independent Sector Complaints Adjudication Service, [online], accessed August 2022.

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## What are medical practitioners' responsibilities?

- To seek appropriate help if experiencing pressures that may lead to an impairment of their practice.
- 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.
- Where complaints are made by patients, to fully participate in the independent provider's complaints process, including meeting with patients and the provision of statements if necessary and to always use complaints as an opportunity to learn and improve.
- 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) and their Private Medical Insurer.
- To notify providers (independent or NHS) of any incidents, complaints or 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 (themselves included) in being able to speak up if they have any concerns about patient safety in the setting where they work<sup>68</sup>.

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## IHPN Development plan

- The Parliamentary and Health Service Ombudsman (PHSO) is currently piloting the NHS Complaint Standards<sup>69</sup>. These standards will provide strong reinforcement of both regulatory requirements and best practice to NHS and independent sector providers about making a complaint. IHPN will work closely with the Independent Sector Complaints Adjudication Service and the PHSO, as well as the Care Quality Commission, DHSC and others, to ensure that these new standards provide strong reinforcement of both regulatory requirements and best practice to independent sector providers. Linked to MPAF 4.7.
- In addition, IHPN will work with the independent sector to highlight the value of arrangements for patients to access independent resolution of their complaints. Linked to MPAF 4.7.

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<sup>68</sup> The General Medical Council GMC has a Speaking up hub for doctors to support them in speaking up.

<sup>69</sup> Health Service Ombudsman, NHS Complaint Standards, [online] accessed August 2022.

## Appendix 1

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# Dataset for Practising Privileges

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### **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.
- 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 is risk assessed, including the requirement to have back-up for known non-availability, appropriate to the level of cover required.**

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### **Dataset to be considered in 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, e.g. 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 2

# IHPN Development plan

1. IHPN will continue to provide leadership across the sector to support MPAF implementation. A suite of support tools (for example, to support standardisation of Practising Privileges Policies) and learning events will be continuously developed and available to IHPN members and more widely.
2. IHPN will work with other stakeholders to enable national initiatives that deliver a repository of information about medical practitioners' scope of practice that can be viewed by all relevant organisations and patients. This includes the NHS Digital Staff passport, the Acute Data Alignment Programme (ADAPT), the continued development of the Private Healthcare Information network data sets and the National Consultant Information Programme (NCIP). Linked to MPAF 1.9.
3. IHPN will continue to work across the sector and with other stakeholders to share best practice around decision making and consent, and conflicts of interest for medical practitioners. Linked to MPAF 1.8.
4. IHPN will work with patient groups to develop a patient-focused summary version of the MPAF. This can be used by independent providers and other stakeholder organisations to explain in lay terms the expectations that the independent sector has of itself with regard to patient safety and medical practitioners.
5. IHPN will continue to work across healthcare sectors to remove barriers that prevent the independent sector contributing to single, comparable datasets and accessing 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 will be sought. Linked to MPAF 2.5.
6. IHPN will continue to identify and share good practice on multidisciplinary team (MDT) working, recognising that whilst much current guidance focuses on cancer patients, MDTs take place in other medical settings. At the same time, IHPN will continue to work nationally with NHSEI and the Care Quality Commission on whether it's necessary and appropriate for further national guidance on MDTs to be developed<sup>70</sup>. Linked to MPAF 2.8.
7. Guidance on information sharing about medical practitioners is available from both the General Medical Council and NHS England. However, there remains confusion about what <sup>71</sup> and how information can be shared between the NHS and the independent sector. This means that practice varies across the country. IHPN will work with the General Medical Council, the NHS, independent providers and Private Medical Insurers, to identify and disseminate examples of good practice so that learning can be shared and good practice accelerated.
8. The Parliamentary and Health Service Ombudsman (PHSO) is currently piloting the NHS Complaint Standards<sup>72</sup>. These standards will provide strong reinforcement of both regulatory requirements and best practice to NHS and independent sector providers about making a complaint. IHPN will work closely with the Independent Sector Complaints Adjudication Service and the PHSO, as well as the Care Quality Commission, DHSC and others, to ensure that these new standards provide strong reinforcement of both regulatory requirements and best practice to independent sector providers. Linked to MPAF 4.7.
9. In addition, IHPN will work with the independent sector to highlight the value of arrangements for patients to access independent resolution of their complaints. Linked to MPAF 4.7.

<sup>70</sup> Department of Health and Social Care (2021) *Government response to the independent inquiry report into the issues raised by former surgeon Ian Paterson*. (online), accessed August 2022.

<sup>71</sup> Department of Health (2003), *Confidentiality: NHS Code of Practice* [online pdf], accessed August 2022.

<sup>72</sup> Health Service Ombudsman, *NHS Complaint Standards*, online, accessed August 2022.

## Appendix 3

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# 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 an independent provider 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 independent provider. Where the Medical Advisory Committee reports to in that structure, and 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 declarations of interests and how these are managed. 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. This should include defining how the Medical Advisory Committee works with the Responsible Officer.
- The Chair of the Medical Advisory Committee should be familiar with NHS information sharing principles<sup>73</sup>. Both the Medical Advisory Committee Chair and NHS Medical Director(s) should be encouraged to forge effective relationships between organisations in order to maximise the flow of intelligence about, and between local providers and medical professionals.

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<sup>73</sup> NHS England (2016), *Information flows to support medical governance and responsible officer statutory function*, [online pdf] accessed August 2022.

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Further copies can be requested from:  
Email: [info@ihpn.org.uk](mailto:info@ihpn.org.uk)

Independent Healthcare Providers Network  
Thomas House, 84 Ecclestone Square,  
London SW1V 1PX

Email: [info@ihpn.org.uk](mailto:info@ihpn.org.uk)  
or visit: [ihpn.org.uk](http://ihpn.org.uk)

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