

Guidelines

for Medical Advisory Committee
Chairmen and Members in the
Independent Sector

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GLOSSARY OF TERMS

CEO	Chief Executive Officer
CGC	Clinical Governance Consultant
CNO	Chief Nursing Officer
CSA	Care Standards Act
FIPO	Federation of Independent Practitioner Organisations
FIPO CGAC	Federation of Independent Practitioner Organisations Clinical Governance Advisory Committee
FIPO Nat-MAC	Federation of Independent Practitioner Organisations National Medical Advisory Committee
GMC	General Medical Council
GP	General Practitioner
HCGC	Hospital Clinical Governance Committee
HGC	Hospital Governance Committee
HQS	Health Quality Service
IHF	Independent Healthcare Forum
ISTC	Independent Sector Treatment Centre
MAC	Medical Advisory Committee
NICE	National Institute for Clinical Excellence
RMO	Resident Medical Office

1. INTRODUCTION

1. (A) Background to the FIPO MAC Guidelines

1. Increasing regulation of acute independent healthcare facilities and of consultants, coupled with an entirely appropriate desire from all sides (including patients) for improved quality of care has placed new responsibilities on the members of the Medical Advisory Committee (MAC) and its Chairman in independent hospitals.
2. Several official bodies and documents govern MAC and consultant activities some legal, some contractual and some based on professional guidelines. For example the Healthcare Commission who implement the Care Standards Act, the GMC guidelines (*Good Medical Practice*), and the Independent Hospital Forum (IHF) contracts for consultants – some with local independent hospital modifications – are all interwoven. Others, such as The Health Quality Service (HQS) are a voluntary inspectorate to which hospitals may subscribe and which has its own set of standards.
3. Although the Care Standards Act is clear in its requirements many MAC Chairmen and MAC members are confused about their responsibilities and legal status. They question whether they are part of management (similar to a Medical Director in a NHS Trust), a mouthpiece for their colleagues, an advocate for the patients or a combination of all these. Some MAC Chairmen may take on more managerial roles than others and in these cases they should be aware of the guidance issued by the GMC in *“Management in Healthcare – The Role of Doctors”*.

4. This booklet provides guidance for consultants on a MAC and represents The Federation of Independent Practitioner Organisations (FIPO) interpretation of the role of the MAC and its Chairman and members. FIPO has produced this with input from the GMC, the Medical Defence Union, The Medical Protection Society, certain independent hospital providers and other professional bodies. The Healthcare Commission has been fully consulted at all stages of the preparation of this booklet and has advised on a number of points but as a Regulator it is not in a position to formally endorse a professional publication.

1. (B) Revision of the FIPO MAC Guidelines

5. It has become evident during the production of these guidelines that many areas of clinical governance are evolving i.e. the rules over practising privileges for those over 70 years of age, the methods by which Stream Two complaints to the GMC will be handled and the whole question of consultant revalidation. For this reason it is likely that these guidelines will need revision in the 12-18 months.

2. THE FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS (FIPO)

2. (A) FIPO History and Remit

6. The Federation of Independent Practitioner Organisation (FIPO) was founded in 2000 and is an overarching professional organisation for all private practice committees, independent physician associations, specialty groups in the independent sector and doctors working in groups (Chambers).

7. FIPO has also linked independent hospital MACs throughout the UK into a network known as FIPO Nat-MAC (FIPO National Medical Advisory Committee). Periodic newsletters and meetings organised by FIPO serve to inform MAC Chairmen and MAC members of their developing role under new legislation and healthcare market changes
8. FIPO's remit is to represent the profession on all aspects of independent care with quality issues high on its priorities. Future developments may involve more co-ordination of the quality agenda. FIPO is working with the Healthcare Commission and the major independent hospital providers to co-ordinate the standards and outputs from MAC's and to provide a professional input to these clinical issues.
9. The FIPO supporting organisations and the composition of the FIPO Board (as at 2005) is shown in Appendix 1. Further details about FIPO and information about how to obtain copies of previous FIPO publications can be found at www.fipo.org.

3. THE HEALTHCARE COMMISSION

3. (A) The Healthcare Commission – Roles and Goals

10. The Healthcare Commission (an abbreviated title for the Commission for Healthcare Audit & Inspection) is the successor to the National Care Standards Commission and resulted from a merger of that body with the NHS regulator, CHI (The Commission for Healthcare Improvement) and with the Value for Money arm of the Audit Commission.

11. The role of the independent sector division of the Healthcare Commission will be to review compliance with the regulations which underpin the Care Standards Act via an ongoing system of inspections. These include not just the inspection of all hospital premises but also a review of the MAC structure, its functions, documentation including the files on each consultant. The independent hospital governance data, any outcome studies and audits will be recorded and trends will be analysed.
12. One of the goals of the Healthcare Commission is convergence whereby the standards in the NHS and acute independent healthcare sector will be integrated. Given the differences in services, clinical staffing and management styles offered between the two sectors there could be some difficulties and thus a number of changes may be anticipated in the private sector. Included under the independent division of the Healthcare Commission will be the ISTC's whose clinical governance and audit returns are set contractually with the Department of Health.
13. The authority of the Healthcare Commission remains unchanged and the regulator has the power to close independent hospitals for failure of compliance. The Commission must be informed of any major event such as the death of a patient, the suspension of a consultant in any arena (NHS or private) or of any complaint about an individual consultant to the GMC. The overall involvement of the Healthcare Commission in the complaints system is presently undefined but may increase.

4. THE CARE STANDARDS ACT (2000)

4. (A) The Care Standards Act 2000 and the National Minimum Standards

14. The Care Standards Act 2000 introduced a number of regulations and National Minimum Standards which govern all aspects of care and management in the independent healthcare sector. All healthcare facilities, ranging from hospitals to stand alone consulting rooms, are subject to regular inspections by the Healthcare Commission to ensure that they meet the required standards and regulations.
15. The overriding concern for FIPO is the maintenance and improvement of clinical standards. Central to this objective are the functions and activities of the local MAC and a number of National Minimum Standards refer to the role and responsibilities of the MAC and its Chairman.

4. (B) Legal Obligations of Medical Advisory Committee Members and Chairmen

16. An outline of the main points of the National Minimum Standards and Regulations as they affect MACs is given in Appendix 2. The relevant documents are available on the Healthcare Commission website at www.healthcarecommission.org.uk.
17. The Care Standards Act 2000 incorporates core standards for all healthcare providers, which are the National Minimum Standards set by the Secretary of State for Health. In addition, there are service-specific standards for acute hospitals which are incorporated in Chapter 9 (Standards A1 - A48) of the 'National Minimum Standards' DoH publication dated February 2002 and can be found at <http://www.dh.gov.uk/assetRoot/04/07/83/67/04078367.pdf> and also on the Healthcare Commission website.

18. The Standards themselves do not have statutory force but the regulations relating to the Standards, incorporated in the same document, are legally enforceable through the Healthcare Commission via their inspection teams. The regulations are known as the Private and Voluntary Healthcare (England) Regulations 2001, available at the website.
19. All consultants working in the independent sector - and particularly those who sit as members of an MAC - are advised to be familiar with the Regulations because they impact substantially on individual clinical performance, the monitoring of consultant practice and the maintenance of admitting privileges.
20. For each hospital there is required to be a registered provider (i.e. the owner of the hospital) and also a 'registered person' who is the manager of the hospital and who is ultimately legally responsible for what goes on within it including the granting and withdrawal of practising privileges to medical practitioners. This normally is the Chief Executive Officer (CEO) or equivalent.
21. Part III of the Regulations relates to 'quality of service provision'. Regulations 15-24 have significant relevance for consultant users and particular responsibilities for members of a MAC, including clinical governance and medical audit groups.
22. Within the main National Minimum Standards for acute hospitals, A3 and A4 cover the qualifications, experience and competence of consultant users. Standard A5 is concerned particularly with the requirement for there to be a Medical Advisory Committee for the hospital "which is responsible for representing the professional needs and views of medical practitioners to the registered manager of the hospital".

5. THE CONTRACTUAL RELATIONSHIP BETWEEN CONSULTANTS AND PATIENTS

5. (A) FIPO Documentation and the Patient Consultant Contract

23. All doctors practice within a well-known professional framework. Within the private sector there is an added feature, namely the financial contractual relationship between the patient and the doctor. In to this may come other stakeholders such as the payer, which may be an insurance company, the NHS or some other party such as an employer or the patients themselves. It is essential that this financial contract does not affect the relationship between patient and doctor.
24. As part of its various functions FIPO has produced documentation to assist consultants and also a leaflet for patients outlining their Rights and Responsibilities and their contractual relationship with consultants (Appendix 3). It is recommended that all MAC Chairmen use these documents as a template and advise local colleagues accordingly (for more information see www.fipo.org).

6. THE CONTRACTUAL RELATIONSHIP BETWEEN CONSULTANTS AND INDEPENDENT HOSPITALS

6. (A) Consultant Practising Privileges Contract

25. The great majority of independent hospitals in the UK signed up to three documents which were drafted jointly by the former Independent Healthcare Association (part of whose role has now been assumed by the Independent Healthcare Forum - IHF) and

the BMA in consultation with the GMC, FIPO, and the medical defence bodies. The following three template documents have been agreed:

- I. a model policy on practising privileges
- II. a model letter for consultants' practice privileges
- III. a paper on private practice data for appraisal.

26. These documents have been adopted by most hospitals although some groups have made certain changes. These set the terms and conditions for consultants and their work practices. It is imperative that the MAC be fully aware of the local documents and should ensure that the consultant body are aware of their implications.

7. THE MEDICAL ADVISORY COMMITTEE STRUCTURE

7. (A) MAC Membership / Selection / Term of Office

27. Rules governing MAC structure and functions have been produced by different hospital groups and are similar in outline but vary slightly in detail. Those hospitals wishing to undergo HQS assessment will need Terms of Reference for their MAC. This should be based on the following criteria.
28. It is generally agreed that the MAC comprises "elected" consultants and co-opted management, nursing or other consultant members. The core voting group of consultants should ideally number more than six (plus a Chairman); the maximum size will depend on local factors (i.e. number of specialities needing representation) and could be up to twelve or more. The MAC should have the power to co-opt members as required and for variable periods. Some co-opted members will attend on a regular basis (CEO or deputy, senior nurse manager) and others including consultants on a regular or

sporadic basis. The Clinical Governance Consultant and the Consultant Chairman of the Hospital Clinical Governance Committee (if this latter appointment has been made) should attend. Co-opted members should not have voting rights. The MAC should have the right to meet in private with only elected consultant members should the need arise to discuss specific issues.

29. It is helpful to have a GP member on the MAC Committee from the surrounding district. Consultant MAC members should broadly represent the specialist interests of the hospital. MAC members should be impartial and fair in their decisions and must carry the confidence of their colleagues. Selection of MAC membership should either be by election from specialist groups, by agreed rotation amongst the specialist group, or by selection by the existing MAC (the least preferred route but one which may be essential in certain circumstances). Depending on the size of the hospital there may be a case for a general election of MAC members by the whole consultant body after nominations have been sought.
30. The term of office of each member of the MAC is not critical but should be for 3 years with the option of an extension, subject to the selection process.

7. (B) MAC Chairman and Deputy Chairman / Selection / Term of Office

31. The core MAC membership should elect the Chairman of the MAC. He/she may or may not already be a member of the MAC but some experience of MAC functions would be a prerequisite for the post. A trusted senior impartial consultant with good interpersonal and administrative skills would be required.

32. Primarily the Chairman's position is an MAC appointment but clearly the hospital management will have an interest and there must be agreement over this matter. The balance between the MAC's and hospital management's input to the appointment of the Chairman is delicate. However, if there is an attempt to enforce an appointment of Chairman on the MAC or if there is no consensus of support from the MAC for a particular candidate then this would result in a serious undermining of the Chairman's authority.
33. It is important to remember that the MAC has two major roles - one to advise hospital management and the other to represent professional (and thus patient) interests. There is therefore a potential for occasional conflicts and the Chairman needs to be sensitive to the balance.
34. The MAC Chairman should have defined term of office, probably 3 years being ideal with the option of an extension with no specific limits but subject to review. Some hospitals require annual renewal during this period by a MAC proposed and seconded motion. Removal of a Chairman from office would be only if there were serious health issues or if there was a formal vote of no confidence by the MAC.
35. A Deputy Chairman may be appointed and this is a matter for local decision. The Deputy Chairman may act in the absence of the Chairman, carry out some of his/her responsibilities and may eventually succeed to the Chairman's post if this is agreed local policy. If the Chairman and Deputy Chairman are unable to attend a meeting the Committee should elect a Chairman for that meeting only.

7. (C) Administrative Functions of the MAC Chairman and Members

36. The MAC Chairman should have secretarial support provided by the hospital for his/her official functions. This should extend to the preparation of Minutes, Agenda, meeting documentation (including details of all applicants for practising privileges), note keeping at meetings and any official or other MAC related correspondence.
37. The MAC Chairman should be personally responsible for writing the Minutes and for the content of the MAC Agenda. There is merit in having a regular structure to the Agenda with fixed items such as presentations or reports from the Governance team, CEO, Chief Nursing Officer (CNO) and MAC Chairman. A template for a MAC Agenda is shown in Appendix 4 but this is not prescriptive.
38. All Minutes should be formally confirmed at subsequent MAC meetings. MAC Chairmen and members should note that the Minute Book may be subject to inspection by the Healthcare Commission.
39. The circulation of copies of the MAC Minutes to some or all of the consultant body or to other hospital managers or departments may be considered as a positive and transparent approach. This is a matter for local decision. However, there could be matters of commercial sensitivity or details of individual consultant reviews contained within the Minutes and so these should be written carefully. In general it is preferable to anonymise any reviews about individual consultant performance.
40. Apart from regular attendance at MAC meetings, members of the MAC may be required to advise on specific issues or to

take part in specific enquiries. They will be called upon to review in detail all applications for practising privileges in their own speciality.

7. (D) Indemnification for MAC Chairmen and Members

41. The Care Standards Act and the model policy on practising privileges defines the roles of MAC and its Chairman including authority of recommending the granting, suspension or renewal of practising privileges of consultants and general practitioners (GPs). Thus, the MAC Chairman (or designate) is required to either sign off and approve or otherwise reject all consultants with privileges jointly with the hospital manager who will only act on the MAC Chairman's professional advice in this renewal process.
42. This responsibility of the MAC Chairman and members could, in theory, lead to potential challenges by consultant or GP users. Although ultimately it is the hospital CEO or manager who is responsible for all decisions this does not necessarily absolve the MAC Chairman or other MAC members from possible accusations of depriving doctors of their admission rights inappropriately or of damaging their reputation. An even less likely scenario is if, in a negligence case against a consultant user, the action could be construed in some way as resulting from an inappropriate granting or renewal of practising privileges. For these reasons the MAC Chairman and all members who are making recommendations to the hospital CEO as the registered person, must have full indemnity cover provided under the hospital's indemnity insurance.
43. The hospital providers may withdraw indemnification in the event that an MAC

Chairman, MAC member or other “appointed” consultant (i.e. a governance consultant or lead clinician) should act in a way that infringes hospital policy or breaches confidentiality. For this reason a formal agreement or contract should be given to all consultants on the MAC.

7. (E) Reimbursement for the MAC Chairman, MAC Members and Clinical Governance Consultant(s)

44. Membership of the MAC has always been a voluntary obligation. It has been traditional for the MAC Chairman not to receive any reimbursement for fear that it would compromise his/her position as an impartial advocate for colleagues. Reimbursement, it is suggested, could lead to the Chairman becoming over identified as part of management.
45. There is no clear guidance about reimbursement for the MAC Chairman. In view of the enlarging role of MAC Chairman and also because a small number do receive financial reimbursement there may be an argument in favour of a national agreement to pay all MAC Chairmen in the sector. This may evolve but until such time as a decision is made Chairmen are advised not to receive payment or if they do so to make this transparent and preferably to utilise the funds in some appropriate but non personal fashion.
46. Reimbursement for MAC members is not the norm although they may obtain certain indirect hospital benefits. Some, such as MAC dinners or an away study and review day on hospital business, are acceptable. Others, such as financially beneficial rates for consulting room rental or secretarial assistance are unacceptable.
47. The position of the Clinical Governance Consultant (CGC)

or clinical Chairman of the Hospital Clinical Governance Committee (HCGC) (see below) is different as he/she is appointed for a specific administrative function, he/she reports to the MAC Chairman and CEO and specific time must be given to this task. Reimbursement is appropriate for this and may be paid according to equivalent NHS sessional rates. If the MAC Chairman fulfils this Governance role then reimbursement may be paid subject to MAC approval.

7. (F) Probity Issues Affecting the MAC, Consultant Staff and Hospital Management

48. The MAC Chairman and members should act in an open and impartial manner and should declare at any stage if there is a conflict of interest in any MAC matter. For example, consultant applications for privileges, renewal of privileges or suspensions may directly or tangentially involve individual members of the MAC or its Chairman and in this case they should not take part in the decision making process. In the event of a complaint or case review involving an MAC member then that person should take no part in the process.
49. The MAC is not normally involved in financial negotiations or arrangements with the hospital. Such arrangements might involve negotiated reimbursement with radiologists, pathologists or other groups or hospital financial support for individual consultants, secretaries or consulting room rental rates. In some instances the hospital may provide reception or other administrative support for specific clinical units but in general there should be an equitable situation with all consultants receiving equal treatment. Exceptions to this may be an initial relief on a consulting room rental for a short period (3 - 6 months)

for newly appointed consultants starting in practice.

50. If the hospital should negotiate contract work with the NHS or another purchaser then the MAC should ensure that all consultants in the required speciality have equal and fair access to this work. Emergency or other work referred from the hospital should be shared out equally. Difficulties can arise if consultants, who are only occasional and sporadic users of the hospital, wish to become involved over and above more regular users.
51. The development of Chambers may also lead to other tensions with the possibility of preferential treatment to one group over another or to individuals who cannot gain access to the Chambers group. Some Chambers or even individual consultants may seek preferential hospital rates for their self pay patients, particularly if they are major users of the hospital. Whilst there is a market force to be considered, this is generally not thought to be a good idea as it gives an unfair advantage to certain consultants over others.
52. The changing role of the insurers may also impinge if tendering becomes more common and in many hospitals there will be different streams of patients being treated from different “purchasers”. It is the duty of the MAC to ensure that the same high standards apply to all patients.
53. It is self evident that probity and transparency are also required in these and all other matters from the hospital management. Although the MAC is not directly involved with financial issues it is an initial court of appeal for local consultants and the MAC should be concerned to ensure that there is no preferential treatment given

to any individual or group. In the event that a consultant(s) appeals to the MAC as a result of some dispute the Chairman (plus committee) may need to intercede according to the circumstances.

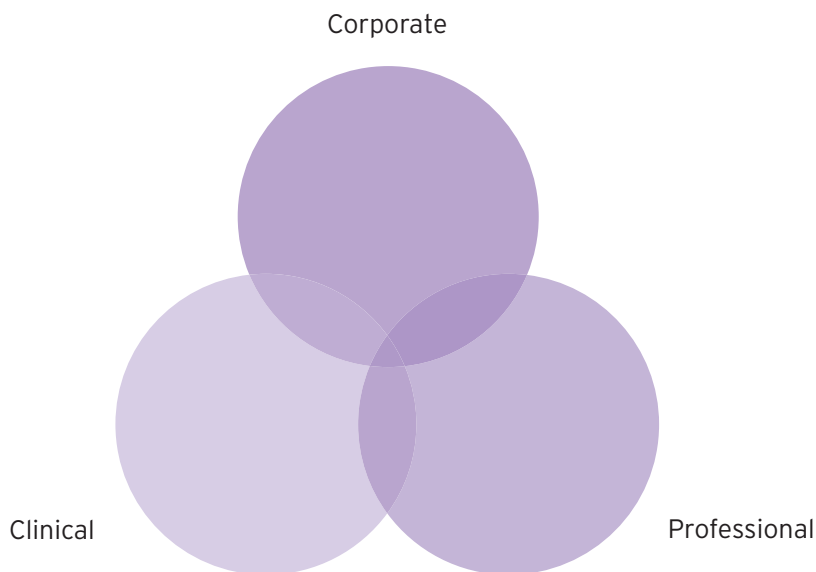
54. Throughout this guidance document reference has been made to the obligations of the MAC and its Chairman in particular. These increasing regulations may bring the MAC into conflict with their colleagues who are in effect their constituency. The fine line between a management member and a consultant advocate is a hard one to tread.

55. The Chairman and the whole MAC must act with fairness and transparency (but retain confidentiality). Documentation on each consultant should be kept confidential and only reviewed if there is an issue. This consultant database and files should be open for inspection and challenge by the consultant (if necessary) and should be available for his/her appraisal.

8) CLINICAL GOVERNANCE IN THE INDEPENDENT SECTOR

8 (A) Governance Responsibilities in Acute Independent Hospitals

56. Governance responsibilities may be best considered under three main overlapping headings as shown (above).
57. There may be confusion about terminology and responsibilities. It must be made clear that the overall hospital governance is the responsibility of the registered manager (i.e. the CEO). However, clinical and professional governance can only take place if managed and led by consultants.
58. **Corporate (or Organisational)** governance will involve the hospital's response to its



facilities, personnel, complaints system, financial controls and all the other general functions and risk management of the hospital. This is the responsibility of the hospital management.

59. **Professional** governance relates to the medical staffing and questions of practising privileges, renewal of privileges and suspensions. This is the direct responsibility of the MAC, which must advise the CEO accordingly.
60. **Clinical** governance refers to the range of ways in which the hospital clinical performance is monitored and hopefully improved. This will thus involve all clinical records, audits, reviews, clinical incidents, deaths and complaints. This is the professional responsibility of the MAC, which may provide a filtering mechanism in the shape of a designated consultant who may function alone or within the framework of a Hospital Clinical Governance Committee.
61. This manner in which each hospital organises itself is a matter for local discussion. An overlap between the various aspects of governance is obvious and thus, for example, systems failures are a major source of

clinical incidents. Likewise behavioural problems which may be considered professional could lead to clinical incidents. There is thus some merit in setting up a specific Hospital **CLINICAL** Governance Committee to evaluate all sources of potential problems and as this is a clinical committee it should be clinically led.

8. (B) The Role of the Clinical Governance Consultant (CGC)

62. In order to facilitate an efficient and accurate collection and interpretation of all the hospital governance and audit data the MAC may wish to recommend the appointment of a Clinical Governance Consultant (CGC) to lead the governance programme. In some cases, particularly if the hospital is small, the CGC role will be assumed by the MAC Chairman.
63. The appointment of a CGC should be made jointly by the MAC Chairman (taking advice from MAC members) and the hospital CEO. This consultant may or may not already be a member of the MAC but if not he/she should be invited to sit on the MAC as an ex officio member. Voting rights for this individual may or may not be granted at the discretion of

the MAC. The period of appointment of the CGC should be determined and extended as required. There would be a need for administrative support and reimbursement for this consultant.

64. The CGC is responsible to the Chairman of the MAC and thus to the hospital CEO. The functions of the CGC are to review all the clinical data as required and to filter and refine this crude information in to a presentable and comprehensive package for the MAC. The CGC should be part of the Hospital Clinical Governance Committee (HCGC) if this exists and ideally should chair this group. In larger hospitals more than one consultant may be involved with governance issues and a division of responsibilities would be necessary with one consultant to chair the HCGC and one to be the lead clinician in clinical audit. The CGC should take note of the overall governance of the hospital and not feel confined to the purely clinical aspects of his/her role.

8. (C) Hospital Clinical Governance Committee (HCGC)

65. The manner in which hospitals handle their governance issues will vary and depends on the hospital size and work patterns. Normal risk management will cover all aspects of the hospital and may be handled and reviewed in a different forum to clinical issues but there is an overlap. Many hospitals have a specific Hospital Clinical Governance Committee (HCGC) with a wide remit covering all aspects of care systems within the hospital. Thus, membership would necessarily involve all major departments (i.e. nursing, theatres, pharmacy, physiotherapy, infection control, risk management etc). Many of these may have separate subgroups to control managerial functions.

66. The HCGC brings these together with a focus on clinical issues and the hospital management would normally be represented on this group as would the CGC or a MAC representative. As stated previously it is preferable that a consultant chairs this committee and this may be the CGC or in larger hospitals by another consultant, which leaves the CGC to deal specifically with consultant and audit issues.

8. (D) Functions of the Hospital Clinical Governance Committee (HCGC)

67. The Hospital Clinical Governance Committee needs to consider all the relevant functions of the hospital including clinical incidents, near misses and complaints. There needs to be an appropriate system of recording and reporting incidents and complaints. As these frequently involve both service aspects and direct clinical problems it is essential to have consultant input to their review and the CGC involvement should not be restricted to clinical incidents alone.
68. Although hospitals may vary in their approach to clinical governance depending on their size and workload patterns the demand for a quality assured programme and consultant involvement is overwhelming. In the NHS there has been a dislocation between management aspirations (mainly to fulfil government objectives) and the clinicians desire to improve the quality clinical services. The need to refocus on a clinically driven governance strategy is a concept that may be more easily achieved in the independent sector where there is a more restricted range of services and fewer political objectives.

69. Thus the overall clinical thrust of the HCGC should be based on the clinical protocols derived from NICE and other professionally led guidelines and these should be encouraged in a multidisciplinary team approach. These should be interpreted locally and constantly reviewed with regard to clinical and cost effectiveness and other aspects of patient satisfaction and risk management.

70. The HCGC reports to the MAC and should make recommendations about service improvements and take appropriate follow up action to check implementation. The data sets required by the National Minimum Standards should be prepared and reviewed by this committee or consultant. Specific clinical incidents should be filtered and graded by severity; minor incidents should be recorded and dealt with by the HCGC whilst the more severe ones should be passed through to the MAC for consideration (see Section 11(E)). Similarly all deaths should be reviewed and classified accordingly. The committee should review complaints or issues relating to misconduct by a specific medical practitioner.

71. Hospital audit data may be suitable for merger either at group level or at a wider national level for presentation and promotion of standards and of the independent sector as a whole. Some of this may be commercially driven and is the responsibility of the hospital providers but some aspects may be requested by the Healthcare Commission working via FIPO and various other bodies.

9. THE MEDICAL ADVISORY COMMITTEE FUNCTIONS

9 (A) Legal and Professional Functions of the MAC

72. The National Minimum Standards sets out the legal functions of the Medical Advisory Committee for the hospital 'which is also responsible for representing the professional needs and views of medical practitioners to the registered manager of the hospital'.
73. The MAC is by definition an advisory group and does not have executive or management functions within the hospital. However, it would be most unwise for any hospital Chief Executive or manager to ignore the considered professional advice of the MAC as he/she would then be in an untenable position in the event of a subsequent incident.
74. The MAC and its Chairman in particular have two broad functions of regulatory compliance and professional matters which commonly overlap.
 - I. Functions of the MAC relating to the Regulations and the National Minimum Standards
 - II. Functions of the MAC relating to Professional Issues

10. FUNCTIONS OF THE MAC RELATING TO THE REGULATIONS AND THE NATIONAL MINIMUM STANDARDS

75. The MAC functions relating to the National Minimum Standards may be grouped as follows;
 - Hospital and Consultant Data Sets and Statutory Reports
 - Consultant Appraisal and Assessment of Competency
 - GMC Revalidation Proposals
 - Criteria for Consultant Practising Privilege
 - Renewal of Consultant Practising Privileges
 - Practising Privileges after the age of 70 years
 - Suspension of Consultant Practising Privileges
 - Resident Medical Officers

10. (A) Hospital and Consultant Data Sets and Statutory Reports

76. The MAC has several functions as defined by the National Minimum Standards. Each MAC is required to meet formally at least quarterly, to maintain suitable records (Minutes) and to make recommendations to the registered manager on various issues. Whilst the MAC may receive briefings from senior managers, nurses and others and may also discuss other general matters, a core function of the MAC is to review the information required under the National Minimum Standards, and to consider all Clinical Governance and other relevant professional matters.
77. All data disclosed to members of the MAC must be processed in compliance with the Data Protection Act 1998 and professional members of the MAC are also bound by the GMC guidance on patient confidentiality. The MAC should ensure that such arrangements are in place in their hospitals.
78. In terms of clinical governance the MAC is required to review at least twice a year the clinical data sets for all practitioners working in the hospital with a minimum requirement of
 - I. any deaths at the hospital;
 - II. unplanned re-admissions to hospital;
 - III. unplanned returns to theatre;
 - IV. unplanned transfers to other hospitals;
 - V. adverse clinical incidents;
 - VI. incidence of post-operative deep vein thrombosis;
 - VII. post-operative infection rates for the hospital.
79. This data set for the whole hospital staff should be aggregated and presented in a suitable format for the MAC by the CGC. MAC Chairmen may wish to place summaries of these reports in the MAC Minutes.
80. The confidential data for individual consultants, which makes up this summary,

should be made available to each consultant for the purpose of appraisal (Appendix 4). The MAC Chairman may need to refer to this data set when writing a consultant reference for an outside enquiry.

81. In analysing these reports the MAC should be certain of the veracity of the information presented and must interpret the crude data with caution. For example, deaths should be noted in terms of 'anticipated' or 'not anticipated' and whether or not there were any adverse events leading up to the death; it is the responsibility of the CGC to have previously reviewed all these deaths. Reasons for unplanned transfers to other hospitals may be for non clinical reasons such as insurance restrictions. The incidence of post-operative deep vein thrombosis is hard to obtain even under trial circumstances and post-operative infections may not be manifest until long after the patient has been discharged.
 82. The review of adverse clinical incidents is dealt with in Section 11 (E). These require a balanced approach and an understanding of recognised complications and the statistical likelihood of a true trend or an acceptable, if regrettable, situation.
- ### 10. (B) Consultant Appraisal and Assessment of Competency
83. Appraisal and assessment are different. Appraisal of consultants is not a function of the MAC or of the hospital management but assessment is.
 84. Appraisal is a confidential professional issue between appraiser and appraisee. This may be whole practice appraisal in the NHS and in this case the consultant should bring to the attention of the NHS appraiser the details of his/her private work. Some consultants only work in the

- independent sector or may choose not to be appraised by their NHS colleague for their private work. In these cases a private appraisal must be arranged through some managed environment which can guarantee that the process is thorough.
85. The CEO and management should make available to the consultant his/her work sheet, complications, results of any audits, complaints and all positive reports and these should be used by the consultant during appraisal. However, the appraiser is not required to judge the scope of practice of the appraisee but should ensure that the consultant is comfortable with their work and to advise if further training or help is required. Personal goals may be set.
 86. The consultant must return proof of a complete appraisal to the CEO and MAC Chairman. It is not necessary to return all the appraisal forms in the independent sector and these should remain confidential to the consultant and his/her appraiser. The CEO and MAC Chairmen must however be sure that the appraisal process has been completed in a proper fashion, preferably in a managed environment.
 87. Whilst this proof of appraisal is required it is a CEO and MAC responsibility to look separately at the consultant's scope of practice and results. It should be noted that appraisal is a professional non-judgmental process not a licensing process and the results are just one of the factors to be considered when renewing practising privileges or a consultant's work practices.
 88. Appraisal is not the same as "assessment" which looks at the actual results of the consultant. Thus the MAC Chairman and the MAC are responsible for the assessment of a consultant's

performance rather than their appraisal, which also looks at many other aspects of the consultant's professional life and aspirations.

89. The principle plank of service and standards in the independent sector is the quality and competence of the consultant staff. A major function of the MAC will be to ensure that the scope of practice of all consultants is appropriate to their skills and this task will be facilitated by careful reviews of practice. However caution is needed as a small workload may make the statistical validity of any audit very hard to interpret. Other information about a consultant may be obtained from the medical defence organisations that have systems for monitoring claims and adverse incidents affecting their individual members.

10. (C) GMC Revalidation Proposals

90. As at September 2005 the GMC proposals for revalidation in the independent sector suggest that this can be obtained for doctors working within a "GMC approved environment". These doctors will be able to secure revalidation through "local certification" - where local systems generate the evidence on which local certification is based. For doctors who are not able to secure local certification there will be a more detailed review of their fitness to practice.
91. A GMC improved environment means:
 - I. has in place an effective system of clinical governance or, if outside the National Health Service, an effective quality assurance system;
 - II. has in place an effective annual appraisal system which is based on the principles in good Medical Practice and
 - III. is regulated or quality assured by an independent body or organisation.
92. Independent hospitals will need to fulfil the above criteria in order to gain recognition by the GMC.

93. For appraisal, local certification would confirm for each doctor that:
 - I. appraisal has taken place
 - II. the appraisal process produced an agreed Personal Development Plan
 - III. the appraisal process was carried out and signed off by a trained and experienced appraiser
 - IV. the appraisal process was informed by verifiable data about the doctors actual practice
94. In terms of the doctor's fitness to practice, local certification would confirm that, locally:
 - I. there are no concerns about the doctors health
 - II. there are no known concerns about the doctor's probity.
 - III. no disciplinary procedures are currently in progress
 - IV. there have been no relevant disciplinary findings over the specified period
 - V. clinical governance processes - including appraisal - are quality assured
95. Employing authorities will need to set in place procedures for producing local certification. For independent or non-NHS consultants there are alternative recognised professional bodies prepared to offer appraisal by suitably trained appraisers at a fee (see <http://www.london-consultants.org/>).

10. (D) Criteria for Consultant Practising Privileges

96. The MAC must make recommendations to the registered manager on
 - I. eligibility criteria for practising privileges;
 - II. each application for practising privileges;
 - III. the review and possible suspension, restriction or withdrawal of practising privileges;
97. A vital governance function of the MAC is the recommendation of practising privileges to medically qualified applicants. The criteria for granting admission rights are generally accepted for the applicant to be the possession of a CCST and to hold a substantive NHS Consultant appointment or to have previously held such an appointment. Difficulties may arise over applicants holding a locum consultant appointment with each case being dealt with on its merits.

98. All applicants should be interviewed by the CEO prior to consideration by the MAC. It is not generally appropriate for the MAC or any individual MAC member or Chairman to interview prospective applicants, although they may be asked to act as referees in some cases.
 99. Each applicant should have a complete set of documentation which is
 - I. Up to date CV
 - II. Two references
 - III. Confirmation of Hepatitis B immunisation status
 - IV. Copy of GMC Registration
 - V. Copy of NHS appointment letter
 - VI. Copy of Medical Defence certificate (see below*)
 - VII. Photocopy of current passport
 - VIII. Criminal Record Bureau Enhanced Certificate
 100. *The Medical Defence organisations vary in their approach with the MDU providing an insurance policy and others discretionary indemnification. Thus consultants should furnish either a copy of their clinical negligence insurance policy or a certificate of membership of a medical defence organisation.
 101. There may be more requirements for certain specialties such as cosmetic surgery and paediatrics, which will depend on changing regulations and local interpretation.
 102. Particular attention should be made to the scope of practice of each applicant and in general this should follow the applicant's normal NHS practice. Partial or limited privileges may be granted based on an analysis of the consultant's practice profile. Newly appointed consultants may not have been through the process of an appraisal at this level and so this should be ignored at this stage and emphasis placed upon the references. Attention should be paid to the geographical domicile of the applicant and their availability for emergency attendance. It can be possible to accept an arrangement for suitable cover from another colleague for aspects of the consultant's work but this needs careful monitoring.
 103. Consultants wishing to perform paediatric procedures will need to satisfy enhanced criminal record clearance and to confirm their attendance at paediatric life support and other paediatric courses. The hospital will need to provide appropriate paediatric nursing and other facilities as required by the Care Standards Act.
 104. The question of non-consultant applications for practising privileges may arise (i.e. podiatrists) and these should be considered within the hospital policy. Attitudes to this will vary. This trend of non-medical practitioners performing certain procedures may develop in the NHS but is contrary to the current philosophy and organisation of private practice. The MAC may have difficulty in accepting non-medical qualified staff that come under different "professional" regulations.
- ### 10 (E) Renewal of Consultant Practising Privileges
105. Renewal of practising privileges on at least a two yearly basis has to be made on all consultants with practising privileges. This exercise will require a review of the consultants' basic documentation (listed above) together with evidence of a formal appraisal. In addition a statement from the managing group running the appraisal in the private sector and a statement from the NHS appraiser (or a Medical Director) that the appraisal has been appropriate and inclusive of the consultant's private work will be required.
 106. As part of the renewal process the personal data set of each consultant (covering workload, complications, complaints etc) should be reviewed. This data set should in any event have been made available to the consultant for review during their appraisal. Any specific complaints or incidents should be discussed but care should be taken not to make inappropriate judgements based on small numbers of cases which may not achieve statistical validity.
 107. Difficulties may occur if a consultant has been removed from an insurance company's recognition list. This has happened on occasions and will give rise to administrative difficulties within the hospital. The MAC should consider these issues carefully and in particular the reasons why the consultant has been de-listed by the insurance company.
 108. The renewal of practising privileges will be confirmed and signed off by the CEO and Chairman of the MAC or his designate. This exercise may be onerous when there are large numbers of consultants and thus may be dealt with outside the normal MAC meetings. However, the MAC should review the list of all consultants who are granted renewal of privileges and should consider in detail all cases where there is a question of competence or any other matter which may have arisen.
 109. A system of renewing privileges for the MAC members and Chairman should be instigated from within the MAC and, in the unlikely event that a question arises over a MAC consultant, then that consultant should absent himself from any MAC discussion.
- ### 10. (F) Practising Privileges after the age of 70 years
110. Previously most practising privileges policy documents indicate that all practice should cease at the practitioner's 70th birthday. Furthermore many medical insurance companies

withdraw recognition at this age. However, future changes in the law may make it an infringement to discriminate on the grounds of age.

111. As the MAC may face requests from consultants or GP's who wish to practise after reaching 70 years, it must decide its policy. Hospital groups have adopted different attitudes to this matter and some may not wish to continue to allow practice after the age of 70 years. The IHF have produced Guidelines to assist which state that the ultimate decision is referred back to the MAC.

112. It is clear that acceptance of consultants over the age of 70 years will depend on the type of practice and the competence of the doctor. It is recognised that competency is particularly difficult to measure and also that loss of physical and cognitive abilities with increasing age may be subtle and hard to detect. The MAC may agree to ongoing privileges subject to closer annual review by the MAC although the precise nature of this review is poorly defined. The MAC should consider all relevant aspects of the practitioner's practice and consider the safety and protection of patients as their main priority.

10. (G) Suspension of Consultant Practising Privileges

113. Suspension of a consultant's practising privileges in an independent hospital may have to be considered in certain circumstances. The predominant cause for this would be if the conditions or undertakings do not provide the necessary degree of protection for the patients. Great care and sensitivity must be employed in these decisions and the MAC should note that the suspension of a consultant is reported to other hospitals where the consultant works.

114. The acceptance of practice privileges policy, in some provider hospitals, precludes the practitioner from independent and professional representation at appeal meetings. This is inherently unfair and against natural justice.

115. Suspension may be necessary
- When a consultant loses his/her GMC licence to practise
 - When a consultant loses his/her insurance recognition
 - When a consultant is reported to the GMC
 - When a consultant is suspended in his/her NHS Trust or another private hospital
 - When a consultant is in breach of his/her contractual relationship with the hospital
 - When a consultant is found by the MAC to be behaving inappropriately
 - When a consultant is found by the MAC to be acting incompetently

a) When a consultant loses his/her GMC licence to practise

116. It is self evident that loss or suspension of GMC recognition will mean loss of practising privileges. Restoration of the consultant's licence to practice may result in his/her reapplication for practising privileges. In this circumstance the MAC will need to carefully consider the circumstances of the GMC suspension.

b) When a consultant loses his/her recognition by a private medical insurer

117. On occasions consultants have lost recognition by an insurance company. The reasons for this have been various and are usually due to financial disputes rather than clinical issues. The MAC should be clear about the cause of the de-listing and support the consultant. If allegations of fraud are being made against the consultant the MAC should not become involved, as the consultant will seek representation elsewhere. In certain cases the removal of a major insurance recognition will create an impossible management issue for the

hospital which may have to restrict privileges for commercial reasons (i.e. the hospital may also be excluded from payment).

c) When a consultant is reported to the GMC

118. The policy of the GMC in handling complaints against consultants has changed since September 2005. All complaints are triaged in to Stream One (more serious complaints which could raise an issue of impaired fitness to practise) or Stream Two (less serious complaints, which would not normally raise issues of fitness to practice). In Stream One cases references and information will be sought from all the independent and NHS hospitals where the consultant is affiliated. In this situation the MAC Chairman should advise the CEO about the consultant's performance based on local information and a review of the consultant's file.

119. The reason for the GMC complaint should be discussed locally by the CEO, MAC Chairmen and relevant Governance and speciality MAC members.. In general it is not recommended that a consultant be suspended until the full GMC ruling has been made unless there are serious clinical charges or there is strong local evidence which casts some doubt on the consultant's performance. It may be that the MAC will consider some partial restrictions on the consultant whilst awaiting the outcome of the GMC enquiry.

120. Stream Two complaints against consultants will be referred back to the NHS Trust for investigation under NHS procedures. Employing and contracting authorities will be invited to refer the case back to the GMC if information emerges which changes the complexion of the complaint to one in which there may be doubt about the doctors continued fitness to practice.

121. Stream Two complaints that arise from within the independent sector or affect consultants without a NHS appointment will be referred back to the GMC although this policy is under review

d) When a consultant is excluded in his/her NHS Trust or another private hospital

122. The reason for the suspension should be reviewed. In general it is not recommended that an automatic suspension is made unless there are serious clinical charges or there is strong local evidence which casts some doubt on the consultant's performance. As with a complaint to the GMC the MAC may consider some partial restrictions on the consultant if there are clinical implications to the original suspension.

e) When a consultant is in breach of his/her contractual relationship with the hospital

123. If a consultant should breach his/her contractual relationship with the hospital there may be a case for suspension of practising privileges. Some hospitals have given authority to the CEO to act independently but this should be done in consultation with the Chairman of the MAC. Clear breaches, such as repeated failure to comply with hospital protocols (i.e. operation consent forms) or failure to complete the necessary consultant documentation data set, could give rise to a suspension.

124. Difficulties may arise over "conflicts of interest" which has been introduced to many practising privileges contracts. There may be glaring examples of this such as a consultant(s) opening an alternative facility in direct competition with the hospital. Other situations may be less clear and consultants should for example not be derived of rights because they choose to

utilise an alternative facility for some of their patients or if their utilisation of hospital facilities is less than others.

125. Another contractual statement is that consultants should "support the hospital's wider quality assurance objectives by referring patients requiring investigation to radiologists and pathologists within the hospital's established and quality assured network". This could preclude the practitioner from referring his patients to centres for special expertise and opinion not available within the hospital's established and quality assured network. Consultants have the right to refer elsewhere in the best interests of the patient but must be certain about the clinical standards of any such area of referral.

f) When a consultant is found by the MAC to be behaving inappropriately

126. Inappropriate consultant behaviour is a difficult problem. Substance abuse, physical or mental problems, social or behavioural issues will need sensitive handling. Non-compliance such as repeated failure to attend when summoned for clinical problems or persistent failure to comply with hospital regulations over note keeping, consent forms or other documentation may (after suitable warnings and counselling) be grounds for action against a consultant.

127. The MAC Chairman should appoint a suitable senior colleague(s) or take the lead himself in assessing and assisting colleagues facing such problems. Depending on the nature of the problem there may be a need to immediately suspend a consultant. The GMC may need to be consulted at any stage of the investigation and guidance on this is available from the GMC websites and directly.

a) When a consultant is found by the MAC to be acting incompetently

128. Suspension of a consultant for incompetence needs careful professional assessment. Usually this follows a specific incident or it may arise after a train of events. Partial restriction of privileges may be employed in some cases. It is obviously wise and just to ensure that all the details of the issue are fully assessed. Rarely an immediate suspension has to be implemented by the CEO and MAC Chairman. The GMC may need to be consulted early in the investigation and guidance on this is available from the GMC websites and directly.

10. (H) New Clinical Techniques

129. Another function of the MAC dictated by the National Minimum Standards is over the introduction of new techniques and advice must be given on

- I. the introduction of new clinical techniques to the hospital, including the training requirements for medical practitioners to undertake the technique;
- II. the equipment required and the training/experience required by other clinical staff to support the technique(s).

130. New clinical techniques refer to any invasive or radiological procedure which has not been employed previously in the hospital. Such procedures may be new to the consultant; some may or may not be performed in other hospitals but generally this would not be a widespread technique.

131. Each hospital group will have its own policy but the general steps are likely to be

- I. Request for the technique to the CEO by a consultant(s) which must be backed by some evidence that this has been referenced by NICE (NICE Interventional Procedures Register www.nice.org.uk/ip)
- II. CEO to consider if he/she wishes to support the technique depending on resources
- III. CEO refers the question to the MAC which must consider the acceptability of the technique (based on national guidelines), the competency of the consultant(s), the

possible adverse clinical consequences, the information for patients and others, the manner in which informed consent will be obtained and the impact on nursing and other resources

- IV. Specific consent for procedures where the risks and benefits are unclear have been developed by NICE
(<http://www.nice.org.uk/page.aspx?o=212184>)
- V. The MAC may recommend temporary acceptance of the technique but should then refer this to the HCGC to monitor and audit the technique (or do so itself)
- VI. The CGC should report back to the MAC as the results of audit become available
- VII. The MAC should constantly review the technique and advise the CEO according to changing information.

132. In the event of a clinical emergency which may demand the new technique the CEO and MAC Chairman may give temporary approval for its use.

10. (I) Resident Medical Officers (RMO)

133. Resident medical officers (RMOs) in private hospitals have traditionally been either employed on a permanent or temporary basis or appointed in association with NHS Trusts or academic departments on a part time basis. The interview process for these posts will therefore vary but it is assumed that the medical bona fides and suitability of the appointee will have been confirmed. It would be desirable for an MAC representative to be present at the interview but it is recognised that this may not always be possible.
134. All RMOs must fulfil the criteria for health, registration and probity as set by the employing hospital which should also provide professional indemnity. However, as there may be conflicts over clinical issues it is advisable for all RMOs to have their own professional medical defence indemnification.
135. RMOs should have a clear job plan with a proper induction and orientation course at the independent hospital. The European Working Time

Directive will need consideration and suitable rest periods and accommodation must be arranged. The MAC Chairman or a designate should ensure that the hand over of patients between shifts of RMOs is efficient.

136. RMOs should not be given responsibilities beyond their capability and if possible or when necessary they should be sent on recognised courses (i.e. resuscitation). In some hospitals specific teaching programmes have been developed for the RMOs. Such teaching may be based on examination requirements or on the specific ward work of the RMOs (i.e. tracheostomy care). Some hospitals have intensivist RMOs restricted to the ICU and in this case they should report directly to the consultant intensivist in charge of the unit or the consultants responsible for each patient.

137. The relationship between the RMOs and the general consultant staff is different than in the NHS and tensions can arise over communications, emergency admissions and specific policies. The MAC Chairman should therefore appoint one or more consultant mentors for the RMOs (not necessarily from within the MAC) and these consultants should meet with the RMOs on a regular and as required basis to discuss confidential professional issues. Conflicts or difficulties should be reported to the MAC Chairman who should act accordingly. The mentor and/or the MAC Chairman should be prepared to provide a professional reference for the RMOs.

138. Future changes in postgraduate medical training (Modernising Medical Careers) and the shift of large volumes of elective NHS surgery in to the independent

sector may mean that more teaching will be carried out in private hospitals. It is conceivable that some RMO posts will become recognised as part of training, probably as part of a modular programme and in rotation with other NHS centres. This will require careful review and attention to the training as opposed to the service requirements of these RMO posts.

10 (J) Surgical or other Assistants - Practical and Training Issues

139. Most independent hospital will have policies covering the role of surgical assistants. There needs to be a method of recording attendance and verifying the bona fides of the assistants. This will need to include their health status, medical indemnification and professional qualifications.
140. No surgical assistant can carry out an independent role in clinical care and must be supervised at all stages. The ultimate responsibility will fall upon the consultant in all clinical matters. As training opportunities may become more formalised in the independent sector there will be a need to refine the responsibilities of these trainees.

10. (K) Foreign and Non-Consultant Contracted Medical Staff Working Independently

141. Future changes in consultant training (leading to a CCT) and the possibility of applicants from Europe or elsewhere requesting privileges will need further consideration. The employment of UK doctors by independent hospitals at a sub-consultant grade (other than Resident Medical Officers) has been mooted. Any doctor working within the hospital would have to be under the professional jurisdiction of the MAC and need to satisfy the same criteria as all other applicants.

142. A more immediate issue is foreign doctors working in Independent Sector Treatment Centres (ISTCs) who would not normally fall under the MAC jurisdiction. The employment status of these doctors is different in that they are contracted employees falling within the organisation's corporate and clinical governance structures. Within an ISTC there may be an MAC but accountability and responsibility lies with the Registered Manager.
143. The MAC may be asked to review the details of these foreign doctors who may be on contract to work independently for variable but often short periods within private hospitals. Whilst such doctors may have fulfilled certain basic legal registration requirements and even hold various certifications of specialist training from abroad, it may be very difficult for the MAC to reliably give impartial and professional advice as to the expertise of such doctors. In such instances it is recommended that the MAC make no comment about the doctors concerned. The MAC should not become involved in any form of interview of such doctors. The MAC Chairman should make it clear to the management that they are unable to advise or to take any responsibility for the appointments.
144. In the event that the management appoints such doctors the MAC should insist that all clinical workloads are properly monitored and that a careful post operative and post discharge audit is maintained. The MAC, via its Governance team, should review all complaints and complications and the results of all audits. The MAC should not hesitate to report and recommend action to the management as they would in any adverse clinical scenario.

The MAC should not be prejudiced or drawn in to political conflict but always act in the best interests of the patient.

145. The ultimate responsibility of the MAC is to maintain patient safety and clinical excellence. There is a danger that double standards could apply and thus the MAC should act firmly to maintain standards.

11 FUNCTIONS OF THE MAC RELATING TO PROFESSIONAL ISSUES

146. The professional functions of the MAC may be grouped as follows:
- The MAC and Management Interface
 - The MAC and Insurance Interface
 - Clinical Guidelines, Audit and Monitoring Quality Assurance
 - Investigation of Clinical Incidents
 - The MAC and Consultant Issues

11 (A) The MAC and Management Interface

147. The MAC Chairman is in a pivotal but ambivalent relationship with management. The MAC Chairman will take the overall responsibility for clinical governance (with the help of others such as the CGC and HCGC) and must work closely with the whole MAC, CEO, CNO and others. In this role the MAC Chairman and indeed the whole MAC must also be the mouthpiece for their professional colleagues. The MAC Chairman must try and square this circle by having a reasonably high profile and by heading off problems. Many hospital managers have little clinical knowledge and the MAC Chairman should ensure that management is fully informed of the clinical repercussions of any decisions that they should make.
148. Many issues arise out of communication problems and periodic Newsletters and general consultant meetings will help and are required for HQS endorsement. The

Chairman must be prepared to meet, inform and persuade colleagues when necessary. Maintaining an appropriate balance is perhaps the most difficult of all MAC functions and every matter must be considered on its merits. The MAC Chairman must be unwavering in support of colleagues when the situation demands but also must be supportive of management when there is a clear unremitting consultant transgression.

11. (B) The MAC and Insurance Interface

149. Private medical insurers are commonly in discussion with hospitals and consultants over reimbursements. Generally these are not issues for the MAC but some trends suggest that the MAC may become increasingly involved.
150. Fraudulent claims by hospitals and consultants cannot ever be condoned but as the insurers are increasing their surveillance of this matter there is concern that genuine mistakes of coding could lead to fraud charges. The MAC may be called upon for evidence and should exercise judgement and precision in their response but should not become embroiled in legal disputes.
151. Apart from responding to coding inconsistencies the MAC Chairman should encourage all consultants to give the patient a proper estimate of fees (although this may not always be possible for clinical reasons) and try to ensure that extortionate fees are not being charged. The FIPO documentation may help by giving all parties an explanation of their positions.
152. In some cases the consultant will appeal to the MAC if challenged about the appropriateness of the care (i.e. the length of stay, the specific indications for the procedure or need for

- admission etc). In these cases the MAC Chairman should seek opinions from the MAC specialist member and others before responding.
153. Problems have also been reported over insurance policies with a 'six week rule' restriction, which bans private care if the NHS waiting list is less than 6 weeks for the specific problem. Difficulties arise when an emergency presents to the private hospital or consultant that needs immediate treatment and thus a duty of care exists. Even in more controlled circumstances it is not always possible to know what the specific waiting list is at any moment or what geographical limits there are to this restriction. The onus is being increasingly placed upon the consultant to make this determination but this is not a consultant responsibility. It is in the hospital's interest to make available up to date information on local waiting lists. Failing this consultants should not complete this section of the insurance form and refer the matter back to the insurer.
154. Some consultants have been "de-listed" by certain insurance companies. The reasons for this have usually been over financial disputes rather than clinical matters. In some cases consultants in support specialties (i.e. anaesthetics) have been forced to work without receiving reimbursement. Consultants in front line specialties (i.e. surgeons who need to book patients in to hospitals) are different as the hospital may be drawn in to the dispute and not receive payment for the consultant's patients. This may mean that the consultant will not be able to admit these patients to the hospital. The MAC Chairman cannot be drawn in to this dispute unless there has been a clinical background to the de-listing.
155. There is the possibility that insurance reimbursements may become linked to specific care plans and it is possible in some circumstances that the care of the patient could be compromised. This is a developing situation.
- 11. (C) Clinical Integrated Care Plans, National Guidelines, Audit and Monitoring Quality Assurance**
156. There is increasing demand from purchasers and patients for cost effective and integrated clinical care pathways. These should be based on national guidelines and interpreted locally by clinicians. The MAC should ensure that care plans are professionally led and based on best evidence. The MAC should resist the introduction of care plans by those with outside vested interests. There may be conflicts over issues such as the type of prosthesis that should be used and the MAC should always obtain the best expert opinion and only act in the patient's best interest. If all other clinical issues are equal then it would be reasonable to recommend the most cost effective approach to the use of prostheses. GMC guidance on financial and commercial issues is contained in "*Good Medical Practice*".
157. Individual clinical units should be encouraged to engage in audits and in general this should be a bottom up process rather than an imposed one. The HCGC and/or the MAC may wish to set up specific audits. These may be part of an ongoing programme or in response to specific problem. Audits should be encouraged but results should be anonymised. The MAC should be aware of all audit results and may need to take action as a consequence of these reports.
158. The Chief Nursing Officer may well engage in specific nursing audits and these should be encouraged and incorporated in to the overall governance programme. Nurse administered clinics (i.e. pre-assessment clinics) should be reviewed. Nurse empowerment and an increasing role of nurses in clinical therapies is a trend that will increase even in the independent sector which is traditionally a consultant based service. Such services must come under the HCGC and the MAC in terms of governance.
159. Many private and NHS hospitals are part of the QUIP (Quality Indicator Project) an international programme of external audit. This supplies some of the basic and generic data on the whole hospital as required under the Care Standards Act and the Healthcare Commission (i.e. deaths, returns to theatre, unplanned readmissions etc). Such data is relatively crude generic aggregated information and may be of some limited value.
160. The clinical quality assurance programme is a function of the MAC, which should discuss with the management how the hospital should be benchmarked. Some external reviews are costly and so management must be involved. The MAC should encourage cooperation with external registries and benchmarking whenever appropriate. NCEPOD (the National Confidential Enquiry into Patient Outcomes and Deaths) does not now require hospitals to submit data on all deaths and are instead focussing on 'topic' audits.
161. Some other national registries and databases are listed below and whilst data returns are variable support of these will lead to an open and transparent ethos. Examples of registries which record data but which do not provide much comparative results are as follows:
- I. Cancer Registries
 - II. NCEPOD
 - III. Human Fertilisation & Embryology Authority
 - IV. National Joint Registry
 - V. National Tonsillectomy Audit
 - VI. UK Heart Valve registry

162. There are several external independent benchmarking audits which supply more powerful returns such as;

- I. British Society of Interventional Cardiology
- II. British Society of Cardiothoracic Surgeons
- III. Paediatric Cardiac Database
- IV. Intensive Care National Audit Research Centre
- V. London Health Observatory
- VI. Nosocomial Infection National Survey

11. (D) FIPO's Role in Clinical Governance and Audit

163. The results of these and other audits should be brought together by the MAC and may be used if of sufficient size and statistical reliable in hospital reports and for promotional purposes. Some hospital groups aggregate the data between hospitals. There is an argument for the whole independent sector to aggregate data and FIPO has agreed to co-ordinate this under FIPO CGAG (FIPO Clinical Governance Advisory Committee). It is vital that all such data is professionally interpreted before presentation.

11. (E) Investigation of Clinical Incidents

164. Apart from Stream Two complaints referred to the GMC the MAC may need to investigate other clinical incidents or complaints generated locally. In each case of the latter the MAC will need to consider whether there are concerns that should be reported to the GMC or whether matters can be best handled at local level.

165. Each hospital should have an appropriate system of governance which ensures that clinical incidents are recorded and investigated promptly. Normally this would be through the HCGC, which reports to the CEO and the Chairman of the MAC and the full MAC Committee.

166. In all clinical incidents the CEO acting on MAC advice should advise the relevant

consultant(s) as soon as possible and should give a clear written indication of the concerns. The consultant(s) should be given any relevant statements or information about the incident and should be invited to comment upon these.

167. In some clinical incidents the matter is so serious that the MAC Chairman and CEO (having also taken whatever other urgent advice as is necessary) may decide to immediately suspend or partially withdraw practising privileges from a consultant. In some cases there may have been a legal action taken by the patient or relatives or a complaint to the GMC. In these circumstances it may be inappropriate for the hospital to undertake its own enquiry but a non-prejudicial action may have to be taken to curtail privileges.

168. Clinical incidents should be graded according to severity by the governance team and/or the MAC (Chairman, deputy or committee). The grading of severity can be based on the system developed by the National Patient Safety Agency (Appendix 6). All incidents should be investigated in an appropriate and impartial manner. Only in the most severe circumstances should admission or partial rights be withdrawn immediately by the MAC Chairman who will advise the CEO. The MAC Chairman should always take advice from relevant specialty colleagues.

169. Clinical incidents may either be an "Act of God" or part of a clinical trend for an individual consultant. If there is doubt about an incident or trend the MAC Chairman should instigate a further investigation. Such investigations may include a review of other aspects of the consultant's work and could take several forms depending on circumstance and the

degree of severity or anxiety over the case. The action taken may be either:

- I. Ongoing assessment by the governance team or MAC
- II. An internal inquiry - involving designated hospital consultants with others
- III. An external inquiry - involving outside experts from relevant colleges or associations
- IV. An immediate review by the MAC Chairman and/or MAC colleagues and managers.

170. If a clinical incident is minor, but suspect, the MAC may warn the consultant, ask for further audits or information and review the reports from the HCGC. It is important to identify trends early but it is recognised that there may be statistical blips in relatively low workloads.

171. In more serious cases the MAC may set up a suitable panel of inquiry which may be either an internal or external review. In all inquiries there is a need to maintain absolute fairness, impartiality and confidentiality. It should be noted that the results of the inquiry and the fact that it has taken place will ultimately placed in the consultant's personal file which will become available for review by outside bodies and also at appraisal.

172. An internal inquiry team should consist of the CGC, the Chairman of the HCGC (if not the CGC) and one or two relevant specialist consultants from the MAC or hospital. In general it is better if the MAC Chairman is not directly involved at this stage but receives the report later from the panel. The internal panel should review all relevant clinical data and cases, take evidence from staff and interview or take evidence from the consultant(s) concerned. All those giving evidence should have the right of bringing a friend or representative to the panel. A report should be issued and the consultant(s) concerned should be given the opportunity to comment before the report is sent to the MAC.

173. For an external review the appropriate Royal College(s) should be approached to nominate a suitable consultant assessor. The hospital should appoint another consultant in the same specialty but not directly connected to the hospital. If there are multi-disciplinary issues to review then more experts are required. The hospital should appoint a Chairman for this panel who should not be directly involved or working at the hospital. A practising clinician with suitable skills is preferred although not necessarily in the same specialty.

174. The MAC Chairman and CEO must ensure that the panel has

- I. a clear and focused remit
- II. all the necessary notes
- III. administrative help
- IV. written guarantees of indemnification
- V. written guarantees of reimbursement

175. The MAC Chairman and CEO should meet with the panel in order to explain the situation and set the remit of the inquiry and to provide the necessary documentation. Where doubt exists a legal opinion may be obtained before the panel meets.

176. The CEO should inform the consultant(s) under review of the proposed inquiry at an early stage. All other relevant witnesses and the consultant(s) concerned should be asked to submit a written statement and

informed that they may be asked to appear to answer questions. All should be warned off their rights and that they may have with them a medical defence union representative, friend, trade union representative or lawyer. These representatives should have a right to cross examine any witness. The inquiry is not a court and no one is under oath. However, failure to attend by any consultant under review could lead to a suspension.

177. The inquiry panel (internal or external) should take evidence from witnesses and the proceedings should be recorded. The administrator should be responsible for producing a draft of the proceedings which the Panel Chairman should develop into a report. This report should analyse the clinical incident(s), report on causation and make recommendations. All panel members should agree or make their own conclusions known.

178. Depending on the outcome of any such inquiry the MAC Chairman would be best advised to consult carefully with relevant clinical colleagues and the MAC before recommending action to the CEO. Such action might involve for the independent consultant concerned:

- I. Local reviews of further outcomes +/- some form of local mentoring
- II. Partial withdrawal of privileges for specific procedures +/- recommendation for retraining process through appropriate College.

- III. Complete suspension of privileges +/- recommendation for retraining process through appropriate College.
- IV. GMC action in the extreme (noting the duty of all doctors to report any colleague who is in their view unfit to practise).

179. MAC Chairmen should note that the hospital is obliged to report any suspended consultant to his/her NHS Trust and to other independent hospitals where he/she may work.

180. All hospital groups should have an Appeal process and suspended consultants should be advised of their rights to use this process.

11. (F) Interpersonal Consultant Disputes

181. The MAC may be asked to arbitrate in disputes between consultants. This may involve referral of patients, management issues or be based on personal antagonism. Formal complaints to the MAC may bring these difficult matters under the committee's purview. The MAC Chairman, MAC members and the CEO should take advice from the BMA and its ethics department and even legal advice before acting. Outside counsellors and experts may sometimes be brought in to resolve issues. Approaches to the GMC could escalate matters but in this and in other clinical issues the MAC should not shirk from its responsibility if the need should arise.

APPENDIX 1

FIPO is supported by the following organisations and/or their private practice committees

- Association of Anaesthetists of Great Britain & Ireland
- Association of Coloproctology of Great Britain & Ireland
- Association of Independent Radiologists
- Association of Surgeons in Training
- British Association of Aesthetic Plastic Surgeons
- British Association of Otorhinolaryngologists - Head & Neck Surgeons
- British Association for Surgery of the Knee
- British Association of Plastic Surgeons
- British Hip Society
- British Medical Association
- British Orthopaedic Association
- British Orthopaedic Training Association
- Federation of Surgical Specialty Associations
- FIPO – National Medical Advisory Committee
- Hospital Consultants and Specialists Association
- London Consultants' Association
- NHS Private Healthcare Association
- Sussex Association of Consultants
- UK & Ireland Society of Cataract and Refractive Surgeons

The Board of FIPO as at October 2005

Mr Geoffrey Glazer

Chairman of FIPO, Chairman
London Consultants' Association,
Chairman MAC Wellington Hospital,
Member BMA Private Practice
Committee

Mr Robin Allum

British Orthopaedic Association

Mr Grant Bates

Secretary Inter-Specialty
Professional Practice Committee,
Federation of Surgical Specialty
Associations

Mr Ciaran Brady

Association of Surgeons in Training

Mr Dai Davies

British Association of Plastic
Surgeons

Dr William Harrop-Griffiths

Association of Anaesthetists of
Great Britain & Ireland

Mr Derek Machin

Chairman of the BMA Private
Practice Committee

Mr Ian McDermott

British Orthopaedic Trainees
Association

Mr Martin Stone

MAC Chairman,
St Joseph's Private Hospital, Gwent

Mr Robert Tranter

Chairman of the Private Practice
Committee of HCSA

APPENDIX 2 The Care Standards Act 2000

Summary of the main points affecting MAC Functions.

MAC Responsibility

"The MAC is responsible for representing the professional needs and views of the medical practitioners to the Registered Manager" (A5.1)

"The MAC meets quarterly as a minimum and formal minutes are kept of meetings" (A5.2)

MAC – Clinical Performance Review

"The MAC reviews twice a year as a minimum, information collated on the clinical work undertaken at the hospital..." (A5.4)

- Deaths
- Unplanned readmission
- Unplanned returns to theatre
- Unplanned transfers
- Adverse clinical incidents
- Post-op DVT
- Post-op infection rates

Clinical Performance Review and UK QIP Quality Indicator Project

1,800 hospitals worldwide reporting on;

- In-patient mortality
- Unplanned readmission
- Unplanned returns to operating theatre
- Surgical site infections
- Unplanned transfers

Practice Privileges (C10.2)

- All consultants will be interviewed, a record of the interview retained and written references obtained
- Identification must be confirmed
- References must be from the two most recent employers
- Relevant qualifications must be verified by validation at the interview

Consultant Appraisal

The Regulation

- "Any medical practitioner with practicing privileges receives regular and appropriate appraisal..." (18(3))

The Standard

- "All medical practitioners have annual appraisals and are re-validated in line with the GMC's requirements" (A3.2)"

Practice Privileges Review

The Standard

- "Practicing privileges are reviewed for each practitioner every two years, as a minimum and may be reviewed more frequently as a result of concerns about practice or complaints received by the establishment" (C10.6)

Clinical Practice Standards

- "There are written policies and procedures to ensure that surgeons comply with the National Joint Registry" (A20.6)
- "The full details of all implanted medical devices are recorded in the patient's individual records and on a master list held in the operating theatre dept. A copy of this information is passed to the patient" (A20.7)
- "The anaesthetist is present in the operating theatre throughout the operation and on site until the patient has been discharged from the recovery room" (A22.7)
- "The person undertaking the surgical procedure ensures the patient has given valid consent for the proposed surgery and/or anaesthesia and ensures the relevant consent forms are signed" (A21.5)
- "While a patient is receiving level 1 critical care, the responsible consultant visits the patient a minimum of twice daily" (A29.5)
- "Where level 2 or level 3 critical care is not provided within the hospital, contingency emergency transfer arrangements are in place that are documented and agreed in advance with each of the appropriate specialist units to which patients may be transferred." (A29.10)

Management of Patient Conditions C3.1)

"The management of specific conditions takes account of the evaluations by the National Institute for Clinical Excellence (NICE) in relation to effective clinical practice and patient safety and specific clinical guidelines from the relevant medical Royal Colleges, healthcare professional organisations and the NHS National Service Frameworks."

Regulation 9 (1)(j)

- Ensuring that where research is carried out in the establishment, it is carried out with consent of any patients involved, is appropriate for the establishment and is conducted in accordance with up-to-date and authoritative published guidance on the conduct of research projects.

Review of quality of treatment

Regulation 17 (1)

- "The registered person shall introduce and maintain a system for reviewing at appropriate intervals the quality of treatment and other services provided in or for the purposes of the establishment"

Treatment Information

- "Information materials for patients are written in concise, plain language and explain in non-technical language what the procedure involves and treatment alternatives" (A1.1)
- "Written information for patients about the relevant surgery or treatment is made available for them to take away after consultation at the hospital" (A1.2)
- "The written information given at the consultation includes general and procedure specific risks and complications associated with the surgery or other treatment" (A1.3)

Treatment Information

- "Documented post-operative instructions are given to patients to take home after the procedure/operation" (A1.4)
- "Patient information materials are agreed by the Registered Person before being published and made available to patients" (A1.5)

Monitoring Quality (C4.1)

- Participation in national confidential enquiries
- Effective information and clinical record systems
- Procedures for identifying and learning from adverse health events and near misses
- A complaints procedure

APPENDIX 3 Patients Rights and Responsibilities

This is essence of the FIPO Leaflet directed to patients and outlining their Rights and Responsibilities. This reflects FIPO's concern to put the patient first.

FIPO is committed to promoting:

- the highest quality of patient care
- close and effective patient-doctor relationships
- Independence and freedom of choice for patient and doctor
- transparency in all aspects of your care

The leaflet was approved by the organisations supporting FIPO, the Medical Protection Society and the Patient Liaison Group of the Royal College of Surgeons of England.

For supplies of this leaflet please contact mpsmarketing@mps.org.uk

HELPING THE PROFESSIONALS TO HELP YOU

Only by working together can patients and doctors secure the best outcome. Clear communications and a commitment to honouring responsibilities are the keys to success.

As a patient in the independent sector in the UK, whether inpatient or outpatient, you can expect:

- 1 Treatment by a recognised specialist(s) with all the necessary expertise to care for you.
- 2 Treatment from the specialist of your choice. Your general practitioner (GP) or another specialist can help you choose the right doctor for you. Your choice should not be restricted by third parties e.g. an insurance company.
- 3 Treatment in an appropriate hospital on the advice of your specialist or GP, noting that some insurance policies place restrictions on certain hospitals.

4 Treatment in facilities that meet government standards and which respect your privacy and confidentiality, and provide all appropriate assistance (including the right to request chaperoned examinations) and can meet the specific needs that arise from your disability, ethnic background or other factors.

5 To see information and records kept about you provided doing so would not infringe anyone else's legal rights.

6 Up to date treatment complying with recognised national standards and monitored to ensure the quality of care.

7 To have a timely and accurate assessment of your condition.

8 To receive a clear explanation of the proposed treatment including material risks, side effects and any alternatives to treatment and to have your questions fully answered.

9 To have a second opinion about your condition if you so wish.

10 To have the opportunity to comment about any aspects of your care and to receive a prompt response to any complaint made.

11 Transparency about charges wherever possible, which includes:

- a fair estimate of potential fees from your initial consultant which will include as far as can be ascertained potential charges for other specialists who may be involved in your care, including anaesthetists and those who provide diagnostic or other background services such as radiologists and pathologists. It must be recognised that in many cases an accurate financial prediction is difficult to make, if not impossible, prior to a full clinical diagnosis nor is it possible to anticipate every potential clinical event that might occur.

- an estimate of potential hospital charges may be available from your consultant although for your own peace of mind these should be checked with the hospital concerned. You should also clarify whether the costs of an extended stay for clinical reasons are covered by any hospital package deal.

- a fully itemised account from all your doctors and the hospitals, reflecting the terms agreed with the insurance company, if they apply.

12 To receive full reimbursement from your insurer for all treatment within the constraints of your particular policy.

As a patient we would ask you:

13 To provide all relevant clinical information and other details necessary for your care to those entrusted with your treatment.

14 To co-operate with the staff taking care of you and report any change in your clinical condition.

15 To tell staff if you are uncertain or do not understand any aspect of your treatment.

16 To take medicines as recommended and seek medical advice before stopping or changing treatment.

17 Make sure that you understand the full implications of declining or stopping medical treatment.

18 If you have parental responsibility for a minor, to exercise this carefully and with full consideration and attention to the needs of the child.

19 To understand the limitations, restrictions and exclusions of your insurance policy and to answer fairly and openly (with the help of your consultant or GP if necessary) any insurance company queries about your condition or anticipated treatment.

- 20 To understand that a contractual relationship exists between you and your doctors (including those clinicians who provide background diagnostic or other services such as anaesthetists, intensive care specialists, radiologists or pathologists) and also the hospital where you are treated. In some cases the hospital will make a direct charge that includes some of these services. You will not be charged twice. You have a separate contractual relationship with the hospital where you are treated.
- 21 To accept responsibility for the professional and other fees generated and for their timely payment. In the event that your insurance policy is not comprehensive then any financial shortfalls become your responsibility. If your policy has a specific excess (meaning that you are responsible for a proportion of the charges) then that may need to be paid either to the hospital or to the doctors treating you according to circumstances.
- 22 To give adequate notice if you are unable to attend an appointment and to understand that charges may be made for such visits if you have not given a reasonable notice of cancellation.

APPENDIX 4

Consultants are responsible for collecting their own data and for maintaining their own portfolio. This material may be derived from various sources. It is helpful for all positive data to be collated (for example patient letters or other professional recommendations). The data collected should normally include the following, by reference to the appropriate headings of Good Medical Practice:

The Independent Hospital should be prepared to provide much of the statistical data listed under Good Clinical Care and any other examples of good or bad practice.

Good clinical care

- A practice profile indicating the procedures performed
- Clinical indicators (including deaths, transfers-out, returns to theatre, infections etc for the acute sector; and physical assault, use of seclusion, use of restraint etc for mental health) whether via the UK Quality Indicator Project (UKQIP®) or an alternative system;
- Any results of the Hospital's medical records audit and Governance Team;

- Any adverse occurrences involving the consultant and the outcome (if possible evaluated on the basis of the criteria set by the National Patient Safety Agency);
- Any areas of concern brought to the attention of the Medical Advisory Committees (MAC's) (e.g. adherence to hospital clinical policies);
- Any limitations on practice - whether voluntary or imposed.

Maintaining good medical practice

- Examples of participation in appropriate provider based continuous professional development (CPD); this might include individual development activity, locally-based development and participation in college or speciality association activities.

Relationships with patients

- Any completed investigated complaints involving the consultant, and the outcome;
- Any relevant significant results of patient questionnaires or follow up surveys.

Teaching and training (within the independent practice)

- Example of documentation where teaching does occur: a summary of formal teaching/lecturing activities any recorded feedback from those taught.
- Supervision/mentoring duties.

Working with Colleagues

- Copies of, or extracts from, any relevant surveys
- Any completed investigated incidents
- Relevant feedback from appropriate clinical colleagues.

Probity¹

- Copy of Criminal Records Bureau disclosure
- Self-certification by the appraisee that there are no matters requiring to be drawn to the attention of the appraiser, (or details of any matter arising).

Health

- Self-certification by the appraisee that there are no matters requiring to be drawn to the attention of the appraiser, (or details of any matter arising)

¹Letter to confirm I (Name) confirm that that there no matters concerning my probity/health that I wish/need to be drawn to the attention of (Name)
Appraiser

APPENDIX 5 Template Agenda for an MAC Meeting

This TEMPLATE Agenda is clearly only an outline but it will ensure a common structure to meetings. Governance reports should include all the required reports and any other audits, complaints etc that need to be brought before the MAC.


1. Apologies
2. Minutes of last meeting
3. Welcome or election of MAC Officials
4. Matters arising not dealt with elsewhere
5. Matters arising from the Minutes
6. Governance Team Report and Presentation
7. CEO's Report
8. Senior Nurse Manager's Report
9. Chairman of the MAC Report
10. To consider applications for consultant practicing privileges
11. To consider renewal of consultant practicing privileges
12. Any other business

APPENDIX 6 Risk Grading Tool for Clinical Incidents

(Adapted from National Patient Safety Agency Grading Tool)

N.B. The scoring is subjective and should be ideally the opinion of more than one person familiar with the area.

Likelihood ↓		None	Minor	Moderate	Major	Catastrophic
	→ Most Likely Consequence					
Almost certain						
Likely						
Possible						
Unlikely						
Rare						

Risk =  Very Low  Low  Moderate  High

Action plans must be drawn up for high and moderate risks. Such risks when identified will be reported to the Clinical Governance Committee or directly to the CEO and MAC Chairman.

Table 1. Definition for likelihood (within the local organisation)

Descriptor	Description
Almost Certain	Will undoubtedly recur, possibly frequently
Likely	Will probably recur, but is not a persistent issue
Possible	May recur occasionally