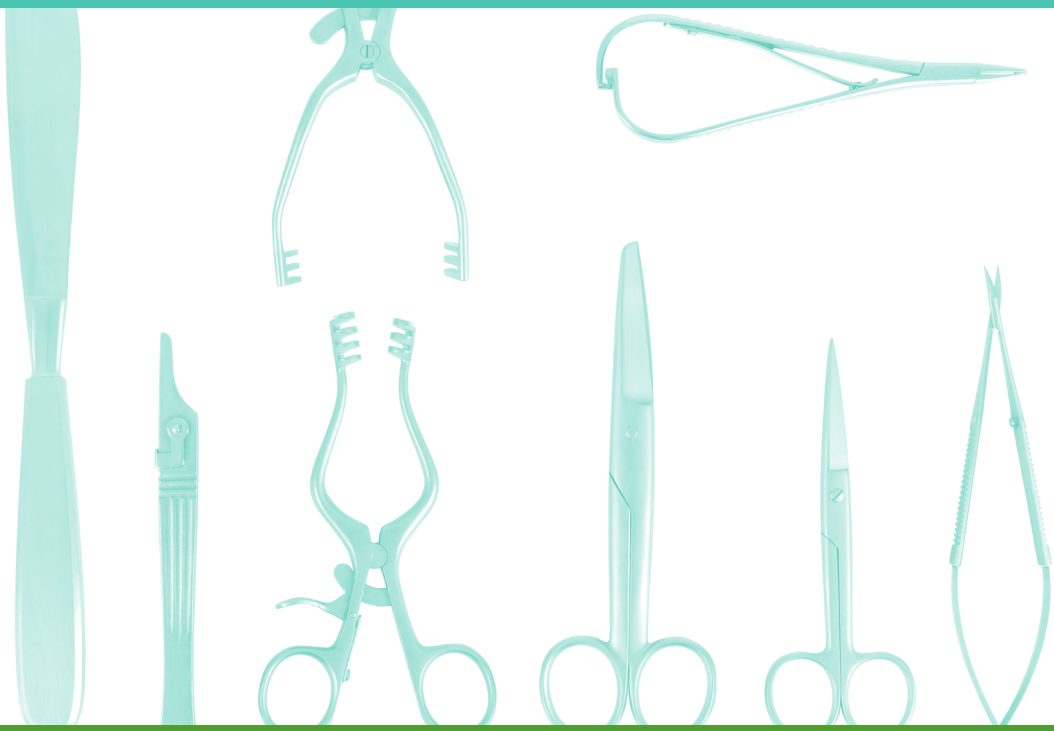
WORKING IN THE INDEPENDENT SECTOR

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

WORKING IN THE INDEPENDENT SECTOR

A guide to good practice

May 2022



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1. Introduction

Recent years have seen a growing demand for private services, with a significant proportion of elective surgery carried out in private hospitals. The NHS and the independent healthcare sector have evolved to include a range of interdependent measures and supporting structures to meet the demands of the service and the patient population. Any standards of practice and administrative requirements must thus take into account their combined effect on the health system and patient outcomes overall.

The College embraces its position as the leader in setting standards for surgery across the UK and aims to support the totality of surgical practice wherever this takes place, in the NHS or in the independent sector. In the recent context of the COVID-19 pandemic, which has aggravated significantly the problem of waiting lists in the UK, we are working with partners to ensure that the record numbers of patients waiting for surgery will be able to be treated as soon as possible. We are, however, concerned that an important part of the surgical capacity is being compromised, due to specific challenges facing the private sector in surgery and anaesthesia. These challenges include training opportunities and insurers' billing practices, which are prohibitive of surgery and anaesthesia being carried out in the independent sector. We will be working with our members and other medical royal colleges to support the negotiation of billing practices that allow sufficient surgical capacity in the independent sector and provide patients with additional treatment options.

Recognising that there are specific challenges facing private practice, this guide aims to provide advice and support to members who work or would like to work in the independent sector, while ensuring that the same standards of care are applied in both the NHS and in private practice. Members of the College, like all surgeons and doctors, must comply with the requirements of the General Medical Council's (GMC) *Good Medical Practice*,[1] and must follow the recommendations of the College's *Good Surgical Practice*.[2] This document further aims to:

- Promote high standards of care and professional responsibility.
- Outline good practice in the relationship between surgeons' NHS and private practice.
- Identify ethical behaviours, skills and attitudes in the context of private practice.
- Provide a benchmark for surgeons to use for self-evaluation.

2. What to consider when setting up your practice in the independent sector

REGULATION

Like all surgeons, independent practitioners must be registered with the General Medical Council and hold a licence to practise. They also retain all professional obligations regarding ethical standards, revalidation and fitness to practise. In addition, any person who provides regulated activity must be registered with the Care Quality Commission (CQC) in England, the Regulation for Quality Improvement Authority (RQIA) in Northern Ireland, or the Healthcare Inspectorate Wales (HIW). This normally takes place through an application that will include details about the specific work (regulated activity) they intend to carry out, and each place in which they will be practising. Registration is conditional on the locations in which the regulated activity will be provided.

INDEMNITY

The GMC requires all doctors to have adequate professional indemnity or insurance cover so that in the event of patient harm through clinical negligence there will be the means to provide appropriate compensation. NHS indemnity schemes only apply to negligence claims against NHS bodies; they do not cover private work. Surgeons will need to arrange separate indemnity cover for any work outside the scope of the NHS indemnity arrangements.

If a surgeon is treating NHS patients in the private sector, they need to check the indemnity arrangements to ensure whether the NHS is providing indemnity or whether they will be personally liable. If the latter, surgeons should make sure that they are covered by their own insurance policy for their practice. It is also important for employers to ensure that there is full indemnity cover for trainees and junior staff who get involved in the treatment of NHS patients in the private sector.

If a surgeon employs other healthcare professionals, such as surgical care practitioners, nurses and others, they should ensure that they have their own appropriate indemnity cover and, were relevant, that they are also registered. The consultant's indemnity will not normally extend to nurses, trainees or surgical care practitioners for work that they undertake in the independent sector.

Most medical defence organisations provide discretionary indemnity, which means that legal and financial assistance is provided at the discretion of that organisation: there is no insurance contract and therefore no guaranteed right to assistance. In contrast, a medical insurance contract comes with a

contractual obligation to compensate the healthcare practitioner for a defined loss or damage, provided that the insured practitioner has complied with the relevant policy requirements, such as declaring accurate details of income, scope of practice, practice history and notifying the insurer of adverse events and complaints.

OCCURRENCE OR CLAIMS-MADE INDEMNITY INSURANCE?

For surgeons in private practice, it is important to understand the difference between occurrence-based and claims-made insurance before purchasing a policy. With an occurrence-based policy, surgeons will be protected as long as the loss happened while the policy was active. Therefore, occurrence policies accommodate 'long-tail' events – situations that do not produce lawsuits or claims right away.

With a claims-made policy, the insurance coverage only comes into effect when a claim is filed during the policy period – this means that one needs to have active insurance when filing a claim.

Surgeons should also bear in mind that most policies have an aggregate limit of liability (i.e. a maximum amount of money the insurer will pay for all covered losses during the policy period, typically one year). With occurrence policies, the aggregate limit resets every year, providing renewed coverage, whereas with claims-made policies, the amount of coverage purchased must last for the duration of the policy. This means that, with claims- made insurance, once a claim is paid that reaches the aggregate limit, there will be no further protection.

In summary, occurrence-based policies provide more comprehensive coverage as long as they are regularly renewed. However, they are also more expensive, whereas claims-made policies generally have lower initial premiums.

RECOGNITION WITH PRIVATE MEDICAL INSURERS

Most patients in private treatment belong to a private health insurance scheme, which requires that the surgeon has specialist recognition with them to reimburse the patient for their fees. The criteria and processes for obtaining specialist recognition vary between insurers and often include a cap on the consultant's billable fees. Surgeons will need to contact the medical insurer directly to confirm their terms and criteria, and will need to consider the financial impact of the required fee levels to their practice.

The College is mindful of members' concerns about recent changes in the terms of a number of private insurers, which limit maximum billable values and thus indirectly increase insurance costs considerably. Although the College recognises that insurance fees need to reflect the potential higher risks of surgery carried out outside the NHS and, like most other Colleges, it does not get involved in terms and conditions of employment, we also do not support fee structures that are disproportionate or prohibitive of surgery being carried out in the independent sector, as this is an integral part of the diversity of surgical practice and makes a significant contribution in the delivery of health services in the UK.

BALANCING NHS AND PRIVATE PRACTICE

The 2003 NHS consultant contract recognises that clinical staff have a range of skills that are valuable to other providers and organisations and allow them to pursue 'private professional services'.

This includes:

- Offering private surgical services.
- Undertaking external investigations.
- Offering advice to the pharmaceutical industry.
- Providing expert testimony to the courts and prisons.
- Offering medical advice to local authorities.
- Offering advice to employers.
- Teaching.
- Speaking at national and international conferences.

Surgeons are also often asked to undertake fee paying work for patients within their NHS care but outside their contracts. However, those surgeons who work both in the NHS and in private practice have a responsibility and need to take appropriate measures to minimise any risk of a conflict of interest between their NHS work and their private practice. Surgeons should therefore ensure that:

- As part of the annual job planning process, they disclose details of regular private practice commitments, including the timing, location and broad time of activity, to facilitate effective planning of NHS work and out of hours cover.
- Except in emergencies, private commitments, including on-call duties, do not conflict with or disrupt NHS activities included in their NHS job plan and do not prevent them from being able to attend an NHS emergency while they are on call at the NHS.

In some cases, surgeons can see patients privately within NHS facilities provided that there is no detriment to the quality or timeliness of services for NHS service users, and as long as there is explicit agreement of the responsible trust or health board, which will decide to what extent their facilities, staff and equipment may be used for private patient services.

Surgeons should not initiate discussions about providing private services for NHS patients while carrying out NHS duties, nor should they ask other NHS employees to initiate such discussions on their behalf.

DATA CONTROLLER REGISTRATION

As a surgeon in private practice, you will control the personal data of patients and, under the Data Protection Act 2018, you will be a ‘data controller’. You may ask others to process data on your behalf (a practice manager or secretary) and they will be ‘data processors’. However, your own role as data controller remains, together with the responsibility for compliance with the Act and the General Data Protection Regulation (GDPR) that regulate the lawful collection and processing of ‘personal data’, meaning any information relating to an identifiable person who can be directly or indirectly identified by reference to an identifier.

All private healthcare establishments will need to register as data controllers with the Information Commissioner’s Office and pay a relevant fee, which is based on the number of people in the organisation. Surgeons can find out more about how to register as a data controller and paying the relevant fees from the Information Commissioner’s Office website.

Larger, multiple-location or corporate medical providers will also need to appoint a data protection officer, who has the operational responsibility to ensure that the organisation processes the personal data of its staff, customers, providers or any other individuals (also referred to as data subjects) in compliance with the applicable data protection rules. The Information Commissioner’s office also provides a self-assessment tool for those who are unsure whether they need to register.

3. Ethical responsibilities in financial dealings

Surgeons must behave ethically in their financial and commercial dealings and must not allow considerations of financial reward or career advancement to compromise the care they provide.

SETTING FEES

Surgeons in private practice are generally able to set their own fees for private surgical procedures, except when they treat patients linked with insurers, who limit maximum billable values to the level of benefit that they provide their customer (**see section 2**). Nevertheless, surgeons' fees should be justifiable and should reflect a fair remuneration for the services provided, taking into account circumstances such as resources used, effort, skills and experience. Manifestly excessive fees or fees that exploit a patient's vulnerability or take financial advantage of the patient are unethical and go against the *College's Good Surgical Practice*.[2]

All fees and the full cost of treatment should be agreed with the patient before seeking consent to treatment. This includes fees relating to follow-up treatment and potential complications and revisions. Information should include what is covered and what is not covered in the fees, and a full breakdown of costs, including consultation fees and allocation of fees to the hospital and other healthcare professionals.

DISCLOSURE OF INTERESTS

Surgeons must ensure that they do not have a conflict of interest that may influence the advice they provide to their patients. According to the GMC's Financial and Commercial Arrangements and Conflicts of Interest:[3]

you must not allow any interests you have to affect the way you prescribe, treat, refer or commission services for patients … you must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients.

Surgeons should have the care and wellbeing of their patient as their primary consideration and they should disclose all interests and financial benefits relevant to the circumstances of the patient's care. This includes any personal affiliation or other financial or commercial interest relating to their practice, including other private healthcare companies, pharmaceutical companies or instrument manufacturers. Financial interest or financial benefit includes the following:

- Receiving a financial benefit indirectly (e.g. through one or more interposed entities).
- Receiving a financial benefit by making an informal or verbal agreement.

- Receiving a financial benefit that does not involve paying money (e.g. by receiving a financial advantage).
- Buying an asset from or selling an asset to a person.
- Leasing an asset from or to a person.
- Supplying services to or receiving services from a person.
- Receiving a grant of securities or an option from a person.
- Having a person take up or release an obligation.

Surgeons should pay particular attention to indirect benefits and soft inducements, such as theatre tickets, free use of property and other gifts that can create conflict between the patient and the surgical team. These should be avoided to the extent possible and a clear process should be followed ensuring transparency and openness. If surgeons are faced with a conflict of interest, they must be open about the conflict, declaring their interest formally, and must be prepared to exclude themselves from decision making.

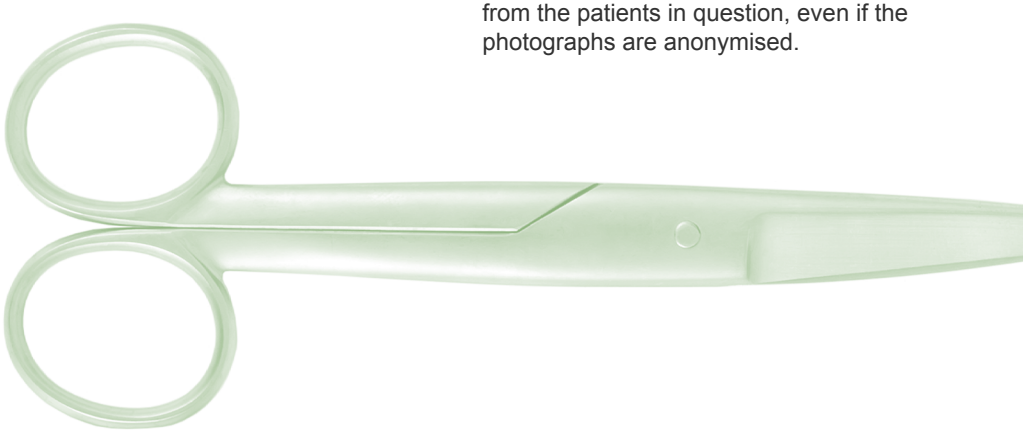
ADVERTISING AND PROMOTION

Surgeons in private practice should ensure that any marketing activities are honest and responsible and that promotional statements are realistic and ethical, in line with the code of the Advertising Standards Authority. When advertising their services, surgeons should aim to provide clear, factually correct and verifiable information. Advertising must not minimise or trivialise the risks of interventions nor mislead about the results they are likely to achieve.

Surgeons remain responsible for promotion or advertising carried out by a third party on their behalf and should therefore proactively ensure that any relevant information is not misleading or deceptive about their skills, experience, qualifications, professional status and current role. Advertisements must not minimise or trivialise the risks of surgical interventions and must not exploit patients' vulnerability.

Surgeons should also refrain from the use of inducements that may influence the patient's decision and undermine the informed consent process, such as commercial discounts, time-limited offers or two-for-one offers.

If they use patient photographs or testimonials, it is essential that surgeons ensure that they have written consent from the patients in question, even if the photographs are anonymised.



4. Competence, scope of work and practising privileges

MAINTAINING COMPETENCE

As with all surgeons, those who work in private practice must comply with GMC guidance and RCS England recommendations, which require surgeons to recognise and work within the limits of their competence and refer a patient to another practitioner when they cannot safely meet their needs.[1,3]

In most specialties, a surgeon's private practice will mirror their NHS practice. In some cases, however, particularly in cosmetic surgery, NHS and private practice will probably be different, so it is important that surgeons are mindful of their areas of expertise and have a low threshold for referring patients to more experienced colleagues where appropriate. The College recommends that all surgeons at various stages of their practice make mentoring arrangements to support their professional development.[4]

Surgeons must also ensure that their skills and knowledge are up to date by taking part in annual appraisal and the revalidation process, and by undertaking a minimum of 50 hours of continuing professional development activity per year across their whole practice, or 250 hours across the five-year revalidation cycle. These activities must be relevant to their practice and support their current knowledge, skills and career development, including communication skills. In each revalidation cycle, they should also undertake at least one patient feedback exercise that includes patients' experience from their private practice and must present the results for discussion at appraisal, demonstrating any actions taken in response to this feedback and the learning achieved.

For surgeons practising in cosmetic surgery, the College also expects that they certify in their area of practice in line with the cosmetic surgery certification scheme, which has been developed and supported by all four surgical royal colleges and the relevant specialty associations. Certification provides surgeons with accreditation of key competencies, demonstrating their expertise to patients and helping to make the cosmetic surgery industry safer.

PRACTISING PRIVILEGES

In contrast to the NHS, surgeons are not technically employed by independent hospitals and are instead granted 'practising privileges' to work in them. Although not employees of the hospital, CQC regulations suggest that consultants working under practising privileges are considered to be in 'employment' so the provider has the same regulatory accountability for both. When a patient undergoes private treatment, the surgeon holds a contract directly with them, while there is a separate contract between the patient and the independent provider to

cover the hospital's facilities and services such as nursing. Practising privileges at a private hospital is a matter between the consultant and the hospital concerned, and are generally approved and monitored through the hospital's medical advisory committee. The criteria for granting practising privileges vary between hospitals, but as a minimum, a consultant surgeons should:[5]

- Be on the GMC's specialist register.
- Provide evidence to demonstrate relevant clinical experience of a nature appropriate to practice in an independent hospital or clinic.
- Have evidence of all procedures to be performed under practising privileges, demonstrating adequate numbers performed in each procedure over the previous two years.
- Hold, or have held in the past five years, a substantive consultant post within the NHS or a Defence Medical Services hospital.
- If a consultant has not held a substantive consultant post, then they must be able to demonstrate experience of independent practice over a sustained period applicable to working in the independent sector.

Hospitals are required to review the practising privileges of each practitioner every two years, and a satisfactory appraisal process must be carried out to maintain practising privileges.

WHOLE-PRACTICE APPRAISAL

It is an essential requirement of revalidation that surgeons are subject to whole-practice appraisal, covering all the settings where they work and providing supporting evidence for their fitness to practise across both their NHS and private practice, including quality improvement activities, significant events, feedback from colleagues and complaints, and contribution to relevant national clinical and audits.

Surgeons may work exclusively in private practice and may hold practising privileges with one or more providers, or they may hold an NHS contract and carry out part-time private practice. In either case, it is the individual surgeon's responsibility to ensure that they are appraised annually and to participate in whole-practice appraisal covering all elements of their practice. For those who have a combined NHS and private practice, such appraisal will be their NHS appraisal, and will result in a completed NHS form 4 confirming satisfactory appraisal, and a certificate confirming the renewal of practising privileges in the independent sector. Those who work exclusively in the private sector can participate in an appraisal process via the Federation of Independent Practitioner Organisations or the Independent Doctors Federation.

5. Patient care, safety and quality

CONSENT

Surgeons should be familiar with and follow the RCS England guidance *Consent: Supported Decision-Making*.[6] The patient's first consultation should be with the operating surgeon or another registered healthcare practitioner who works with the operating surgeon. It is not appropriate for the first consultation to be with someone who is not a registered health practitioner, such as a patient advisor or an agent. If the first consultation is with another registered health practitioner, the patient should have a consultation with the operating surgeon before scheduling the procedure.

For cosmetic surgery in particular, the additional requirements for the first consultation with the patient in the RCS England guidance *Professional Standards for Cosmetic Surgery* should be followed.[7]

Informed consent must normally be obtained by the operating surgeon, who must provide the patient with enough information for them to make an informed decision about whether to have the procedure. The practitioner should also provide written information in language that the patient can understand. This information must include:

- Treatment options and what they involve.
- Whether a procedure is new or experimental.
- The range of possible outcomes of the procedure.
- The risks and possible complications associated with the procedure.
- The possibility of the need for revision surgery or further treatment in the short term (e.g. rejection of implants) or the long term (e.g. replacement of implants after expiry date).
- Recovery times and specific requirements during the recovery period.
- The surgeon's qualifications and experience.
- Total cost, including details of deposits required and payment dates, payments for follow-up care and possible further costs for revision surgery or additional treatment.
- The complaints process and how to access it.

The consent discussion may vary in duration, depending on a range of factors such as the complexity of the patient's condition, as well as the complexity and risks of treatment and the range of treatment options. In any case, patients should be given enough time to make an informed decision about their treatment. For complex decisions, this may require that the discussion takes place over more than one session. The patient should have the opportunity to take away a copy of the consent form at the end of the discussion to allow for reflection.

For cosmetic surgery in particular, there should be a two-stage process of consent with a period of at least two weeks between the stages to allow the patient to reflect on their decision.

Surgeons should also ensure they have the patient's written agreement if video, photographic or audio records are to be made available for purposes other than the patient's records (e.g. for promotional and marketing purposes).

CONTINUITY OF CARE AND POSTOPERATIVE CARE

The consultant who will perform the procedure is normally responsible for the care of the patient, including ensuring that the patient receives appropriate postoperative management. If the operating surgeon is not personally available, formal alternative arrangements must be made with another named, suitably qualified person, in case the patient experiences complications outside regular working hours. These arrangements should be made in advance where possible, and made known to the patient and other staff at the hospital. The operating surgeon should be satisfied that any other person participating in the patient's care has appropriate qualifications, training and experience, and is adequately supervised as required.

When a surgeon is assisted by another registered health practitioner or assigns an aspect of a procedure or patient care to another registered health practitioner, the surgeon retains overall responsibility for the patient. This does not apply when the medical practitioner has formally referred the patient to another registered health practitioner.

Surgeons should be satisfied that operations are performed in a facility that is appropriate for the level of risk involved in the procedure. Facilities should be appropriately staffed and equipped to manage possible complications and emergencies, and sufficient protocols should be in place for managing complications and emergencies that may arise during the procedure or in the immediate postoperative phase.

On discharge, surgeons should include full instructions of care and other relevant diagnostic information in the discharge letter, and share that letter with the patient's general practitioner with the patient's consent. Such instructions include:

- The contact details of the operating surgeon.
- Alternative contact details in case the operating surgeon is not available.
- The usual range of post-procedure symptoms instructions for the patient if they experience unusual pain or symptoms.
- Instructions for medication and self-care.
- Dates and details of follow-up visits.

NEW TECHNIQUES AND TECHNOLOGIES

A wave of surgical innovation has been gaining pace in recent years, including during the COVID-19 pandemic, with a number of new techniques, technologies and ways of working, which have a great potential to transform surgery for millions of patients, improving the care they receive. The private sector has a significant role to play in catalysing surgical innovation and strengthening surgical systems.

As exciting as these innovations are in terms of their potential, however, the risks faced by patients from new approaches are substantial without a clear guiding framework and proper oversight. It is essential that the introduction of new approaches to surgery takes place with the same rigour and structure associated with the development of new medicines and devices, and follows clear standards taking into account existing challenges in the following areas:

- The processes by which a surgeon (and the surgical team) train in a new approach.
- The oversight and quality assurance underpinning the training.
- Patient selection.
- Obtaining consent.
- Evaluation and audit of the outcomes of the new approach, including through peer review.

Establishing a strong clinical governance framework and gathering an evidence base will not only help to establish safety and effectiveness but can also change the way in which the surgical innovation is undertaken and widen the pool of patients who benefit. The College has published detailed guidance with recommendations on the development of surgical innovation, adopting the IDEAL framework for implementing, assessing and reporting new surgical techniques and technologies.[8] We encourage surgeons and those responsible for introducing or overseeing surgical innovation to use this guidance.

RECORD KEEPING

When it comes to surgical records, surgeons should:

- Take clear and where possible contemporaneous records for every procedure.
- Include enough detail to allow another practitioner to assume immediate management for a patient in the event that the operating surgeon is temporarily or permanently not available to continue managing the patient.
- Organise records in a way that allows identification of patients who have been treated with a particular device or medicine in the event of product safety concerns or regulatory enquiries.
- Develop recording systems that allow details of specific implants or injectables to be provided rapidly to the regulatory authorities.
- Keep records of innovative techniques and treatments.

Records that contain personal information about patients should be kept securely, in line with the GMC's confidentiality guidance,[9] and must comply with the General Data Protection Regulation and Data Protection Act 2018, which includes informing patients about what data are being collected and why, and patients' rights with respect to their data. Surgeons in private practice who process electronic data relating to patient treatment should also register as a data controller through the Information Commissioner's Office (ICO) website: **ico.org.uk** (**see section 2**).

SAFETY AND OUTCOME DATA COLLECTION AND PUBLICATION

Independent hospitals should be subject to equivalent reporting requirements as NHS hospitals for safety and outcomes data. Following the Competition and Markets Authority (CMA) report in 2014,[10] all UK consultants undertaking private activity are required to submit information to the Private Healthcare Information Network (PHIN), which will publish hospital and consultant data with the aim of empowering patients to make better informed choices.

The following data and outcome measures must be reported by hospitals and individual consultants as part of the CMA's requirement:

- Consultant fees.
- Volumes of procedures undertaken.
- Average lengths of stay.
- Infection rates.
- Readmission rates.
- Revision surgery rates.
- Mortality rates.
- Unplanned patient transfers, including to the NHS.
- Patient satisfaction.
- Information from registries and audits.
- Procedure-specific measures of improvement in health outcomes.
- Frequency of adverse events.

Consultants must also check the accuracy of their data in the PHIN consultant portal (**portal.phin.org.uk/consultants**) and submit corrections or sign them off as accurate. This portal also allows surgeons to also upload other information about them and their practice, such as special interests.

Finally, surgeons should aim to send a pre-consultation letter to all patients with the following information:

- The initial consultation fee.
- The follow-up consultation fee.
- Whether the consultant has any financial interests in the hospital or clinic, or any equipment.
- All private medical insurers who recognise them.
- A reminder for insured patients to check the terms of their policies, especially regarding the type and level of outpatient cover.
- The PHIN website where the patient can be directed for quality information.

COMPLAINTS

The GMC requires that healthcare practitioners 'must respond promptly, fully and honestly to complaints and apologise when appropriate ... [They] must not allow a patient's complaint to adversely affect the care or treatment provided'.[1] Independent hospitals are required to have a complaints process that is clearly set out and communicated to patients and staff. All complaints, even verbal ones, should be logged and dated. The CQC, the HIW and the RQIA monitor private complaints across the UK and, in England, independent practitioners are also required to provide an annual summary of complaints to the CQC. Surgeons should make sure that they also report complaints to their insurers as soon as possible, in line with the insurance policy.

If a patient has suffered harm or distress, the GMC (paragraph 55) suggests that a healthcare practitioner should:[1]

- Put matters right (if that is possible).
- Offer an apology.
- Explain fully and promptly what has happened and the likely short-term and long-term effects.

A timely and sympathetic response to a complaint, including an apology where appropriate, may help resolve the complaint at an early stage and avoid further escalation. The following considerations can be useful when a complaint has been made:

- Try to understand the complainant's perspective.
- Establish all the facts before attempting to explain what happened.
- Once you know what happened, provide a full explanation to the complainant as soon as possible.
- Apologise when this is indicated.
- Provide assurance that steps will be taken to prevent a recurrence.
- Keep a record of the complaint and response.
- Contact your indemnifier.

ADVERSE EVENTS

Adverse events are part of surgery; independent hospitals must have robust processes for responding to such incidents. Surgeons should be familiar with local processes and agreed thresholds for recording and reporting adverse events, and they should also keep a record of any incidents they have been directly involved and present them for discussion at appraisal.

In line with the College's Duty of Candour guidance,[11] all surgeons should have an open discussion with patients about a safety incident that resulted in harm. In practice, this means that surgeons should:

- Notify patients (or, where appropriate, their supporters) of the incident as soon as possible once it is established that something has gone wrong with their care.
- Provide a factual explanation of all the facts known about the incident at the date of notification. Share all relevant information known to be true, explaining if anything is still uncertain and respond honestly and fully to any questions.
- Provide a verbal apology. The verbal apology may also need to be provided in writing if this is required by local policy or the patient requests it.
- Explain fully to the patient the short- and long-term effects of the incident.
- offer an appropriate remedy or support to put matters right (if possible).
- Explain the steps that will be taken to prevent recurrence of the incident (where relevant).
- Record details of the discussion in the patient's clinical record.

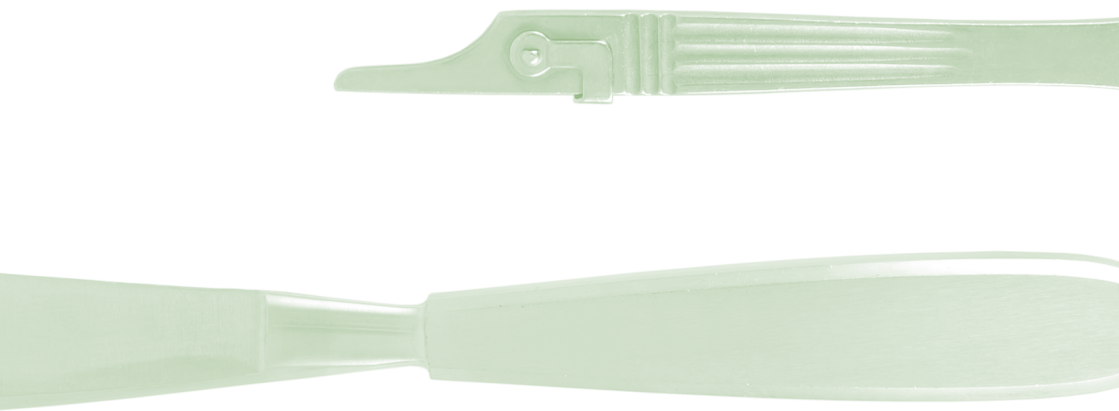
In addition to caring for patients, it is clear that adverse events also have an impact on the wellbeing of surgeons which affects them both personally and professionally. The College, in collaboration with the Bournemouth University Surgical Wellbeing Research Team has provided advice on what might be done to mitigate the impact of an adverse event on surgeons while supporting patient safety, so that they are better able to care for their patients and lead satisfying and productive professional lives.[12] Among our recommendations, we propose the introduction of a new, first responder role, which is focused on the wellbeing and immediate needs of a surgeon involved in an adverse event.

6. Leadership and teamwork

Private practice can be isolating when it does not take place within a wider consultant team, which can result to patient safety risks. Surgeons in the independent sector must make sure that they have a support network of experienced professional colleagues who can support and advise them, and can carry out regular morbidity and mortality meetings.

Surgeons should also work collaboratively with the multidisciplinary team where appropriate, particularly when there are comorbidities, and should ensure that there is a rapid and easy access to adequate support with the assessment and management of complex patients.

Consultants in independent practice should be mindful of the loss of training opportunities in the NHS in recent years following a significant shift of work to the private sector. They should take the lead and encourage their hospitals to provide more education and training, offering opportunities for surgical trainees to develop the technical and operative skills required for their Annual Review of Competence Progression.



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The RCS England produces a wide range of standards and guidance to support the surgical profession within the areas of team working and leadership, legal and ethical concerns, personal development and service improvement. To find out more about our work visit **www.rcseng.ac.uk/standardsandguidance.**

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