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<tr>
<th>Title</th>
<th>Responsible Officer’s Annual Medical Appraisal and Revalidation Report 2016/17</th>
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<tr>
<td>Status</td>
<td>For information</td>
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<tr>
<td>History</td>
<td>This is a new report</td>
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<th>Dr Tony Berendt, Medical Director</th>
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Executive Summary

1. This report provides assurance that the statutory functions of the Responsible Officer are being appropriately and adequately discharged. The structure of the report meets the requirements of NHS England.

2. The report details the Trust’s performance in medical appraisal and revalidation for the year 2016/17. It also reviews governance arrangements, analyses risks and issues, and presents an overview of priorities and an action plan for 2017/18.

3. **Recommendation**
   - The Trust Board is asked to receive this report, noting that it will shared with the Tier 2 Responsible Officer (along with the Annual Organisational Audit) at NHS England.
   - The Trust Board is asked to note the Statement of Compliance as Appendix 1 of this report which confirms that the Trust, as a Designated Body, is in compliance with the regulations.
1. **Purpose**

1.1. This report provides assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; reports on performance in relation to those functions; updates on progress since the 2015-16 annual report (TB2016.91 14 September 2016); highlights current and future issues, and presents action plans to mitigate potential risks.

2. **Background**

2.1. Medical revalidation was launched in 2012 to strengthen the regulation of doctors, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession.

2.2. The purpose of medical revalidation is to assure patients and the public that doctors are up to date and fit to practice.

2.3. Each doctor must have a Responsible Officer who oversees a range of processes including annual appraisal, and who makes, at five yearly intervals, a recommendation to the General Medical Council (GMC) regarding the doctor's revalidation.

2.4. The Responsible Officer is appointed by the Board of an organisation termed a Designated Body, to which a doctor is linked by a Prescribed Connection. This link is created when a contract of employment, (substantive, locum or honorary), is agreed between the doctor and the Designated Body.

2.5. Designated Bodies have a statutory duty under the Responsible Officer Regulations to support their Responsible Officers in discharging their duties. It is expected that provider Boards will oversee compliance by;

2.5.1. Ensuring that the Responsible Officer is provided with adequate resources to fulfil the obligations of the role

2.5.2. Monitoring the frequency and quality of medical appraisals in their organisations.

2.5.3. Checking that there are effective systems in place for monitoring the conduct and performance of their doctors.

2.5.4. Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and

2.5.5. Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.6. It should be noted that compliance with these regulations forms part of the Care Quality Commission’s surveillance model.

2.7. The last report (to the Trust Board) was submitted on 14 September 2016 for the year 2015-16. This report covers the period 1<sup>st</sup> April 2016 – 31<sup>st</sup> March 2017.
3. Governance

3.1. The current Responsible Officer (Dr Tony Berendt, Medical Director) was appointed by the Trust Board on 1st April 2014 in line with statutory requirements. He is supported by the Deputy Medical Director (1WTE) and Associate Medical Director for Workforce (0.5WTE) who have both completed the accredited Responsible Officer training. Requirements are operationalised by the Medical Revalidation Team; currently the Medical Revalidation Manager (0.8WTE), the Medical Revalidation Systems Co-ordinator and the Medical Revalidation Administration Assistant. This structure has been updated since the last annual report following the successful submission of a business case to purchase an online Appraisal and Revalidation Management System (RMS) and to increase the size of the team, as recommended by NHS England in their Independent Verification Visit of March 2015. This increase in resources reflects the increase in the number of Prescribed Connections during the implementation period from 822 (January 2013) to 1372 (March 2017).

3.2. Progress and compliance with the regulations are monitored in a variety of ways. Internally there is a well-established Medical Revalidation Group (MRG) which oversees the development and implementation of revalidation and appraisal related policies and procedures, monitors performance and is currently acting as the oversight group for the implementation of the RMS. This group has medical representation from each Division as well as the Divisional Medical Directors, University representation and 2 lay members, who have been co-opted to comply with the requirement for increased patient and public involvement in the revalidation process. The Group reports to this meeting and thence the Trust Board via the Workforce Committee. It is chaired by Dr Ivor Byren, Associate Medical Director for Workforce and the Trust’s Medical Appraisal lead.

3.3. Other methods of assurance include, but are not limited to, weekly appraisal compliance updates to the Medical Director’s Office, monthly appraisal compliance updates to the Divisions, quarterly audits of missed appraisals and submission of quarterly reports and an Annual Organisational Audit to NHS England. The AOA submission for the period which this report covers is attached as Appendix 2.

3.4. Numbers of doctors with a prescribed connection rose slowly. At the time of submission of the last Annual Report the Trust had 1310 connected doctors. This figure now stands at 1373. In addition to this number, the Trust is also responsible for appraising military doctors working at the hospital, dental surgeons affiliated to the General Dental Council and doctors training in the UK under the Medical Training Initiative scheme.

4. Policy and Guidance

4.1. The Medical Appraisal and Revalidation Policy is reviewed annually prior to the start of the new round of appraisals on 1st October of each year. The policy was reviewed in September 2016.
5. Medical Appraisal

5.1. Appraisal Performance Data

5.1.1. During the 2016-17 appraisal period 1160 doctors required an appraisal at the Trust. At the close of the period (31\textsuperscript{st} March 2017) and after allowing for the 28 day submission period as set out in the Trust’s policy, 921 (79.40%) appraisal forms had been received. A further 118 forms (an additional 10.17%) were received in the days following expiry of the deadline. This gives a total compliance rate of 89.56%. A further 38 doctors (3.28%) were issued with a certificate confirming an “approved miss” of their appraisal. Such certificates are issued where a doctor is absent for valid reasons for all or a significant part of the appraisal period. Long term sickness absence, maternity leave, sabbaticals etc. are all considered valid reasons. Taking all complete and approved miss appraisals into consideration the total compliance rate for the period was 92.84%. This represents an improvement in performance against last year’s published total of 87% compliance.

5.1.2. The following charts summarise appraisal performance during the reporting period by Division, Directorate and Staff Group.
5.2. Analysis of Results

5.2.1. Appraisal documentation for 83 doctors was not received during the 2016-17 period. Follow up work identified that only 16 doctors were out of process and relevant Divisional Management were asked to make contact with individuals.

5.2.2. The compliance rate in the NOTSS Division is much lower that other Divisions. Increasing compliance in this Division has been included on the action plan for 2017-18.

5.2.3. A key improvement against previous years is the compliance rate in the ‘Locum’ and ‘Other’ staff groups. Historically these groups have been harder to target because of the temporary and/or peripheral nature of their roles. It can be inferred that processes put in place to combat these challenges are working however additional work is required to ensure these doctors can provide complete portfolios at the point of revalidation.

5.2.4. Appraiser capacity improved during 2016-17 with a successful recruitment campaign leading to an increase in capacity. Towards the end of the period appraiser capacity began to fall due to a number of retirements and resignations. Appraiser recruitment, retention and support has remained on the action plan for 2017-18.

5.3. Audit of Missed Appraisals

5.3.1. An audit of missed appraisals was completed on a quarterly basis. Due to a change in policy by NHS England and the GMC removing the allowed 9-15 month window for appraisal completion and replacing it with an annual review, monthly missed appraisal audits have been included on the action plan for 2017-18.

5.3.2. Each audit reviewed appraisals which were considered to be overdue for the period and followed up with the individuals concerned to ascertain the reasons for the delay. Where appropriate, action plans were developed for each doctor/appraiser to bring them back in line with their revalidation trajectory and to deal with any issues which contributed to the delay.
5.3.3. During the period covered by this report appraisals for only 16 of 1160 doctors could not be accounted for. These cases were referred to Divisional Management for action and followed up by the Revaluation Team. Each doctor received a letter from the Responsible Officer.

5.4. **Appraisers**

5.4.1. The Trust has 146 active appraisers.

5.4.2. Support for Appraisers ranged from official events, such as the joint OUH/NHS England Annual Appraiser Conference and quarterly Trust Appraiser Network Events, to quality feedback reports for new appraisers and individual meetings with the Associate Medical Director for Workforce.

In addition the Revalidation Team actively supported appraisers and provided bespoke assistance. Examples included advising on acceptable evidence for doctors with non-standard roles, assisting with non-compliant doctors and escalating more serious concerns that arise during the appraisal process to ensure a doctor receives the necessary support and intervention.

5.4.3. Two surveys were undertaken during 2016-17 that included appraisers. The first obtained feedback from appraisers themselves on the appraisal process. This informed process and policy development and allowed the Revalidation Team to target resources effectively. The second requested feedback from all doctors who completed an appraisal.

5.5. **Quality Assurance**

5.5.1. Medical appraisal is quality assured through the following mechanisms:

5.5.1.1. Each appraisal in a revalidation portfolio is checked for key items against the GMC's 5 domains and the Trust's local requirements. Discrepancies are notified to the doctor and, if necessary, an action plan prepared to rectify omissions.

5.5.1.2. For appraisers, attendance at OUH Appraiser Networks and the OUH/NHSE Appraiser Conference is recorded. Appraisers not attending at least one development activity each year are followed up by the Associate Medical Director for Workforce and / or the Divisional Medical Director as appropriate. In 2016-17 the Associate Medical Director for Workforce commenced a programme of formal individual meetings with active appraisers as well as a formal review of first appraisals for new appraisers with written feedback being provided for development purposes.

5.5.1.3. To strengthen quality assurance the action to implement a formal quality assurance methodology will be added to the 2017-18 action plan along with a peer review of systems and processes to provide assurance that Trust processes are aligned to national expectations.

5.6. **Access, Security and Confidentiality**

5.6.1. Completed appraisal forms comprise part of a doctor's revalidation portfolio. This information is securely held on a separate Trust server to which only the Responsible Officer, Deputy Medical Director, Associate
5.6.2. Doctors are advised both verbally by their appraiser and in writing via Trust policies that any material containing patient identifiable data which they wish to submit as evidence must be redacted prior to doing so.

5.6.3. In relation to the RMS, it should be noted that the tender process contained a rigorous security check which was overseen by colleagues from both the IM&T and Information Governance teams. The winning bidder was able to supply written assurances that all statutory and NHS IT security requirements are met by their system and also that they have robust processes in place to identify and prevent any threats from hacking, spyware etc. The contract was reviewed and approved by the Trust’s Chief Information and Digital Officer. In addition the transfer of data to the company providing the system to enable accounts to be set up is being managed by the IM&T server team to ensure compliance with all security requirements.

5.7. **Clinical Governance**

5.7.1. Doctors are required to reflect on their involvement in incidents and complaints at appraisal. These are two of the key components of the revalidation process.

5.7.2. Historically the Trust provided each doctor with a report from the Datix system detailing any incidents and complaints that they had been involved in over the course of the year in question. However, Datix was not designed to deliver such data and therefore routine provision of reports has been discontinued. Doctors can still request a report but it is supplied with the caveat that they should verify the data with the appropriate colleagues and comment on any anomalies to avoid confusion. A significant piece of work is underway to review how governance and activity data for revalidation can be provided to doctors in the wake of the Pearson report (see Appendix 3) with delivery expected late in 2017 to coincide with the introduction of the RMS.

5.7.3. Consultants are able to use the self-service facility linked to ORBIT, the Trust’s in house performance data collection program, and are expected to bring data and a reflection on it to their appraisal. Work continues on how to address this requirement for the significant number of doctors at sub-consultant level for whom ORBIT data are not available. Provision of team and / or service metrics is currently being reviewed to satisfy the Trust’s obligation in this regard.

6. **Medical Revalidation**

6.1. **Medical Revalidation Performance Data**

6.1.1. During the period 1/4/16 – 31/3/17 the Responsible Officer made 146 recommendations. Of these 85 were recommendations to revalidate and 41 were deferrals. There were no recommendations of failing to engage.

6.1.2. The breakdown by date of recommendations relative to the due date is shown below
6.2. Analysis of Results

6.2.1. All recommendations were made on or before the due date.

6.2.2. There was significant improvement in the making of recommendations in advance of the due date. In 6 out of 12 months there were no same day recommendations made.

6.2.3. There was also a significant reduction in the number of recommendations becoming due against the same period last year (146 versus 484). This increased the ability of the team to prepare and review portfolios in advance and to manage any issues which arose.

6.2.4. The deferral rate rose from 21.49% in 2015-16 to 28.08% in 2016-17 however the incidence of repeat deferrals fell. The reasons for this were assessed and the top 3 were as follows;
6.2.4.1. **Doctor had no portfolio.** The majority of these doctors had been overseas for all or the majority of their first cycle and were not aware of revalidation requirements.

6.2.4.2. **Doctor had a portfolio with insufficient evidence**– Doctors in this category often join the OUH with an inadequate portfolio and insufficient time to rectify it.

6.2.4.3. **Doctor had been out of clinical practice** – Doctors had either been out of clinical practice for all or some of their cycle or were highly specialised non patient facing roles.

![Reasons for Deferral 2016-17](image)

6.2.5. Of the 17 doctors with no portfolio at the point of their due date, 10 had only recently joined the Trust. Of the 7 doctors with longer term connections to the Trust, 4 had mitigating reasons which included long term sickness, maternity leave and an extended career break. The remaining 3 doctors were given personalised management plans to ensure compliance.

6.2.6. Of the 19 doctors who had insufficient evidence to revalidate, 7 had only recently joined the Trust prior to their due date. Of the remaining 12 with longer term connections to the Trust, 6 had mitigating reasons which included long term sickness and an extended career break. The remaining 6 doctors were given personalised management plans to ensure compliance.

7. **Recruitment and Engagement Background Checks**

7.1. The Medical Staffing Team in HR is responsible for ensuring that all necessary pre and post-recruitment checks are completed in full and for taking any required action, including dealing with start dates or withdrawing offers of
employment, where the responses to these checks are not satisfactory. Checks include but are not limited to;

7.1.1. Identity check
7.1.2. Qualification check
7.1.3. GMC Conditions / Undertakings and past history
7.1.4. Ongoing GMC / MPTS / NCAS investigations
7.1.5. Disclosure and Barring Service (DBS) check
7.1.6. Appraisal History
7.1.7. Employment References
7.1.8. Language Competency (either via PLAB or addresses at interview)

7.2. These checks apply to both permanent, fixed term and locum staff. For doctors appointed through a locum agency, the agency is responsible for the majority of these checks but assurance is always sought that there are no issues at the time of booking.

7.3. In the 15/16 Annual Report commitments were made to rectifying 2 areas where compliance had been noted as being lower than expected. Progress in these areas is as follows;

7.3.1. Re-Audit of Compliance With Obtaining Immigration Information – The re-audit of Trust compliance with obtaining Immigration information was conducted by KPMG in late March 2017. The Human Resources team is awaiting the final report. Initial feedback from KPMG suggested changes identified in the first audit had been successfully implemented.

7.3.2. Audit of Compliance with Pre-employment Checks - This audit was paused in 2016/17 due to the HR team being in a period of transition. 13,000 employee personnel files were bulk scanned onto a newly procured HR Records system. This project revolutionised how the Divisions access employee personnel files. The audit will now be taking place in 17/18.

8. Monitoring Performance, Responding to Concerns and Remediation

8.1. Concerns about a doctor’s performance are managed under the Trust’s Performance Management Procedure for Medical Staff. Issues are generally dealt with by Divisional Management unless it is felt that the problem is serious enough to be escalated to the Medical Director and / or the Director of Workforce and Organisational Development and a formal process entered into.

8.2. Monthly Doctors’ Cases meetings are held between the Medical Director and the Director of Workforce and Organisational Development to manage these more serious cases. Where appropriate a Non-Executive Director is assigned to each case to monitor compliance with process and ensure a timely resolution. A report on exclusions and involvement in such processes is presented periodically to the Trust Board for information. An annual report summarising such investigations is also submitted to the Trust Board.

8.3. The Responsible Officer and members of the Revalidation Team meet with the GMC’s Employer Liaison Advisor quarterly to discuss cases which may be, or
have been, escalated to the GMC by the RO, or have been referred to the GMC via other routes.

8.4. Concerns may be raised as part of appraisal. The Trust Medical Appraisal and Revalidation policy includes an appendix detailing the processes to be followed in such an eventuality.

9. **Risks and Issues**

9.1. **Implementing the recommendations of the Pearson Report.** Some recommendations, such as the focus on improving support for locums, are straightforward. Others, for example provision of activity data to sub-consultant level doctors, present operational and financial challenges. The Pearson report, and the GMC’s response, make it clear that the onus is on the Designated Body to provide this information and that it must invest in IT systems to do so if necessary. The other area of focus, which requires detailed scoping, is the tracking of a doctor’s whole scope of practice and ensuring that appropriate governance information is provided. For the medical workforce at the OUH a process which balances compliance with the recommendation alongside the extensive administrative input that could be required, needs to be established.

9.2. **Improving quality assurance of appraisal, appraisers and engagement.** Quality assurance is a focus for 2017-18 with an action on the revalidation action plan. Improved quality assurance will help the revalidation team to proactively identify, provide support and resolve issues with individual portfolios early in a revalidation cycle to ensure better engagement.

9.3. **Implementing the RMS and maximising its potential.** The successful implementation of this system will be key in 2017/18. The challenge is to ensure that the system does not alienate any individual or group of individuals and that the returns from improved reporting, oversight and support it brings, can be maximised and quantified in order to provide opportunities for continuous improvement which will, in turn, benefit other areas within the Trust.

10. **Review of Actions, Improvement Plan and Next Steps 2016-17**

10.1. **Resource / Revalidation Management System** – As outlined above the Trust has purchased a Revalidation Management System and increased the capacity of the Medical Revalidation Team. Despite a delay in the procurement process and a knock on delay in implementation it is still anticipated that the system will be live in time for the 2017/18 round of appraisals which commences on 1st October 2017.

10.2. **Appraiser Retention, Recruitment and Support** – As outlined above a successful recruitment campaign was undertaken. Issues surrounding payment continue to be resolved as they are reported but the payment tariff is clearly documented in Trust Job Planning Guidance. The Appraiser Network development events and annual Conference are well attended and additional initiatives such as quality assurance of all new appraisers’ first submitted appraisal form and 1:1s with the Associate Medical Director have been implemented to focus on quality and strengthen the support given to the medical appraiser community.

10.3. **Strengthen the Monitoring of Fitness to Practice Issues**
10.3.1. Concerns raised as part of the appraisal are dealt with in line with the Appraisal and Medical Revalidation Policy.

10.3.2. A project to create a Professional Standards Framework that supports doctors has been initiated. This is led by the Associate Medical director with support from the HR Team with completion expected later in 2017.

10.3.3. A process to create an independent pathway via the Clinical Governance Framework that will feed incident and complaints data into the Appraisal process has started. This process is intended to be completed in parallel with the introduction of the digital revalidation management system.

10.3.4. The Medical Director jointly chairs the Doctors Cases meeting which involves HR and Divisions and the Revalidation Team on a monthly basis. The Medical Director also meets with the GMC’s Employer Liaison Advisor quarterly.

11. 2017-18 Actions and Next Steps

11.1. The following table details the action plan for 2017/18

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<th>Actions</th>
<th>Expected Outcome</th>
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<tr>
<td>Increase appraisal compliance within NOTTS Division</td>
<td>Work with Divisional Medical Director to identify key barriers to compliance and produce action plans for each.</td>
<td>Improved compliance rates over each of the next 4 quarters</td>
<td>By end Quarter 3 (31/12/17)</td>
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<tr>
<td>Introduce formal Quality Assurance methodology</td>
<td>Proposals for methodology to be agreed by MRG.</td>
<td>Formal QA process to be implemented with quarterly reports and action plans submitted to MRG</td>
<td>By end of 2017/18</td>
</tr>
<tr>
<td>Peer review of systems and processes</td>
<td>Proposals for methodology to be agreed by MRG</td>
<td>Outcome of peer review to include benchmarking to ensure alignment with national standards</td>
<td>By end of 2017/18</td>
</tr>
<tr>
<td>Appraiser recruitment, retention and support</td>
<td>Options for longer term sustainability to be debated by TME and plan implemented.</td>
<td>Agreed plan to be implemented.</td>
<td>Decision due Summer 2017. Implementation timescale dependant on option agreed.</td>
</tr>
<tr>
<td>Audit Schedule</td>
<td>Missed appraisal audit and classification of “unapproved misses” to be changed from quarterly to monthly</td>
<td>Reports to be submitted to MRG on a quarterly basis along with recommendations and action plans.</td>
<td>Already implemented.</td>
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<tr>
<td>Implementation of online appraisal and revalidation management system</td>
<td>Project Group is monitoring the progress of the agreed Project Plan</td>
<td>Monthly reports are submitted to the Project Group and quarterly reports to MRG.</td>
<td>Due for completion by end 2017/18</td>
</tr>
<tr>
<td>Devise and implement a performance management framework for doctors classed as “unapproved miss” for appraisal</td>
<td>Procedure to be agreed and monitored by MRG</td>
<td>Quarterly reports to be submitted to MRG</td>
<td>End quarter 3 (31/12/17)</td>
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### 12. Recommendations

12.1. The Trust Board is asked to receive this report, noting that it will be shared with the Tier 2 Responsible Officer at NHS England.

12.2. The Trust Board is asked to note the Statement of Compliance attached as Appendix 1 of this report which confirms that the Trust, as a Designated Body, is in compliance with the Regulations. This has been signed by the Chief Executive as required by NHS England.

**Dr Tony Berendt, Medical Director and Responsible Officer**

Report prepared by;

Nicki Sullivan, Medical Revalidation Manager
Dr Ivor Byren, Associate Medical Director - Workforce
Designated Body Statement of Compliance

The Trust Board Oxford University Hospitals NHS Foundation Trust can confirm that
- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;  
   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;  
   Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;  
   Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);  
   Yes

5. All licensed medical practitioners either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;  
   Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;  
   Yes

7. There is a process established for responding to concerns about any licensed medical practitioners' fitness to practise;  
   Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's

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1 http://www.england.nhs.uk/reevaluation/ro/app-syst/
2 Doctors with a prescribed connection to the designated body on the date of reporting.
responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works; ³

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners⁴ have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes

Signed on behalf of the designated body

Official name of designated body: Oxford University Hospitals NHS Foundation Trust

Name: Dr Bruno Holther
Role: Chief Executive
Date: 2016/2017

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Annual Organisational Audit (AOA)
End of year questionnaire 2016-17
The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOA s from all designated bodies will be collated to provide an overarching status report of progress across England.

**Cross Reference**
A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142

**Superseded Docs**
2015/16 AOA cleared with Publications Gateway Reference 04543

**Action Required**

**Contact Details for further information**
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**Document Status**
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Annual Organisational Audit (AOA)

End of year questionnaire 2016-17

Version number: 4.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016 & 24 March 2017


Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.
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1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed into a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors’ fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors’ fitness to practice are in place, functioning, effective and consistent.
This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer
Section 2: Appraisal
Section 3: Monitoring Performance and Responding to Concerns
Section 4: Recruitment and Engagement
Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed during April and May 2017 for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a ‘designated body’ in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations’ developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer’s recommendations.

For further information, references and resources see pages 31-32 and www.england.nhs.uk/revalidation
2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes”
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.
# Section 3 – The Designated Body and the Responsible Officer

<table>
<thead>
<tr>
<th>Section 1</th>
<th>The Designated Body and the Responsible Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1</strong></td>
<td>Name of designated body: Oxford University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Head Office or Registered Office Address if applicable line 1 John Radcliffe Hospital</td>
</tr>
<tr>
<td></td>
<td>Address line 2 Headley Way</td>
</tr>
<tr>
<td></td>
<td>Address line 3 Headington</td>
</tr>
<tr>
<td></td>
<td>Address line 4</td>
</tr>
<tr>
<td></td>
<td>City Oxford</td>
</tr>
<tr>
<td></td>
<td>County Oxfordshire</td>
</tr>
<tr>
<td></td>
<td>Postcode OX3 9DU</td>
</tr>
<tr>
<td></td>
<td>Responsible officer:</td>
</tr>
<tr>
<td></td>
<td>Title *****</td>
</tr>
<tr>
<td></td>
<td>GMC registered first name *****</td>
</tr>
<tr>
<td></td>
<td>GMC reference number *****</td>
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<tr>
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<td>Email *****</td>
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<tr>
<td></td>
<td>GMC registered last name *****</td>
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<td></td>
<td>Phone *****</td>
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<tr>
<td>Medical Director:</td>
<td></td>
</tr>
<tr>
<td>Title *****</td>
<td></td>
</tr>
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<td>GMC registered first name *****</td>
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<td>Email *****</td>
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<tr>
<td>GMC registered last name *****</td>
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<td>Phone *****</td>
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<tr>
<td>Chief executive (or equivalent):</td>
<td></td>
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<tr>
<td>Title *****</td>
<td></td>
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<tr>
<td>First name *****</td>
<td></td>
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<tr>
<td>GMC reference number (if applicable)</td>
<td></td>
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<tr>
<td>Email *****</td>
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<tr>
<td>Last name *****</td>
<td></td>
</tr>
<tr>
<td>Phone *****</td>
<td></td>
</tr>
</tbody>
</table>

Please do not use this version of the form to submit your response.
<table>
<thead>
<tr>
<th>1.2</th>
<th>Type/sector of designated body: (tick one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>NHS</strong></td>
</tr>
<tr>
<td></td>
<td>Acute hospital/secondary care foundation trust</td>
</tr>
<tr>
<td></td>
<td>Acute hospital/secondary care non-foundation trust</td>
</tr>
<tr>
<td></td>
<td>Mental health foundation trust</td>
</tr>
<tr>
<td></td>
<td>Mental health non-foundation trust</td>
</tr>
<tr>
<td></td>
<td>Other NHS foundation trust (care trust, ambulance trust, etc)</td>
</tr>
<tr>
<td></td>
<td>Other NHS non-foundation trust (care trust, ambulance trust, etc)</td>
</tr>
<tr>
<td></td>
<td>Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)</td>
</tr>
<tr>
<td></td>
<td><strong>NHS England</strong></td>
</tr>
<tr>
<td></td>
<td>NHS England (local office)</td>
</tr>
<tr>
<td></td>
<td>NHS England (regional office)</td>
</tr>
<tr>
<td></td>
<td>NHS England (national office)</td>
</tr>
<tr>
<td></td>
<td><strong>Independent / non-NHS sector</strong> (tick one)</td>
</tr>
<tr>
<td></td>
<td>Independent healthcare provider</td>
</tr>
<tr>
<td></td>
<td>Locum agency</td>
</tr>
<tr>
<td></td>
<td>Faculty/professional body (FPH, FOM, FPM, IDF, etc)</td>
</tr>
<tr>
<td></td>
<td>Academic or research organisation</td>
</tr>
<tr>
<td></td>
<td>Government department, non-departmental public body or executive agency</td>
</tr>
<tr>
<td></td>
<td>Armed Forces</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
</tr>
<tr>
<td></td>
<td>Charity/voluntary sector organisation</td>
</tr>
<tr>
<td></td>
<td>Other non-NHS (please enter type)</td>
</tr>
</tbody>
</table>
### 1.3
**The responsible officer's higher level responsible officer is based at:**
[tick one]
- NHS England North
- NHS England Midlands and East
- NHS England London
- NHS England South
- NHS England (National)
- Department of Health
- Faculty of Medical Leadership and Management - for NHS England (national office) only
- Other (Is a suitable person)

### 1.4
**A responsible officer has been nominated/appointed in compliance with the regulations.**

To answer 'Yes':
- The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer.
- There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.

Yes [✓] No [ ]
### 1.5 Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?

(Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty’s Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer)

To answer ‘Yes’:
- The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection.

To answer ‘No’:
- A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed.

To answer ‘N/a’:
- No cases of conflict of interest or appearance of bias have been identified.

**Additional guidance**

Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity.

In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer (NHS Revalidation Support Team, 2014).
1.6 In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.

Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.

1.7 The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.

To answer ‘Yes’:

- Appropriate recognised introductory training has been undertaken (requirement being NHS England’s face to face responsible officer training & the precursor e-Learning).
- Appropriate ongoing training and development is undertaken in agreement with the responsible officer’s appraiser.
- The responsible officer has made themselves known to the higher level responsible officer.
- The responsible officer is engaged in the regional responsible officer network.
- The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems.
- The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.
| 1.8 | The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.  
The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to ‘new starters’, etc. | ✔ Yes  
☐ No |
| 1.9 | The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.  
To answer ‘Yes’:  
• An evaluation of the fairness of the organisation’s policies has been performed (for example, an equality impact assessment). | ✔ Yes  
☐ No |
| 1.10 | The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.  
To answer ‘Yes’:  
• The designated body’s board report contains explanations for all missed and late recommendations, and reasons for deferral submissions. | ✔ Yes  
☐ No |
| 1.11 | The governance systems (including clinical governance where appropriate) are subject to external or independent review.  
Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer. | ✔ Yes  
☐ No |
| 1.12 | The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment) | ☑ Yes | ☐ No |
## Section 2 – Appraisal

<table>
<thead>
<tr>
<th>Section 2</th>
<th>Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong></td>
<td><strong>Number of Prescribed Connections</strong></td>
</tr>
<tr>
<td><strong>2.1.1</strong> Consultants (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).</td>
<td>793</td>
</tr>
<tr>
<td><strong>2.1.2</strong> Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).</td>
<td>70</td>
</tr>
<tr>
<td><strong>2.1.3</strong> Doctors on Performers Lists (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).</td>
<td>0</td>
</tr>
<tr>
<td><strong>2.1.4</strong> Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).</td>
<td>0</td>
</tr>
<tr>
<td><strong>2.1.5</strong> Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).</td>
<td>59</td>
</tr>
<tr>
<td><strong>2.1.6</strong> Other doctors with a prescribed connection to this designated body (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).</td>
<td>238</td>
</tr>
<tr>
<td><strong>2.1.7</strong> TOTAL (this cell will sum automatically 2.1.1 – 2.1.6).</td>
<td>1160</td>
</tr>
</tbody>
</table>

**IMPORTANT:** Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is ‘nil’ please enter ‘0’.

See guidance notes on pages 16-18 for assistance completing this table.

Please do not use this version of the form to submit your response.
Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)

- Yes
- No

Was the reason for missing the appraisal agreed by the RO in advance?

- Yes
- No

Unapproved incomplete or missed appraisal (3)

No

Approved incomplete or missed appraisal (2)

Was this in the 3 months preceding the appraisal due date*, AND was the appraisal summary signed off within 28 days of the appraisal date, AND did the entire process occur between 1 April and 31 March?

- Yes – to all 3 statements
- No – to any of the 3 statements
- Don’t know?

Completed Appraisal (1a)

Completed Appraisal (1b)
2.1 **Column - Number of Prescribed Connections:**

Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017

The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return.

**Column - Measure 1a Completed medical appraisal:**

A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context.

**Column - Measure 1b Completed medical appraisal:**

A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:

- the appraisal did not take place in the window of three months preceding the appraisal due date;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.

However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

Please do not use this version of the form to submit your response.
Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*.

**Column - Measure 2: Approved incomplete or missed appraisal:**

An *approved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*.

**Column - Measure 3: Unapproved incomplete or missed appraisal:**

An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.

**Column Total:**

Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017.

* Appraisal due date:

A doctor should have a set date by which their appraisal should normally take place every year (the ‘appraisal due date’). The appraisal due date should remain the same each year unless changed by agreement with the doctor’s responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an ‘appraisal month’ for appraisal scheduling, a doctor’s appraisal due date is the last day of their appraisal month.

For more detail on setting a doctor’s appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).
### Measure 2: Approved incomplete or missed appraisal:

An approved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an Approved incomplete or missed annual medical appraisal.

### Measure 3: Unapproved incomplete or missed appraisal:

An Unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an Unapproved incomplete or missed annual medical appraisal.
| 2.3 | There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)  
To answer ‘Yes’:  
- The policy has been ratified by the designated body's board or an equivalent governance or executive group. |
|-----|--------------------------------------------------|
| 2.4 | There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.  
To answer ‘Yes’:  
- The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are:  
  - Personal information.  
  - Scope and nature of work.  
  - Supporting information:  
    1. Continuing professional development,  
    2. Quality improvement activity,  
    3. Significant events,  
    4. Feedback from colleagues,  
    5. Feedback from patients,  
    6. Review of complaints and compliments.  
  - Review of last year’s PDP.  
  - Achievements, challenges and aspirations.  
- The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are:  
  - Summary of appraisal,  
  - Appraiser’s statement,  
  - Post-appraisal sign-off by doctor and appraiser. |
Additional guidance:
Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in Supporting Information for Appraisal and Revalidation (GMC, 2012), Good Medical Practice Framework for Appraisal and Revalidation (GMC, 2013) and the Medical Appraisal Guide (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body’s appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.

2.5 There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.

To answer ‘Yes’:
- There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor’s portfolio and discussed at appraisal.
- There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened.

Additional guidance:
It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised.

In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor’s portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see Information Management for Revalidation in England (NHS Revalidation Support Team, 2014).
2.6 **The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection**

To answer ‘Yes’:

The responsible officer ensures that:

- Medical appraisers are recruited and selected in accordance with national guidance.
- In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20.
- In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body.

**Additional guidance:**

It is important that the designated body’s appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty.

Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include:

- Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor
- Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal
- Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements.

Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Please do not use this version of the form to submit your response.
### 2.7 Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.

To answer ‘Yes’:

The responsible officer ensures that:

- Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (*Quality Assurance of Medical Appraisers*), including equality and diversity and information governance, before starting to perform appraisals.
- All appraisers have access to medical leadership and support.
- There is a system in place to obtain feedback on the appraisal process from doctors being appraised.
- Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (*Quality Assurance of Medical Appraisers*).

**Additional guidance:**

Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).
# Section 3 – Monitoring Performance and Responding to Concerns

<table>
<thead>
<tr>
<th>Section 3</th>
<th>Monitoring Performance and Responding to Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection. To answer ‘Yes’:</td>
</tr>
<tr>
<td></td>
<td>- Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor’s fitness to practise and is shared with the doctor for their portfolio.</td>
</tr>
<tr>
<td></td>
<td>- Relevant information is shared with other organisations in which a doctor works, where necessary.</td>
</tr>
<tr>
<td></td>
<td>- There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors.</td>
</tr>
<tr>
<td></td>
<td>- Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings.</td>
</tr>
<tr>
<td></td>
<td>- The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues.</td>
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<td>- The quality of the data used to monitor individuals and teams is reviewed.</td>
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<td>- Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate.</td>
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</table>

### Additional guidance:
Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor’s work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying
| 3.2 | The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).

To answer ‘Yes’:
- A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group).

**Additional guidance:**
- It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations.
- National guidance is available in the following key documents:
  - *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013).
  - *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010).

The responsible officer regulations outline the following responsibilities:
- Ensuring that there are formal procedures in place for colleagues to raise concerns.
- Ensuring there is a process established for initiating and managing investigations of capability, conduct,
health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).

- Ensuring investigators are appropriately qualified.
- Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
- Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
- Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
- Taking any steps necessary to protect patients.
- Where appropriate, referring a doctor to the GMC.
- Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
- Sharing relevant information relating to a doctor’s fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
- Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor’s comments are taken into account where appropriate.
- Appropriate records are maintained by the responsible officer of all fitness to practise information.
- Ensuring that appropriate measures are taken to address concerns, including but not limited to:
  - Requiring the doctor to undergo training or retraining,
  - Offering rehabilitation services,
  - Providing opportunities to increase the doctor’s work experience,
  - Addressing any systemic issues within the designated body which may contribute to the concerns identified.
- Ensuring that any necessary further monitoring of the doctor’s conduct, performance or fitness to practise is carried out.

<p>| 3.3 | The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome. | Yes | No |</p>
<table>
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<tr>
<th>3.4</th>
<th><strong>The designated body has arrangements in place to access sufficient trained case investigators and case managers.</strong></th>
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<td><strong>To answer ‘Yes’:</strong></td>
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<td>The responsible officer ensures that:</td>
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<td></td>
<td>- Case investigators and case managers are recruited and selected in accordance with national guidance</td>
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<td></td>
<td><em>Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor’s Practice</em> (NHS</td>
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<td>Revalidation Support Team, 2013).</td>
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<td>- Case investigators and case managers have completed a suitable training programme, with essential core</td>
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<td>content (see guidance documents above).</td>
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<td></td>
<td>- Personnel involved in responding to concerns have sufficient time to undertake their responsibilities</td>
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<td></td>
<td>- Individuals (such as case investigators, case managers) and teams involved in responding to concerns</td>
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<td></td>
<td>participate in ongoing performance review and training/development activities, to include peer review and</td>
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<td>calibration (see guidance documents above).</td>
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<td></td>
<td><strong>Additional guidance</strong></td>
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<td></td>
<td>The standards for training for case investigators and case managers are contained in *Guidance for Recruiting</td>
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<td>for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for</td>
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<td></td>
<td>Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case</td>
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<td></td>
<td>investigators or case managers may be within the designated body or commissioned externally.</td>
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</table>
6 Section 4 – Recruitment and Engagement

There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).

In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer.

Additional guidance

The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers.

The prospective responsible officer must:

- Ensure doctors have qualifications and experience appropriate to the work to be performed,
- Ensure that appropriate references are obtained and checked,
- Take any steps necessary to verify the identity of doctors,
- Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and
- For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations.

It is also important that the following information is available:

- GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date,
- Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and

Please do not use this version of the form to submit your response.
The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer’s statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes:

- Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory).
- It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to:
  - The doctor’s competence, performance or conduct,
  - Appraisal dates in the current revalidation cycle, and,
  - Local fitness to practise investigations, local conditions or restrictions on the doctor’s practice, unresolved fitness to practise concerns.

See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details.

The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer’s statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes:

- setting out the common legitimate channels along which information about a doctor’s medical practice should flow, describing the information that might apply and arrangements to support its smooth flow
- providing useful toolkits and examples of good practice

The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below.

https://www.england.nhs.uk/revalidation/ro/info-flows/

Please do not use this version of the form to submit your response.
## 7 Section 5 – Comments

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<tr>
<th>Section 5</th>
<th>Comments</th>
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<tbody>
<tr>
<td>5.1</td>
<td>Re Q3.1 We are unaware of any organisation that has such a comprehensive process of central oversight for each doctor. Appraisal is a doctor-driven process and clinical governance a team-driven one built on trust, evidence and good team-working. Regardless of size and practicalities, this process appears to be outside the expectations of appraisal.</td>
</tr>
</tbody>
</table>
8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty’s Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty’s Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty’s Stationery Office, 1983)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance (Department of Health, 2010)
7. Revalidation: A Statement of Intent (GMC and others, 2010)
8. Good Medical Practice (GMC, 2013)
9. Good Medical Practice Framework for Appraisal and Revalidation (GMC, 2013)
10. Good Medical Practice: Supplementary Guidance - Writing References (GMC, 2012)
12. Supporting Information for Appraisal and Revalidation (GMC, 2012)
17. Providing a Professional Appraisal (NHS Revalidation Support Team, 2012)
18. Information Management for Medical Revalidation in England (NHS Revalidation Support Team, 2014)
19. Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor’s Practice (NHS Revalidation Support Team, 2013)
22. Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer (NHS Revalidation Support Team, 2014).
26. How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)
27. Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)
28. Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)
Appendix 3

The Pearson Report

1. As the implementation phase of medical revalidation came to a close, Sir Keith Pearson was asked to review the impact revalidation had made to date and to make recommendations on ways to continue to increase the value which the process adds to patient safety and the medical profession. His report was published in January 2017.

2. Sir Keith concluded that “overall, revalidation has settled well and is progressing as expected”. He also stated that “Revalidation has also delivered significant benefits….it has ensured that annual whole practice appraisal is now taking place and….has strengthened clinical governance within healthcare organisations”.

3. The report contained a number of recommendations to improve the process during the second and subsequent cycles of revalidation. These were aimed at the GMC, Responsible Officer and their Trust Boards and government health departments. The recommendations pertaining to Responsible Officers and Designated Bodies are listed below along with the OUH actions taken.

a. Work with local patient groups to publicise and promote processes for ensuring that doctors are up to date and fit to practise. – The Trust has already co-opted two lay members to the Group which oversees medical revalidation. All doctors with patient contact are also required to collect patient feedback and materials are available to help them explain this requirement to patients.

b. Continue work to drive up the quality and consistency of appraisal and make sure the process is properly resourced. – The Revalidation management system provides opportunities to improve both the consistency and quality of the appraisal process and to target the available resources to where they are most needed.

c. Explore ways to make it easier for doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support teams. – In 2016-17 the Trust purchased an online appraisal and revalidation management system. The Medical Revalidation staffing establishment was also increased by 1 WTE.

d. Ensure effective processes are in place for quality assurance of local appraisal and revalidation decisions, including provision for doctors to provide feedback and to challenge decisions they feel are unfair – Quality Assurance is a key 2017-18 focus. There is a formal mechanism for challenging revalidation decisions via the Trust’s Grievance Policy. During 2016-17 there was 1 formal challenge.

e. Avoid using revalidation as a lever to achieve local objectives above and beyond the GMC’s revalidation requirements – The Trust does have a number of local requirements that it asks doctors to include in their appraisal documentation such as a Declaration of Interests and signing the Private Practice Code of Conduct, should this be applicable. This is to
support governance and assurance structures locally. It should be noted that no doctor’s revalidation has been deferred due to non-provision of these documents. The Trust is therefore already compliant in this regard.

f. **Boards should hear regularly about the learning coming from revalidation and how local processes are developing. They should also challenge their organisations as to how revalidation is helping to improve safety and increase assurance for patients.** – The Board receives an annual Responsible Officer report. A seminar on Medical Revalidation for Governors is planned for 2017-18. Quarterly updates are submitted to the Medical Revalidation Group, which oversees the process and reports to the Board via Workforce Committee.

4. The report also contained a number of recommendations to the GMC. In their response, the GMC noted that involvement from designated bodies would be required to achieve compliance with some of these. Recommendations that the Trust needs to consider are;

   a. **Reducing unnecessary burdens and bureaucracy for doctors.** The GMC state “Doctors must have access to good data and good IT in the organisations in which they work. NHS boards and independent sector providers need to focus their attention on improving the data they provide to doctors about their practice. This may require investment in IT systems to help doctors access, and then reflect on, that data to make sure that appraisal can contribute to improvements in the care that doctors provide”

   b. **Increasing oversight of, and support for, doctors in short-term locum positions** – The GMC state “we will work with Responsible Officers (ROs) in provider organisations to make sure that short-term locums are provided with the information they need to support their appraisal following every placement.”

   c. **Extending the RO model to all doctors who need a UK licence to practise.** The GMC state “Although we have established alternative routes to allow doctors without an RO to revalidate and maintain their licence, we urge the four health departments across the UK to consider amending the Responsible Officer Regulations, to end the anomalies and make sure that all doctors who need a licence are linked with an RO.”