Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: 30 September 2026

TB2026.79

Title:	**Responsible Officer's Annual Medical Appraisal and Revalidation Report 2025/26**

Status:	**For Information**
History:	**Annual Reporting**

Board Lead:	**Chief Medical Officer**
Author:	**Nicki Colling, Medical Revalidation and Job Planning Manager; Dr Elaine Hill, Director of Medical Workforce / Deputy Chief Medical Officer**
Confidential:	**No**
Key Purpose:	**Assurance, Performance**

Executive Summary

1. This report is presented to the Trust Board for assurance that the statutory functions of the Responsible Officer are being appropriately and adequately discharged.
2. Medical appraisal performance at OUH remains strong, with 1,935 appraisals completed during 2025/26 and an overall appraisal compliance rate of 95.71%, representing an improvement from 95.4% in the previous reporting period.
3. Compliance across staff groups has remained broadly stable despite continued growth in the number of doctors with a prescribed connection to the Trust, which increased from 1,963 to 1,994.
4. Demand for appraisal continues to rise, driven by increasing doctor numbers, staff turnover, less than full-time working, and responsibility for appraisal for doctors working via Patchwork (OUH Bank workers platform). This has created growing pressure on appraiser capacity, with 206 active appraisers supporting approximately 2,030 appraisals annually and a projected requirement of around 2,275 appraisal appointments when turnover is taken into account.
5. Compliance has been maintained at a high level through the proactive and agile working of the Medical Revalidation Team and appraiser workforce. Dynamic allocation of appraisers to meet deadlines, targeted support for doctors and appraisers, personalised action plans for overdue appraisals and close performance management have enabled the service to continue to meet demand effectively.
6. This represents a significant achievement for both the Medical Revalidation Team and the Trust's appraiser community.

7. Recommendations

The Trust Board is asked to:

- Receive this report for information;
- Note that the report will be shared with the Trust Board and Tier 2 Responsible Officer at NHS England.
- Note the Statement of Compliance which confirms that the Trust, as a Designated Body, is in compliance with the Regulations. This will be signed by the OUH Chief Executive as required by NHS England.
- Note the Statement of Compliance for Helen and Douglas House for which the Trust provides Responsible Officer Services, which confirms compliance with regulations. This will be signed by the Board of Helen and Douglas House as required by NHS England.

Contents

Responsible Officer's Annual Medical Appraisal and Revalidation Report 2025/26

1. Purpose

1.1. This report is presented to the Trust Board to provide assurance that the statutory functions of the Responsible Officer (RO) are being appropriately fulfilled; to report on performance in relation to those functions; to update on progress since the 2024/25 annual report; to highlight current and future issues and to present action plans to mitigate potential risks.

2. Background

2.1. The last report was submitted to Trust Board for the year 2024/25 on 10th September 2025. This report covers the period 1st April 2024 – 31st March 2025.

2.2. More information on the background to revalidation can be found in Appendix 1 – Background Summary.

3. Governance

3.1. The RO for the period 1st April 2025 – 31st March 2026 was Professor Andrew Brent, Chief Medical Officer (CMO), appointed by the Trust Board on 9th October 2023 in line with statutory requirements. The CMO is supported by a team who managed 2005 doctors to complete the appraisal and revalidation processes during the reporting period.

3.2. Progress and compliance with the regulations is monitored by:

- Monthly compliance reports supplied to Divisional and Directorate Management and personal action plans for those whose appraisals are overdue.
- Submission of the Annual Organisational Audit to NHS England (appended to this report).
- Comprehensive dashboards within SARD to enable Divisional management to access and review their own data and interrogate this in a number of ways to inform Divisional strategies.
- A formal audit schedule for other activities such as the management of multi-source feedback.

3.3. The number of doctors with a prescribed connection to OUH has increased again from 1,963 in the year 2024/25 to 1,994 at the time of writing. The shift towards less than full time working and trainee doctors

taking time out of the national scheme has contributed to the increase in the number of connections. The Trust is also responsible for appraising military doctors working at the hospital, dental surgeons, and doctors in posts who do not hold a national training number.

3.4. During the reporting period OUH continued to provide external RO services for 1 local hospice and thus has responsibility for oversight of their governance processes in relation to medical appraisal and revalidation.

4. Policy and Guidance

4.1. The Medical Appraisal and Revalidation Policy is reviewed regularly. The most recent review is currently in progress. It has been approved by the Medical Revalidation Group and is now in the HR Policies and Procedures approval process.

5. Environmental Factors

5.1. Current challenges:

5.1.1. Appraiser numbers are stable and prescribed connections continue to increase. (See section 6 below for more information on figures).

5.1.2. This means that there is a waiting list for assignment to an appraiser in some Divisions and at times limited capacity to accept honorary contract applications where a prescribed connection is needed.

5.1.3. 501 formal extensions to deadlines were needed in the appraisal period (this does not include appraisals which did not take place within the allocation month for which an extension was not requested). 336 (67.1%) were for Consultants, 21 (4.2%) were for SAS colleagues and 144 (28.7%) were for Resident Doctors. This is the first year that data on extensions has been collected and further analysis will be undertaken for 2026/27.

5.1.4. There has been a significant increase in the number of doctors needing their recommendation date to be deferred. There are a number of factors reported by doctors including clinical pressures affecting their ability to prepare, limited or portfolio working which impacts their ability to collect required evidence, and periods of absence which also affect preparation (see section 8 below).

6. Medical Appraisal

6.1. Appraisal performance data and compliance by staff group for years 2024/25 and 2025/26 is provided at Appendix 5.

Analysis of Results

6.2. The Trust's overall compliance rate for the period was 95.71% This compares to 95.4% in 2024/25.

6.3. Compliance amongst medical staff groups was relatively static compared with the previous year. There was a slight increase in missed appraisals in the "other" group which was balanced out by a marginal improvement in the Consultant rate.

6.4. Temporary contract holders have a lower compliance rate compared to other groups and this has also declined from 60% to 44% over successive years, although the small numbers will magnify percentage changes. Other groups remain stable or improve compliance over the same time period. This reflects the challenges faced by both doctors who change employers regularly or work via portfolio careers and their designated bodies when it comes to appraisal and revalidation.

6.5. All of the 86 doctors with unapproved, incomplete appraisals at 31 March 2025 have been contacted with personalised action plans to assist them to get back on track. At the time of writing this report:

- 12 appraisals have been completed.
- 37 doctors with appraisals due have left the organisation.
- 3 accounts were identified as Physician Associates who are currently exempted from these metrics.
- 19 doctors have their appraisal meeting booked.
- 15 appraisals remain outstanding. These have been referred to the relevant Divisional Medical Director for progression and, if necessary, the GMC will be asked to send a "requirement to engage" notice.

6.6. This raises the overall compliance rate to 98.30%.

Audit of Missed Appraisals – Performance Management Framework

6.7. The Trust completes a summary of missed appraisals on a monthly basis with regular reports being submitted to Divisional Management for action.

6.8. Each summary reviews appraisals considered to be overdue for the period and follows up with the individuals concerned to ascertain the reasons for the delay. Where appropriate, action plans are developed for each doctor / appraiser to bring them back in line with their revalidation trajectory and to deal with any issues which have contributed to the delay.

6.9. A Performance Framework for Managing Medical Appraisals is employed. The key aims of the framework are to:

6.9.1. Ensure all doctors are treated equally in relation to appraisal compliance.

6.9.2. Facilitate earlier intervention where it is ascertained a doctor needs support by reducing the time the doctor is able to remain non-compliant.

6.9.3. Reduce “tacit acceptance” of non-compliance by escalating outliers more quickly and involving sources of support earlier.

6.10. Doctors whose appraisals are 90+ days overdue or have failed to comply with their action plan are also referred to their Divisional management for escalation to the CMO for consideration of disciplinary action. This has significantly reduced the number of doctors who remain non-compliant for appraisal for long periods of time and has allowed the team to give targeted support to doctors who are struggling. Interventions have included referrals to Occupational Health, personalised training, and IT / administration support to enable doctors to complete their appraisals in a timely manner and reduce the need for deferral at the point of revalidation.

Appraisers

6.11. There are currently 206 trained available appraisers to deliver c.2,030 appraisals (doctors attached to OUH via a prescribed connection and those who are revalidated elsewhere but appraised by OUH as part of a service level agreement). The number of appraisers is the same as in the last reporting period. The 206 appraisers that are currently active can deliver a maximum capacity of 2,201 appraisals. An increasing number of doctors leave and join each year with a significant percentage of each requiring an appraisal whilst employed. This takes the total number of projected appraisal spaces needed to c.2,275 per annum which exceeds current capacity. The number of appraisals required exceeds the headcount due to turnover of medical staff. The projected figures allow for 10% turnover. Agile working with allocation of appraisers to appraisees to meet appraisal deadlines enables delivery of the service in an appraiser-resource efficient way. Agile allocation of appraisers represents a significant workload for the Medical Revalidation Team.

6.12. The appraiser cohort has continued to see a number of resignations from appraiser posts over the past 12 months. The main reasons for this are retirement from the Trust and reported difficulty in obtaining agreement from their host Directorates to pay the SPA allocation attached to the post, which is hypothecated into the running budget.

6.13. 15 appraisers were trained or retrained during the period to which this report pertains. These are included in the figures noted above. The appraiser recruitment pipeline is managed in collaboration with Divisional Medical Directors.

6.14. Support for appraisers is diverse and ranges from official events such as Appraiser Network Events (held 3 times a year) to individual feedback reports for appraisers and 1:1s with the Medical Revalidation Manager and Director of Medical Workforce as required.

6.15. The Great Appraiser event was not held in 2025 due to lack of funding. Future iterations of this very popular conference are dependent on financial support from outside the Trust which has not been possible to source and thus, at this time, there are no plans to hold future events.

6.16. The Medical Revalidation Team actively support appraisers with challenging situations and provide bespoke assistance depending on the issue. Examples include advising on acceptable evidence for 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.

6.17. All of the above also supports the governance framework referred to earlier in this report.

Medical Appraisal Quality Assurance

6.18. A number of quality assurance mechanisms are used in relation to medical appraisal:

- Each appraisal in a revalidation portfolio is checked for key items against the GMC's domains of Good Medical Practice and the Trust's local requirements. Discrepancies are notified to the doctor and, if necessary, an action plan prepared to rectify omissions to ensure a recommendation to revalidate can be made.
- For appraisers, attendance at OUH Appraiser Networks and the OUH/NHSE Appraiser Conference (when it is held) is recorded. Those not attending at least one development activity a year are followed up as appropriate.
- All doctors submit feedback on their appraisal experience as the final step in the appraisal process. This not only allows personalised reports for appraisers to be generated but also enables the Medical Revalidation Team to create an overview of how doctors perceive the process and thus to target resources and communications more effectively.

- A formal audit tool – ASPAT – is now available through SARD and a pilot of this tool has been undertaken. This showed that the outputs were relatively generic and, due to the labour-intensive nature of the exercise and a view that a different approach may offer more benefit, the return on effort was not considered proportionate. Investigations will continue into a validated tool that can be applied within the team's available resource.
- An Appraiser portal has been created within MS Teams to enable appraisers to offer peer support, ask questions and share best practice. This is moderated by the Medical Revalidation Team.

Access, Security and Confidentiality

6.19. More information on access, security and confidentiality can be found in Appendix 2. This information has not changed since it was reported in 2017.

7. Medical Revalidation

Medical Revalidation Performance Data

7.1. During the period 1/4/25 – 31/3/26, 171 recommendations were made. This is a decrease from 426 during the period 1/4/24 – 31/3/25. Recommendations will increase again significantly from 1/4/2026. 569 recommendations are predicted for 26/27. This figure does not allow for any deferrals made in the early part of the financial year which will require re-evaluation and re-submission within the same reporting period.

7.2. No recommendations were missed during the reporting period.

7.3. The following table shows the breakdown of recommendations made:

Year	Revalidate	Defer	Non-engagement	Total recommendations made
2024/25	336	90	0	426
2025/26	124	46	1	171

Analysis of results

7.4. The overall deferral rate for the period was 27.05% which is up from 21.1% in 2024/25.

7.5. The main reasons for requesting a deferral (additional time to complete the requirements) were:

- Inability to collect patient feedback.

- Delays to submission of the final appraisal.
- Illness of either doctor or appraiser.

Recruitment and Engagement Background Checks

7.6. More information on recruitment and engagement background checks can be found in Appendix 3. This information has not changed since it was reported in 2017.

Monitoring Performance, Responding to Concerns and Remediation

7.7. More information on monitoring performance, responding to concerns and remediation can be found in Appendix 4. This information has not changed since it was reported in 2017.

8. Risks and Issues

Team Capacity

8.1. More than 2,000 doctors were supported for appraisal and revalidation and associated tasks by 1 WTE Band 5 and approximately 0.3 WTE Band 8a (the Medical Revalidation Manager is also responsible for a number of other outputs) during the reporting period.

8.2. The trend noted in 2024/25 of appraisals being delayed and recommendations being deferred is continuing to increase. Reasons cited are clinical pressures, industrial action and sick leave across the Trust. This is putting the team under additional pressure as it requires more follow-up and support for appraisees and repeat recommendations being prepared in-year. There is a risk that the team will become overloaded and unable to keep up with the volume of recommendations required. This is particularly relevant to the coming year 2026/27 when a minimum of 473 recommendations will be required to be made. It should be noted that this does not take into account repeat recommendations caused by deferrals.

9. Action Plan

Review of 2025/26 Action Plan

Objective	Actions	Expected Outcome	Outcome
Peer review of systems and processes	Carried forward from previous plan – national guidance dependant	Peer review completed. Recommendations shared.	Not conducted due to competing priorities and lack of / suitable partners
Fully implement ASPAT	Carried forward from last plan – team capacity dependant	More support for appraisers Higher quality summaries Early intervention for appraisers requiring support	Pilot showed that the data returned was insufficient to inform meaningful interventions. The return on effort not considered viable. An alternative tool will be sought to ensure formal QA work can be carried out.
Implement Appraisal and Revalidation for Physician Associates	Carried forward from last plan – dependant on GMC guidance	Quality assured system for Physician Associates which mirrors the Medical Appraisal process	Physician Associates now have access to SARD with adapted advice and guidance and bespoke MSF forms. Further guidance is awaited from the GMC.
Development of support framework for neurodiverse colleagues	Undertake R&D to understand difficulties faced by this group and issue advice and support materials in response.	Supports the EDI agenda. Increased compliance and positive feedback achieved.	An appraiser network event was dedicated to appraising neurodiverse colleagues with an external speaker presenting and was well attended and engaged with. Support materials and signposting is now available on this topic.
Further automation of appraisal evidence	Investigate possibilities of SARD / ESR Implement import of Foundry documentation for Educational Supervision “revalidation”	Administrative preparation time for doctors minimised. New GMC requirements for Educational Supervisors are met.	Foundry reports for Educational Supervisors are now auto imported. SARD exports job planning information to ESR automatically for NHS England KPI purposes.

Proposed Action Plan for 2026/27

Objective	Actions	Expected Outcome	Outcome
Peer review of systems and processes	Carried forward from previous plan – national guidance dependant	Peer review completed. Recommendations shared.	
Preparation of an appraiser development framework	Offer a more structured programme of activities to assist appraisers in their professional development. .	Support appraisers in their development, opportunities for networking and sharing of good practice.	
Reduction in deferral recommendation rate	Analyse data on reasons for deferral from the GMC (available April 2026 onwards). Prepare individual targeted actions to address each category in order of volume – to note that deferral rates are still dependant on doctors completing the requirements so this objective is to identify and implement actions to support this.	Reduction in “avoidable” deferrals. Reduction in repeat work for the team.	

10. Recommendations

10.1. The Trust Board is asked to:

- Receive this report for information;
- Note that the report will be shared with the Tier 2 Responsible Officer at NHS England.
- Note the Statement of Compliance (Annex A) confirms that the Trust, as a Designated Body, is in compliance with the Regulations. This will be signed by the OUH Chief Executive as required by NHS England.
- Note the Statement of Compliance for Helen and Douglas House for which the Trust provides Responsible Officer Services, confirms compliance with regulations. This will be signed by the Board of Helen and Douglas House as required by NHS England.

Appendix 1 – Background Summary

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. The purpose of medical revalidation is to assure patients and the public that doctors are up to date and fit to practice.
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.
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.
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;
6. Ensuring that the Responsible Officer is provided with adequate resources to fulfil the obligations of the role
7. Monitoring the frequency and quality of medical appraisals in their organisations.
8. Checking that there are effective systems in place for monitoring the conduct and performance of their doctors.
9. Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and
10. 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.

Appendix 2 – Access, Security and Confidentiality

1. Completed appraisal forms comprise part of a doctor's revalidation portfolio. This information is securely held within an access-controlled section of the SARD system to which only the Responsible Officer, Deputy Chief Medical Officer, and the Medical Revalidation Team have access.
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.
3. In relation to SARD, 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 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.

Appendix 3 - Recruitment and Engagement Background Checks

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:
    - Identity check
    - Qualification check
    - GMC Conditions / Undertakings and history
    - Ongoing GMC / MPTS / NCAS investigations
    - Disclosure and Barring Service (DBS) check
    - Appraisal History
    - Employment References
    - Language Competency (either via PLAB or addresses at interview)
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.

Appendix 4 - Monitoring Performance, Responding to Concerns and Remediation

1. Concerns about a doctor's performance are managed under the Trust's Handling Concerns and 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 Chief Medical Officer and / or the Director of Workforce and Organisational Development and a formal process entered.
2. Monthly Doctors' Cases meetings are held between the Chief Medical Officer and relevant colleagues to manage these issues in line with Trust policies and in consultation with external partners including the Practitioners Performance Advisory Service (PPA) and GMC Employee Liaison Advisor (ELA) as appropriate.
3. The Responsible Officer and members of the Medical 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.
4. Concerns may be raised as part of appraisal. The Trust Medical Appraisal and Revalidation policy includes the processes to be followed in such an eventuality.

Appendix 5: Medical Appraisal data

Performance data

Category 1 is classed as:

A completed annual medical appraisal is one where either:

a)All of the following three standards are met:

i.the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*

ii.the output of the appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting

iii.the entire process occurred between 1 April and 31 March.

Or

b)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 three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

			1		1a		2		3	
	2024/25	Prescribed Connections	Completed Appraisal	Percentage	Completed Appraisal (Optional)	Percentage	Approved incomplete or missed appraisal	Percentage	Unapproved incomplete or missed appraisal	Percentage
2.1.1	**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.)	1291	1092	84.59	552	42.76	166	12.86	33	2.56
2.1.2	**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.)	72	59	81.94	36	50.00	12	16.67	1	1.39
2.1.3	**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.)	0	0	0.00	0	0.00	0	0.00	0	0.00
2.1.4	**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.)	9	7	77.78	1	11.11	0	0.00	2	22.22
2.1.5	**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)	9	4	44.44	3	33.33	4	44.44	1	11.11
2.1.6	**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.)	623	472	75.76	279	44.78	103	16.53	48	7.70
Unallocated	**Medics without an AOA medic group** (Medics that have not been allocated an AOA medic group on SARD)	2	0	0.00	0	0.00	0	0.00	2	100.00
2.1.7	**Total**	2006	1634	81.46	871	43.42	285	14.21	87	4.34

			1		1a		2		3	
	2025/26	Prescribed Connections	Completed Appraisal	Percentage	Completed Appraisal (Optional)	Percentage	Approved incomplete or missed appraisal	Percentage	Unapproved incomplete or missed appraisal	Percentage
2.1.1	**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.)	1233	1051	85.24	596	48.34	141	11.44	41	3.33
2.1.2	**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.)	72	58	80.56	32	44.44	11	15.28	3	4.17
2.1.3	**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.)	0	0	0.00	0	0.00	0	0.00	0	0.00

2.1.4	**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.)	9	6	66.67	5	55.56	0	0.00	3	33.33
2.1.5	**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)	5	3	60.00	3	60.00	1	20.00	1	20.00
2.1.6	**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.)	642	497	77.41	298	46.42	104	16.20	41	6.39
Unallocated	**Medics without an AOA medic group** (Medics that have not been allocated an AOA medic group on SARD)	2	0	0.00	0	0.00	0	0.00	2	100.00
2.1.7	**Total**	1963	1615	82.27	934	47.58	257	13.09	91	4.64

Compliance by Staff Group

2024/25

		1		1a		2		3	
Staff Group	Prescribed Connections	Completed Appraisal	Percentage	Completed Appraisal (Optional)	Percentage	Approved incomplete or missed appraisal	Percentage	Unapproved incomplete or missed appraisal	Percentage
Consultant	1233	1051	85.24	596	48.34	141	11.44	41	3.33
Staff Grade, Associate Specialist, Speciality Doctor	72	58	80.56	32	44.44	11	15.28	3	4.17
Doctors with Practising Privileges	9	6	66.67	5	55.56	0	0.00	3	33.33
Temporary or Short Term Contract Holders	5	3	60.00	3	60.00	1	20.00	1	20.00
Other Doctors with a Prescribed Connection	642	497	77.41	298	46.42	104	16.20	41	6.39
	1963	1615	82.27	934	47.58	257	13.09	89	4.53

"Approved incomplete" includes appraisals missed for an acceptable reason eg: maternity leave or long term sick leave. Unapproved incomplete relates to doctors whose appraisal has been missed without an acceptable reason being provided.

"Other" comprises all doctors who are not in the national training scheme and are not SAS or Consultant grades.

2025/26

		1		1a		2		3	
Staff Group	Prescribed Connections	Completed Appraisal	Percentage	Completed Appraisal (Optional)	Percentage	Approved incomplete or missed appraisal	Percentage	Unapproved incomplete or missed appraisal	Percentage
Consultant	1291	1091	84.51	550	42.60	166	12.86	33	2.56
Staff Grade, Associate Specialist, Speciality Doctor	72	59	81.94	36	50.00	12	16.67	1	1.39
Doctors with Practising Privileges	9	7	77.78	1	11.11	0	0.00	2	22.22
Temporary or Short Term Contract Holders	9	4	44.44	3	33.33	4	44.44	1	11.11
Other Doctors with a Prescribed Connection	623	471	75.60	279	44.78	104	16.69	47	7.54
	2006	1632	81.36	869	43.32	286	14.26	84	4.19

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:
Oxford University Hospitals NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	n/a
Comments:	Prof Andrew Brent GMC 4645232 was appointed to the role of Responsible Officer on 9th October 2023.

Action for next year:	n/a

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	n/a
Comments:	Revalidation team in place including Revalidation manager and Director of Medical workforce to support RO in role
Action for next year:	n/a

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	n/a
Comments:	The Trust uses the SARD appraisal and revalidation system to keep track of doctors with a prescribed connection, monitor appraisal compliance and log revalidation dates. This is now linked directly to the GMC's GMC Connect database to ensure all doctors with a prescribed connection are identified and contacted within 48 hours of created a connection
Action for next year:	n/a

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	

Comments:	The Medical Appraisal and Revalidation Policy is routinely reviewed every 3 years and more frequently if required. No major changes have been proposed since the last return.
Action for next year	

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	Peer review to be undertaken
Comments:	It has not been possible to complete this due to competing demands on the Revalidation's teams resources and issues identifying a suitable partner to undertake the review.
Action for next year:	Peer review to be undertaken (if resource allows)

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	n/a
Comments:	All doctors with a prescribed connection for revalidation are supported equally with appraisal and revalidation requirements regardless of tenure. The Trust has brought management of its medical bank in house and therefore doctors supplying short term or locum services must hold

	either a substantive or an honorary contract of employment with the Trust and are able to access the same support as other medical staff. This includes medical induction, access to Trust training resources for CPD, and appraisal and revalidation support. Governance arrangements are the same for all medical staff including locum doctors and those on a short-term placement.
Action for next year	n/a

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	n/a
Comments:	Appraisals are monitored to ensure that they take place on time and to standard. SARD is used as the appraisal platform which includes information about complaints, significant events and clinical outcomes. All appraisers receive training to ensure they are equipped to fulfil the appraiser role including ensuring that the appraisal covers a doctor's whole practice and takes account of all relevant information.
Action for next year:	n/a

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	n/a
Comments:	A robust follow up process and escalation strategy is in place to ensure any outliers are supported appropriately to comply with requirements. Appraisal completion rate remains high.
Action for next year:	n/a

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	n/a
Comments:	In place as per 1A(iv) above
Action for next year:	

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	n/a
Comments:	Numbers are continually monitored and refreshed as needed - organisation has appropriate number of appraisers who undertake between 5 and 20 appraisals per year
Action for next year:	n/a

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	n/a
Comments:	Appraisers are required to attend 2/3 network events per annum. These appraiser network events provide an opportunity for both continuing professional development and peer support. Appraisers are also able to access advice from the Director of Medical Workforce / Deputy Chief Medical Officer and the Revalidation team. The Appraisal Summary and PDP Audit Tool (ASPAT) Quality Assurance tool is available within the SARD system. Feedback is also sought from appraisees for all appraisers.
Action for next year:	n/a

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	n/a
Comments:	The appraisal and revalidation process is closely monitored and all departures from expected process or standards are escalated so that appropriate support/actions can be instigated. These processes and outcome metrics are included in the annual Responsible Officer's Report to the Trust Board.
Action for next year:	n/a

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	n/a
Comments:	The Responsible Officer takes prompt action to make any necessary recommendations to the GMC following discussion with the Chief People Officer and senior medical and HR colleagues in the Trust Medical Concerns group. The Responsible Officer meets regularly with the GMC Employer Liaison Advisor.
Action for next year:	n/a

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	n/a
Comments:	All doctors receive a personal letter from the Responsible Officer, including the reasons for deferral and an action plan if a recommendation has been made to defer revalidation.
Action for next year:	n/a

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	n/a
Comments:	Clinical governance is embedded throughout the organisation. The Chief Medical Officer and Chief Nursing Officer are joint executive leads for quality and safety which includes clinical governance and there is a longstanding, reliable system of governance meetings, practitioners and reporting structures. Mechanisms include, but are not limited to, clinical audit, peer reviews, morbidity and mortality meetings, Patient Safety Incident Response Framework, formal medical concerns processes, Getting It Right Frist Time, formal risk registers and quality improvement

	frameworks. Further details are included in the OUH annual report.
Action for next year:	n/a

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	n/a
Comments:	Performance is reviewed as part of the appraisal process. Specific issues may also be raised through morbidity and mortality meetings, patient safety incidents and learning from deaths processes. Issues related to conduct are raised by exception and there is a strong executive support for raising concerns, including in relation to bullying and harassment including sexual harassment. For those individuals flagged as having conduct or performance concerns, both dedicated ad hoc meetings and regular monthly Medical Concerns meetings are held with the CMO, CPO, Divisional Medical Directors / Divisional Directors and other senior medical and HR representatives to discuss any conduct and/or performance concerns about doctors working at OUH. The Responsible Officer meets regularly with the GMC Employer Liaison Advisor with whom he discusses relevant issues. Information is shared with other Responsible Officers and designated bodies as required in line with national guidance (see below).
Action for next year:	n/a

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	n/a
Comments:	Statutory and mandatory training records, MSF reports conducted in SARD, job plans and research reports are directly imported into a doctor's appraisal form. Information on involvement in incidents and complaints is provided to each doctor by the Revalidation Team.
Action for next year:	n/a

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	n/a
Comments:	The Trust has a Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure in place which includes arrangements for investigation and intervention for all concerns relating to medical practitioners.
Action for next year:	n/a

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of

concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Extend the reporting of medical concerns to include outcome of concerns, country of primary medical qualification, and protected characteristics.
Comments:	All formal concerns are recorded on our employee relations system and reported quarterly to our Trust Board via the Chief People Officer. Information includes number and type of cases as well as protected characteristics. A separate quarterly report on concerns related to doctors is reported to the Trust Board via the Chief Medical Officer which includes details of GMC fitness to practice concerns. The system (Casework ER) does not have the ability to record country of primary medical qualification.
Action for next year:	n/a

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	**n/a**
Comments:	The Trust uses the Medical Practitioners Information Transfer form generated through the SARD system and process to “push” and “pull” information in line with NHS England standards
Action for next year:	n/a

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	n/a
Comments:	An equality impact assessment is completed for the Trust procedure for handling concerns which addresses the potential impact on staff in each protected characteristic group and where action is required to ensure fair process. The Responsible Officer also discusses all serious medical concerns with the Chief People officer, with senior medical and HR colleagues in the Medical Concerns group and with the Practitioner Performance Advisory service (PPA).
Action for next year:	**n/a**

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Review updated national guidance around regulation of Physician Associates and update Trust policy as required.
Comments:	Information shared via the South East medical directors group and South East Responsible Officer and appraiser network meetings is reviewed and incorporated where relevant and appropriate into OUH systems

	The Trust has reviewed guidance for Physician Associates and ensures that they are working towards revalidation using the information currently available. The Trust awaits the publication of the GMC's guidance in relation to Physician Associates and will implement this as required.
Action for next year:	Review updated national guidance around regulation of Physician Associates and update Trust policy as required.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Y/N	Yes
Action from last year:	n/a
Comments:	There is a Supporting Employee Workforce Performance Procedure in place (previously Managing Work Performance Procedure and Capability Due to Ill Health Procedure) which covers standards for all non-Medical and Dental Health Professionals. This links to other policies such as the Core Skills Policy and the Expected Standards of Conduct and Behaviour Policy. There is a separate Policy for Medical and Dental staff (Handling of Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners)
Action for next year:	n/a

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	n/a
Comments:	All recruitment checks are completed as per NHS Employers standards. There is a dedicated recruitment and selection procedure for Consultant recruitments which also aligns to NHS Employers standards.
Action for next year:	n/a

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	n/a
Comments:	OUH has implemented Leading with Kindness and Inclusive leadership training for senior leaders, and Kindness into Action training for all staff. Policies and procedures support a just culture throughout the organisation, which is reinforced by senior leaders. The GMC have also provided face to face training on professional standards in 2024 and further training is planned for 2025.
Action for next year:	n/a

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	n/a
Comments:	Inclusive recruitment training has been implemented for all recruiting managers from October 2024. A mandatory requirement is that the lead interviewer has completed the training for all interview panels from April 2025. Kindness into Action is our Trust wide approach to creating a kinder, more respectful and civil working environment and the vision of the OUH People Plan 'To make OUH a great place to work where we all feel we belong'. The Kindness into Action programme began in October 2022 and is now entering its third year. The programme is designed to help our staff to have better conversations at work by developing their skills and confidence to speak up and give feedback. The Leading with Kindness course recognises the important role that people managers play in creating a positive work culture by providing more time to consider your impact at work. The course consists of a live workshop and three e-learning modules. Support is provided for key staff groups through Staff Networks, each of which has an executive sponsor. These include the Women's Network, Disability Network, BAME Network and the LGBT+ Network.
Action for next year:	n/a

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	n/a
Comments:	The Trust has appointed several Freedom to Speak Up Guardians who support any worker to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken. The Trust looks to ensure that Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon.
Action for next year:	n/a

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	n/a
Comments:	Feedback mechanisms are in place to enable continuous improvement in professional activities. For example, all appraisees are invited to review their appraisal experience. This forms the basis of an annual personal report for each appraiser and feeds into continuous improvement of appraisal services. There is a formal grievance procedure in place for staff and a clear process for patients and / or members of the public to follow if they wish to complain.

Action for next year:	n/a

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	Extend the reporting of medical concerns to include outcome of concerns, country of primary medical qualification, and protected characteristics.
Comments:	OUH has not recorded this information up to this point but propose to start recording and reporting country of primary medical qualification and protected characteristics going forward. All formal concerns are recorded on our employee relations system and reported quarterly to our Trust Board via the Chief People Officer. Information includes number and type of cases as well as protected characteristics. A separate quarterly report on concerns related to doctors is reported to the Trust Board via the Chief Medical Officer which includes details of GMC fitness to practice concerns and outcomes. The system (Casework ER) does not have the ability to record country of primary medical qualification.
Action for next year:	n/a

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	
Comments:	The Chief Medical Officer and Deputy Chief Medical Officer / Director of Medical Workforce attend regional RO & Appraiser network meetings. The CMO meets with the Higher Level RO and quarterly with the GMC Employee Liaison Advisor. The Revalidation Manager is an active member of local, regional and national networks for both managers and Responsible Officers. Visits from other Trusts have been hosted to share ideas and calibrate standards
Action for next year:	Consider a formal peer review if resources allow

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	2005
Total number of appraisals completed	1633
Total number of appraisals approved missed	286
Total number of unapproved missed	86
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	171
Total number of late recommendations	0
Total number of positive recommendations	124
Total number of deferrals made	58
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	0
Total number of trained case investigators	56
Total number of trained case managers	28
Total number of concerns received by the Responsible Officer[2] (total number of new concerns discussed at medical concerns group)	44 (5 leading to formal processes)
Total number of formal concerns processes completed	7
Longest duration of formal concerns process of those open on 31 March (working days)	571
Median duration of concerns processes closed (working days)[3]	222

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	4
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	680
Total number of new employment checks completed before commencement of employment	680
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Please see full Board report accompanying this document
Actions still outstanding
Please see full Board report accompanying this document
Current issues
Please see full Board report accompanying this document

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
Please see full Board report accompanying this document
Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):
Please see full Board report accompanying this document

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

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

Name:	Professor Meghana Pandit
Role:	Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	Professor Andrew Brent, Chief Medical Officer / Responsible Officer
Email address:	Nicki.sullivan@ouh.nhs.uk