Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: 10 September 2025

TB2025.79

Title:	**Responsible Officer's Annual Medical Appraisal and Revalidation Report 2024/25**

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

Board Lead:	**Chief Medical Officer**
Author:	**Nicki Sullivan, 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.

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2. Recommendations

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 (Appendix 1) 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 (Appendix 2), 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 2024/25

1. Purpose

1.1. This report is presented to the Trust Board to provide assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; to report on performance in relation to those functions; to update the Trust Board on progress since the 2022/23 annual report; to highlight current and future issues and to present action plans to mitigate potential risks.

2. Background

2.1. More information on the background to revalidation can be found via this link.

2.2. The last report was submitted to Trust Board for the year 2022/23 on 13th September 2023. This report covers the period 1st April 2023 – 31st March 2024.

3. Governance

3.1. The Responsible Officer for the period 1st April 2024 – 31st March 2025 was Professor Andrew Brent, Chief Medical Officer, appointed by the Trust Board on 9th October 2023 in line with statutory requirements. The Chief Medical Officer is supported by a team who managed 1963 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 OUHFT has increased again from 1886 in the year 2023/24 to 1970 at the time of writing. The effect of bringing the medical bank in-house continues to increase the demand for appraisals with the shift towards less than full time working also contributing to the increase in the number of connections. The Trust is also responsible for appraising military doctors working at the hospital, and dental surgeons and doctors in training posts who do not hold a national training number.

3.4. During the reporting period the Trust continued to provide external Responsible Officer 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 was in September 2017. The policy is currently being updated and is going through the formal HR process of approval.

5. Environmental Factors

5.1. Current challenges:

5.1.1. Appraiser numbers have continued to remain a challenge due to retirement of appraisers and the other requirements of job plans.

5.1.2. This, combined with the ongoing uplift in the number of doctors needing to be appraised, means that there is a waiting list for assignment to an appraiser in some Divisions and limited capacity to accept honorary contract applications where a prescribed connection is needed.

5.1.3. Extensions to appraisal deadlines have needed to be given more regularly due to pressures of work. This is particularly true for some locally employed doctors who do not have time set aside for appraisal in their rotas.

5.1.4. There has been an increase in the number of doctors needing their recommendation date to be deferred. There are a number of factors 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.

6. Medical Appraisal

Appraisal Performance Data

2023/24

		Number of Prescribed Connections	1 Completed Appraisal	1a Completed Appraisal (Optional)	2 Approved incomplete or missed appraisal	3 Unapproved incomplete or missed appraisal
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.)	1219	1041	583	152	26
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.)	62	49	28	11	2
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	0	0
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.)	6	3	1	0	3
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)	3	2	1	0	1
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.)	594	482	336	75	37
Unallocated	**Medics without an AOA medic group** (Medics that have not been allocated an AOA medic group on SARD)	2	0	0	0	2
2.1.7	**Total**	**1886**	**1577**	**949**	**238**	**71**

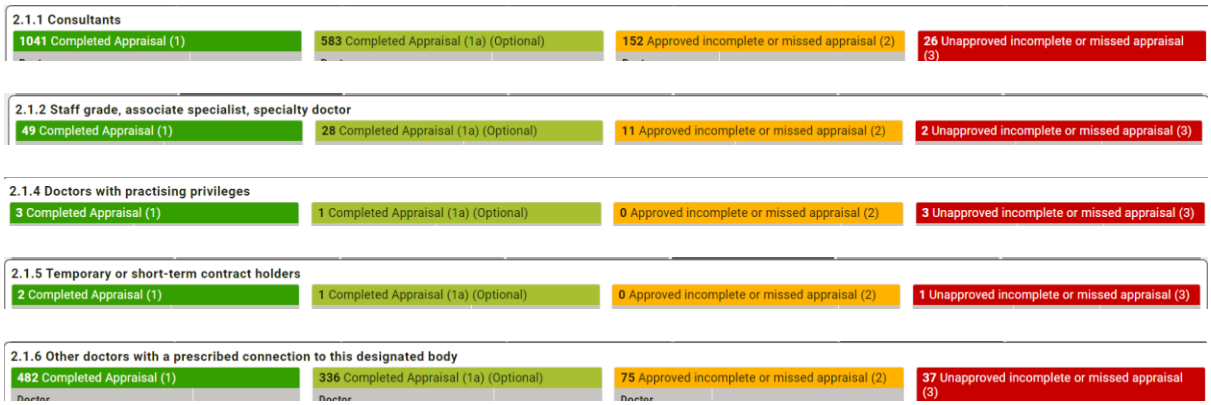
2024/25

		Number of Prescribed Connections	1 Completed Appraisal	1a Completed Appraisal (Optional)	2 Approved incomplete or missed appraisal	3 Unapproved incomplete or missed appraisal
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	596	141	41
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	32	11	3
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	0	0
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	5	0	3
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	3	1	1
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	298	104	41
Unallocated	**Medics without an AOA medic group** (Medics that have not been allocated an AOA medic group on SARD)	2	0	0	0	2
2.1.7	**Total**	**1963**	**1615**	**934**	**257**	**91**

Please see Appendix 1 for a summary of appraisal category classifications

Appraisal Compliance by Staff Group

2023/2024

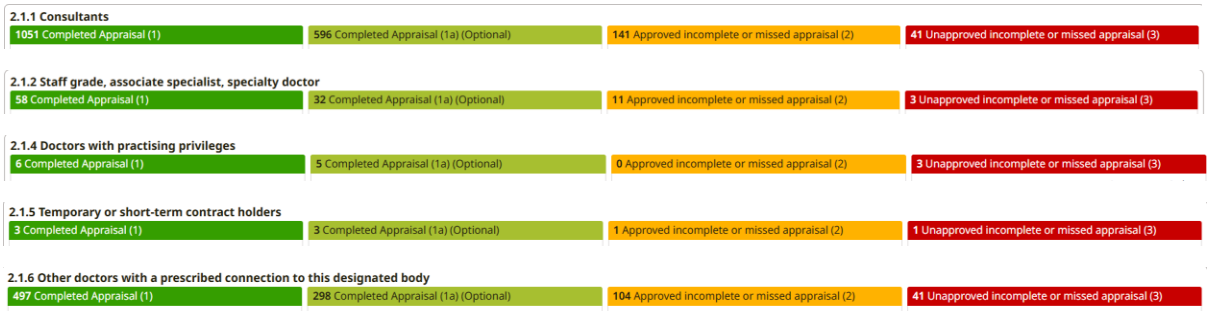


“Approved incomplete” includes appraisals missed for an acceptable reason eg: maternity leave or long term sick leave.

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.

2024/2025



"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.

Analysis of Results

6.1. The Trust's overall compliance rate for the period was 95.4% This compares to 96.2% in 2023/24.

6.2. Compliance amongst medical staff groups was relatively static compared with the previous year.

6.3. All of the 91 doctors with unapproved incomplete appraisals at 31 March 2024 have been contacted with personalised action plans to assist them to get back on track. At the time of writing this report:

- 6 appraisals have been completed
- 36 doctors with appraisals due have left the organisation
- 9 accounts were identified as Physician Associates who are currently exempted from these metrics
- 25 doctors have their appraisal meeting booked
- 14 appraisals remain outstanding with no action taken.

6.4. This raises the overall compliance rate to 98.0%.

Audit of Missed Appraisals – Performance Management Framework

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

6.6. Each summary reviews appraisals which are 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.

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

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

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

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

6.8. 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 have 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

6.9. There are currently 206 trained available appraisers to deliver circa 2025 appraisals (doctors attached to the OUH via a prescribed connection and those who are revalidated elsewhere but appraised by the OUH as part of a service level agreement). The 206 appraisers that are currently active can deliver a maximum capacity of 2244 appraisals assuming no long term leave is required. 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.2250 per annum which slightly exceeds current capacity.

6.10. The appraiser cohort has continued to see a number of resignations from appraiser posts over the past 12 months.

6.11. 22 appraisers were trained or retrained during the period to which this report pertains. These are included in the figures noted above.

6.12. 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 Revalidation Manager and Director of Medical Workforce.

6.13. The Great Appraiser event was not held in 2024 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.

6.14. The 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.

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

Medical Appraisal Quality Assurance

6.16. A number of quality assurance mechanisms are in use 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 (where it is held) is recorded. Those not attending at least one development activity 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 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.
- 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 Revalidation Team.

Access, Security and Confidentiality

6.17. More information on access, security and confidentiality can be found via this link. This information has not changed since it was reported in 2017.

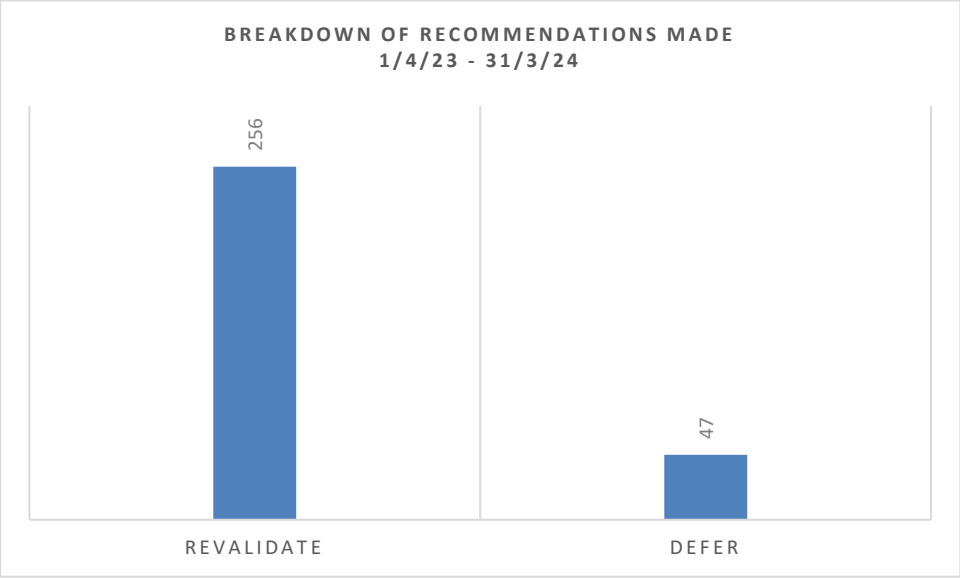
7. Medical Revalidation

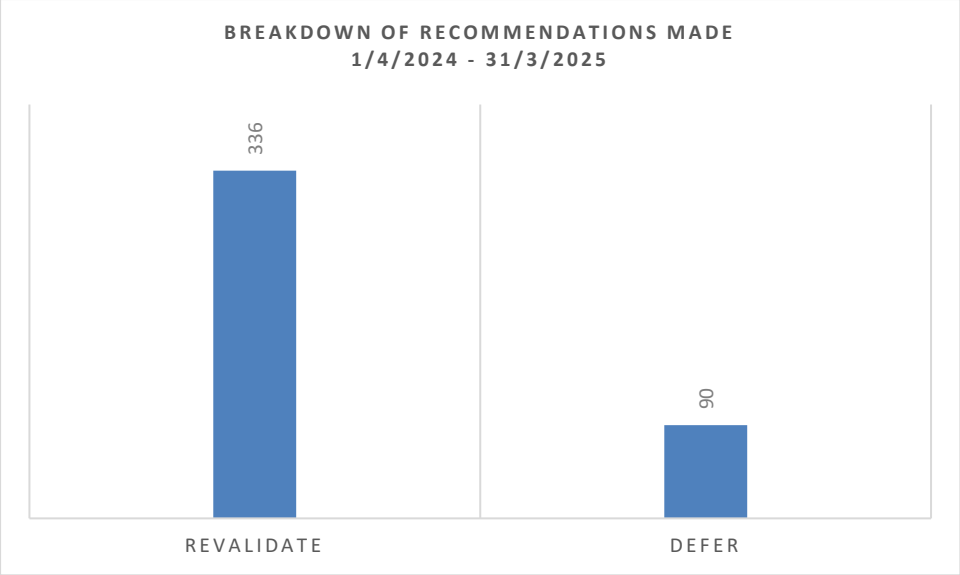
Medical Revalidation Performance Data

7.1. During the period 1/4/24 – 31/3/25, 426 recommendations were made. This is an increase from the 303 made in the period 1/4/23 – 31/3/24

7.2. 1 recommendation was missed during the reporting period. This occurred due to a delay in the transfer of information from HR to the Revalidation Team meaning that the Trust were not aware of an imminent recommendation date for a new starter. It was not possible to increase the frequency of reports provided by HR therefore a new "self service" process via TRAC has been implemented by the Revalidation Team to avoid similar issues in future.

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





Analysis of results

7.4. The overall deferral rate for the period was 21.1% which is up from 18.4% in 2023/24.

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

7.5.1. Inability to collect patient feedback

7.5.2. Delays to submission of the final appraisal mainly caused by clinical pressures.

7.5.3. Illness of both doctors and appraisers

Recruitment and Engagement Background Checks

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

8. Risks and Issues

Team Capacity

8.1. The administrative vacancy in the Revalidation Team was lost to cost saving measures during the reporting period. This means that nearly 2000 doctors are being supported for appraisal and revalidation and associated

tasks by 1 WTE Band 5 and approximately 0.3 WTE Band 8a (the Revalidation Manager is also responsible for a number of other outputs). This makes it one of the smallest teams in the country supporting one of the largest cohorts of prescribed connections. There is a risk that the team will not be able to continue to provide as much support and that there is no contingency in the case of unplanned leave and / or a vacancy arising.

8.2. In addition to the above the number of appraisals being delayed and recommendations being deferred are increasing due to clinical pressures across the Trust. This is increasing the already heavy workload for the team as it requires additional 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.

9. Action Plan

Review of 2023 / 24 Action Plan

Objective	Actions	Expected Outcome	Outcome
Peer review of systems and processes	Carried forward from previous plan	Peer review completed. Recommendations shared.	Not undertaken due to changes at national level and lack of available guidance
Implement a number of processes to improve appraiser capacity	12 PA cap on job plans temporarily removed for appraiser activity. Process for enabling honorary contract holders to appraise more in progress. Possibility of implementing a “pay per appraisal” system via the bank	The risk to the Trust of not being able to comply with its contractual obligations is mitigated. Doctors are appraised in a timely and supportive manner. Pressure on appraisers is reduced.	12 PA cap lifted by 0.4SPA for 1 year. Process for recruiting honorary appraisers implemented but unsuccessful. Pay per appraisal process not adopted. Appraiser numbers currently equal to demand but no contingency.
Fully implement ASPAT	QA 10-20% of appraisal summaries and use data to inform a range of	More support for appraisers Higher quality summaries	Not undertaken. Team staffing levels have reduced and core business

	support materials and activities	Early intervention for appraisers requiring support	processes have had to be prioritised.
Review Appraisal Policy	Ensure all updates to statute, contract and local requirements are included and that the policy remains current and supportive.	Updated reference source to ensure all doctors are aware of their responsibilities and have the most up to date information available to support them.	In Progress – currently under review through the HR Policies and Procedures process
Implement Appraisal and Revalidation for Physician Associates	Ensure the Trust is compliant with GMC requirements for this group	Quality assured system for Physician Associates which mirrors the Medical Appraisal process	GMC update still awaited. Now due Dec 2025. All Physician Associates now registered on SARD with individual access and support.

Proposed Action Plan for 2024/25

Objective	Actions	Expected Outcome	Outcome
Peer review of systems and processes	Carried forward from previous plan – national guidance dependant	Peer review completed. Recommendations shared.	
Fully implement ASPAT	Carried forward from last plan – team capacity dependant	More support for appraisers Higher quality summaries Early intervention for appraisers requiring support	
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	
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.	

Further automation of appraisal evidence	Investigate possibilities of SARD / ESR integration Implement import of Foundry documentation for Educational Supervision "revalidation"	Administrative preparation time for doctors minimised. New GMC requirements for Educational Supervisor's are met.	

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 (Appendix 1) 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 (Appendix 2), confirms compliance with regulations. This will be signed by the Board of Helen and Douglas House as required by NHS England.

Appendix 1 – Appraisal Category Classifications

10.2. 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 outputs of 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.

10.3. Category 1a is classed as

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