Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 26th July 2017

Title and Author of Paper: Medical Revalidation Annual Board Report 2017

Executive Lead:

Dr Rajesh Nadkarni, Executive Medical Director & Responsible Officer
Professor Eilish Gilvarry, Deputy Medical Director (Appraisal & Revalidation)

Paper for Debate, Decision or Information: Information & Sign-Off

Key Points to Note:

The purpose of this paper is to:

- Update the Board on the situation with regards to Medical Revalidation within the Trust
- Highlight emerging issues and risks
- Request the authority to sign-off the Statement of Compliance for the higher level Responsible Officer for NTW & St Oswald's Hospice

Risks Highlighted to Board :

The report highlights the processes in place to provide assurance of compliance with Medical Regulations (the regulations are described in the paper)

Figures for 2016/17 show:

- 187 out of 225 doctors with a prescribed connection with NTW completed appraisal
- 37 had a reasonable excuse for non-completion (agreed by the RO)
- 10 doctors had revalidation dates in the 2016/17 year and all received positive recommendations to the GMC by the RO

Does this affect any Board Assurance Framework/Corporate Risks?
Please state NO

Equal Opportunities, Legal and Other Implications: None

Outcome Required: Agreement for Board to Sign-Off Report and Statement of Compliance for both NTW & St Oswald's Hospice

Link to Policies and Strategies:

- Appraisal Policy and Medical Appraisal Practice Guidance NTW(C)33,V02
- Medical Job Plan Policy NTW(C)56,V01.2
- Private Practice Policy NTW(O)46,V01.3
- Medical re-skilling, rehabilitation, remediation and targeted support policy NTW(C)57,V01
- Handling Concerns about Doctors Policy NTW(HR)02, V02.2

Medical Revalidation Annual Board Report 2017

Executive summary

In 2016/17 there were 225 doctors with a prescribed connection to the Trust.

187 doctors had a completed appraisal in support of their revalidation and
37 had adequate reasons for incomplete appraisals such as sickness. There was one doctor who did not complete their appraisal within the appraisal window despite regular contact from the HR Revalidation Team; however this has now been satisfactorily completed.

As part of the revalidation process 10 doctors (83%) had positive recommendations made to the GMC within the year. 2 doctors (17%) were given deferrals due to one having insufficient clinical evidence following a return to clinical practice, and the other due to long-term sickness absence. There were no instances of non-engagement with the revalidation process.

At the end of March 2017 the appraisal compliance for the Trust was at 99%.

The Responsible Officer (RO) within NTW is the Executive Medical Director.

The RO is also responsible for Appraisal and Revalidation for the doctors working at St Oswalds' Hospice. The Annual Report has recently been approved by their Board (Copy attached).

Purpose of the paper

The purposes of this report are to:-

- Update the Board on the situation with regard to medical revalidation in the Trust.
- Highlight emerging issues and risks.
- Request the authority to sign off the Statement of Compliance for the higher level Responsible Officer.

Background

Medical Revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practice and that they are complying with all the relevant professional standards.

The purpose of revalidation is to ensure that licensed doctors remain up to date and are fit to practise. It is also to provide assurance of this fitness to practise to patients, the public, employers and other healthcare professionals. Revalidation also aims to improve the quality and safety of patient care, strengthen professional development and identify doctors who need support early.

Revalidation is achieved through satisfactory annual appraisal that is based upon the doctor collecting and reflecting upon specified data about their performance. (The Medical

Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012')

Provider organisations are known as Designated Bodies and appoint a Responsible Officer who has duties which are set out in statute. The Responsible Officer (RO) has to have been a licensed medical practitioner for 5 years and is accountable to the Board. Every doctor has a prescribed connection to a specific designated body and RO.

The process of Revalidation is that the RO makes a recommendation to the GMC on the fitness to practice of every doctor for whom they are responsible once every five years. The RO makes the recommendation but it is the GMC that revalidates the doctor. If the RO does not feel that there is enough evidence to make a positive recommendation he or she can defer the recommendation until such information is available or give notice of non-engagement in the process. The RO also has responsibilities covering the clinical governance of the doctors.

Provider organisations have a statutory duty to support their RO in discharging duties under the Responsible Officer Regulations[1] and it is expected that trust boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors, responding to concerns and communicating with the GMC
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- 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.

This report will show how the above is achieved

Governance arrangements

Responsible Officer (RO)

The Trust RO is the Executive Medical Director who is managed by the Chief Executive Officer and professionally accountable to the GMC and to the Level 2 Responsible Officer in NHS England. The RO meets quarterly with the GMC Employment Liaison Advisor (ELA) and minutes of this meeting are taken. The RO makes direct contact with the ELA about any issues of concern. The RO is supported by the Deputy Medical Director for Revalidation and Appraisal, supported by an Acting Associate Medical Director for Revalidation and Appraisal. The RO/Deputy Medical Director and Medical Staffing Manager for the HR Revalidation Team regularly attend the Regional Revalidation Network meetings.

Ensuring the list of doctors with a connection to NTW is accurate and up to date.

The GMC web-site (called GMC Connect) provides lists of doctors and their connections to designated bodies. The web site is regularly checked against staff lists held on the Electronic Staff Record by a member of the HR Revalidation Team.

Compliance with regulations

- *Monitoring the frequency and quality of medical appraisals*

  An electronic database SARD (Strengthened Appraisal and Revalidation Database) records appraisal information for all doctors with a prescribed connection to NTW and provides information regarding compliance with timing of appraisal.

  The RO/Deputy Medical Director and HR Revalidation Team review all completed appraisals for each individual doctor to ensure they have the requisite information prior to making a recommendation for revalidation to the GMC.

  All appraisers in the Trust receive training on how to perform appraisals and how to judge the information provided against the standards set. There are regular support and development meetings for appraisers and all must attend at minimum one meeting per year.

- *Checking there are effective systems in place for monitoring the conduct and performance of their doctors*

  All concerns about doctors are dealt with using the Handling Concerns about Doctor's Policy.

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

  Multi source feedback is produced by every doctor at least once in each 5 year revalidation cycle to inform their appraisal. Without this minimum standard a recommendation cannot be made. More feedback using different sources is encouraged.

- *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.*

  Prior to employment a checklist is completed to ensure that the doctor has appropriate qualification, registration and a current appraisal or equivalent, and that any concerns raised about the doctor in a previous employment are given to the RO.

Policy and guidance

The relevant policies are: -

- Appraisal Policy and Medical Appraisal Practice Guidance NTW(C)33,V02
- Medical Job Plan Policy NTW(C)56,V01.2
- Private Practice Policy NTW(O)46,V01.3
- Medical re-skilling, rehabilitation, remediation and targeted support policy NTW(C)57,V01
- Handling Concerns about Doctors Policy NTW(HR)02, V02.2

All these policies are currently in consultation for review, update and should be completed by autumn 2017.

• Medical Appraisal

Appraisal and Revalidation Performance Data

- Number of doctors 225
- Number of completed appraisals 187
- Number of approved incomplete/missed appraisals 37
- Number of doctors in remediation or disciplinary processes 0

See appendices A and C

Appraisers

During the period 2016/17 the Trust had 36 trained appraisers who are appointed through interview and receive specific training prior to commencement as an appraiser. Each appraiser must have regular training updates, once in five years as a minimum. Each appraiser is expected to have further training by attending at least one of the four Appraiser Development Group meetings per year. The Appraiser Development Group meetings provide an opportunity for appraisers to discuss current appraisal issues, calibrate their judgements, problem-solve and to share good practice. Within 2016/17 the Group changed their focus from a simpler appraiser support group to a more developmental and training approach with updates from the network provided to all appraisers.

In 2016/17 26 appraisers attended one or more support group meetings. We arranged to provide Support Groups in different localities during 2016/17 to ensure a higher attendance and this has shown to be successful. A revised process of support and monitoring of the appraisers is now in place following the appointment of the Deputy Medical Director for Revalidation & Appraisal. This is to ensure

greater support and assurance of quality of the appraisals. The 10 appraisers who did not attend during 2016/17 have been individually addressed by the HR Revalidation Team.

Quality assurance

Outline of quality assurance processes:

For the appraisal portfolio:-

Prior to each doctor's revalidation date the RO, Deputy Medical Director and HR Revalidation Team comprehensively review all aspects of the doctor's appraisals over the previous years to provide assurance that all required inputs and outputs are of the required standard. A standard assurance template from the Appraisal Policy is used for this purpose. In addition, serious untoward incident and complaint data is cross-checked with Trust databases to ensure that the doctor has declared all relevant information at their appraisal.

For appraisers:-

Every appraiser is expected to attend at least one appraisal development group meeting per year. An attendance register is kept.

Every doctor is asked to complete a feedback form after their appraisal. These are collated for each appraiser and the appraisers are expected to reflect on this feedback in their own appraisal.

For the organisation:-

During the year 31 appraisals were reviewed to measure compliance with appraisal input and output standards. The ASPAT Tool was used for this purpose. All met the appropriate standards. Areas for improvement were noted and fed back to Appraiser Development Group on Themes for future development. Any particular issues were discussed individually.

The electronic database SARD produces information regarding timelines and timeliness of appraisals inputs and outputs.

See appendix B

Access, security and confidentiality

Appraisal information is stored securely on the database SARD on the Trust servers. The only people that have access to all this information are the RO, Deputy Medical Director, Associate Medical Director, the HR Revalidation Team and their nominated administrative support staff. Appraisers have access to the doctor's appraisals whom they appraise.

Doctors and appraisers are warned not to include patient identifiable information in appraisal folders. No such information was found in any of the 31 appraisals that were reviewed last year.

Clinical Governance

All serious untoward incidents (SUI) and complaint data held by the Trust Safety Team, that names an individual doctor, and all clinical activity data that is held on RiO, is made available to the doctor. The doctor is expected to bring this information to the appraisal, appropriately removing all identifiable information.

• Revalidation recommendations

Revalidation dates are set by the GMC. The RO has a period of 120 days prior to the doctor's revalidation date in which to make their recommendation to the GMC. There are only three possible recommendations: that the doctor is up to date and fit to practice (a positive recommendation), a request to defer the date of the recommendation (deferral request) a notification of the doctor's non-engagement with revalidation (non-engagement notification).

In order to make a positive recommendation, the RO must be satisfied that the doctor has met the GMC's requirements for revalidation, they have participated in systems and processes to support revalidation and they have collected the required supporting information for revalidation. The RO must also be able to confirm that there are no unaddressed concerns about the doctor's fitness to practice.

A deferral request is a request made by the RO to ask the GMC to provide more time in which to submit a recommendation. Deferral requests can be made for doctors who are engaged in the systems and processes that support revalidation, but their required supporting information is incomplete, for example, because of prolonged sickness or other absence from work. A deferral request can also be made in connection with a doctor who is involved in an ongoing human resource or disciplinary process, the outcome of which will need to be considered in making the revalidation recommendation.

A doctor is not engaging in revalidation where, in the absence of reasonable circumstances, they are not participating in local processes and systems that support revalidation or do not participate in the formal revalidation process. It is a matter for the RO's judgement to determine what a "reasonable circumstance" may be and whether therefore to issue a notification of non-engagement.

In the last year, all revalidation recommendations were made on time and within the 120-day window prior to the doctor's revalidation date. There was no non-engagement from medical staff with the revalidation process.

- ## Recruitment and engagement background checks

The Medical Education, Development and Workforce Team collect information prior to employment of all doctors. For the unusual case where a doctor does not have previous appraisal information (for example doctors from Egypt do not have an appraisal system) other information is taken into account to make a decision about employment and appraisal organised soon after the doctor starts working

See appendix E

- ## Monitoring performance

The performance of doctors is monitored by medical managers through the Medical Dashboard, which displays the performance data held on each doctor. This data consists of attendance information, compliance with essential training requirements, SUI and complaint data and clinical activity data.

- ## Responding to concerns and remediation

The Trust's response to concerns about the performance of doctors is governed by the Handling Concerns about Doctors Policy NTW.

See appendix D

- ## Risk and issues

Although there has been much improvement over the last year with regards to appraisal, there is still a potential risk in the timeliness of completion within the year and signed completion within the 28 day deadline. We have procedures in place to address these concerns including review of the Policies, more training and greater monitoring.

- ## Recommendation

The Board is asked:-

To accept this Report and approve the sign-off of the Statement of Compliance confirming to the Higher Level RO that the Trust, as a Designated Body, is in compliance with the regulations as outlined below:

Provider organisations have a statutory duty to support their RO in discharging duties under the Responsible Officer Regulations and it is expected that trust boards will oversee compliance by:-

- ***Monitoring the frequency and quality of medical appraisals in their organisations***
- ***Checking there are effective systems in place for monitoring the conduct and performance of their doctors, responding to concerns and communicating with the GMC***
- ***Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors***
- ***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.***

Additional documents attached:-

Appendix F NHS England Comparator document with similar sector and national organisations appertaining to revalidation.

Appendix G Statement of compliance for the 2016/17 revalidation period

Dr Rajesh Nadkarni
Executive Medical Director (RO)
July 2017

REVALIDATION REPORT FOR CLINICAL GOVERNANCE AND QUALITY COMMITTEE MEETING, ST. OSWALD'S HOSPICE
JULY 2017

The purpose of this report is to assure and inform St. Oswald's Hospice Directors and Management that Northumberland, Tyne & Wear NHS Foundation Trust is providing an efficient and reliable revalidation function in terms of the Responsible Officer role.

1. Dr Rajesh Nadkarni has been appointed to the role of Executive Medical Director and Responsible Officer for NTW since 16th January 2016.

2. St. Oswald's Hospice currently employs 6 doctors, who are subject to the GMC Revalidation process.

3. St Oswald's Hospice currently has 2 fully trained appraisers, both of which have been actively involved in appraising staff. Northumberland, Tyne & Wear also continue to provide appraisals for St Oswald's staff.

4. All doctors employed by St Oswald's have engaged with and are up to date with appraisal.

5. SARD (Strengthened appraisal and revalidation database), an online appraisal system, was implemented on 22nd September, 2014 and has been well received. This system provides electronic storage function and the relevant appraisal documentation with appropriate expiry dates so that doctors can plan and prepare for their appraisal in preparation for revalidation. The evidence portfolio automatically informs pertinent sections of the appraisal document. Both documents function using the 'traffic light' system so progress is visual making it a relatively simple process. NTW IT governance requirements were extremely exacting and an audit and monitoring of the process is in place.

6. There have been no concerns reported around Fitness to Practice since the last Board Report in July 2016.

7. Monthly meetings are scheduled into diaries of key staff at St Oswald's Hospice and Northumberland, Tyne & Wear NHS Foundation Trust to raise any Fitness to Practice concerns that may arise. So far no concerns have been reported, therefore, the meetings have not taken place.

Dr Rajesh Nadkarni
Executive Medical Director & RO

REVALIDATION BOARD REPORT

This is the first of such reports to be submitted bi-annually. The reports are intended to improve and maintain communication and to inform St. Oswald's Board of Directors in regard to Revalidation.

1. Revalidation was introduced by the General Medical Council on 3rd December, 2012 with the purpose of assuring patients, the public, employers and other healthcare professionals that licensed doctors in the UK are up-to-date and practising to the appropriate professional standards. It was intended that revalidation would be a formal, structured process which would provide a platform to ensure ongoing improvement in the quality of medical care delivered to patients. Revalidation should be supported by appraisal and clinical governance processes that were already in place and embedded in the practice of individual organisations.

2. Within the terms of the regulations governing revalidation, St. Oswald's Hospice is a Designated Body. In common with many Hospices, St Oswald's is supported in its work as a Designated Body by using the services of a Responsible Officer (RO) employed by a nearby NHS Foundation Trust. In this case the relationship between St Oswald's and the RO is governed by a Service Level Agreement between the hospice and Northumberland Tyne and Wear Foundation NHS Trust (NTW). As part of this agreement, NTW supplies the service of its RO to the hospice to make revalidation recommendations about its doctors and to oversee the quality assurance of the processes that support revalidation.

3. St. Oswald's Hospice currently employs six doctors, all of whom have participated in annual appraisal for the 2016/17 period. 1st April 2016 to 31st March 2017. There have been no doctors required to revalidate during this period the next one for revalidation with the GMC is 2019.

4. The main responsibility of the Designated Body within the revalidation regulations is to ensure that the processes to support revalidation are adequately resourced. Therefore it is important that time is allocated to doctors for CPD activities, participation in quality improvement activity and appraisal. The Designated Body must also ensure that doctors have timely access to accurate supporting information that is required for appraisal. This is particularly important in regard to Clinical Governance information, such as the outcomes of complaint and untoward incident investigation. The Designated Body also has important responsibilities for supporting the remediation of doctors whose performance causes concern. There must be explicit policies in place to govern these areas.

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Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03551**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template
Author	Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team
Publication Date	16 June 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs
Description	A template board report for use by designated bodies to monitor their organisation's progress in implementing the Responsible Officer Regulations.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template, version 4 April 2014.
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.
Timing / Deadlines (if applicable)	**From June 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

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Annual Board Report Template

Version number: 2.0

First published: 4 April 2014

Updated: 16 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Contents

1. Executive summary

Insert here an executive summary of the report including highlights such as the number of doctors with a prescribed connection and the number of completed appraisals within the appraisal year, as well as any issues and the action plan to respond to those issues.

2. Purpose of the Paper

Include here the purpose of the report.

3. Background

Include here some background to reporting within the organisation and perhaps reference to any previous reports that may have been submitted.

The following may be of use:

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[2] and it is expected that provider boards / executive teams [*delete as applicable*] will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- 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] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

4. Governance Arrangements

Insert here an outline of the organisational structures and responsibilities, including how progress is monitored monthly/quarterly.

Include details of the process within the organisation for maintaining an accurate list of prescribed connections

Include details of your process of internal assurance, perhaps including what assurance the board / executive can have regarding compliance to regulations. Include details of any new guidance that has been published or amendments to existing documentation.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Include here detailed activity levels of appraisal outputs in individual departments such as:

- *Number of doctors,*
- *Number of completed appraisals,*
- *Number of doctors in remediation and disciplinary processes*

Also include details of any exceptions (missed appraisals and reasons, incomplete appraisals etc). See "**Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit" *as an example of what could be carried out.*

b. Appraisers

Include here numbers of appraisers, details of new appraiser training and quality assurance of this, further appraiser training support provided, such as attendance at appraiser networks etc

c. Quality Assurance

Include an outline of quality assurance processes such as:

Appraisal portfolios:

- Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is appropriate and available - by whom and sign offs.
- Review of appraisal folders to provide assurance that the appraisal outputs: personal development plan, summary and sign offs are complete and to an appropriate standard - by whom and sign offs.

- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs - by whom and sign offs.

For the individual appraiser:

- An annual record of the appraiser's reflection on his or her appropriate continuing professional development.
- An annual record of the appraiser's participation in appraisal calibration events such as reflection on appraisal network meetings.
- 360° feedback from doctors for each appraiser – how collected, reviewed, collated and fed back to the appraiser, how calibrated with the feedback for other appraisers?

For the organisation:

- Audit of timelines of process of appraisal by department,
- System user feedback,
- Review of lessons learned from any complaints,
- Review of lessons learned from any significant events.

Also see **"Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs" *as an example of what could be carried out*

d. Access, Security and Confidentiality

Include an outline of any information access, quality, security or retention issues relating to appraisal folders.

Include reference to the steps taken to ensure that patient Identifiable data is not found in appraisal portfolios.

Note any information governance breaches with actions taken.

e. Clinical governance

Include reference to the type of data for appraisal, such as corporate data used for individual doctors as a contribution to their supporting information. Perhaps detail what is provided to individuals by the organisation for appraisal e.g. clinical incident and complaint database, record keeping audit, activity data etc

Also see **"Annual Report Template Appendix C;** Audit of concerns about a doctor's practice" *as an example of what could be carried out*.

6. Revalidation Recommendations

Include statistics such as the number of:

- *Recommendations between April – March*
- *Recommendations completed on time / not on time,*
- *Positive recommendations,*
- *Deferral requests,*
- *Non-engagement notifications,*

Also include reference to reasons recorded for missed or late recommendations. See **"Annual Report Template Appendix D;** Audit of revalidation recommendations" *for an example of an audit that can be carried out in this area.*

7. Recruitment and engagement background checks

Include details of pre and post-employment checks including checks carried out on locums.

Also see "**Annual Report Template Appendix E.** Audit of recruitment and engagement background" *as an example of an audit that can be carried out in this area.*

8. Monitoring Performance

Include an outline of the process by which the performance of all doctors is monitored.

9. Responding to Concerns and Remediation

Include reference to any relevant resources and/or policies. Perhaps include numbers and types of remediation programmes used.

10. Risks and Issues

List any risks and issues that should be escalated to the board's / executive team's attention.

11. Board / Executive Team [Delete as applicable] Reflections

Include here anything about future developments proposed for the revalidation process.

12. Corrective Actions, Improvement Plan and Next Steps

Include here anything about future developments proposed for the revalidation process.

13. Recommendations

Normal practice would be to ask the board to accept the report (noting it will be shared, along with the annual audit, with the higher level responsible officer) and to consider any needs/resources.

The board should also be requested to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations. This is also submitted annually to the higher level responsible officer.

14. Reporting with small numbers

When completing appendices A-E, please note:

It is recommended that the submission of this report to your organisation's Board takes into account whether the contents should be treated as confidential annexe with an appropriately controlled distribution. Any further publication or dissemination of the report should take into account whether this will identify individuals or make them potentially more identifiable. In such cases, it would be appropriate to provide a summary of the findings that removes or reduces these issues. Organisations with small numbers of relevant staff should take particular note of this issue.

15. Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**38**
Maternity leave during the majority of the 'appraisal due window'	*7*
Sickness absence during the majority of the 'appraisal due window'	*5*
Prolonged leave during the majority of the 'appraisal due window'	*2*
Suspension during the majority of the 'appraisal due window'	
New starter within 3 month of appraisal due date	
New starter more than 3 months from appraisal due date	*14*
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	*1*
Lack of time of doctor	
Lack of engagement of doctor	*1*
Other doctor factors	*2*
(describe) Bereavement	
Appraiser factors	
Unplanned absence of appraiser	*1*
Appraisal outputs not signed off by appraiser within 28 days	*4*
Lack of time of appraiser	
Other appraiser factors (describe)	
(describe)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	*1*
Insufficient numbers of trained appraisers	
Other organisational factors (describe)	

16. Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		187
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	31	31
Scope of work: Has a full scope of practice been described?	31	30
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	31	31
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	31	31
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	31	29
Review of complaints: Have all complaints been included?	31	31
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	31	31
Is there sufficient supporting information from all the doctor's roles and places of work?	31	31
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	31	31
Appraisal Outputs	31	31
Appraisal Summary	31	31
Appraiser Statements	31	31
Personal Development Plan (PDP)	31	31

17. Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[3]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				
Capability concerns (as the primary category) in the last 12 months	0	2	8	10
Conduct concerns (as the primary category) in the last 12 months	1	0	0	1
Health concerns (as the primary category) in the last 12 months	0	1	3	4
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2017 who have undergone formal remediation between 1 April 2016 and 31 March 2017. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				11
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				8
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				4
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
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)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical				3

[3] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	3
TOTALS	18
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	1 month
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	1
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	0

18. Annual Report Template Appendix D – Audit of revalidation recommendations

Revalidation recommendations between 1 April 2016 to 31 March 2017	
Recommendations completed on time (within the GMC recommendation window)	10
Late recommendations (completed, but after the GMC recommendation window closed)	
Missed recommendations (not completed)	
TOTAL	10
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	
New starter/new prescribed connection established within 2 weeks of revalidation due date	
New starter/new prescribed connection established more than 2 weeks from revalidation due date	
Unaware the doctor had a prescribed connection	
Unaware of the doctor's revalidation due date	
Administrative error	
Responsible officer error	
Inadequate resources or support for the responsible officer role	
Other	
Describe other	
TOTAL [sum of (late) + (missed)]	0

19. Annual Report Template Appendix E – Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	12
Temporary employed doctors	25
Locums brought in to the designated body through a locum agency	70
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	107

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS	Disclosure and Barring Service	2 recent references	Name of last responsible officer	Reference from last responsible	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance
Permanent employed doctors	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Temporary employed doctors	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
Locums brought in to the designated body through a locum agency	70	70	70	70	70	70	70	70	70	70	70	70	70	70	70	70

Locums brought in to the designated body through 'Staff Bank' arrangements																
Doctors on Performers Lists																
Other (independent contractors, practising privileges, members, registrants, etc)																
Total	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry	70	41	14	15	70
Obstetrics/Gynaecology					
Accident and Emergency					
Anaesthetics					
Radiology					

Pathology					
Other					
Total in designated body (This includes all doctors not just those with a prescribed connection)	70	41	14	15	70
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	2	2	2	0	0
3 days to one week	7	7	7	0	1
1 week to 1 month	11	11	11	3	0
1-3 months	16	16	16	4	0
3-6 months	12	12	12	5	0
6-12 months	22	22	22	9	2
More than 12 months	0	0	0	0	0
Total	70	70	70	21	3

Exit reports are sent to the appropriate Line Manager following the end of a placement. We are currently devising a system to collect the outputs of these reports in a more systematic way as the return rate is rather low.

Please note the system we use cannot provide details on number of days/WTE. The figure quoted is the number of agency doctors booked per assignment.