Trust Board paper P

To:	**Trust Board**
From:	Dr Kevin Harris, Medical Director and Responsible Officer
Date:	**31 July 2014**
CQC regulation:	Outcome 14

Title:	**Medical appraisal and revalidation at UHL: report for Trust Board on the appraisal year April 2013-March 2014.**

Author/Responsible Director:
Prof Peter Furness/Dr Kevin Harris

Purpose of the Report:
To inform the Trust Board about work in relation to the duties of the University Hospitals of Leicester (UHL) in its role as a Designated Body for the majority of its medical employees.
To satisfy members of the Board that the Trust is appropriately discharging its statutory duties in this area, and that it can continue to do so in the coming year.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	

Summary / Key Points:
The current system of medical appraisal, with its link to medical revalidation, was established at UHL by the time medical revalidation was introduced by the GMC in 2012 and a detailed description was provided to Trust Board in 2013. The system has continued to function largely as previously described.
UHL has an adequate number of appropriately trained medical appraisers.
Doctors have gained familiarity with the system; the number of delayed appraisals has fallen since last year, as has the number of doctors reported to the GMC for failure to engage with the revalidation process (6 doctors in 2013-14, 14 in 2012-13).
Audit has revealed some minor problems in the documentation of some appraisals. These issues are being addressed by ongoing appraiser training and by the removal of a small number of appraisers.
External oversight of our appraisal and revalidation processes has been taken over by NHS England. This has resulted in increased demands for quality assurance information which may require investment of additional resources in the future.
Independent external review is also being strongly recommended. This has resource implications.

Recommendations:

- To accept this report (noting that it will be shared, along with the annual audit, with the higher level Responsible Officer)
- To alter the Trust's Medical Appraisal and Revalidation Policy and guidance, to clarify the process to be taken in the case of missed appraisals
- To approve the 'statement of compliance' confirming that UHL, as a designated

body, is in compliance with the regulations.

- To provide support for additional funding as reasonably justified and agreed by the Executive to allow UHL to discharge its responsibilities as a designated body.

Previously considered at another corporate UHL Committee?
No

Board Assurance Framework:	**Performance KPIs year to date:**
N/A	As described in the report

Resource Implications (eg Financial, HR):
Provision of adequate resources is a statutory requirement on UHL as a Designated Body. Maintenance of current funding is essential to the discharge of these duties. The report identifies two areas (support staff and IT contract renewal) where additional funding will be needed.

Assurance Implications:
UHL is a Designated Body in law, and as such has a statutory duty to appoint an appropriate Responsible Officer and to provide support to that Responsible Officer to allow him/her to discharge his/her statutory responsibilities.

Patient and Public Involvement (PPI) Implications:
The GMC has repeatedly stated in public that having a good system for medical appraisal and revalidation provides reassurance that a healthcare organisation is employing doctors who can fulfil their roles safely. Having a robust appraisal system is an essential part of maintaining public confidence.

Stakeholder Engagement Implications:
If UHL did not discharge its duties as a Designated Body then its doctors could face difficulty in maintaining a GMC Licence to Practise. Without such a licence a doctor cannot practice medicine in the UK.

Equality Impact:
Doctors arriving from overseas may be unfamiliar with the UK's system of medical revalidation unfamiliar. We work to assist such doctors to comply with the national requirements.
Equality issues have been considered and apart from this there is no impact.

Information exempt from Disclosure:
No

Requirement for further review?
Annual

Medical Appraisal and Revalidation at UHL

Report for Trust Board on the appraisal year April 2013- March 2014

1. Purpose of the Paper

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] . NHS England has now taken over the role of the Revalidation Support Team and has reaffirmed the expectation that provider 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
- 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.

The purpose of this document is to inform the Trust Board about work in relation to the duties of the University Hospitals of Leicester (UHL) in its role as a Designated Body for the majority of its medical employees. It covers the appraisal year from 1st April 2013 to 31st March 2014, including steps taken after the end of the appraisal year in respect of doctors who did not complete an appraisal within that year. The information contained is needed to satisfy members of the Board that the Trust is appropriately discharging its statutory duties in this area, and that it can continue to do so in the coming year.

2. Background

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. UHL was in a strong position to implement the reforms, because the Trust had been one of a small number of pilot sites prior to the introduction of revalidation. The Trust's revalidation lead, Professor Furness, had experience of leading on revalidation for the Academy of Medical Royal Colleges during the development of

[1] 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'

the new processes and was therefore already familiar with what would be required.

In 2013 Trust Board was provided with a report on the appraisal year 2012-13. That report documented in some detail the implementation in UHL of a system of medical appraisal in a form that complies with GMC requirements for revalidation, and our early experience of running such a scheme. That experience was in most respects successful, so to a large extent the appraisal year 2013-14 followed the model previously set. Consequently this report (which is now based on a template provided by NHS England) will only summarise existing appraisal and revalidation mechanisms and document events and results in 2013-14. A copy of last year's report is available on request.

3. Governance Arrangements

Policy and Guidance

UHL's Medical Appraisal and Revalidation Policy, and its associated Guidance document, were approved in 2012. Minor changes were made in 2013-14, merely to adapt the number of Senior Appraisers to UHL's modified management structure. A further change is planned in 2014-15, as discussed below, to clarify the processes to be followed in respect of doctors who fail to deliver an annual appraisal. This change has been approved by the Local Negotiating Committee but has yet to be approved by the Policy and Guidance Committee.

Process for maintaining accurate list of prescribed connections

At the level of the GMC, if a doctor modifies the GMC's record of his/her Designated Body, UHL's Medical Appraisal and revalidation manager is automatically informed. She then contacts the doctor to confirm the connection and to obtain the necessary information to set up the doctor with an account on our online medical revalidation system (PReP).

At the level of the Trust, Trust's HR department informs UHL's Medical Appraisal and revalidation manager of any new medical employees who are not in formal training posts (trainees are monitored by and revalidate through the Deanery). She follows the same procedure and also ensures that the GMC's records correctly reflect the doctor's new Designated Body.

All new medical employees receive a short summary of UHL's medical appraisal and revalidation processes, including how to find more detailed information online and how to contact UHL's Medical Appraisal and revalidation manager .

We have had a small number of doctors where this three- level process did not work; usually in respect of non-consultant doctors who are in posts where there is close supervision and in practice some training is given, but the post is not recognised by the Deanery as a training post. These have come to light by various means, usually as a result of the doctor receiving some communication that reminds them about

revalidation, such as messages from the GMC. We have had to ask the GMC for deferral of the revalidation date in two such cases but no doctor's revalidation has been jeopardised.

4. Medical Appraisal

Appraisal and Revalidation Performance Data

The system for reminding doctors about the need to organise an appraisal is set out in Trust policy and guidance. In brief, each doctor is allocated an 'appraisal due' date. Email reminders are sent two months, one month and one week before an appraisal is due. If a completed appraisal is not recorded using the online medical appraisal software ('PReP'), a further reminder is sent 2 weeks after the appraisal due date.

At the end of the appraisal year (31st March 2014) UHL was the Designated Body for 678 doctors. Of these, 62 did not complete an appraisal within the 2013-14 appraisal year. 57 of these did not have previous agreement (e.g. on grounds of ill-health or maternity leave) to miss an appraisal. All of these missed appraisals have been analysed. All have been contacted with a warning and an invitation to provide any mitigating circumstances.

Dr Harris and Professor Furness met the GMC's local Employment Liaison Officer on 29th April and all the doctors who still had not delivered an appraisal on that date were discussed. On the advice of the GMC's local Employment Liaison Officer, 34 doctors were sent a further communication warning them that if they had not completed an appraisal by a specified date (determined on the basis of individual circumstances, but in most cases 1st July 2014) then the GMC would be asked to initiate its processes for failure to engage with the process of revalidation. As of mid-July 2014, most of the doctors concerned have now completed an appraisal, but the GMC has been formally notified of non-compliance in respect of six doctors. This is fewer than last year (14 doctors, none of whom is included in the list referred this year).

NHS England has recently issued guidance including a definition of a late or missed appraisal which is not identical to that used within UHL, because it included appraisals conducted more than 2 months before or more than 2 months after the appraisal due date. The 'PReP' medical appraisal software we use currently does not allow us to use this new definition. We have discussed this with Premier IT, the supplier of PReP, and we have received assurances that they are working on an update that will implement the new definition.

Reasons for missed appraisals

The circumstances which led doctors to miss appraisals display enormous variety. At one extreme, some doctors have an excellent justification such as prolonged sickness or maternity leave. One doctor is the subject of an investigation by the

GMC, and consequently had been told that this meant that his revalidation would be suspended until the investigation is complete; he had erroneously assumed that this meant that he did not need to complete an appraisal. At the other extreme there are doctors who do not respond to communications about appraisals, even if sent by email and conventional post, until the last minute; some doctors seem to be willing to undertake the process but are disorganised and have not given the process sufficient priority. Some only recently started work at UHL and had taken the view that an appraisal would be pointless until they had worked here for several months. A few, mostly doctors not trained in the UK, deny understanding of the system. Some have been let down by an appraiser who agreed a date then cancelled the meeting. This problem is exacerbated by the disproportionate number of doctors attempting to undertake an appraisal at the end of the appraisal year, in March, when there is no time for rescheduling.

A number of doctors have taken the position that an appraisal cannot be demanded more frequently than once every 12 months. Unfortunately, this group includes many who had a delayed appraisal in 2012-13; typically in April or May of 2013. As a result they ignore the reminders and plan their next appraisal in April or May 2014; thus guaranteeing another 'late' appraisal.

Proposed clarification of penalties for missed appraisals

It is currently UHL policy that doctors who do not deliver a timely appraisal (a) may be reported to the GMC (b) may have annual pay progression blocked and (c) may have disciplinary processes imposed. However, the spectrum of mitigating circumstances described above means that a process is needed to decide what action is justified in each individual case.

The process for (a) is described above. To date (b) and (c) have never been applied, although in the future HR will require a positive recommendation of eligibility for pay progression – including the completion of an annual appraisal – before pay progression is implemented.

The decision to apply a penalty will require judgement on a case-by-case basis and any decision may result in an appeal. Consequently we have proposed that the decisions will be made by the Medical Performance Committee. This will require amendment of the Trust's revalidation policy, as mentioned above.

It is anticipated that missed appraisals will result in blockage of pay progression by default, unless the Medical Performance Committee is convinced that there are exceptional circumstances; whereas further disciplinary processes will be applied only where the Medical Performance Committee is persuaded that there is a wilful determination not to deliver a timely appraisal.

Appraisers

At the end of March 2014 UHL had 159 approved appraisers, all of whom have completed the prescribed training. This meets the acceptable appraiser:appraisee

ratios recommended by NHS England, which is from 1:5 to 1:20. There is a reasonable spread of appraisers across the medical specialties; when appraisal training is offered, CBU leads are invited to consider how many new appraisers their specialty needs and to encourage appropriate doctors to undertake the training.

The in-house full appraiser training course, developed in 2012-13, was run again in January 2014, training 14 new appraisers. It will be run again in early 2015. Those who have completed the course are required to undertake and document a 'mock' appraisal of another trainee appraiser before their names are added to the list of UHL appraisers. The documentation of this appraisal is reviewed by Professor Furness before approval is granted.

In addition, six short 'top-up training' sessions for approved appraisers were run in 2013-14 at each of UHL's hospitals. Further half-day sessions are planned for 2014-15. Attendance registers have been kept; it is anticipated that attendance at at least one top-up session will be made mandatory by the end of 2015-16.

Quality Assurance of Appraisals

For the appraisal portfolio:

The quality of individual appraisal portfolios is audited by two separate but similar processes.

1. Individual appraisal portfolios are audited by an experienced office manager who has received specific training for the purpose, using an audit template provided by NHS England. We do not audit every appraisal in this way, but NHS England's expectation is that a sample (of unspecified size) will be examined. The selection of cases for this audit is designed to include at least one appraisal by each of UHL's approved appraisers.
   In practice, many of the supposedly objective questions are difficult to answer with a simple 'Yes' or 'No'; for example '*Is there evidence that the appraisee was challenged?*'. Consequently, in practice the audit results in any portfolios where there are grounds for concern about the quality of the process or the documentation to be flagged to Professor Furness.
2. When a doctor's revalidation date approaches (i.e. every 5 years) the doctor's appraisal portfolio is checked by UHL's Medical Appraisal and Revalidation Manager. This is primarily to identify any problems with the documentation of which the Responsible Officer should be aware before considering a revalidation recommendation, ideally with time for the doctor to correct those problems. But she also considers the quality of each portfolio in a similar way to that taken in the audit described above.

These processes have identified a number of common problems, mainly around the level of detail of documentation and the appropriate use of the PReP software. The latter has informed the subsequent content of top-up training for appraisers.

In the case of four appraisers it has been necessary to discuss the quality of their work and in three of those cases there was an immediate decision for them to cease undertaking appraisals. Remedial training is offered but in practice this has not been taken up. It remains a concern (discussed in the 2012-13 report), that in the absence of incentives for UHL's doctors to train as appraisers, any expression of concern about appraisal quality is likely to result in the loss of an appraiser, with little motivation for remediation or for others to step forward. However this is not an immediate issue, as UHL currently has the required number of medical appraisers;

After each appraisal, the appraisee is automatically asked to complete a short questionnaire on the quality of the process. This questionnaire has proved very disappointing as a tool to assess the quality of appraisals, because for each appraiser the number of respondents is too small to allow the 'Likert scale' approach of the questionnaire to generate valid numeric results. We have used the information generated to target appraisers who appear to be 'outliers' for review in the audit, as described above, but it is not appropriate to use the results for feedback to individual appraisers.

Audit of individual portfolios feeds into the audit of individual appraisers as described above.

Appraisers are offered support in relation to general issues or individual cases from a group of Senior Appraisers (one per CMG) and the Revalidation Lead. Update training is offered as explained above.

For the organisation:

Progress and problems in the delivery of medical appraisal and revalidation are discussed at quarterly meetings of the Medical Revalidation Support Network; minutes are available on request. The major issues discussed are considered in other parts of this report.

Access, security and confidentiality

This is provided by the mandatory use of the secure 'PReP' online medical appraisal software, which is provided by Premier IT and is designed for the purpose. We have continued to enjoy a good service from Premier IT in relation to technical support, problem solving and further product development.

Outline of data for appraisal.

All appraisers and appraisees should be aware of the GMC's requirements on supporting information for appraisal. The provision of appropriate information is primarily the appraisee doctors' responsibility; it should be checked by the appraiser and it is subject to audit as set out above.

To deliver the required colleague feedback and patient feedback informs that comply with GMC requirements, UHL offers the system provided for that purpose by

Edgecumbe. Its use is not mandatory, but a GMC-compliant system is required and UHL will not fund any other system.

The provision of information on quality improvement, clinical audit, clinical incidents and outcome measures is the responsibility of the appraisee doctor. Availability will vary between different specialties and appraisers are encouraged to demand compliance with the guidance of the relevant medical Royal College.

We have investigated the automated provision of information on clinical incidents using the Datix system, but that system was not designed for this purpose. Therefore appraisers have been informed that they are entitled to ask about clinical incidents on Datix that are associated with their appraisee's name.

The relevance of outcome data in appraisal varies between specialties. In those specialties where outcome data is recommended by the relevant Royal College we would expect it to be provided; it is the responsibility of the individual appraisee to ensure that this information is delivered and discussed with their appraiser. We have investigated providing such information automatically using the Trust's data collection and clinical governance systems, but we have not yet identified a solution that is not excessively complicated. However exploration of this area will continue.

Doctors are told that their record of statutory and mandatory training must be discussed at appraisal. Appraisers have been told that any deficiencies should at minimum become items on the Personal Development Plan, for urgent attention, and may if critical be reported to the relevant UHL manager. The Trust's online system for managing such training does not interface directly with the PReP system for appraisal, but a summary of training can readily be downloaded or printed and provided as an item of supporting information for review.

5. Revalidation Recommendations

Number of recommendations falling due in 2013-14	164
Number of positive recommendations	145
Number of deferral requests	19
Number of non-engagement notifications made at revalidation date	0
Number of non-engagement reports made before revalidation date	6

6. Recruitment and engagement background checks

The UHL Recruitment Services is a centralised recruitment function and conducts the recruitment of all posts into the organisation to ensure full compliance with all of the NHS Employers 'Employment Check Standards'. A dedicated team for doctors

conducts the recruitment of all non-trainee (and trainee) Doctors in line with these standards which consist of the following checks:

Verification of Identity Check
Right to Work in the UK Check
Professional Registration and Qualifications Check e.g. GMC Registration
Employment History and References Check
Criminal Record and Barring Check
Workplace Health Assessment Check

Robust audit and monitoring processes are in place for these checks including the NHSLA and Home Office immigration controls to give assurance that these checks are carried out in accordance with legislation and best practice.

For further information follow the link http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standardshttp://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards

7. Monitoring Performance

Approaches include:

- Medical appraisal, as discussed above
- Analysis of outcome data, as provided by Dr Foster / HED / CHKS
- Action on clinical incidents, reported through DATIX
- Action on complaints received
- Reports from CMG leads
- Reports from other doctors following the GMC requirement to act to protect patient safety

8. Responding to Concerns and Remediation

UHL manages all medical cases relating to conduct, capability and health in line with the national Maintaining High Professional Standards (MHPS) document. The Trust has agreed a process through the Medical Local Negotiating Committee, by which MHPS is implemented. All cases where concern about a doctor has been raised are discussed monthly with the Medical Director and Director of Human Resources to ensure that a supportive and proactive approach is being taken.
In addition, the Medical Director meets regularly with the GMC's employment liaison officer to discusses cases as appropriate with the GMC, and review those cases relevant to the Trust which are currently subject to a GMC process.

9. Risk and Issues

Appraisal quality. Our ongoing audit of appraisals has demonstrated some variable quality, with some showing inadequate documentation. This risk is managed by the ongoing process of checks prior to any revalidation recommendation. Appraisers are continually reminded that their role is to make a meaningful and constructive assessment. This issue is being addressed gradually, as explained above, by a combination of training and removal of any appraisers not meeting the required standard.

We have so far followed the original national guidance to allow doctors to choose their own appraiser. This approach may not be justified, but to date we have not changed this approach without appropriate national guidance.

Inadequate numbers of appraisers. We cannot force doctors to act as appraisers so there is a risk of having insufficient numbers to be able to discharge the statutory duties of the Responsible Officer. To date this has not been an issue.

Funding. UHL, as a Designated Body, has a statutory duty to provide sufficient resources to allow the Responsible Officer to deliver his/her responsibilities. This duty has so far been delivered, but there are foreseeable cost pressures on the horizon, notably:

a) The contract for appraisal support software (PReP) is due for renegotiation in April 2015. The current 3-year contract was won on very favourable terms as Premier IT recognised the need to have UHL: as an 'early adopter' of its new product. Premier IT will also be aware that changing to a different supplier would generate considerable disruption so we anticipate a significant increase in cost.
b) NHS England has strongly recommended that organisations undertake external review of the quality of their medical appraisal and revalidation processes. This is not yet mandatory but may become so. We have not yet commissioned such a review and the medical appraisal budget currently does not include funds to support such a review.

Appraisal support staff. Our Medical Revalidation manager is single handed. She understands the role well and has delivered an excellent service, but there are times of year (notably around the end of the appraisal year) when demands of the role are high. If she was to resign or become unavailable it would be extremely difficult to train a replacement in an acceptable time. Other organisations the size of UHL employ more than one person in this role. The provision of support staff therefore needs to be reviewed but provision of additional staff is currently constrained by funding. Training an existing member of staff in the role to provide backup and cover is a priority.

10. Corrective Actions, Improvement Plan and Next Steps

- Continue the programme of training for new appraisers and updates for existing appraisers, making it mandatory that appraisers attend an update session either this year or next year
- Continue to challenge appraisers whose performance, identified through ongoing audit, raises cause for concern, while anticipating that any such challenge will probably result in the appraiser ceasing to act as an appraiser rather than re-training
- Implement the modified policy for dealing with delayed and missed appraisals, including appropriate publicity to ensure that all doctors are aware of the policy
- Attempt to improve the delivery of outcome data and information about clinical incidents to the appraisal process
- Implement NHS England's new definition of missed or late appraisals (dependent on software updates promised by Premier IT).
- Negotiate renewal or replacement of the contract for medical appraisal support software

11. Recommendations

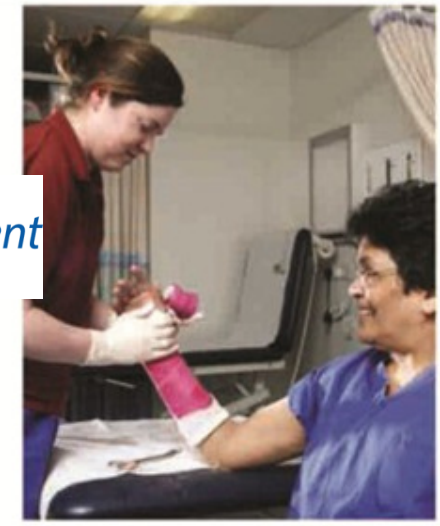
- To accept this report (noting that it will be shared, along with the annual audit, with the higher level Responsible Officer)
- To alter the Trust's Medical Appraisal and revalidation Policy and guidance, to clarify the process to be taken in the case of missed appraisals
- To approve the 'statement of compliance' confirming that UHL, as a designated body, is in compliance with the regulations.
- To provide support for additional funding as reasonably justified and agreed by the Executive to allow UHL to discharge its responsibilities as a designated body.

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014



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Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
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)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
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 (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.net/revalidation/

Document Status

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Annex E – Statement of Compliance

Designated Body Statement of Compliance

The board of the University Hospitals of Leicester has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

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

   Comments:

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

   Comments:

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

   Comments:

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

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1]Doctors with a prescribed connection to the designated body on the date of reporting.

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member]

Date: _ _ _ _ _ _ _ _ _ _

[2]Doctors with a prescribed connection to the designated body on the date of reporting.