Responsible Officer Annual Board Report and Statement of Compliance

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Trust Board paper G

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board	EQPB 27/8/19	Assurance
Trust Board Committee		
Trust Board		

Executive Summary

Context

The format for presenting information about the statutory duties of the Responsible Officer to the Trust Board has changed. The Annual Organisational Audit (AOA) has been simplified and information that was previously contained in the audit is now in the Board Report and more qualitative detail is included. It is anticipated that the amount of detail in the report will increase over time in an attempt to understand and to further improve RO functions. It is aligned with the joint CQC and GMC publication "Effective clinical governance for the medical profession: A handbook for organisations employing, contracting or overseeing the practice of doctors". This report is entitled a Framework of Quality Assurance for Responsible Officers and Revalidation. Annex D – Annual Board Report and Statement of Compliance. The report is at Appendix A.

At 31st May 2019, the time of submission of the AOA, UHL has 977 doctors with prescribed connections and of these 21 had not had their annual appraisal as required. Reasons for these unauthorised missed appraisals and action taken are included in the report. All practitioners have now had their appraisal. This appraisal rate (97%) compares favourably with peer group average (90%). During the last appraisal year 191 doctors were due for revalidation and of these 180 positive recommendations were made with 11 deferrals. A deferral recommendation was mainly made for reasons of lack of evidence in practitioners who were new to the organisation. All recommendations were made on time.

During the last appraisal year, the Trust has successfully changed its electronic appraisal software from the Premier IT product, PrEP to the Strengthened Appraisal and Revalidation Database Joint Venture product, SARD JV. This is a more "user friendly" package with better support and reporting features.

At the present time UHL has sufficient appraisers (166 with an appraiser/appraisee ration of 1 to 6) but the distribution throughout the CMGs remains uneven and recruitment and retention of appraisers remains a challenge.

Questions

1. Is Trust Board assured that UHL RO functions are being carried out satisfactorily?
2. Is Trust Board content to recommend that the Chairman sign the Statement of Compliance?

Conclusion

The report shows that UHL is in compliance with RO regulations.

Input Sought

Sign off of the Statement of Compliance

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Not applicable]
Safely and timely discharge	[Not applicable]
Improved Cancer pathways	[Not applicable]
Streamlined emergency care	[Not applicable]
Better care pathways	[Not applicable]
Ward accreditation	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Not applicable]
e-Hospital	[Not applicable]
More embedded research	[Not applicable]
Better corporate services	[Not applicable]
Quality strategy development	[Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required

- How did the outcome of the EIA influence your Patient and Public Involvement ?

- If an EIA was not carried out, what was the rationale for this decision?

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None	x	

5. Scheduled date for the **next paper** on this topic: August 2020
6. Executive Summaries should not exceed **5 sides** My paper does comply

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of University Hospitals of Leicester can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission:	31st May 2019

Action from last year:

	Number of prescribed connections	Completed appraisals	Approved incomplete or missed appraisals	Unapproved incomplete or missed appraisals	Total
Consultants	709	692	6	11	709
Staff grade, associate specialist, specialty doctor	115	98	7	10	115
Doctors on Performers Lists	0	0	0	0	0
Doctors with practicing privileges	0	0	0	0	0
Temporary or short-term contract holders	152	152	0	0	152
Other doctors with a prescribed connection to this designated body	1	1	0	0	1
Total	977	943	13	21	977

At the end of the appraisal year (31st March 2019), UHL was the designated body for 977 doctors (an increase from 952 described in last year's report). Of these 943 (97%) completed their appraisal. 34 doctors did not complete an appraisal, 13 of these had an approved missed appraisal (usually maternity leave or long term sick leave).

Comments and action for next year

Performance in UHL against the national appraisal metrics remain good (overall appraisal rate 97% cf 90% in same sector Designated Bodies (DBs)) The individual circumstances of the 21 doctors who had not completed their annual appraisal at the time of submission of the AOA have been considered at the 26th June 2019 meeting of the Medical Conduct Committee (MCC), with a view to deciding what sanctions, if any, would be appropriate in each case. Of the 21, 2 had left the Trust and once the Trust has been informed of their new DBs, the information about their missed appraisal will be shared with the new DB. Of the remaining 19, all have now completed their appraisal. In 10 cases it was decided that the circumstances did not justify further actions as appraisals had been completed and previous appraisals had generally been completed on time. 9 individuals were written to by the RO to inform them that no formal action was to be taken but that their late appraisal had been noted and expectations for future compliance with deadlines were made clear. Formal action was taken in the case of one individual who had had 3 previous significantly late appraisals which consisted of:

Pay progression for 2018-19 would be withheld (resulting in a permanent 12 month delay in pay progression for any doctor not already at the top of the pay scale), any application for a local Clinical Excellence Award would not be accepted this year, the Trust would not support any application for a national Clinical Excellence Award, their case would be discussed with the Trust's GMC Employment Liaison Advisor (ELA) in terms of possible non-engagement with the revalidation process.

The escalation process for ensuring timely appraisal has been reviewed by the appraisal and revalidation team and no changes to existing processes are necessary.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Mr John Jameson, who took over as RO from Dr Catherine Free in 2017, continued as RO for UHL.

Comments: None

Action for next year: Mr Jameson will continue as RO, supported by Dr Mushambi as Appraisal Lead and Ms Tracey Hammond as Medical Revalidation Support Manager and Ms Stacy Rowley as Medical Revalidation Administrator.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: Appraisal software has been changed from Premier IT's PReP product to the Strengthened Appraisal and Revalidation Database Joint Venture product (SARD JV) at the end of the last appraisal year which required a 2 week period during which transfer of data took place and therefore no appraisals were carried out in this period.

Comments: The data transfer from PReP to SARD is now complete and the new system is functioning well.

Action for next year: The next year will entail familiarisation of the new software and liaison with the SARD to enhance the system as necessary.

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

Action from last year: An accurate record of all licenced medical practitioners with a prescribed connection to UHL is always maintained using the electronic appraisal system. During 2018/19 the Trust dealt with 977 doctors with a prescribed connection to UHL.

Comments: A registered doctor has a duty to inform the GMC of their Designated Body. If a doctor modifies the GMC's record of his/her Designated Body, UHL's Revalidation Manager (Tracey Hammond) 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 (SARD).

At Trust level, the Trust's HR department informs UHL's Revalidation Manager of any new medical employees who are not in formal training posts (trainees are monitored by and revalidate through the Deanery who is their DB) in order that the same procedure can be followed to ensure that the GMC's records correctly reflect the doctor's new Designated Body.

Action for next year: Review the processes between UHL HR Department and the revalidation team to ensure timeliness of notifications.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: UHL's Medical Appraisal and Revalidation Policy, and its associated Guidance document was due for update in 2019.

Comments: UHL's Medical Appraisal and Revalidation Policy, and its associated Guidance document have been updated and are awaiting approval from the P&G committee.

Action for next year: Once these have been approved by the P&G committee the documents will be uploaded onto Insite. Next review date will be 2022 unless there are mandated changes in the interim.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: An audit took place in 2016 carried out by the Trust's Internal Auditors, PWC.

Comments: An audit by PWC took place in 2016, and as a result of the findings and feedback, we now have guidance or procedures notes on what the revalidation support manager does in case other staff are needed to cover her role, we use a revalidation check list to provide a clear audit trail regarding revalidation decisions and we now audit some output forms using a modified NHS England audit tool.

Action for next year: It is now three years since the last review, and consideration will be given to when this should be repeated.

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

Action from last year: Doctors with short term placements in UHL for who UHL is the Designated Body are identified as described above and are supported with an electronic appraisal account and a UHL appraiser. There are no formal arrangements in place at Trust level to support locum doctors and these doctors are supported by the relevant clinical teams and their locum agency, who is their DB.

Comments: The support provided for doctors for whom UHL is the DB is through the Revalidation support assistant (Ms Stacy Rowley), and seven senior appraisers (1 for each CMG). All new medical employees receive a short summary of UHL's medical appraisal and revalidation processes, including how to find more detailed information online (including revalidation guidance pages on UHL's intranet) and how to contact UHL's Revalidation Manager. Through the Trust grade programme we have also improved education (by giving talks at several meetings) regarding revalidation and appraisal to this group of UHL employees. A power point presentation introducing the functionality of the new SARD system has been sent to all new doctors at the time of setting up the appraisal account.

Action for next year: Deliver more lectures on appraisals to this group of doctors and recruit more appraisers to deal with this group. Doctors who work in UHL but from whom UHL is not the DB will continue to be supported at speciality level.

Section 2 – Effective Appraisal

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

Action from last year: All but two of the doctors for whom UHL is their DB have had an appraisal in the 2018/19 cycle and the 2 outstanding doctors have an appraisal planned. All appraisals are carried in accordance with the UHL appraisal guidelines and training.

Comments: 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 is checked by the appraiser and it is subject to audit as set out below.

To deliver the required formal colleague feedback and patient feedback in forms that comply with GMC requirements, UHL offers the system provided for that purpose by SARD, a GMC-compliant system. For doctors who do clinics, they have optional access to the feedback through 'Friends and Family' feedback process which can be used as informal annual patient feedback.

The provision of information on quality improvement, clinical audit, clinical incidents and outcome measures is the responsibility of the appraisee and is checked by the appraiser. Appraisers seek compliance with the guidance of the relevant Medical Royal College in addition to complying with GMC guidance.

The utility of outcome data in appraisal varies between specialties. In those specialties where outcome data is recommended by the relevant Royal College the expectation is that it will 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. Doctors are asked to provide a list of significant events and complaints that they were involved in as supporting evidence for their appraisals. Some hospitals in England (mostly these are smaller than UHL) provide a list of complaints and significant events that doctors were involved in to all doctors prior to their appraisal. UHL does not, at present, provide doctors with a list of their complaints prior to an appraisal. The current system relies on doctors declaring their complaints and significant events in their appraisal documents.

Doctor's record of statutory and mandatory training must be discussed at appraisal. Appraisers have instructed that any deficiencies should, as a 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 SARD system for appraisal, but a summary of training can be

downloaded or printed and provided as an item of supporting information for review.

Action for next year: Continue to provide well trained appraisers to carry out robust appraisals in UHL and explore how the Trust can provide additional information to inform appraisal, including re-exploring with the Patient Safety Team the feasibility of providing complaints and investigations data to appraisees or appraisers.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: The number of doctors not having an appraisal in the last appraisal year have been described above together with actions taken.

Comments:

Action for next year: To continue with the current process.

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

Action from last year: UHL's Medical Appraisal and Revalidation Policy, is due for update in 2019.

Comments: UHL's Medical Appraisal and Revalidation Policy has been updated and is awaiting approval from the P&G committee.

Action for next year: Once these have been approved by the P&G committee the documents will be uploaded onto Insite.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Currently, UHL has sufficient numbers of appraisers. UHL has 161 appraisers. With 977 doctors requiring appraisals, this gives a ratio of 6 doctors per appraiser.

Comments: The number of appraisals needed in UHL does present a significant challenge to the organisation. Recruitment of new appraisers is an on-going task and there has been a recent decline in people coming forward for the role. In November 2017, only 4 doctors attended training and two of these left the Trust shortly after training. More training was carried out in November 2018 at which 8 more doctors were trained as appraisers.

Action for next year: New appraiser training is planned for October 2019 and Clinical Directors have been asked to ensure they support the Revalidation team in ensuring each CMG has enough appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Medical appraiser top up training was carried out on two occasions in the last appraisal year (May and November 2018).

Comments: UHL has a robust process for ensuring the quality of medical appraisal. All appraisers are expected to attend top up training every 2-3 yrs. 44 appraisers attended in May 2018 and 48 in November 2018.

Action for next year: Top up training is planned for July, September and October 2019.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: 191 doctors were considered for revalidation last year. The revalidation checking process for each of these doctors involves the input and output forms being subject to quality assurance checks. Assuming that each doctor has two forms (input and output) a year, and most had done 5 years, this would mean that approximately 1,910 forms were checked in the revalidation checking process. All new appraisers' output forms have been checked using the ASPAT audit tool on two occasions. Firstly, when they carry out a mock appraisal as part of their training and secondly, following their first appraisal.

Comments: After each appraisal, the appraisee is automatically asked to complete a short questionnaire on the quality of the process. The Appraisal Feedback Report is then sent to each Appraiser who can then reflect on their performance.

The quality of individual appraisal portfolios is audited when a doctor's revalidation date approaches (i.e. every 5 years – see above). The doctor's appraisal portfolio is checked by UHL's Revalidation Manager and Revalidation and Appraisal Lead. 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. A number of common problems were identified, mainly around the level of detail of documentation and the appropriate use of the appraisal software. The latter has informed the subsequent content of top-up training for appraisers and has led to the Appraisal Lead giving personal feedback to some appraisers.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action for next year: Continue to carry out audit of appraisal forms using the ASPAT audit tool.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Number of recommendations falling due in 2018/19 - 191

Number of positive recommendations - 180

Number of recommendations for deferral - 11

Number of non-engagement notifications made at revalidation date - 0

Number of non-engagement reports made before revalidation date - 0

Comments:

A revalidation checklist is now used for checking doctor's supporting evidence for revalidation purposes. This gives a robust audit trail on how the revalidation checks were carried out. All revalidation recommendations were made on time in the last appraisal year

Action for next year: To continue with the current process. It should be noted that the number of revalidations due in the 2019/20 cycle is expected to be high (approximately 298) as this is now the second five year cycle of revalidation since the introduction of revalidation in 2012.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: See above.

Comments: Revalidation checks by the Revalidation team take place between one and two months prior to the revalidation due date. This gives the revalidation team enough time to identify any potential issues. Doctors are contacted in advance if any issues are identified to allow them time to rectify issues that can be rectified such as formal patient and colleague feedback or if a deferral is thought to be necessary. Any doctor being considered for a Rev6 form submission (early notification of non-engagement before a revalidation recommendation is necessary) is contacted directly by the Appraisal Lead and then by the RO as well as the case being discussed by the RO with the Trust's ELA.

Action for next year: Continue to carry out revalidation checks using the revalidation check list.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: UHL has a robust medical governance structure in place. There have been no major changes over the last year in the way medical governance is delivered. The UHL Trust's medical practitioner concerns policy was reviewed in October 2018 and changes were made to strengthen how concerns regarding agency locum practitioners are dealt with. Otherwise there were no major changes made and the policy is due for review in October 2021.

Comments: UHL manages all medical cases relating to conduct, capability and health in line with the national Maintaining High Professional Standards (MHPS) document. The Trust's "concerns policy" is the "The Conduct, Capability, Ill Health and Appeals Policy for Medical Practitioners", and is based on Maintaining High Professional Standards in the Modern NHS (MHPS). There is a Medical Conduct Committee, chaired by the MD (or RO in his absence) with HR, the Director of Medical Education, Occupational Health and Appraisal and Revalidation lead representation that considers all concerns arising in doctors practicing in UHL.

Action for next year: The Trust is benchmarking itself against the publication "Effective Governance for the Medical Profession" that was produced jointly at the end of 2018 by the GMC, CQC and other national bodies.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Comments: As an organisation we routinely monitor concerns raised through the sources stated below with triangulation through the MD, RO and Deputy Director of HR in order for us to act upon them:

Medical appraisal

Analysis of outcome data, as provided by Dr Foster / HED / Specialist societies

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

Feedback from education visits (HEEM, GMC)

Reports through the Freedom to Speak Up Guardian

Following up on concerns from any source

Action for next year: To continue with the above processes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: The Medical Conduct Committee meets monthly with representation as described above to consider all "live" cases, and to ensure that an appropriate approach is being taken.

Comments: UHL manages all medical cases relating to conduct, capability and health in line with the national Maintaining High Professional Standards (MHPS) document. The Trust's "concerns policy" is the "The Conduct, Capability, Ill Health and Appeals Policy for Medical Practitioners", and is based on MHPS.

The Medical Director and Responsible Officer meet on a 3 monthly basis with the Trust's GMC employment liaison advisor to discuss cases as appropriate, and review those cases relevant to the Trust which are currently subject to a GMC process. In addition, the RO meets on a 3 monthly basis with the Manager of the 2 local private hospitals and the Post Graduate Dean (RO for doctors in training).

A Remediation Policy has been developed, based on the National Clinical Advisory Service "Back on Track" guidance.

Action for next year: Continue with current processes.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year:

As stated above, the working group dealing with concerns about doctors is the Medical Conduct Committee. The annual ROs report (this report) is considered at the Executive Quality and Performance Board. In addition, in response to a letter to NHS Trust and NHS Foundation chairs and chief executives on 24th May 2019 regarding the suicide of a practitioner under investigation, the August meeting of the People and Culture committee will receive a report reviewing all case work activity carried out by the HR department.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

For the last appraisal year there were 35 new cases considered by the Medical Conduct Committee. Of these:

17 were Consultants

3 were Registrar/SpR

4 were Trust Grades

3 were Trust employed Specialty Trainees

3 were Core Trainees

4 were Foundation Doctors

1 was a GP

26 of these were closed within the year and 9 remain open

There were 2 MHPS investigations carried out leading to 1 being closed with informal action and 1 remains open.

There were 4 formal Bully and Harassment Investigations, 1 was resolved informally, 2 with warnings and 1 remains open.

2 cases related to heath issues

1 was a case of a doctor for whom UHL is not the DB and which is being dealt with by their DB.

The remainder of the cases were closed without formal action (26) or remain open (7) with no formal action as yet.

Currently UHL has no exclude doctors and 1 doctor who is working with UHL applied restrictions.

Comments: Concerns may present themselves through complaints, serious incidents or never events and DATIX reports. Information may be held by the quality and safety team, the medical directors office (Rosemarie Hughes, PA to the MD, supports the GMC work) and HR. Our existing record keeping is transitioning from being paper/"manual" electronic system to an "organised" electronic system (ER Tracker)

Action for next year: Embed the use of ER tracker to more easily monitor process and outcomes and to store documentation regarding concerns and to ensure that equality and diversity data are also recorded. Consider how this will link in to the Workforce Race Equality Standard report and the Workforce Disability Equality Standard report.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: The RO responded to requests from other organisations for information about doctors and responded to a number of GMC enquiries into doctors who had at some time, had been employed in or had worked in, UHL. The RO had 3 monthly meetings with the managers of the 2 local private hospitals and the Deputy Post-Graduate Dean during which cases of mutual interest are discussed.

Comments: Medical Practitioner Information Transfer forms are completed when doctors move from UHL to another designated body, on request from the new DB, and the requesting of information from previous organisations when doctors join UHL is part of the recruitment process.

Action for next year: Consider how to monitor transfer of information requests from and into UHL and to ensure the robustness of the processes.

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

Action from last year: All cases of concerns were considered by the MCC which is multidisciplinary and relies on the professionalism of senior members of staff involved.

Comments:

Action for next year: As described above.

Section 5 – Employment Checks

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

Action from last year:

Comments: 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

Compliance is further assured as defined within the UHL Recruitment and Selection Policy and Procedure (Trust reference B43/2009). This includes regular spot checks of candidate files/vacancies on TRAC (applicant tracking IT system) are carried out by Recruitment Officers. Additionally, a quarterly departmental audit is carried out by Resourcing Lead / Recruitment Manager. These checks are the responsibility of the Recruitment Team within the HR Directorate.

Action for next year: Consider how to robustly monitor the checks and ensure that these checks are also applied to doctors employed solely through the bank arrangements.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions**

  At the time of the AOA submission 97% of doctors in UHL had completed their 2018/19 appraisals and since then all but 2 outstanding appraisals have been completed

  The data compare well with our peer group

  The Trust has successfully changed its appraisal software from Premier IT to SARD

  The Appraisal and revalidation policy and guidelines have been updated

  The number of appraisers required remains a challenge but is sufficient at present

- **Actions still outstanding**

  Three sessions of appraisal top up training are planned for 2019.

- **Current Issues**

  Recruitment of more appraisers.

- **New Actions:**

  Consider another external review/audit.

Overall conclusion:

- UHL's completion rate of appraisals is above average compared to other DBs within the same sector and the Trust has a robust appraisal and revalidation process.

Section 7 – Statement of Compliance:

The Board of University Hospitals of Leicester has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

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

Role: _ _ _ _ _ _ _ _ _ _ _ _

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