

Medical appraisal and revalidation

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Trust Board 7th July 2016

Trust Board paper I

Executive Summary

Context

This annual report provides information to the Board on how UHL has fulfilled its statutory duties as Designated Body for medical practitioners employed by the Trust for the year 2015/16.

Questions

- 1) Is the Board in a position to approve the 'statement of compliance' confirming that UHL, as a Designated Body, is in compliance with the regulations?
- 2) Is the Board assured that appropriate systems and processes for appraisal and revalidation are in place, and that they are properly monitored?
- 3) Is the Board assured that existing systems are robust enough to identify concerns about individual doctors at the earliest opportunity and supportive of plans to strengthen these?

Conclusion

- 1) The Responsible Officer (RO) believes that UHL is in compliance with the regulations.
- 2) Revalidation is properly supported and resourced by the Trust. The RO monitors frequency and quality of appraisals: there are adequate numbers of trained appraisers and appropriate systems, including for patient input. The Trust now allocates appraisers.
- 3) There are effective systems in place for dealing with conduct and performance of doctors. The challenge for UHL now is to continue to strengthen the identification of risks or concerns about practitioners within the organization. This will require review of how information about concerns are recorded and retained and whether the links between all of our systems (DATIX, SI reports, complaints) are robust enough to identify concerns at the earliest opportunity. In the coming year a review of how we hold historical concerns about medical staff will be conducted and this is an area which may require investment.
- 4) 98% of doctors completed their appraisal for the year 2015/16. Each case of missed appraisal was considered individually by the Medical Conduct Committee and further action has been taken in 5 cases.

Input Sought

We would welcome the Trust Board's input regarding acceptance of the report, approval of the statement of compliance, and continued support for the executive in providing resource to ensure the Trust continues to meet its obligations as Designated Body.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Not applicable]
Consistently meeting national access standards	[Not applicable]
Integrated care in partnership with others	[Not applicable]
Enhanced delivery in research, innovation & ed'	[Not applicable]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Not applicable]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [No]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk ...			XX

Current Risk Rating is LOW

b. Board Assurance Framework [Yes /No /Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk ...		

3. Related **Patient and Public Involvement** actions taken, or to be taken:

Patient feedback forms part of evidence for revalidation, and the Trust has systems for obtaining feedback on individual doctors for consideration at appraisal.

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: One year (annual report). July 2017.

6. Executive Summaries should not exceed **1 page**. [My paper does comply]

7. Papers should not exceed **7 pages**. [My paper does not comply]

Medical Appraisal and Revalidation at UHL

Report for Trust Board on the appraisal year April 2015-March 2016

1. Purpose of the Paper

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations¹. NHS England 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 2015 to 31st March 2016, 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. Previous Annual Reports to Trust Board have set out how mechanisms were put in place to deliver the requirements of medical appraisal and revalidation within UHL. This report will only summarise existing appraisal and revalidation mechanisms. It will concentrate on describing events, changes and results in 2015-16. A copy of last year's report is available on request. Towards the end of 2015 the statutory role of Responsible Officer was passed from the Deputy Medical Director, Dr Peter Rabey, (following his departure from the Trust) to Professor Peter Furness as an interim arrangement prior to the appointment of substantive RO, Dr Catherine Free in April 2016. For a period, Professor Furness had two roles as RO and as The Appraisal and Revalidation Lead. Dr Mary Mushambi was

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'

appointed as Appraisal and Revalidation Lead in February 2016. Tracey Hammond continues as Revalidation Manager but in addition, a part-time assistant (Stacy Rowley) was appointed in February 2016 in order to address the high workload.

3. Governance Arrangements

Policy and Guidance

UHL's Medical Appraisal and Revalidation Policy, and its associated Guidance document, were approved in 2012. The latest changes implemented in 2015, are the allocation of appraisers to appraisees rather than being chosen by appraisees. This change was made principally because of concerns generated by our quality assurance processes, suggesting that some appraisals were being conducted as quick 'tick-box' exercises by appraisers whose aim was to help colleagues satisfy the demands of the Trust and the GMC rather than to conduct a thorough appraisal. We also wished to address excessive variation in the workloads of our trained appraisers.

Medical appraisal software

We have continued to use the 'PReP' online system from Premier IT for documentation of medical appraisals. Discussion with colleagues from other institutions leads us to believe that it remains one of the best systems available. The initial 3-year contract for its use expired in June 2015 and a further 3-year contract was negotiated without increase in price, at a rate considerably below the advertised cost.

Education role of doctors – The deadline for UHL accreditation with the GMC as a trainer is 31st July 2016 and any consultant, who supervises trainees or medical students in UHL, must be registered. The Trust needs to submit a list of names to the GMC. In order to capture this information on the PReP system, the section on educational role in the Appraisal form has been amended and we have requested Premier IT to be able to provide statistics of doctors with educational roles. At the same time, documentation of doctors who have an educational role has also been updated. There will be a requirement for doctors who have educational roles to provide supporting information related to their level of education role.

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 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 (PReP).

At the level of the Trust, 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). 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 (including a suite of revalidation guidance pages on UHL's intranet) and how to contact UHL's Revalidation Manager.

We have continued to have a small number of doctors where this three-level process does not work; usually in respect of non-consultant clinical academic doctors, specialty grade doctors or 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 (Trust grade doctors). 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 some such cases, to allow the doctor time to collect the necessary information to justify revalidation; but no doctor's revalidation has been jeopardised. Through the Trust grade programme we have also improved education regarding revalidation and appraisal to this group of UHL employees.

4. Medical Appraisal

Appraisal and Revalidation Performance Data

The system for reminding doctors about the need to organise an appraisal is set out in the Trust policy and guidance. In brief, each doctor is allocated an appraisal 'due by' 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.

For 2015/16 NHS England's definition of a late or missed appraisal (one that does not take place within 2 months of the appraisal due date) was not used due to the software. We defined a missed appraisal simply as one which did not occur within the appraisal year. NHS England's definition will be implemented for 2016/17.

	Number of prescribed connections	Completed appraisals (1a)	Completed appraisals (1b)	Approved incomplete or missed appraisals	Unapproved incomplete or missed appraisals	Total
Consultants	605	518	76	3	8	605
Staff grade, associate specialist, specialty doctor	75	68	6	1	0	75
Doctors on Performers Lists	0	0	0	0	0	0

Doctors with practicing privileges	0	0	0	0	0	0
Temporary or short-term contract holders	114	92	18	4	0	114
Other doctors with a prescribed connection to this designated body	0	0	0	0	0	0
Total	794	678	100	8	8	794

At the end of the appraisal year (31st March 2016) UHL was the Designated Body for 794 doctors (an increase from the 751 doctors described in last year's report). Of these, 678 completed an appraisal within the appraisal year and another 100 completed an appraisal slightly late.

16 doctors therefore did not complete an appraisal by May 2016. Of these 8 had justification for missing an appraisal that was known in advance (usually maternity leave or long term sick leave).

All of these missed appraisals have been analysed.

Action on missed appraisals

There are very varied circumstances which lead doctors to miss appraisals. There is a broad spectrum, from sound justification (such as prolonged sick leave) to complete and unjustifiable disengagement with the process. For this reason, it was agreed that the circumstances of each doctor who missed an appraisal would be considered at a meeting of the Medical Conduct Committee, with a view to deciding what sanctions, if any, would be appropriate in each case.

A meeting on 25th May 2016 considered the circumstances of 9 doctors, with the benefit of notes on each compiled by Ms Hammond, Dr Mushambi and Dr Free. The doctors concerned had previously been contacted, with a warning that they had missed an appraisal, an explanation of the process set out in the Trust policy, and an invitation to provide any mitigating circumstances. Responses to these invitations were included in the consideration. The outcome of the meeting was:

- In 4 cases it was decided that the circumstances did not justify further action.

- In 5 cases it was decided that further action was justified.

Further action in these 5 cases consisted of a letter to each informing them that:

- Pay progression for 2015-16 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 refuse to support any application for a national Clinical Excellence Award
- If an appraisal was not delivered within three months, disciplinary action would be initiated
- Their situation would be discussed with the local representative of the GMC, who would consider whether the GMC wishes to take action for failure to engage with the revalidation process
- They should inform any other employers (including the management of private sector hospitals) that this notification and warning had been received.

Quality Assurance of Appraisals

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. Free text comments are invited, but in practice are rarely delivered. A Medical Appraisal Feedback Report is sent to each Appraiser once a year, around May time.

The quality of individual appraisal portfolios is audited when a doctor's revalidation date approaches (i.e. every 5 years). The doctor's appraisal portfolio is checked by UHL's 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 and any concerns are referred to the Appraisal & Revalidation Lead. This process covered 42% of UHL's appraisals for 2015/16.

A number of common problems were identified, 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, discussed below.

As a result of issues identified in this way, Professor Furness and Dr Mushambi had confidential conversations with several appraisers about problems of variable severity. Regrettably, some appraisers resigned rather than agreeing to improve performance.

In several cases there was concern that the appraiser was delivering a short, 'tick-box' appraisal, merely with the intention of satisfying the GMC's requirements for revalidation. This was often evident from extremely brief or inconsistent documentation. 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 below.

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

Allocation of appraisers to appraisees

From April 2015, appraisers were allocated. A small number of appraisers resigned as a result of this change. Furthermore, the renewed focus on job planning has unfortunately led to some appraisers resigning as that role has not been supported by the service as part of the job planning process. The medical director has written to all CMG directors and heads of operation to remind them that appraisal and revalidation are statutory requirements and that these roles must be supported by the organisation.

Appraiser training

For various reasons, there has been a loss of a number of UHL's trained appraisers. As a result of appraiser allocation most appraisers have on average 7 – 8 appraisees. This is well within national guidance (the recommended maximum is 10). However, the change to appraiser allocation has made it more obvious that some specialties have an insufficient number of trained appraisers. The relevant HOS have been contacted with an invitation to identify colleagues in the specialty who might wish to undergo appraiser training.

The in-house full appraiser training course, developed in 2012-13, was run again in November 2015 and February 2016, training 33 new appraisers. Feedback from participants was collected at the end of the course and was almost entirely positive. To ensure that a sufficient number of trained appraisers is maintained we plan to run this course again in the winter of 2016.

In addition, 'top-up training' sessions for approved appraisers were run in December 2015 and January 2016. Attendance registers have been kept; similar sessions will be delivered in 2016-17 and it is anticipated that attendance at, at least one top-up session every 2 years will be made mandatory by the end of 2016.

Administrative support for medical appraisal

Previous Annual Reports have complimented the performance of our Medical Revalidation Manager, Tracey Hammond. Because of the increased workload a part-time assistant, Stacy Rowley, was appointed in February 2016.

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 appraiser 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 in forms that comply with GMC requirements, UHL offers the system provided for that purpose by Edgecumbe, a GMC-compliant 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 2015/16	338
Number of positive recommendations	292
Number of deferral requests	46
Number of non-engagement notifications made at revalidation date	0
Number of non-engagement reports made before revalidation date	0

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

In 2015-16, 2 external audits were undertaken: “A 360 degree assurance review of pre-employment checks” (NHS Counter Fraud, March 2015) and “Recruitment: Review of compliance with tier 2 and tier 5 NHS immigration requirements” (PWC, October 2015). A small number of weaknesses and examples of the Trust’s processes not being followed were identified in relation to some of the files reviewed. The actions raised have been completed and including the establishment of robust audit and monitoring processes 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.

Counter-Fraud has rated us “green” on our 2015/16 Self-Review Tool submission to NHS Protect in relation to the following standard:

“The organisation ensures that all new staff are subject to the appropriate level of pre-employment checks, as recommended by NHS Employers, before commencing employment within the organisation. Assurance is sought from any employment agencies used that the staff they provide have been subject to adequate vetting checks, in line with guidance from NHS Protect and NHS Employers”.

For further information follow the link <http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards>[http://www.nhsemployers.org/your-workforce/recruit/employment-check-standards](http://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 / 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
- Following up on concerns from any source

As an organisation we routinely monitor concerns raised through these sources and the board needs to assure itself that concerns about a practitioner arising from these areas

would be triangulated in order for us to act upon them. This is discussed in more detail under risks and issues.

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's "concerns policy" is the "The Conduct, Capability, Ill Health and Appeals Policy for Medical Practitioners", and is based on MHPS.

The Medical Conduct Committee meets monthly with representation from the Medical Director, Responsible Officer, Director of Human Resources, and Occupational Health, to consider all "live" cases, and to ensure that an appropriate approach is being taken.

The Medical Director and Responsible Officer meet regularly with the GMC's employment liaison officer to discuss cases as appropriate with the GMC, and review those cases relevant to the Trust which are currently subject to a GMC process.

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

9. Risk and Issues

Appraisal quality. Our methods for monitoring appraisal quality are described above. There is more that could be done here to strengthen our processes and this year the focus will be on appointing senior appraisers (one for each CMG) in order to lead on and deliver quality assurance of appraisal forms (minimum of 10% - circa 80 appraisal output forms per year, chosen at random).

Inadequate numbers of appraisers. We have sufficient appraisers at present, but have lost some this year often related to retirement, resignation and also as a result of job planning when doctors were attempting to reduce their SPA activity to satisfy job planning. We are aware that we cannot force doctors to act as appraisers and we find that any criticism of the performance of an appraiser tends to result in resignation rather than improvement. Hence there is a risk of having insufficient numbers, if more resignations occur, to be able to discharge the statutory duties of the Responsible Officer.

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. 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.

Identifying concerns

Having a split role (where the Responsible Officer is separate from the medical director) has benefits and challenges. Information regarding concerns may be flagged to either party or both. Both the Medical Director and the Responsible Officer are required to share information regarding concerns about practitioners with one another. This is helped by joint attendance at medical conduct meetings, meetings with the GMC employment liaison advisor and meetings with local independent providers (Spire Hospital). 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. The risk is that given the diversity of places information can be held or reported in a large organisation such as UHL and without an agreed central mechanism for holding information on concerns, concerns may be identified too late or not at all. Further work is required to review whether our existing record keeping is fit for purpose and whether there is a way of holding concerns in a more robust computerised system so that both the medical director and Responsible officer can access the required information (including historical concerns). This may require investment although the extent is not yet clear. As part of the annual cycle of audits conducted for the Trust by Price Waterhouse Cooper, we have asked them to independently review our processes in this regard.

10. Corrective Actions, Improvement Plan and Next Steps

We have implemented action on missed appraisals and changed to a system of appraiser allocation, as discussed above. Plans for 2016/17 include:

- Continue the programme of training for new appraisers and updates for existing appraisers, making it mandatory that appraisers attend an update session by the end of 2016-17.
- 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
- 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
- Audit the Trust's performance in respect of revalidation and acting on concerns (PWC – Sept 2016)
- Review how information is stored and shared between the key parties (Medical Director, Responsible Officer, HR, Director of Safety & Risk, CMGs)

11. Recommendations

- To accept this report (noting that it will be shared, along with the annual audit, with the higher level Responsible Officer)

- To approve the 'statement of compliance' confirming that UHL, as a designated body, is in compliance with the regulations.
- To continue to provide support for funding as reasonably justified and agreed by the Executive to allow UHL to discharge its responsibilities as a Designated Body.



NHS England INFORMATION READER BOX

Directorate

Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

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/executive management team of University Hospitals of Leicester NHS Trust 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;

Dr Rabey handed over the role of Responsible Officer to Professor Peter Furness who was then the interim Responsible Officer from November 2015 until the appointment of substantive Responsible Officer, Dr Catherine Free on 1st April 2016. Dr Free has undergone the Responsible Officer training and is part of the Regional Responsible Officers' Network.

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

The record of all licenced medical practitioners is maintained via GMC Connect with support from the revalidation office; it is accessible to the Responsible Officer and to the Medical Director; and it is updated on a regular basis.

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

The Trust has sufficient numbers of appraisers. Most appraisers have been allocated between 7 and 9 appraisees. This is within national guidance (recommended maximum = 10).

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);

Top up training is mandatory for appraisers and includes training and development as required. Regular audits of appraisal outputs are undertaken, and quality issues discussed with individuals as indicated.

5. All licensed medical practitioners¹ 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;

Of the 794 doctors with a prescribed connection to UHL, all but 9 have now completed their 2015/16 appraisal. There is full understanding of outstanding

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

appraisals and appropriate further action taken, including discussion with the GMC Employment Liaison Advisor.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners¹, 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;

UHL has such systems, and information is available to appraisers via the PreP appraisal system that UHL uses.

7. There is a process established for responding to concerns about any licensed medical practitioners¹ fitness to practise;

The Trust has appropriate policies, based on Maintaining High Professional Standards in the NHS. The 'Concerns Policy' is called the 'Conduct, Capability, Ill Health, and Appeals Policy for Medical Practitioners'. The Trust also has an appropriate Disciplinary Policy.

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;

Arriving or leaving medical staff are transferred with a Responsible Officer Transfer Form, giving this information.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners² have qualifications and experience appropriate to the work performed; and

UHL Recruitment Services conduct appropriate checks on all posts in the organisation. A dedicated team for medical doctors exists.

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

Although compliant with the regulations, UHL continues to seek improvement. It is planning to adopt the NHS England definition of missed appraisals; one that does not take place within 2 months of the appraisal due date. This will be implemented for 2016/17.

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

Signed on behalf of the designated body

Name: _____

Signed: _____

[chief executive or chairman a board member (or executive if no board exists)]

Date: _____