Airedale NHS
NHS Foundation Trust

Report to:	Board of Directors				
Date of Meeting:	24 September 2014				
Report Title:	Annual Revalidation Report				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X					X
Prepared by:	Dr Harold Hosker, Revalidation Officer				
Executive Sponsor (presenting):	Mr Karl Mainprize, Medical Director				
Appendices (list if applicable):	Appendix 1: Annual Revalidation Report Appendix 2: Statement of Compliance				

Purpose of the Report

As a designated body (DB), the Trust is required to provide NHS England with an annual revalidation report which is approved by the Board of Directors. The content of the report is laid down by NHS England and should cover all aspects of the appraisal and revalidation process.

This report provides an overview of the Trust's recruitment, performance, revalidation and appraisal processes in relation to medical staff working at the Trust; summarises the activities undertaken during the 12 months ending 31st March 2014 and provides further details of the instances where there was a deviation from the expected process. It covers all the aspects of appraisal and revalidation as laid down by NHS England.

Airedale NHS Foundation Trust is the Designated Body for approximately 150 doctors who have a "prescribed connection" with the Trust; the Trusts' Responsible Officer ('RO'), Dr Harold Hosker, is required to make a revalidation recommendation to the General Medical Council ('GMC') about each doctor once every 5 years.

The cornerstone upon which the RO's recommendation is made is the doctor's annual appraisal; it is therefore critical that the appraisal process itself is robust and fit for purpose. During the period April 2013 – March 2014, 158 doctors were expected to undertake an appraisal of which 137 (87%) were completed compared with 67% over the previous period; this improvement is a direct result of the actions plans described in the last report to the Trust Board in November 2013.

The governance arrangements to oversee the appraisal process include appropriate policies and guidance; discrete decision making groups to monitor and implement policies and guidance; an adequate number of trained appraisers; a series of measures to provide quality assurance of the appraisal process; IT systems to facilitate the appraisal process with appropriate access, security and confidentiality safeguards; clinical governance data to ensure that appraisals cover the entirety of a doctor's practice and include relevant data in accordance with national best practice.

The RO has made 39 revalidation recommendations to the GMC during the period with no deferrals or non-engagement notifications.

The Trust has comprehensive recruitment and engagement background checks in place that confirm with NHS Employers recommendations such that there is a high level of confidence that previous concerns about a doctor (whether employed substantively, on a temporary contract, as a locum or as a trainee) would be identified prior to commencement at the Trust. In the 12 month period covered by this report, background checks were undertaken by or on behalf of the Trust on 462 doctors (excluding trainees) prior to their recruitment / engagement.

The Trust has established policies and procedures for monitoring and managing on a case by case basis those doctors who have given cause for concern relating to their conduct, capability or ill health. During

2013/14, 19 doctors were reviewed with the concerns categorised as High, Medium or Low level in 4, 5 and 10 instances respectively.

The Trust does have a remediation policy although as of March 2014 there were no doctors being formally managed under the policy

A number of low-medium level risks have been identified with mitigations and action plans to address those areas of weakness

Overall, at present it is considered that there are adequate resources available to undertake this important work.

Recommendations

The Trust Board is asked to:

(i) Accept this report (noting that it will be shared with the RO for NHS England);
(ii) To continue to support the work of the RO and APO Unit in implementing a robust appraisal process at the Trust and endorse the action plan to ensuring that timely revalidation recommendations continue to be made for all doctors linked to the Trust;
(iii) To approve the 'Statement of Compliance' confirming that the Trust, as a designated body, is in compliance with the regulations; and
(iv) Delegate authority to the Chairman and Chief Executive to sign the Statement on behalf of the Trust.

Airedale NHS
NHS Foundation Trust

Medical Staff Appraisal and Revalidation

1. Executive summary

This report provides an overview of the Trust's recruitment, performance, revalidation and appraisal processes in relation to medical staff working at the Trust; summarises the activities undertaken during the 12 months ending 31st March 2014 and provides further details of the instances where there was a deviation from the expected process.

Airedale NHS Foundation Trust is the Designated Body for approximately 150 doctors who have a "prescribed connection" with the Trust; the Trusts' Responsible Officer (RO), Dr Harold Hosker, is required to make a revalidation recommendation to the General Medical Council (GMC) about each doctor once every 5 years.

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The Trust does have a remediation policy although as of March 2014 there were no doctors being formally managed under the policy

A number of low-medium level risks have been identified with mitigations and action plans to address those areas of weakness

Overall, at present it is considered that there are adequate resources available to undertake this important work.

2. Purpose of the Paper

This report seeks to update the Trust Board and provide assurance that:

- The appraisal and revalidation processes for of established medical staff are robust and fit for purpose.
- The appropriate background checks are completed prior to a doctor being employed by the Trust whether that employment is on a substantive, temporary, locum or trainee basis.
- Robust processes are in place for monitoring the performance of all doctors.
- Robust processes are in place for responding to concerns and providing remediation where the need arises.

A copy of this report including the reflections of the Board (minutes from the Board meeting cf section 11) must be sent to NHS England to provide assurance that an annual report has been submitted and considered by the Board. NHS England has taken over this responsibility from the Revalidation Support Team (RST) which has now been disestablished.

3. Background

This is the third formal report to the Trust Board on this topic; previous reports were presented in September 2012 and November 2013.

The November 2013 report provided assurance that:

- The Trust had been rated as “green” for all quarterly submissions to the RST
- That all doctors who were planned to have been revalidated prior to the end of December 2013 (and who are still connected to Airedale) had been recommended for revalidation by the RO and approved by the GMC
- Whilst the overall percentage of doctors receiving an annual appraisal (67%) was giving some cause for concern; steps had been taken to address this issue with further monitoring planned to ensure compliance.

The national guidance now recommends that an annual report should be presented to the Trust Board based on the activities taking place in the preceding financial year. This report therefore covers the period April 2013 to March 2014 and follows the template previously recommended by the RST.

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

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

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

Ultimate responsibility for revalidation nationally is a duty of the GMC as the regulatory body. This duty is discharged through NHS England (who are responsible for issuing the national strategy, policy and relevant guidelines) and through the network of ROs.

Every doctor practicing throughout the UK must be revalidated every 5 years; this revalidation decision by the GMC will be based on the recommendation of the RO with whom the doctor is linked through a "prescribed connection". The RO has only three options when making a recommendation to the GMC:

1. Revalidation
2. Deferral – this can be for a variety of reasons e.g. maternity leave or sabbatical which would prevent adequate data being available to inform a robust appraisal – this should not be seen as a failure or unsuitable for revalidation
3. Failure to engage – this would only be considered after providing the doctor with adequate opportunities to provide evidence to support their revalidation and to fully engage with the appraisal process

It should be noted that any performance concerns about a doctor should be raised and dealt with via a separate process; any doctor currently in a GMC performance process will automatically be deferred by the GMC removing the responsibility from the RO.

Whilst responsibility for making a recommendation to the GMC about a doctor's suitability for revalidation rests with the RO, the process is dependent upon a robust "enhanced" appraisal process. At Airedale NHS Foundation Trust the RO is supported by the work of the Appraisal, Performance & Outcomes (APO) Unit, the Appraisal Strategy & Operational Groups and the work of appraisers.

The APO Strategy Group meets quarterly; the Group:

- Sets the strategy for revalidation within the Trust

[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'

- Ensures that appropriate systems, policies and guidance are in place and are being adhered to
- Ensures that there are adequate trained appraisers
- Monitors the completion of appraisals and revalidation recommendations against the plan
- Ensures that the Organisational Readiness Self-Assessment (ORSA) reports are completed accurately and submitted to the RST in a timely way

The APO Operational Group meets monthly; the Group:

- Ensures that the list of prescribed connections with the Trust is accurate and up to date
- Ensures that the systems and processes supporting appraisals and revalidation are working effectively
- Monitors, at an individual doctor level, compliance with the appraisal dates taking remedial action where necessary
- Acts as a confidential decision making group to support the RO to make a decision about a revalidation recommendation.

At the beginning of 2014/15 the capacity and robustness of the APO Unit has been improved by the appointment of Dr Gary Reah as an Associate Medical Director (AMD) with responsibility for medical staff appraisal.

a. Policy and Guidance

During 2013/14 additional guidance was published to all established medical staff clarifying the requirements:

- When an appraisal has been missed or undertaken late for whatever reason.
- The requirements for providing appraisal information when a doctor also undertakes work at another organisation whether NHS or private

Since April 2014, the Trust 'Medical Staff Appraisal Policy' has been reviewed and redrafted. The policy is currently going through the consultation and appropriate governance processes.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

During the period April 2013 – March 2014, the appraisal completeness statistics were as follows:

April 2013 – March 2014	Consultants	SAS Drs	Temporary or short term contract	Total
Number of doctors due an appraisal in the period	108	29	21	158
Number of completed appraisals	99	28	10	137
Number of doctors in remediation & disciplinary processes	1			1

Where an appraisal did not take place within the expected timeframe, an audit of the reasons is shown in Appendix A.

b. Appraisers

The Trust currently has approximately 30 appraisers who have undertaken accredited enhanced appraisal training. Appraisers have been assigned to one of 3 groups each with a senior appraiser. Appraisal Support Group meetings are held twice yearly to ensure that all appraisers are kept updated of any new developments / requirements and to provide an internal appraiser network

In response to a number of experienced appraisers leaving the Trust recently (close to the end of the financial year), it will be necessary to recruit and train additional appraisers during 2014/15. New appraiser training is usually undertaken by an external training organisation that delivers training to the standards previously set by the RST.

c. Quality Assurance

The cornerstone upon which the RO's recommendation to the GMC is made is the doctor's annual appraisal; it is therefore critical that the appraisal process itself is robust and fit for purpose. The quality assurance framework of appraisals includes the following checks:

For the appraisal portfolio the RO (or AMD for medical staff appraisal) follow a checklist to provide assurance that:

- All relevant appraisal inputs, including Trust information (see section 5e) and pre-appraisal declarations were available at the time of the appraisal
- All relevant appraisal outputs i.e. PDP, appraisal summary and sign-off documentation has been completed following the appraisal
- The appraisal documentation makes reference to any specific areas identified pre-appraisal as requiring discussion during the appraisal

Further information is contained in the Medical Staff Appraisal Policy

For the individual appraiser, the following quality assurance processes are followed:

- An appraiser is expected to include reflections on their role as an appraiser as part of their own appraisal process including their own continuing professional development as an appraiser
- The APO Unit maintains a record (and circulates notes) of the bi-annual Appraisal Support Group meetings

- As part of the appraisal documentation, the doctor being appraised has the opportunity to "rate" the appraiser and provide comments – this anonymous and aggregated information is shared with the appraiser for their own appraisal
- The RO (or AMD for medical staff appraisal) provide a score rating and feedback to the appraiser based on the appraisal documentation after each appraisal

For the organisation, the quality assurance of the overall appraisal process is as follows:

- Audit and monitoring of appraisal timelines by individual doctor (including MSF planning)
- Feedback from appraisers and the individual doctor about the systems and processes employed within the Trust relating to medical staff appraisal
- All complaints involving a doctor are reviewed by the RO or AMD and, where appropriate, included in the appraisal information for the named doctor(s) so that any lessons can be learnt
- Doctors were expected to include within their own appraisal portfolio details of any serious incidents and /or Root Cause Analysis investigations they have been involved with so that any lessons can be learnt. This was perceived to be an area of potential weakness within the appraisal process; as part of the action plan all SI, RCA, legal cases and coroner's reports involving a named doctor will, from April 2014, be reviewed by the RO or AMD and, where appropriate, included in the appraisal information for the named doctor(s).

Further information is contained in the Medical Staff Appraisal Policy

It was decided that for the first cycle of revalidation that all RST appraisal forms would be reviewed by the RO or AMD to assure the quality and continuing improvement of appraisals prior to being signed off. During the period in question all but one appraisal was regarded as acceptable in the domains listed in Appendix B, and signed off. One appraisal was judged unacceptable and an action plan agreed with the doctor followed by a further appraisal.

Areas of weakness in appraisals which require further action short of stating the appraisal unacceptable are conveyed to individual doctors (and their appraisers) in writing (usually via email) with necessary actions listed to be completed and discussed at the next appraisal. This includes additions to the proposed PDP where further actions are deemed necessary. A record of these communications is kept securely in the APO unit for inclusion in the following year's appraisal portfolio to ensure they are dealt with.

Appendix B provides further data on the recommended metrics for quality assurance audit of appraisal inputs and outputs. This appendix has not been completed (but left for information) since all appraisals are reviewed against the checklist in the way described; sample auditing is not therefore required.

d. Access, security and confidentiality

The Trust has developed an "in-house" secure electronic system to facilitate the sharing of appropriate information between the APO Unit administrative team, the RO, the appraiser and doctor being appraised. Access to the appraisal system is protected by password; there have been no reported breaches of staff confidentiality to date arising from the appraisal process.

All staff are reminded of the requirement to remove any patient identifiable data from appraisal portfolios; there have been no reported breaches of patient confidentiality to date arising from the appraisal process.

Any confidentiality breaches would be managed in accordance with the Trust's existing Information Governance Policy.

e. Clinical Governance

In addition to the data an individual doctor contributes to their appraisal, the Trust provides the following information whenever it is relevant for the doctor concerned:

- Activity Profile
- Theatre statistics
- Complaints
- Teaching Evaluations
- MDT attendance record
- Study Leave (when supported by the Trust by time and /or funding)
- Absence record
- Clinical Outcomes & Benchmarking Report
- Internal CPD
- Mandatory Training record
- Multi Source Feedback (every 5 years)
    - Colleague 360 questionnaire
    - Patient questionnaire
- Independent Sector / Other NHS organisation declaration (where the doctors undertakes work for other organisations)
- Peer Appraisal & Appraisal Quality Assurance feedback

6. Revalidation Recommendations

During the period April 2013 – March 2014, the Revalidation recommendation statistics were as follows:

April 2013 – March 2014	Consultants	SAS Drs	Temporary or short term contract	Total
Number of recommendations	31	7	1	39
Recommendations completed on time	31	7	1	39
Positive recommendations	31	7	1	39
Deferrals requests	0	0	0	0
Non engagement notifications	0	0	0	0

Where a revalidation recommendation did not take place within the expected timeframe, an audit of the reasons is shown in Appendix C.

7. Recruitment and engagement background checks

Airedale NHS Foundation Trust complies with the NHS Employment Check Standards as issued by NHS Employers which applies to all applications for NHS Employment. This includes permanent staff, FTC staff, temp workers (i.e. locums, those on our Trust bank and workers supplied by agency).

The standards include:

- Identity Checks
- Right to Work
- Professional Registration and Qualification Checks
- Employment History and Reference Checks (minimum ref from Clinical Director and Responsible Officer)
- DBS Checks
- Work Health Assessment

The HR and Workforce Department ensure that all relevant checks are completed to meet the requirements of the above standards for staff that are recruited within the Trust including members who join any of the staff banks that are in place. In response to recent changes in the law, all medical staff are subjected to written and oral language checks as part of the recruitment exercise.

HB Retinue provide a managed service to the Trust for locums brought in through locum agencies and ensure that all candidates have the relevant checks in place which are conducted by the agency themselves. HB Retinue provide each locum with an induction pack which includes a locum departmental checklist and an exit report. At present, these checklists are not logged in a way that can be easily retrieved at an aggregated level so, although the information is provided, providing robust evidence about how many locums receive a comprehensive induction or how many exit reports are completed is not currently possible. This gap in assurance is included in the action plan.

Within a month of individuals commencing members of the Medical Directors Unit and the HR Business Partner – Revalidation Lead ensure that the background check information in Appendix E is completed where applicable.

Doctors employed by other organisation who attend the Trust in a visiting capacity have their main employer as their designated body and appropriate checks remain the responsibility of the RO for their main employing organisation.

Trainee doctors on placement at the Trust have the Health Education England (Deanery) as their designated body and appropriate checks remain the responsibility of the Deanery RO.

Appendix E provides an audit of the pre-employment and background checks undertaken by the Trust during 2013/14

8. Monitoring Performance

For individual performance concerns, the Trust has a decision making group (DMG) chaired by the Medical Director which meets monthly to review any concerns related to conduct, capability or ill health of individual doctors and take appropriate action. The DMG also includes the RO, Head of HR, the HR Business Partner linked to the APO unit and the Assistant Director. There are terms of reference, a log of concerns and a RAG rating of concerns which is used to determine which concerns should be escalated to the Trust's CEO (via a monthly private meeting after EDG) and where appropriate to the Trust Board. When necessary, cases are also discussed with NCAS and / or the GMC via the Employer Liaison Advisor (ELA).

The Medical Director and RO hold quarterly, minuted meetings with the GMC's ELA as required by the GMC to discuss individual performance concerns and any cases under investigation by the GMC. The actions of any doctors named in 'Never Events' are also reviewed in accordance with GMC guidance.

ROs are expected to communicate with their counterparts in other designated bodies when a concern has been raised about a doctor who practices in more than one designated body or who has moved to another employer.

Productivity or other operational issues relating to individual doctors remains the responsibility of the Clinical Director / General Manager for the specialty in which they are employed.

9. Responding to Concerns and Remediation

The Remediation policy was introduced to provide a clear framework to be able to address issues of remediation which may arise in relation to poor performance or the inability to maintain the required level of performance required to perform within a role, which may be as a result of a short fall in competency, skill, knowledge or understanding.

The Trust is responsible for setting measurable, realistic and achievable standards of performance and behaviour for medical and dental practitioners and has a responsibility to ensure that employees understand what is expected of them within their role. This will include identifying areas of poor performance and managing these issues in a supportive and consistent way.

As of March 2014, there were no medical or dental practitioners being managed formally under the policy.

10. Risk and Issues

The principal areas of risk addressed in section 12 are:

1. Insufficient and easily reportable evidence that that a robust induction and exit report have been completed for locum doctors.

2. As described in section 5c, the potential for serious incidents to be omitted from an individual doctor's appraisal such that the lessons are not learnt by the individual and the organisation and ultimately that the RO's revalidation recommendation is based on incomplete data

3. The unavoidable reliance on individuals and therefore the need to ensure on-going continuity and / or successions plans exist for a range of staff including:
   - Responsible Officer
   - Appraisers
   - APO Administrative Staff including HR Business Partner
   - IT System Developer

11. Board / Executive Team Reflections

[Minutes from Trust Board Meeting September 2014]

12. Corrective Actions, Improvement Plan and Next Steps

Appendix F provides details of proposed action plans

13. Recommendations

The Trust Board is asked to accept this report (noting that it will be shared with the RO for NHS England).

To continue to support the work of the RO and APO Unit in implementing a robust appraisal process at the Trust and endorse the action plan to ensuring that timely revalidation recommendations continue to be made for all doctors linked to the Trust.

To approve a 'statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations.

Dr Harold Hosker MD FRCP
Deputy Medical Director and Responsible Officer

Audit of all missed or incomplete appraisals audit

Doctor factors	
Maternity leave during the majority of the 'appraisal due window'	2
Sickness absence during the majority of the 'appraisal due window'	
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	
New starter within 3 month of appraisal due date	
New starter more than 3 months from appraisal due date	15
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	
Lack of time of doctor	3
Lack of engagement of doctor	
Other doctor factors	
(describe)	
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	
Other appraiser factors (describe)	
(describe)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	
Insufficient numbers of trained appraisers	
Other organisational factors (describe)	
Overall Total	**21**

Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		137
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	Number audited	Number acceptable
Scope of work: Has a full scope of practice been described?	Number	Number
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	Number	Number
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	Number	Number
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes/No	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	Number	Number
Review of complaints: Have all complaints been included?	Number	Number
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	Number	Number
Is there sufficient supporting information from all the doctor's roles and places of work?	Number	Number
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	Number	Number
Appraisal Outputs		
Appraisal Summary	Number	Number
Appraiser Statements	Number	Number
PDP	Number	Number

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2013 to 31 March 2014	
Recommendations completed on time (within the GMC recommendation window)	39
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**39**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	
New starter/new prescribed connection established within 2 weeks of revalidation due date	
New starter/new prescribed connection established more than 2 weeks from revalidation due date	
Unaware the doctor had a prescribed connection	
Unaware of the doctor's revalidation due date	
Administrative error	
Responsible officer error	
Inadequate resources or support for the responsible officer role	
Other	
Describe other	
TOTAL [sum of (late) + (missed)]	**0**

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	4	5	10	19
Capability concerns (as the primary category) in the last 12 months	1	2	3	6
Conduct concerns (as the primary category) in the last 12 months	2	3	5	10
Health concerns (as the primary category) in the last 12 months	1	0	2	3
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2014 who have undergone formal remediation between 1 April 2013 and 31 March 2014 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				0

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All DBs	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	 1
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	2
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	2
For investigation	2
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	7
Temporary employed doctors	14 (FTC and NHS locums all on ESR and with Airedale as designated body)
Locums brought in to the designated body through a locum agency	396
Locums brought in to the designated body through 'Staff Bank' arrangements	32
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	13 (these are doctors on honorary contracts)
TOTAL	**462**

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)																
	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	BDS	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	7	7	7	7	7	7	7	7	7	7	7	7	7	7	?	7
Temporary employed doctors	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Locums brought in to the designated body through a locum agency	396	396	396	396	396	396	396	396	396	396	396	396	396	396	396	396
Locums brought in to the designated body through 'Staff Bank' arrangements	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)	13	13				13						13				
Total (these cells will sum automatically)	462	462 100%	449 97%	449 97%	449 97%	462 100%	449 97%	449 97%	449 97%	449 97%	449 97%	462 100%	449 97%	449 97%	449 97%	449 97%

Use of locum doctors:

Explanatory note: Number of locum sessions used (days) – this is the aggregated number of days for the duration of locum assignment and not the number of days worked i.e. if a locum is assigned to the Trust from 1st – 30th June this is shown as 30 days; no allowance made for days not worked.

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

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	61.75	514	844	439	1,797
Medicine	78.07	1,524	-	1,461	2,985
Psychiatry		-	-	-	-
Obstetrics/Gynaecology	22.54	238	-	117	355
Accident and Emergency	19.27	101	-	1,240	1,341
Anaesthetics	31.70	427	4	346	777
Radiology	11.45	116	-	-	116
Pathology	4.00	-	-	-	-
Paediatrics	17.70	89	-	42	131
Other	7.31	-	-	-	-
Total in designated body (This includes all doctors not just those with a prescribed connection)	**253.79**	**3,009**	**848**	**3,645**	**7,502**

Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	**Total**	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	**2,867**	2,867	n/a	n/a	
3 days to one week	**77**	77	n/a	n/a	
1 week to 1 month	**20**	20	n/a	n/a	1
1-3 months	**12**	12	n/a	n/a	
3-6 months	**5**	5	n/a	n/a	1
6-12 months	**3**	3	n/a	n/a	1
More than 12 months	**4**	4	n/a	n/a	
Total	**2,988**	**2,988**	n/a	n/a	**3**

Action Plan

Risk	Risk Rating Likelihood x Impact	Action Plan	Mitigations	Target Timescales	Status
Lack of evidence that locum doctors receive a comprehensive departmental induction and that an exit report is completed	2 x 3 = 6	• Work with HB Retinue to ensure evidence is available • Review Induction arrangements in light of evidence	• Procedures do exist for providing locums with departmental induction checklist and exit report	Oct 2014	In-progress
Serious Incident data is omitted from appraisals	2 x 3 = 6	• Copies of SI and RCA data to be sent to RO for inclusion in appraisal data • RO to check appraisal documentation for evidence of discussion having taken place	n/a	Oct 2014	Completed Aug 2014
Reliance on key individuals.	2 x 2 = 4	• Succession plans for key posts • Identify opportunities to provide cross cover with other departments	• Reciprocal RO cover with neighbouring Trust • Appointment of AMD for Medical Appraisal (May 2014)	Dec 2015	In-progress
Appraisal policy is out of date and does not meet national guidance should an issue arise	1 x 2 = 2	• Appraisal policy to be revised and approved by the Trust Board to take into account current national standards and local circumstances	• Previous policy still largely appropriate	Sept 2014	Completed (subject to Trust Board approval)

Department of Health

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014

THE NHS CONSTITUTION
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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 of Airedale NHS Foundation 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;

   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;

   Comments:

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

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 licenced 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 (or executive if no board exists)]

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

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