

## Medical Revalidation Annual Report

**Public Board**  
**25 September 2025**

<b>Presented for:</b>	Approval/Information
<b>Presented by:</b>	Dr Elizabeth Garthwaite Deputy Chief Medical Officer Medical Director - Professional Standards, Medical Workforce and Responsible Officer
<b>Author:</b>	Karen Johnson, Assistant Workforce Manager Elizabeth Garthwaite
<b>Previous Committees:</b>	Revalidation Appraisal Steering Group
<b>Our Annual Commitments for 2025/26 are:</b>	
Recognise and act upon moments that matter to our patients	✓
Support our patients to get home a day sooner	
Be in the top 25% for patient experience and efficiency in outpatients	✓
Support each other to act with kindness and compassion	✓
Reduce our carbon footprint by creating greener patient pathways	
Support our staff to manage every £ wisely	
Make best use of our estate, equipment and digital assets	

<b>Risk Appetite Framework</b>				
<b>Level 1 Risk</b>	<b>(ü)</b>	<b>Level 2 Risks</b>	<b>(Risk Appetite Scale)</b>	<b>Impact</b>
Workforce Risk	ü	Workforce Performance Risk - We will deliver safe and effective patient care through having the right systems and processes in place to manage performance of our workforce.	Cautious	Moving Towards
		Legal & Governance Risk - We will operate the Trust in compliance with the Law and UK Corporate Governance Code, where applicable.	Averse	Moving Towards

<b>Key points</b>	
1. To note the progress, compliance with national policy and legal requirements and our improvement plan	Information
2. Approve the Board assurance statement relevant to this report	Approval

## **1. Summary**

This is the Trust Responsible Officer's annual report covering the 2024/25 appraisal year. This report is a required item of assurance, and the assurance statement we are required to submit to NHSE.

## **2. Background**

The General Medical Council's (GMC) aims for medical revalidation are that it:

- is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.
- supports doctors in their professional development, contributes to improving patient safety and quality of care, and sustains and improves public confidence in the medical profession.
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors.

To achieve these aims, the GMC requires that all doctors identify the Designated Body (usually their employer) that monitors and assures their practice. Leeds Teaching Hospitals NHS Trust (LTHT) is a Designated Body for 1609 doctors.

Revalidation is overseen in England by NHSE through annual audits.

## **3. Proposal**

The Medical Revalidation Responsible Officer Report describes the process for to assure compliance with the mandatory requirements for appraisal, to enable recommendations to be made for revalidation for all doctors who have a prescribed connection with Leeds Teaching Hospitals NHS Trust.

## **4. Financial Implications**

There are no financial implications associated with this proposal.

## **5. Risk**

The Workforce Committee provides assurance oversight of the Trust's most significant risks, which cover the Level 1 risk categories (see summary on front sheet). Following discussion at the Workforce Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories and the Trust continues to operate within the risk appetite for the Level 1 risk categories set by the Board.

## **6. Communication and Involvement**

The work supporting this proposal has involved stakeholder (representing consultant and locally employed doctors) alongside staff side representatives.

## **7. Equality Analysis**

An Equality Impact Assessment was completed as part of the renewal of the revalidation policy in 2022. It now includes reasons for deferrals. Similarly, data is collected surrounding processes to support at risk doctors.

## **8. Improving Health Equity**

There is no impact on Health Equity

## **9. Publication Under Freedom of Information Act**

This paper is available under the Freedom of Information Act.

## **10. Recommendation**

The Board are provided with assurance set out in the annual report that the Trust has continued to maintain good progress to compliance of medical appraisal and revalidation which is set out in more detail with the annual report and supporting data

## **11. Supporting Information**

The following papers make up this report:

Medical Revalidation Responsible Officers Report is presented in Appendix 1

Annual Board report and statement of compliance is presented in Appendix 2.

**Dr Elizabeth Garthwaite**

**Deputy CMO and Responsible Officer for**

**Leeds Teaching Hospitals NHS Trust, St Gemma's Hospice & Martin House Hospice**

## APPENDIX 1

### Medical Revalidation Responsible Officer Report

#### 1. SUMMARY

In the appraisal year 2024/25, LTHT was the Designated Body for 1736 doctors. The Designated Body is the organisation that a licenced doctor has a professional, educational or employment connection with that provides them with support for revalidation.

Of these 1736 doctors, 120 doctors were new starters to the Trust whose start date was after September and who were not required to undertake an appraisal. An additional 37 doctors were unable to complete an appraisal due to mitigating circumstances. Of the remaining 1579 doctors, 1497 (95%) successfully completed their appraisal. LTHT also provided appraisal support for 65 dentists from the Leeds Dental Institute.

The number of doctors continues to rise and in the 2024-25 cycle, we welcomed 228 new starters to the Trust of whom 64 were consultants, 22 were specialty and specialist grade doctors (SAS), 28 Bank Doctors, and 114 other non-training grade doctors.

The focus for 2024/25 has included:

- Moving to appraisers being assigned by doctors themselves instead of the admin team
- Recruiting a new Medical Appraisal Lead – Dr Shelagh Turvill
- Refreshment of training provided for new appraisers with a return to face to face training.
- Embedding the processes to support the appraisal of Physician Associate and Anaesthetic Associate colleagues

We continue to promote a streamlined approach to appraisal, which meets the requirements for revalidation but that is also focussed on health and wellbeing. The appraisal platform (SARD) incorporated questions around health and wellbeing into the updated appraisal form which was completed in time for 1<sup>st</sup> April 2023 appraisal cycle. This is now fully used and further enhances the ability for the appraisal to support the wellbeing of our medical staff and provide rich data to inform the Trust health and wellbeing strategies.

The new Good Medical Practice domains are now fully embedded in the appraisal form on SARD

We have continued to work closely with CSUs to support the development of a sustainable number of appraisers – to enable full delivery of appraisals within job planned activities.

A positive recommendation for revalidation is a consequence of a review of the evidence required by the Responsible Officer, supported by a Revalidation Panel. If doctors have insufficient evidence for the Responsible Officer to make a positive recommendation for revalidation, their recommendation may be deferred for between 4 and 12 months. Deferral rates remain, around 17% which is comparable to our peer organisations. This has increased from previous years, and work is ongoing to support early engagement with appraisal and revalidation systems to enable this.

	<u>2020-21</u>	<u>2021-22</u>	<u>2022-23</u>	<u>2023-2024</u>	<u>2024-2025</u>
<b>Total revalidation recommendations</b>	48	516	205	<b>266</b>	<b>377</b>
<b>Positive Recommendations</b>	47	400	153	<b>221</b>	<b>311</b>
<b>Deferrals</b>	1	115	52	<b>45</b>	<b>66</b>
<b>Non-Engagement</b>	0	1	0	<b>0</b>	<b>0</b>

## 2. BACKGROUND

Designated Bodies have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations, and it is expected that 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 the required standards.

## 3. GOVERNANCE ARRANGEMENTS

At LTHT, management of a high-quality system for revalidation is overseen by the Revalidation and Appraisal Steering Group. A working group and a CSU Lead Appraiser group contribute to this overview. The Steering Group is co-chaired by the Chief Medical Officer (CMO) and Responsible Officer, and its membership includes the Medical Appraisal Lead, clinical leaders, representatives from the professional development and medical workforce teams as well as 'front-line' clinicians who have volunteered to help the group with its work. The Group reports to the Board through this annual report.

## 4. MEDICAL APPRAISAL DATA

### Appraisal Figures at time of the completion of the audit

	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>2024-25</b>
<b>Total Completed (% of doctors requiring appraisal)</b>	1105 (70%)	1345 (93%)	1476 (98%)	1508 (98.6%)	1579 (95%)
<b>No appraisal unapproved missed</b>	467	53	28	20	82
<b>Mitigating circumstances approved missed</b>	18	42	33	39	37
<b>New starters not requiring an appraisal</b>	-	122	79	42	120

In the appraisal year 2024/25, LTHT was the Designated Body for 1736 doctors. Of these, 120 doctors were new starters to the Trust whose start date was after September and who were not required to undertake an appraisal. An additional 37 doctors were unable to complete an appraisal due to mitigating circumstances. Of the remaining 1579 doctors, 1497 (95%) successfully completed their appraisal.

There were 82 unapproved missed appraisals, where doctors did not complete the appraisal process on time. (39 consultants 10 SAS doctors, 9 Bank doctors, 24 locally employed non training grade doctors). Since the audit, 61 have now completed their appraisal, with the remaining seven are in progress and two are not engaging, all others have left. Meaning that at the time of writing 99% of all doctors have completed their appraisal.

Extensive support is given to doctors who are slow to engage with the appraisal process. Non-engagement is often an indication of other challenges, and approaching these individuals with compassion and curiosity has enabled well received interventions. This support is provided by the appraisal administrative team, the medical appraisal leads, the clinical leadership teams in the relevant CSUs and the Responsible Officer, as appropriate.

## **Appraisers**

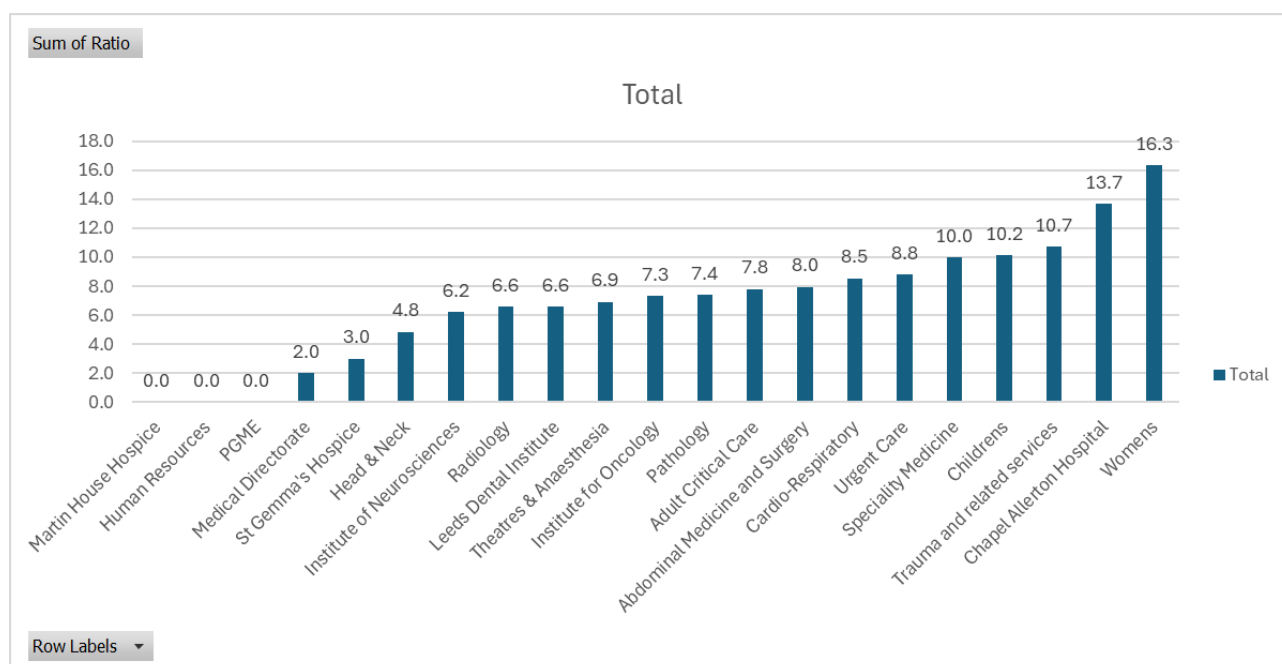
There are currently 218 medical appraisers in LTHT an increase of 11 since last year. All are required to attend two update workshops every three years to maintain their knowledge and skills. Appraiser attendance at these sessions is monitored and individuals who do not attend enough are contacted with dates of future sessions.

We appointed a new Medical Appraisal Lead this year and we have used this opportunity to review and refresh our appraiser training. The new appraiser training is now face to face and is in receipt of very positive feedback. These will be run six monthly.

The refresher training programme is currently being reviewed. These sessions will be shorter and run remotely. Last year five appraisal update sessions were run using a remote format. Feedback from these sessions was good with excellent interaction and contributions from the attendees.

The current number of appraisers matches the demand for appraisals. However, every year experienced appraisers will step down – often citing workload pressures, or the need to take on alternative activities. We are working with CSUs to ensure a pipeline supply of appraisers undertaking training – so that the number of appraisers for each CSU matches the demand.

Each appraiser is allocated 0.25 PA of time to deliver up to 10 appraisals within their job plan. We provide CSU level appraiser data which has highlighted the areas where more appraisers are required (see figure below) and enabled us to have proactive conversations.



Most appraisers appraise doctors within their own department, and whilst this trend does continue, by ensuring the appropriate numbers of appraisers in each CSU, we hope to be able to fairly challenge this. Appraising outside the CSU brings additional perspective and cognitive diversity to the process and feedback from appraisers and appraisees has been consistently positive.

Appraisee feedback on our appraisers is offered on completion of the appraisal. Appraisers can request their individual responses on request from the administration team.

## New Starters

All new doctors are sent a welcome email with information for appraisal and revalidation. Since the 2024/25 cycle, new starter training has been pre-recorded and is available on YouTube. The link to this is available on our Padlet information board and is sent as part of the welcome email. New starters are also invited to attend a Q&A session run by the appraisal admin team, where there is an opportunity to ask questions about the system and processes. New starter training is launched from training interface so that we can track attendance.

We are currently refreshing this training and hope to relaunch this in 2026

To obtain relevant history, doctors are asked to complete a new starter form which asks for details of previous appraisals, feedback exercises, disciplinary action, GMC investigations and restrictions in clinical activity. Additional significant details are also available from Transfer of Information forms which are completed by Responsible Officers in other organisations. HEE (Health Education England) no longer provide these forms automatically, but they inform us directly if there are any concerns.

An information sheet is sent out to individuals and CSUs for local induction and to encourage better engagement with the non-training doctors.

## Strengthening CSU responsibilities

We continue to work with the CSUs by providing them with monthly real time data on numbers of completed and incomplete appraisals, and they are contacted regularly to clarify issues with specific doctors.

CSU Leads for Appraisal are asked for assistance selecting appraisers for colleagues, asked about local issues and to provide support where doctors are late completing their appraisal. They are asked to attend our lead appraiser meetings and are required to quality assure a proportion of appraisals every year using the standardised Appraisal Summary and PDP Audit Tool (ASPAT Tool), which is a national standard tool for quality assuring appraisal.

## Quality Assurance

NHSE requires organisations to quality assure the appraisal process. At LTHT this is done in several ways. Firstly, all appraisers are trained and regularly updated. Update sessions are an opportunity to show examples of good and poor appraisals for discussion. In addition, appraisal documentation is reviewed at monthly revalidation panels and if there are issues with appraisal quality, then appraisers are contacted, issues discussed, and support provided. Finally, the ASPAT (Appraisal Summary and PDP Audit Tool) is used to review up to 20% of all appraisal documentation. In addition, we use this tool to review the first three appraisals undertaken by every newly trained appraiser.

Total ASPATs Completed 2023-2024 cycle	Scored over 40 (out of maximum 50)	Scored between 30 and 40	Scored lower than 30
193	116 - 60%	55 - 28%	22 - 11%

Where appraisal summaries are found to be of inadequate quality (i.e. scores less than 30), the appraisers are contacted for a discussion and signposting to the next available appraiser update session. Our next audit is due in October 2025

## Clinical Governance

Assurance and performance in this area are reported elsewhere, overseen by the Chief Medical Officer (CMO). Key aspects of clinical governance for the Responsible Officer at LTHT is the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems. Detailed discussions with the informatics team have identified the potential and the barriers to the provision of this information and work is on-going.



## 5. MEDICAL REVALIDATION

### Revalidation Recommendations

The Chief Medical Officer, Responsible Officer, Medical Appraisal Lead and HR representative attend monthly revalidation panels. This group assesses doctors who are 'under notice' (i.e. within 12 months of revalidation) to assess whether they have sufficient evidence to be recommended for revalidation. Where they have sufficient evidence, a positive recommendation is made to the GMC.

In the 2024/25 appraisal year, LTHT made 311 positive recommendations. If the doctor lacks sufficient evidence and needs more time to collect that evidence, then their recommendation may be deferred. In 2024/25 there were 66 deferrals, representing 17% of total recommendations which is comparable to previous years.

On rare occasions, doctors do not engage with the appraisal process despite multiple interventions from the appraisal and departmental teams. In these cases, a non-engagement notification (called a REV6) is made to the GMC. During the 2024/25 appraisal year, no REV6 notifications were made.

The recommendations to the GMC are made online via GMC connect.

### Policy and guidance

Revalidation policy has been reviewed and is awaiting final approval by the staff side representatives.

[LTHT Consultant & SAS Doctor Information](#)

[Medical Revalidation](#)

[Medical Appraisals](#)

## 6. RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

All doctors employed by LTHT are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors. In April 2014, a new category of fitness to practise impairment 'not having the necessary knowledge of English' was introduced by the GMC, requiring Trusts to ensure that doctors have sufficient knowledge of the English language necessary for their work to be performed in a safe and competent manner. The pre-employment checks carried out on all doctors provide this assurance at LTHT.

## 7. MONITORING PERFORMANCE

The approach taken in LTHT is to use existing routine systems to monitor the fitness to practise of all doctors. This includes:

- Mortality and morbidity reviews
- Clinical governance forums and meetings in specialties
- Participation in national and local audits
- Quality Improvement Activity
- Whistleblowing systems
- Never Events

Clinical Directors hold responsibility for identifying and managing concerns about all aspects of all performance escalating them where it is felt that they may pose a risk to patient safety or represent a deviation from standards set by the GMC.

## 8. RESPONDING TO CONCERNS AND REMEDIATION

The Trust's approach to identifying and responding to concerns is covered by the Principles for Responding to Concerns and the Guidance and Principles for Remediation.

### Doctors at Risk

The table below contains data regarding the numbers of doctors at risk during 2023-24, who required formal action by the GMC, or by the Trust internally, where there was an outcome other than "case closed with no further action".

**Doctors at Risk - Categorisation and Level of Concern**

	Low	Medium	High	Totals
Conduct	13	4	2	19
Capability	2	2	1	5
Health	1	3	1	5
Totals	16	9	4	29

Doctors at risk, where investigations by the GMC or the Trust are in progress, are supported by the Responsible Officer team, with use of trust and external resource as required.

### Doctors in training

Doctors in training have their RO (Responsible Officer) at the Health Education Yorkshire and Humber Deanery (HEYH). The process for providing HEYH with reports has been agreed with them and implemented.

## 9. RISKS AND ISSUES

There are no risks or issues that need to be escalated for the Board's attention.

## 10. ACTIONS/FOCUS FOR 2025/2026

- Drive high appraisal completion rates by embedding standard work.
- Secure sufficient appraiser capacity – with agreed resource allocation
- Continue to develop processes for information transfer into appraisal system to enhance assurance around quality, safety and governance.
- Empower CSUs to support appraisal and revalidation processes

## **11.RECOMMENDATIONS**

Board Members are asked to:

- Note the assurance provided on medical appraisal and revalidation
- Note the continued progress being made in this area
- Confirm commitment to supporting the progress of this work

**Dr Elizabeth Garthwaite**

**Deputy Chief Medical Officer, Medical Director (Professional Standards & Workforce Development) and**

**Responsible Officer for Leeds Teaching Hospitals NHS Trust, St Gemma's Hospice & Martin House Hospice**

**September 2025**

## APPENDIX 2

### Designated Body Annual Board Report and Statement of Compliance

#### Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to reply yes/no.

#### 1A – General

The board/executive management team of Leeds Teaching Hospitals NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a Responsible Officer.

Action from last year:	Dr Garthwaite is engaged in ongoing RO training, networking, and development. There are other members of the medical directorate team who have undertaken training – ensuring resilience within the organisation.
Comments:	Dr Elizabeth Garthwaite was appointed in 2024 to replace Dr Hamish McLure
Action for next year:	

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	To continue to support the role within the organisation
Comments:	The RO is appointed and is given dedicated time and support to deliver the role.
Action for next year:	The RO Advisory Group is under review – to ensure appropriate representation.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	The contract with SARD is due for renewal – a tender review exercise will be undertaken.
Comments:	There is an automated process to ensure those practitioners with a prescribed connection with LTHT are held in our revalidation register which links to the Trust Appraisal System, SARD. All doctors with a prescribed connection are linked into SARD for the process of appraisal and revalidation. This enables all doctors and dentist access to an electronic system in which to undertake their annual appraisal. The system produces detailed reports to help with tracking appraisals and removed the necessity for complicated excel spread sheets.
Action for next year:	

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	None
Comments:	Revalidation policy is currently being updated
Action for next year:	

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	None
Comments:	<p>A peer review was undertaken with Sheffield THFT on 12<sup>th</sup> January 2024. It was agreed by both parties that LTHT had robust processes in place and Sheffield want to mirror some of our processes including sharing instruction films, implementation of an appraisal declaration form (lead clinician form) and utilising QR technology for patient feedback.</p> <p>The RO attends the regional network events – and peer to peer support with reflection and review of practice with a view to continuous improvement occurs.</p>
Action for next year:	To consider further peer review process

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Continue to improve these processes
Comments:	<p>All locums and short-term doctors are included in our usual welcome email which summarises, what they need to do, how to get access and use the appraisal system, who they need to ask for help and gives them details of training sessions they need to attend, together with links to useful information and guides. An information sheet is sent out to individuals and CSUs (Corporate Service Unit) for local induction and to encourage better engagement with the non-training doctors. All new starters are enrolled into our appraisal and revalidation systems.</p>
Action for next year	Develop standard operating procedure for all short and long term locums starting in the Trust to provide assurance of the processes described and enable confirmation of duties and levels of competence with supervising consultant prior to starting work.

## 1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC (General Medical Council) licence to practise, 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:	Continue to embed robust processes to ensure compliance with annual appraisal programme.
Comments:	<p>The Appraisal Declaration Form is a mandatory document, signed by the Lead Clinician or Clinical Director, which is included in the appraisal input form. This documents any quality indicators for discussions including serious incidents, or adverse events.</p> <p>Within the appraisal output form is a mandatory discussion regarding this, and any other governance concerns shared with the appraiser.</p> <p>In the appraisal year 2024/25, LTHT was the Designated Body for 1736 doctors. The Designated Body is the organisation that a licenced doctor has a professional, educational or employment connection with that provides them with support for revalidation.</p> <p>Of these 1736 doctors, 120 doctors were new starters to the Trust whose start date was after September and who were not required to undertake an appraisal. An additional 37 doctors were unable to complete an appraisal due to mitigating circumstances. Of the remaining 1579 doctors, 1497 (95%) successfully completed their appraisal.</p> <p>LTHT also provided appraisal support for 65 dentists from the Leeds Dental Institute.</p> <p>The number of doctors continues to rise and in 2024-25 cycle, we welcomed 228 new starters to the Trust of which 64 were consultants, 22 were Specialty and Specialist grade doctors (SAS) 28 Bank Doctors, and 114 other non-training grade doctors.</p>
Action for next year:	

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	NA
Comments:	NA
Action for next year:	NA

1B(iii) 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:	None
Comments:	There is a trust appraisal policy owned by Human Resources, approved by the Trust Board
Action for next year:	None



1B(iv) Our organisation has the necessary number of trained appraisers<sup>1</sup> to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Continue to work closely with CSUs to ensure appropriate appraiser numbers to support those requiring appraisal.
Comments:	<p>There are currently 218 medical appraisers in LTHT, an increase of 11 since last year. Each appraiser is allocated 0.25 PA of time to deliver 10 appraisals within their job plan.</p> <p>We provide CSU level appraiser data which has highlighted the areas to enable service units to understand the appraisal requirements and ensure sufficient appraisers are in role to support this, and there is prospective recruitment of appraisers to enable sustainable numbers to be in post and enable those taking on other roles or wishing to relinquish the roles to do so.</p> <p>Appraisee feedback on our appraisers is offered on completion of the appraisal. Appraisers can request their individual responses on request from the administration team.</p>
Action for next year:	To align CSU appraiser numbers with requirements to ensure fair distribution of resources.

1B(v) 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](#) or equivalent).

Action from last year:	None
Comments:	<p>All appraisers are required to attend two update workshops every three years to maintain their knowledge and skills. Appraiser attendance at these sessions is monitored and individuals who do not attend enough are contacted with dates of future sessions. We appointed a new Medical Appraisal Lead this year and we have used this opportunity to review and refresh our appraiser training. The New appraiser training is now face to face and we ran the first one in August 2025 and was well received. We intend to run</p>

<sup>1</sup> While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	these twice a year. The refresher training is being reviewed and we intend to run the next one in October 2025, this will be undertaken remotely. LTHT ran 5 appraisal update sessions using a remote format in 2024/25. Feedback from these sessions was good with excellent interaction and contributions from the attendees.
Action for next year:	None

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None								
Comments:	<p>At LTHT this is done in several ways. Firstly, all appraisers are trained and regularly updated. Update sessions are an opportunity to show examples of good and poor appraisals for discussion. In addition, appraisal documentation is reviewed at monthly revalidation panels and if there are issues with appraisal quality, then appraisers are contacted, issues discussed, and support provided. Finally, the ASPAT (Appraisal Summary and PDP (personal development) Audit Tool) is used to review up to 20% of all appraisal documentation. In addition, we use this tool to review the first three appraisals undertaken by every newly trained appraiser.</p> <table><tr><td>Total ASPATs Completed</td><td>Scored over 40 (out of maximum 50)</td><td>Scored between 30 and 40</td><td>Scored lower than 30</td></tr><tr><td>193</td><td>116 - 60%</td><td>55 - 28%</td><td>22 - 11%</td></tr></table> <p>Where appraisal summaries are found to be of inadequate quality (i.e. scores less than 30), the appraisers are contacted for a discussion and signposting to the next available appraiser update session.</p>	Total ASPATs Completed	Scored over 40 (out of maximum 50)	Scored between 30 and 40	Scored lower than 30	193	116 - 60%	55 - 28%	22 - 11%
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193	116 - 60%	55 - 28%	22 - 11%						
Action for next year:	None								

## 1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None																														
Comments	<p>The Chief Medical Officer, Responsible Officer, Medical Appraisal Lead and HR representative attend monthly revalidation panels. This group assesses doctors who are ‘under notice’ (i.e. within 12 months of revalidation) to assess whether they have sufficient evidence to be recommended for revalidation. Where they have sufficient evidence, a positive recommendation is made to the GMC.</p> <p>In the 2024-25 appraisal year, LTHT made 221 positive recommendations.</p> <p>If the doctor lacks sufficient evidence and needs more time to collect that evidence, then their recommendation may be deferred. In 2022/23 there were 45 deferrals, a reduction of 8 from the previous year.</p> <p>On rare occasions, doctors do not engage with the appraisal process despite multiple interventions from the appraisal and departmental teams. In these cases, a non-engagement notification (called a REV6) is made to the GMC. During the 2023/24 appraisal year, no REV6 notifications were made.</p> <p>The recommendations to the GMC are made online via GMC connect.</p> <table><tr><th></th><th><u>2020-21</u></th><th><u>2021-22</u></th><th><u>2022-23</u></th><th><u>2023-24</u></th><th><u>2024-25</u></th></tr><tr><td><b>Total revalidation recommendations</b></td><td>48</td><td>516</td><td>205</td><td>266</td><td>377</td></tr><tr><td><b>Positive recommendations</b></td><td>47</td><td>400</td><td>153</td><td>221</td><td>311</td></tr><tr><td><b>Deferrals</b></td><td>1</td><td>115</td><td>52</td><td>45</td><td>68</td></tr><tr><td><b>Non-Engagement</b></td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td></tr></table>		<u>2020-21</u>	<u>2021-22</u>	<u>2022-23</u>	<u>2023-24</u>	<u>2024-25</u>	<b>Total revalidation recommendations</b>	48	516	205	266	377	<b>Positive recommendations</b>	47	400	153	221	311	<b>Deferrals</b>	1	115	52	45	68	<b>Non-Engagement</b>	0	1	0	0	0
	<u>2020-21</u>	<u>2021-22</u>	<u>2022-23</u>	<u>2023-24</u>	<u>2024-25</u>																										
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Action for next year:	To communicate proactively with individuals where engagement has been reduced.																														

1C(ii) 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, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Continue to improve deferral rates
Comments:	<p>Doctors are given written notice of their revalidation, 12 months before the date.</p> <p>We hold a monthly revalidation panel to review all doctors who are due to revalidate within 4 months.</p> <p>The doctors are advised after this of our decision and the GMC is updated at this point, where the decisions are a positive recommendation or a deferral.</p> <p>The recommendations for all other doctors are made as soon as their information has been gathered which is monitored monthly and support given where needed.</p> <p>The exceptions to this are where we are chasing doctors for missing information i.e. feedback and this is taking longer than normal to collect. For these doctors we ensure a recommendation is made at least 2 weeks before the revalidation due date.</p> <p>To reduce the delay in MSF (Multi Source Feedback) collection, completion of 360 feedback we recommend this be started in year 3 of the revalidation cycle to further reduce our deferral rate.</p>
Action for next year:	To work with CSU teams to enhance engagement with a view to reducing deferrals due to delays in completing appraisals.

## Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Pursue the process to enable data from NCIP and other approved reporting systems to feed into the appraisal process.
Comments:	<p>Assurance and performance in this area are reported elsewhere, overseen by the Chief Medical Officer (CMO).</p> <p>Key aspects of clinical governance for the Responsible Officer at LTHT is the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems.</p> <p>Detailed discussions with the informatics team have identified the potential and the barriers to the provision of this information and work is on-going.</p>
Action for next year:	Explore alternatives to sourcing NCIP data as this resource is no longer available

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	We will develop processes for collating this information with Trust governance systems and ensure these feeds consistently into appraisal and revalidation processed
Comments:	<p>The approach taken in LTHT is to use existing routine systems to monitor the fitness to practise of all doctors This includes:</p> <ul style="list-style-type: none"> <li>• Mortality and morbidity reviews</li> <li>• Clinical governance forums and meetings in specialties</li> <li>• Participation in national and local audits</li> <li>• Quality Improvement Activity</li> <li>• Freedom to Speak Up Systems</li> <li>• Learning from never events and serious incident reviews as well as PSIRF reports.</li> </ul>

	Clinical Directors hold responsibility for identifying and managing concerns about all aspects of all performance escalating them where it is felt that they may pose a risk to patient safety or represent a deviation from standards set by the GMC.
Action for next year:	

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	To continue this work
Comments:	Information for appraisal is readily available but from varying sources. We are analysing methods which would allow automated data collection to feed into the SARD appraisal system.
Action for next year:	

1D(iv) There is a process established for responding to concerns about a medical practitioner's 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:	We will continue to follow our agreed policies and procedures
Comments:	The Trust's approach to identifying and responding to concerns is covered by the policy, Principles for Responding to Concerns and the Guidance and Principles for Remediation
Action for next year:	We will continue to follow our agreed policies and procedures

1D(v) 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 and country of primary medical qualification.

Action from last year:	To review the composition of the senior team membership – including potential lay representative
Comments:	Responsibility for this is delegated to the RO, via a ‘Senior Team’ – comprised of the CMO, Director of Medical Education, Director of Human Resources, with HR support. Data is collected with routine review of EDI and protected characteristics.
Action for next year:	To produce agreed Terms of Reference including composition of the ROAG.

1D(vi) 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 our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Continue to monitor compliance
Comments:	<p>External requests for information are subject to initial review by the appraisal and revalidation administration team, and the relevant Clinical Director is contacted for information about involvement in incidents, complaints, and investigations. The request is reviewed by the RO (Responsible Officer) before signature and release.</p> <p>The RO contacts the relevant RO with any concerns over practice that may impact on that organisation</p> <p>For doctors connected elsewhere, including doctors in training, initial contact and exchange of relevant information is arranged as needed.</p> <p>Transfer of Information Requests are no longer provided as routine – trainees entering the organisation are now being</p>

	requested to provide the last ARCP outcome form for assurance purposes
Action for next year:	Continue to monitor compliance

1D(vii) 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:	None
Comments:	All processes for responding to concerns are managed according to our Trust Policy (Disciplinary and Capability Procedures for Medical and Dental Staff) which is consistent with MHPS. We have trained Case Investigators and Case Managers to ensure appropriate processes. Issues around potential bias and discrimination are considered by our Senior Team before any formal process is commenced.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	To continue to embed robust processes to allow updates and changes to be incorporated
Comments:	There is a dedicated appraisal and revalidation team supported by the RO and HR team. Through the appraisal and revalidation steering group but also through weekly embedded 'standard work' of team members, developments and opportunities are discussed, shared and used to inform policies and procedures.



	<p>The RO meetings quarterly with the ELA from the GMC who updates on local and regional concerns.</p> <p>Examples include</p> <ol style="list-style-type: none"> <li>1. Guidance regarding the use of MAPs – Leng Review</li> <li>2. Change in format of GMP domains</li> <li>3. Response to the Lucy Letby Case – and reporting and speaking up/sharing concerns</li> <li>4. Regulatory reports (CQC)</li> <li>5. RO attends quarterly RO training sessions</li> </ol>
Action for next year:	

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	Continue to promote clinical leadership development – ambition to develop clinical leadership training.
Comments:	Within LTHT there is a culture of shared and collaborative leadership – CSUs are clinically led with a Clinical Director, Head of Nursing and General Manager. Work continues to develop structure and consistency in leadership development; promotion of collaborative behaviours; and a greater commitment, backed by tangible action, to promoting equality, diversity and inclusion in leadership roles.
Action for next year:	

## 1E – Employment Checks

1E(i) 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:	We will continue to monitor compliance
Comments:	<p>All doctors employed by LTHT are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors.</p> <p>In April 2014, a new category of fitness to practise impairment 'not having the necessary knowledge of English' was introduced by the GMC, requiring Trusts to ensure that doctors have sufficient knowledge of the English language necessary for their work to be performed in a safe and competent manner. The pre-employment checks carried out on all doctors provide this assurance at LTHT.</p>
Action for next year:	We will continue to monitor compliance.

## 1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	To continue this work
Comments:	<p>The Trust promotes leadership – the vision and standards are underpinned by the Leeds Way Values (Patient Centred, Fair, Accountable, Collaborative, Empowered). The 7 commitments – are an annually agreed set of targets – with shared responsibility to ensure with organisation is the best</p>

	<p>for specialist and integrated care and that LTHT can meet the healthcare needs of those we serve.</p> <p>These commitments, which are reviewed as part of standard work underpinning all agenda items are</p> <p>Leadership is devolved to the CSUs, where a triumvirate of medical, nursing and manager are accountable for the delivery of clinical services and report directly to the executive.</p>
Action for next year:	

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	We will continue to work to improve working lives for all staff groups.
Comments:	<p>There is a culture of inclusion; diversity is celebrated. Staffs of all groups are encouraged and empowered to speak up. There is a well-advertised freedom to speak up process which is well used.</p> <p>Underpinning all activities are the Leeds Way Values.</p>
Action for next year:	

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistle-blowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Local reporting structures enable this to be measured – and this will be reviewed – with the intention of supporting the culture of speaking up amongst medical teams, who, historically, have been low user professionals of this service
Comments:	There is a freedom to speak up policy within LTHT which is actively promoted. We are committed to make strides towards our goal of being the best place to work. We will promote an open culture with a “You say, We listen” approach, act on Staff Survey feedback, and act on our strengthened Freedom to Speak Up Governance Structures.
Action for next year:	.

1F(iv) Mechanisms exist that support feedback about the organisation’ professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	6. We will continue to engage with our medical workforce – listening to respond and share
Comments:	There is a formal complaints procedure ‘raising concerns’ policy within the organisation with clear escalation processes. The RO and team actively seek feedback from doctors. After each appraisal there is the opportunity for confidential feedback to be raised – this is shared and delivered in CPD sessions.
Action for next year:	.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Action from last year:	We continue to ensure that our senior team composition is representative of the population we serve
Comments:	This data is reviewed annually with our HR team. We also engage with the GMC ELA to triangulate this.
Action for next year:	

## 1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	To continue to resource this work
Comments:	The RO attends the regional and national networking and CPD events – with positive feedback. They will be engaging in quality review and peer review work this year.
Action for next year:	

## Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	1736
Total number of appraisals completed	1579
Total number of appraisals approved missed	157
Total number of unapproved missed	82
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	377
Total number of late recommendations	9
Total number of positive recommendations	311
Total number of deferrals made	66
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	35
Total number of trained case managers	14
Total number of concerns received by the Responsible Officer <sup>2</sup>	29
Total number of concerns processes completed	27
Longest duration of concerns process of those open on 31 March (working days)	350
Median duration of concerns processes closed (working days) <sup>3</sup>	24
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	228
Total number of new employment checks completed before commencement of employment	228
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld <sup>4</sup>	0

### Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
<p>In the appraisal year 2024/25, LTHT was the Designated Body for 1736 doctors. The Designated Body is the organisation that a licenced doctor has a professional, educational or employment connection with that provides them with support for revalidation.</p> <p>Of these 1736 doctors, 120 doctors were new starters to the Trust whose start date was after September and who were not required to undertake an appraisal. An additional 37 doctors were unable to complete an appraisal due to mitigating circumstances. Of the remaining 1579 doctors, 1497 (95%) successfully completed their appraisal. LTHT also provided appraisal support for 65 dentists from the Leeds Dental Institute.</p> <p>The number of doctors continues to rise and in the 2024-25 cycle, we welcomed 228 new starters to the Trust of whom 64 were consultants, 22 were specialty and specialist grade doctors (SAS), 28 Bank Doctors, and 114 other non-training grade doctors.</p> <p>The focus for 2024/25 has included:</p> <ul style="list-style-type: none"> <li>• Moving to appraisers being assigned by doctors themselves instead of the admin team</li> <li>• Recruiting a new Medical Appraisal Lead – Dr Shelagh Turvill</li> </ul>

<ul style="list-style-type: none"> <li>• Refreshment of training provided for new appraisers with a return to face to face training.</li> <li>• Embedding the processes to support the appraisal of Physician Associate and Anaesthetic Associate colleagues – taking into account the recommendations of the Leng Review.</li> </ul> <p>We continue to promote a streamlined approach to appraisal, which meets the requirements for revalidation but that is also focussed on health and wellbeing. The appraisal platform (SARD) incorporated questions around health and wellbeing into the updated appraisal form which was completed in time for 1<sup>st</sup> April 2023 appraisal cycle. This is now fully used and further enhances the ability for the appraisal to support the wellbeing of our medical staff and provide rich data to inform the Trust health and wellbeing strategies.</p> <p>The new Good Medical Practice domains are now fully embedded in the appraisal form on SARD. We have continued to work closely with CSUs to support the development of a sustainable number of appraisers – to enable full delivery of appraisals within job planned activities.</p> <p>A positive recommendation for revalidation is a consequence of a review of the evidence required by the Responsible Officer, supported by a Revalidation Panel. If doctors have insufficient evidence for the Responsible Officer to make a positive recommendation for revalidation, their recommendation may be deferred for between 4 and 12 months. Deferral rates remain, around 17% which is comparable to our peer organisations. This has increased from previous years, and work is ongoing to support early engagement with appraisal and revalidation systems to enable this.</p>
<p>Actions still outstanding:</p> <p>Procurement of new system, ensuring composition of the RO advisory group is representative of the demographics of those it serves.</p>
<p>Current issues</p>
<p>See above</p>
<p>Actions for next year (replicate list of 'Actions for next year' identified in Section 1):</p>
<p>(1) To explore procurement options for appraisal platform post 2025</p> <p>(2) Embed processes within CSUs to ensure compliance with appraisal processes, enabling a decrease in deferral recommendations</p>



- (3) To resource and recruit additional appraisers to enable effective delivery of appraisals to every staff member
- (4) To work with system partners to allow automated data feeds from peer reviewed platforms to enable accurate descriptions of individual data and clinical performance
- (5) Review the composition of the Responsible Officer Advisory Group to ensure appropriate representation
- (6) Develop and embed clinical leadership training.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

This report is an appendix to the Medical Revalidation Annual Report. The Board are asked to note our priorities for the next year

- Drive high appraisal completion rates by embedding standard work.
- Secure sufficient appraiser capacity – with agreed resource allocation
- Continue to develop processes for information transfer into appraisal system to enhance assurance around quality, safety and governance.
- Empower CSUs to support appraisal and revalidation processes

Board Members are asked to:

- Note the assurance provided on medical appraisal and revalidation
- Note the continued progress being made in this area

Confirm commitment to supporting the progress of this work

## Section 4 – Statement of Compliance

The Board/executive management team have 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 the designated body:	
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Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	