

Medical Revalidation Annual Report

Trust Board

24 September 2026

Presented for:	Approval/Information
Presented by:	Dr Elizabeth Garthwaite, Chief Medical Officer Responsible Officer
Author:	Dr Elizabeth Garthwaite
Previous Committees:	Nil

Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Strategy, leadership and planning
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	Regulation 17: Good governance

Trust Risk Appetite Scale				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Risk
Clinical Risk	✓	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients	Minimal	↔ (same)
External Risk	✓	Strategic Planning Risk - We will deliver Our Vision "to be the best for specialist and integrated care" through the delivery of a set of Strategic Goals and operating in line with Our Values	Cautious	↔ (same)
External Risk	✓	Partnership Working Risk - We will maintain well-established stakeholder partnerships which will mitigate the threats to the achievement of the organisation's strategic goals.	Open	↔ (same)

Key points To note the progress, compliance with national policy and the legal requirements, as well as the improvement plan.	Information
Approve the Board Assurance Statement relevant to this report	Approval

1. Summary

This is the Trust Responsible Officer's annual report covering the 2025/26 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 1767 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 Risk Management Committee provides oversight of the organisations most significant risks, which cover the most significant risk categories. This paper has been reviewed and there are no material changes to the risk appetite statements related to the Level 2 risk categories and we continue to operated within the risk appetite framework

6. Communication and Involvement

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

7. Improving Health Equity

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. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

9. Recommendations

The Board is asked to receive assurance set out in the annual report that the Trust has continued to make good progress to compliance with reference medical appraisal and revalidation which is set out in more detail in the annual report and supporting data.

10. 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
Chief Medical Officer
Responsible Officer Leeds Teaching Hospitals NHS Trust

11 September 2026

APPENDIX 1

Medical Revalidation Responsible Officer Annual Report 2025/26

1. Purpose

This report provides the Board with assurance that Leeds Teaching Hospitals NHS Trust continues to fulfil its statutory responsibilities as a Designated Body and maintains effective arrangements for medical appraisal and revalidation.

The report summarises performance during the 2025/26 appraisal year, describes the governance and quality assurance arrangements in place, and sets out the priorities for 2026/27.

2. Executive Summary

Leeds Teaching Hospitals NHS Trust continues to maintain effective systems and processes for medical appraisal and revalidation.

During the 2025/26 appraisal year, the Trust was the Designated Body for 1,767 doctors. Of these:

- 40 were new starters who joined after 1 October 2025 and were not required to complete an appraisal during the appraisal year;
- 38 were unable to complete an appraisal due to approved mitigating circumstances; and
- 1,689 were required to complete an appraisal.

Of the 1,689 doctors required to complete an appraisal, 1,655 did so, representing an appraisal completion rate of 97.99%, reported as 98.0%.

The Trust also provided appraisal support to 57 dentists working within Leeds Dental Institute.

During the year, the Trust made 175 revalidation recommendations to the General Medical Council. Of these, 133 were positive recommendations and 42 were deferrals. No non-engagement notifications were made.

The number of doctors connected to the Trust continues to increase. During 2025/26, 214 new doctors joined the Trust, comprising:

- 70 consultants;
- 23 specialty and specialist grade doctors;
- 27 bank doctors; and
- 94 other locally employed, non-training grade doctors.

Key improvements during the year included:

- development of a new starter mini-appraisal process;
- agreement of joint appraisal arrangements with the University of Leeds;
- development of a dedicated appraisal and revalidation intranet site;
- review and refresh of appraisal training materials;
- reintroduction of face-to-face training for new appraisers; and
- commencement of discussions with Newcastle upon Tyne Hospitals NHS Foundation Trust regarding external peer review.

Overall, the Responsible Officer is satisfied that the Trust has appropriate arrangements in place to support appraisal and revalidation, promote professional development, and identify and respond to concerns regarding doctors' practice.

3. Background and Statutory Responsibilities

A Designated Body is the organisation with which a licensed doctor has a prescribed professional, educational or employment connection. The Designated Body supports the doctor's appraisal and revalidation and assists the Responsible Officer in discharging their statutory responsibilities.

Designated Bodies are required to support their Responsible Officers in accordance with the Responsible Officer Regulations. Boards are expected to oversee compliance by:

- monitoring the frequency and quality of medical appraisals;
- assuring themselves that effective systems are in place to monitor doctors' conduct and performance;
- confirming that patient feedback is obtained periodically and informs appraisal and revalidation; and
- ensuring that appropriate pre-employment and pre-engagement checks, including checks for locum doctors, are completed to the required standards.

4. Governance Arrangements

The Trust's medical appraisal and revalidation arrangements are overseen by the Revalidation and Appraisal Steering Group. The Steering Group is supported by an operational working group and the Clinical Service Unit Lead Appraiser Group.

The Steering Group is co-chaired by the Chief Medical Officer and Responsible Officer. Its membership includes the Medical Director (Risk and Governance), Medical Appraisal Lead, clinical leaders, representatives from professional development and medical workforce teams, and practising clinicians.

The Steering Group provides oversight of appraisal performance, revalidation recommendations, quality assurance, appraiser capacity, training and improvement activity. The Group reports to the Board through this annual report.

Monthly revalidation panels are attended by the Deputy Chief Medical Officer and Responsible Officer, Medical Appraisal Lead and an HR representative. The panels review doctors who are within 12 months of their revalidation date and assess whether sufficient evidence is available to support a recommendation to the General Medical Council.

5. Medical Appraisal Performance

5.1 Appraisal completion

The Trust achieved an appraisal completion rate of 98.0% in 2025/26.

Appraisal year	Appraisal completion rate
2021/22	93.0%
2022/23	98.0%

2023/24	98.6%
2024/25	95.0%
2025/26	98.0%

The 2025/26 position is summarised below.

Measure	Number
Doctors connected to the Designated Body	1,767
New starters not required to complete an appraisal	40
Approved missed appraisals due to mitigating circumstances	38
Doctors required to complete an appraisal	1,689
Completed appraisals	1,655
Unapproved missed appraisals	34
Completion rate	98.0%

The completion rate represents an improvement from 95.0% in 2024/25 and demonstrates sustained engagement with appraisal across the medical workforce.

Doctors who do not complete their appraisal within the required timescale receive support from the appraisal administration team, Medical Appraisal Leads, relevant clinical leadership teams and the Responsible Officer, as appropriate.

Non-engagement may indicate wider professional, personal or health-related challenges. The Trust therefore seeks to approach doctors with compassion and curiosity while maintaining clear professional expectations and accountability.

5.2 New starter arrangements

All new doctors receive information about appraisal and revalidation as part of the onboarding process. This includes access to introductory training, guidance on local systems and opportunities to raise questions with the appraisal administration team.

New doctors are required to provide relevant information about previous appraisals, patient and colleague feedback, disciplinary action, General Medical Council investigations and any restrictions on clinical practice. Relevant information may also be obtained through formal transfer-of-information arrangements with previous Responsible Officers.

A new starter mini-appraisal process has been agreed for eligible consultants and non-training grade doctors joining the Trust from 1 October 2026. Initially, this will be completed using a paper form, submitted to the appraisal administration team and recorded on SARD as an offline appraisal.

The process is intended to:

- support early engagement with appraisal and revalidation requirements;
- improve understanding of local systems and expectations;
- identify support needs at an earlier stage;
- reduce the number of appraisals not completed due to mitigating circumstances; and
- support continued improvement in overall completion rates.

5.3 Joint appraisal arrangements

An agreed framework has been established with the University of Leeds for doctors who require a joint appraisal across both organisations.

This includes arrangements for new starters and provides a more consistent and streamlined approach, supporting appropriate information sharing and reducing unnecessary duplication for appraisees.

6. Appraiser Capacity and Development

The Trust currently has 222 medical appraisers, an increase of four from the previous year.

The current overall number of appraisers is sufficient to meet demand. However, maintaining sustainable capacity remains an important area of focus because experienced appraisers may step down due to workload pressures or competing professional commitments.

The Trust continues to work with Clinical Service Units to:

- identify areas where additional appraisers are required;
- maintain a sustainable pipeline of newly trained appraisers;
- ensure that appraisal activity is recognised within job plans; and
- support a more equitable distribution of appraisal activity.

Each appraiser is allocated 0.25 programmed activities within their job plan to undertake up to ten appraisals.

Appraisers are required to attend two update workshops within each three-year period to maintain their knowledge and skills. Attendance is monitored, and appraisers who have not met this requirement are contacted and offered future training dates.

Appraiser update sessions are delivered remotely on a quarterly basis by the Medical Appraisal Lead. Training for new appraisers is delivered face to face every six months. All appraisal training materials have been reviewed and refreshed to reflect current guidance, local requirements and good practice.

Most appraisers continue to appraise doctors within their own department. Appraisal outside the appraiser's immediate Clinical Service Unit is encouraged where appropriate, as this can provide additional perspective and cognitive diversity. Feedback from appraisers and appraisees regarding cross-specialty appraisal has been positive.

Appraisees are invited to provide feedback following completion of their appraisal. Appraisers may request their individual feedback from the appraisal administration team to support continuing professional development.

7. Quality Assurance

NHS England requires Designated Bodies to quality assure their appraisal processes. The Trust undertakes this through several complementary mechanisms:

- mandatory initial and refresher training for appraisers;
- discussion of appraisal quality and examples of practice during update sessions;
- review of appraisal documentation through monthly revalidation panels;
- targeted feedback and support where concerns about appraisal quality are identified;
- review of appraisal documentation using the nationally recognised Appraisal Summary and Personal Development Plan Audit Tool; and
- review of the first three appraisals completed by every newly trained appraiser.

Clinical Service Unit Lead Appraisers are expected to quality assure a proportion of appraisals each year using the standardised audit tool.

The most recent reported audit findings were:

Audit outcome	Number	Percentage
Total appraisals reviewed	126	100%
Score above 40 out of 50	103	81%
Score between 30 and 40	16	13%
Score below 30	7	6%

The findings indicate that most appraisal documentation reviewed was of a high standard. Where appraisal summaries scored below 30, the relevant appraisers were contacted to discuss the findings and were directed to further training and development support.

Issues relating to appraisal quality identified through monthly revalidation panels are similarly addressed through individual feedback, discussion and support. No systemic quality concern has been identified through the processes described in this report.

8. Appraisal and Revalidation Programme Improvements

During 2025/26, a number of initiatives were progressed to strengthen the Trust's appraisal and revalidation arrangements, improve compliance and enhance the experience of appraisees and appraisers.

8.1 Appraisal information and guidance

A dedicated appraisal and revalidation intranet site has been developed for consultants and non-training grade doctors.

The site provides a single point of access to relevant guidance, policies, training materials, documentation and frequently asked questions. This is intended to make information easier to access and promote timely engagement with appraisal and revalidation requirements.

8.2 Appraisal content and wellbeing

The Trust continues to promote a proportionate and streamlined approach to appraisal that meets revalidation requirements while supporting doctors' health and wellbeing.

The SARD appraisal form includes questions relating to health and wellbeing. This supports reflective discussion between appraiser and appraisee and may also provide information to inform the Trust's wider medical workforce health and wellbeing work.

The domains of Good Medical Practice are fully incorporated within the appraisal documentation on SARD.

8.3 External peer review

Discussions have commenced with Newcastle upon Tyne Hospitals NHS Foundation Trust regarding the development of a peer review process for the appraisal and revalidation programme.

External peer review would provide an opportunity to benchmark the Trust's arrangements, share good practice and strengthen independent assurance regarding the quality and effectiveness of the programme.

8.4 Policy development

The medical revalidation policy has been reviewed and is progressing through the final approval process with staff-side representatives.

9. Medical Revalidation

9.1 Revalidation recommendations

A positive revalidation recommendation is made following review of the evidence required by the Responsible Officer, supported by the monthly Revalidation Panel.

Where there is insufficient evidence to support a positive recommendation, the recommendation may be deferred for a period of between four and 12 months to allow the doctor additional time to provide the required evidence.

Revalidation outcomes over the past five years are shown below.

Appraisal year	Total recommendations	Positive recommendations	Deferrals	Non-engagement
2021/22	516	400	115	1
2022/23	205	153	52	0
2023/24	266	221	45	0
2024/25	377	311	66	0

2025/26	175	133	42	0
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During 2025/26:

- 133 positive recommendations were made;
- 42 recommendations were deferred;
- deferrals represented 24.0% of all recommendations; and
- no non-engagement notifications were made.

The total number of deferrals reduced from 66 in 2024/25 to 42 in 2025/26. Work will continue to support earlier engagement with appraisal and revalidation requirements, with the aim of reducing avoidable deferrals further.

Where a doctor does not engage with the appraisal and revalidation process despite repeated interventions, the Responsible Officer may submit a non-engagement notification to the General Medical Council. No such notifications were required during 2025/26.

All recommendations are submitted electronically through GMC Connect.

10. Recruitment and Pre-engagement Checks

All doctors employed or engaged by the Trust, including locum doctors, are subject to the required NHS pre-employment or pre-engagement checks before commencing work.

These checks include assurance that doctors have the necessary knowledge of English to perform their duties safely and competently, in accordance with General Medical Council requirements.

11. Monitoring Medical Performance

The Trust uses established clinical governance processes to monitor doctors' conduct, capability and professional performance. These include:

- mortality and morbidity reviews;
- clinical governance meetings within specialties;
- participation in national and local clinical audit;
- quality improvement activity;
- Freedom to Speak Up and whistleblowing arrangements; and
- review of serious incidents and Never Events.

Clinical Directors are responsible for identifying and managing concerns relating to medical performance and for escalating concerns where these may pose a risk to patient safety or represent a departure from professional standards.

The Responsible Officer's appraisal and revalidation functions are informed by relevant clinical governance information. Work continues to improve the transfer of appropriate clinical, quality and safety information into the appraisal process.

12. Responding to Concerns and Remediation

The Trust's approach to identifying and responding to concerns regarding doctors is set out in its established principles and guidance for responding to concerns and supporting remediation.

During 2025/26, 29 doctors were subject to formal Trust or General Medical Council action where the outcome was other than closure with no further action.

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

Doctors subject to ongoing Trust or General Medical Council processes are supported by the Responsible Officer's team, with access to internal and external expertise where required.

Most cases were categorised as low concern. Appropriate governance and oversight arrangements are in place for all active cases.

13. Doctors in Training

Doctors in postgraduate training have their Responsible Officer within the relevant NHS England education and training function.

An agreed process is in place for the Trust to provide relevant information regarding doctors in training when required.

14. Risks and Issues

There are no risks or issues requiring escalation to the Board currently.

The principal areas requiring continued management and oversight are:

- maintaining sufficient appraiser capacity as the number of doctors connected to the Designated Body increases;
- ensuring timely engagement by new starters and locally employed doctors;
- further reducing avoidable appraisal non-completion and revalidation deferrals;
- improving the transfer of relevant governance and performance information into appraisal;
- completing the procurement and implementation of a replacement appraisal management system; and
- maintaining appropriate information governance and business continuity arrangements during any transition to a new system.

These matters will continue to be monitored through the Revalidation and Appraisal Steering Group, with escalation through established governance arrangements if required.

15. Priorities for 2026/27

The priorities for the appraisal and revalidation programme in 2026/27 are to:

- sustain an appraisal completion rate above 95%;

- embed the new starter mini-appraisal process from 1 October 2026;
- further reduce avoidable revalidation deferrals through earlier engagement and targeted support;
- maintain sufficient appraiser capacity across all Clinical Service Units, supported by appropriate job-planned resource;
- strengthen Clinical Service Unit ownership of appraisal completion and appraiser capacity;
- improve the transfer of relevant governance, quality and safety information into the appraisal process;
- complete the approval and implementation of the revised medical revalidation policy;
- progress external peer review arrangements;
- refresh the new starter training package; and
- procure and implement a replacement appraisal management system.

16. Responsible Officer Assurance Statement

Based on the evidence presented in this report, the Responsible Officer is satisfied that Leeds Teaching Hospitals NHS Trust has effective arrangements in place to:

- support medical appraisal and revalidation;
- identify and respond to concerns relating to doctors' professional practice;
- provide appropriate quality assurance of appraisal processes;
- support doctors' professional development and wellbeing; and
- fulfil its statutory responsibilities as a Designated Body.

Performance remains strong, with a 98.0% appraisal completion rate, a reduction in the number of revalidation deferrals and no non-engagement notifications during 2025/26.

There are no significant concerns requiring escalation to the Trust Board at this time. The areas requiring continued attention are identified within the report and will remain subject to oversight through the Trust's established governance arrangements.

17. Recommendations

The Board is asked to:

1. **note** the performance of the medical appraisal and revalidation programme during 2025/26;
2. **receive assurance** that the Trust has effective arrangements in place to discharge its statutory responsibilities as a Designated Body;
3. **note** the key areas of risk and continuing management attention;
4. **endorse** the priorities for 2026/27; and
5. **support** the continued provision of appropriate capacity and resources required to maintain effective appraisal and revalidation arrangements.

APPENDIX 2**Designated Body Annual Board Report and Statement of Compliance****Section 1 Qualitative/narrative****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:	RO training and networking will continue to ensure compliance. Dr Adams will also undertake the same.

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:	Nil.
Comments:	There is an automated process to ensure those practitioners with a prescribed connection with LTH 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:	
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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:	A peer review was undertaken with Sheffield THFT on 12th 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. A new peer review is currently being planned with Newcastle Upon Tyne Hospitals NHS Foundation Trust. 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.
Action for next year:	Peer review being worked up with Newcastle Hospitals

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	Continue to improve these processes
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year:	
Comments:	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.
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:	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. Within the appraisal output form is a mandatory discussion regarding this, and any other governance concerns shared with the appraiser. In the appraisal year 2025-26, LTHT was the Designated Body for 1767 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 1767 doctors, 40 doctors were new starters to the Trust whose start date was after October and who were not required to undertake an appraisal. An additional 38 doctors were unable to complete an appraisal due to mitigating circumstances. Of the remaining 1689 doctors, 1655(97.98%) successfully completed their appraisal. LTHT also provided appraisal support for 57 dentists from the Leeds Dental Institute. The number of doctors connected to the Trust continues to rise and in the 2025-26 cycle, we welcomed 214 new starters to the Trust of whom 70 were consultants, 23 were specialty and specialist grade doctors (SAS), 27 Bank Doctors, and 94 other locally employed and non-training grade doctors.

Action for next year:	To ensure high quality appraisal systems for all doctors with focus on locally employed doctors not in training
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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:	The policy will be reviewed

1B(iv) Our organisation has the necessary number of trained appraisers¹ 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.
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¹ 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.

Comments:	There are currently 222 medical appraisers in LTHT an increase of 4 since last year. Each appraiser is allocated 0.25 PA of time to deliver 10 appraisals within their job plan 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. Appraisee feedback on our appraisers is offered on completion of the appraisal. Appraisers can request their individual responses on request from the administration team.
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:	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. This training was reviewed and is delivered remotely and quarterly by our medical appraisal lead. The New appraiser training is now running successfully face to face and we have held 2 sessions in the last year 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:	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.			
	Total ASPATs Completed	Scored over 40 (out of maximum 50)	Scored between 30 and 40	Scored lower than 30
	126	103 (81%)	16 (13%)	7 (6%)
	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			
Action for next year:	Continue to embed robust QA processes for appraisers and ensure support and mentoring processes in place			

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	Strong working relationship with the GMC ELA and regular meetings enables proactive discussions and careful referral processes
Action for next year:	To maintain this and ensure the referrals are promptly communicated and enacted

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:	Doctors are given written notice of their revalidation, 12 months before the date. We hold a monthly revalidation panel to review all doctors who are due to revalidate within 4 months.

	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. 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. 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. 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.
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:	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.
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:	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 • Freedom to Speak Up Systems • Learning from never events and serious incident reviews as well as PSIRF reports. 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:	We will continue to follow policies and procedures with proactive support

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:	NA

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

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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:	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. The RO contacts the relevant RO with any concerns over practice that may impact on that organisation For doctors connected elsewhere, including doctors in training, initial contact and exchange of relevant information is arranged as needed. Transfer of Information Requests are no longer provided as routine – trainees entering the organisation are now being requested to provide the last ARCP outcome form for assurance purposes

Action for next year:	Continue to monitor compliance
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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:	As above

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. The RO meetings quarterly with the ELA from the GMC who updates on local and regional concerns. Examples include 1. Guidance regarding the use of MAPs – Leng Review 2. Change in format of GMP domains 3. Response to the Thirwell Report – and reporting and speaking up/sharing concerns 4. Regulatory reports (CQC) 5. RO attends quarterly RO training sessions

Action for next year:	Continue to embed processes robust processes for information sharing and monitoring.
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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 or 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:	Director tri teams are also in place to support and monitor CSU performance – appraisal and revalidation data feeds into the integrated accountability meetings.

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:	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.
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:	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 for specialist and integrated care and that LTHT can meet the healthcare needs of those we serve. These commitments, which are reviewed as part of standard work underpinning all agenda items are 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.
Action for next year:	Above work continues to be embedded

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:	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. Underpinning all activities are the Trust Values
Action for next year:	Embedding people framework along with work on inclusion and belonging.

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:	Continue to embed this work.

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

Action from last year:	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:	.Continue to embed this work

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 ROAG/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:	We are reviewing the terms of reference for the ROAG (senior team) to ensure effective function and appropriate reporting and escalation structures

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:	Continue to ensure processes are embedded but also increase the training in this area to Medical Director Team to enhance resilience

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

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	1767
Total number of appraisals completed	1655
Total number of appraisals approved missed	38
Total number of unapproved missed	34
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	175
Total number of late recommendations	3
Total number of positive recommendations	133
Total number of deferrals made	42
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 ²	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) ³	24
Total number of doctors excluded/suspended during the period	2
Total number of doctors referred to GMC	3
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	214
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld ⁴	1

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
Leeds Teaching Hospitals NHS Trust continues to maintain effective systems and processes for medical appraisal and revalidation.

During the 2025/26 appraisal year, the Trust was the Designated Body for 1,767 doctors. Of these:

- 40 were new starters who joined after 1 October 2025 and were not required to complete an appraisal during the appraisal year;
- 38 were unable to complete an appraisal due to approved mitigating circumstances; and
- 1,689 were required to complete an appraisal.

Of the 1,689 doctors required to complete an appraisal, 1,655 did so, representing an appraisal completion rate of 97.99%, reported as 98.0%.

The Trust also provided appraisal support to 57 dentists working within Leeds Dental Institute.

During the year, the Trust made 175 revalidation recommendations to the General Medical Council. Of these, 133 were positive recommendations and 42 were deferrals. No non-engagement notifications were made.

The number of doctors connected to the Trust continues to increase. During 2025/26, 214 new doctors joined the Trust, comprising:

- 70 consultants;
- 23 specialty and specialist grade doctors;
- 27 bank doctors; and
- 94 other locally employed, non-training grade doctors.

Key improvements during the year included:

- development of a new starter mini-appraisal process;
- agreement of joint appraisal arrangements with the University of Leeds;
- development of a dedicated appraisal and revalidation intranet site;
- review and refresh of appraisal training materials;
- reintroduction of face-to-face training for new appraisers; and
- commencement of discussions with Newcastle upon Tyne Hospitals NHS Foundation Trust regarding external peer review.

Overall, the Responsible Officer is satisfied that the Trust has appropriate arrangements in place to support appraisal and revalidation, promote professional development, and identify and respond to concerns regarding doctors' practice.

Actions still outstanding:

Procurement of new system

Update terms of reference and composition of RO advisory group

Current issues:

See above

There are no risks or issues requiring escalation to the Board currently.

The principal areas requiring continued management and oversight are:

- maintaining sufficient appraiser capacity as the number of doctors connected to the Designated Body increases;
- ensuring timely engagement by new starters and locally employed doctors;
- further reducing avoidable appraisal non-completion and revalidation deferrals;
- improving the transfer of relevant governance and performance information into appraisal;
- completing the procurement and implementation of a replacement appraisal management system; and
- maintaining appropriate information governance and business continuity arrangements during any transition to a new system.

These matters will continue to be monitored through the Revalidation and Appraisal Steering Group, with escalation through established governance arrangements if required.

The priorities for the appraisal and revalidation programme in 2026/27 are to:

- sustain an appraisal completion rate above 95%;
- embed the new starter mini-appraisal process from 1 October 2026;
- further reduce avoidable revalidation deferrals through earlier engagement and targeted support;
- maintain sufficient appraiser capacity across all Clinical Service Units, supported by appropriate job-planned resource;
- strengthen Clinical Service Unit ownership of appraisal completion and appraiser capacity;
- improve the transfer of relevant governance, quality and safety information into the appraisal process;
- complete the approval and implementation of the revised medical revalidation policy;
- progress external peer review arrangements;
- refresh the new starter training package; and
- procure and implement a replacement appraisal management system.

This report is an appendix to the Medical Revalidation Annual Report. The Board is asked to:

1. **note** the performance of the medical appraisal and revalidation programme during 2025/26;
2. **receive assurance** that the Trust has effective arrangements in place to discharge its statutory responsibilities as a Designated Body;
3. **note** the key areas of risk and continuing management attention;
4. **endorse** the priorities for 2026/27; and

5. **support** the continued provision of appropriate capacity and resources required to maintain effective appraisal and revalidation arrangements.

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:	Antony Kildare
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Name:	Antony Kildare
Role:	Trust Chair
Signed:	
Date:	

Name of the person completing this form:	
Email address:	