NHS
East Suffolk and North Essex
NHS Foundation Trust

Board of Directors

Report Title:	2018/19 Annual Report for Medical Appraisal & Revalidation
Executive/NED Lead:	Dr Angela Tillett, Interim Chief Medical Officer
Report author(s):	Jane Clarke, Revalidation Manager
Previously considered by:	Dr Crawford Jamieson, Medical Director Dr Martin Mansfield, Responsible Officer Dr Sean MacDonnell, Lead Appraiser Mr Gautam Banerjee, Senior Appraiser Mr Robert Brierly, Senior Appraiser Dr Catherine Brosnan, Senior Appraiser

☑ **Approval** ☐ **Discussion** ☐ **Information** ☑ **Assurance**

Executive summary

This paper is to inform Trust Board of the year end compliance for medical appraisal across ESNEFT

The role of Responsible Officer (RO) is held by Dr Martin Mansfield, who is required to make revalidation recommendations to the GMC about each doctor once every 5 years. The cornerstone upon which the RO's recommendation is made is the doctor's appraisal history over the past 5 years, and it is therefore critical that the appraisal process itself is robust and fit for purpose.

Between 1st April 2018 and 31st March 2019, 148 recommendations were made to the GMC. 122 were for positive recommendations to revalidate and 26 were requesting a deferral of the revalidation date. No non-engagement notices were filed with the GMC during the reporting period.

On 31st March 2019, ESNEFT was the Designated Body for 673 doctors and for the appraisal year 2018/19 the Trust reported 607 completed appraisals, giving the Trust an overall compliance rate of 90% for medical appraisal.

Trust Board is requested to agree the Statement of Compliance detailed at appendix A. Once approved and signed by the Managing Director, this will be sent to NHSE to provide confirmation of the Trusts compliance with the Quality Assurance Framework as set out by the Department of Health and NHS England for Responsible Officers and Revalidation.

Action Required of the Board/Committee

1. Trust Board is requested to accept this report and to consider potential resource implications. The report will be shared, along with the Annual Organisational Audit, with the higher level Responsible Officer at NHSE.

2. Trust Board is requested to confirm that the Trust, as a designated body, is in compliance with the regulations. This statement, on completion by the Managing Director, will then be submitted the Regional Medical Director, NHS England – Midlands and East by 30th September 2019.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☐
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☑
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If we do not have a local organisational systems of appraisal and clinical governance, we may not be able to fulfil our responsibilities as the designated body for medical revalidation.
Trust Risk Appetite	**Compliance/Regulatory** - The Board has a cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	Medical Profession (Responsible Officers) Regulations 2010 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: 1. Regulation 12: Safe care and treatment 2. Regulation 17: Good Governance 3. Regulation 18: Staffing
Financial Implications	There are no identified financial implications
Equality and Diversity	Nothing detailed within the report contravenes Trust legal/statutory responsibilities or the human rights of staff and/or public.

Background

1. Medical Revalidation was launched in 2012. It is the process by which a doctor's licence to practise is renewed and is based on local organisational systems of appraisal and clinical governance.

2. Licenced doctors have a formal link, known as a prescribed connection, with a single organisation, known as the designated body, which will provide support with appraisal and revalidation. Each revalidation cycle is for a period of 5 years and all doctors holding a license to practice in the UK are now in a managed system of governance that requires them to undertake an annual whole-practice appraisal and to be revalidated by the GMC once every five years.

3. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that ESNEFT will oversee compliance by:

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

4. The purpose of this report is to provide assurance to the Board, our regulators and commissioners that effective systems are in place and to ensure the Trust meets with nationally agreed standards for medical appraisal and revalidation. The report outlines how the appraisal process is monitored and quality assured, how the Trust aids those doctors whose performance or conduct requires further support and how employment checks improve the level of patient care by ensuring only doctors with the appropriate qualifications and experience are employed by the Trust.

Governance Arrangements

5. This annual report also provides further audit information following the Trust's submission of the Annual Organisational Audit (AOA). This mandatory return was submitted to NHS England on 9th May 2019. It is an exercise designed to provide assurance to the Board that the Trust has effective systems in place which comply with the requirements of the Responsible Officer Regulations for medical appraisal and revalidation.

6. The AOA provides a process by which every Responsible Officer, on behalf of their designated body, provides a standardised return to the higher-level responsible officer.

7. The Associate Medical Director for Appraisal & Revalidation fulfils the role of Responsible Officer with formal training for this role conducted on 25th and 26th June 2019. The RO is accountable to the Trust Board. In line with guidance received from NHS England, when revalidation decisions are made on behalf of the RO the Trust must

be able to show direct involvement of the RO to substantiate the decision taken on their behalf. Delegation of this role is permitted for short-term periods but longer absences require a temporary change in RO.

8. Compliance data is provided by the Revalidation Manager on a monthly basis for the Accountability Framework and also for inclusion in the HR Workforce Dashboard. This data is available to the Divisions via the Accountability Framework and appraisal compliance is fed into the Training Portal. The Revalidation Manager monitors and supports doctors in ensuring appraisal is undertaken in the allocated period. Any repeated non-engagement of a doctor is escalated to the Divisional Medical Director, Lead Appraiser and RO.

9. The Trust Board receives the annual report at appraisal year-end (the annual Organisational Audit), confirming the number of appraisals completed across the organisation The Board is also made aware of any key themes that are emerging and recommendations for improving the process and quality for the following year in line with national guidance.

10. Maintenance of the GMC list of prescribed connections is managed by the Revalidation Manager. The GMC sends e-mail notifications when a doctor is added to the Trust's Designated Body list. These notifications are checked and any unknown additions to the list are scrutinised with the Medical Staffing Recruitment Manager and rejected or accepted as appropriate. The GMC has developed a decision-making tree to assist designated bodies in identifying whether a doctor should have a prescribed connection to a Designated Body.

11. The Medical Appraisal and Remediation Policies have been reviewed fully since the formation of ESNEFT and amended in line with current processes. The Remediation Policy has been approved by Joint LNC in September 2018. The Medical Appraisal policy is due for review/agreement at LNC in September 2019 with ratification expected by Board shortly thereafter.

Follow up on next steps

12. Next steps identified in last year's annual report concentrated on the alignment of the appraisal processes across Ipswich and Colchester Hospitals following the organisational merger.

    Eight headline areas were identified: -

    - Job alignment of the Revalidation Manager role
    - Revalidation Management Software
    - Appraisal Scheduling
    - Reporting process
    - Appraisal requirement for Short Term and MTI Doctors
    - Quality Assurance processes
    - Appraiser allocation
    - Job role anomalies

13. With the departure of Dr Barbara Buckley at the end of 2018, Dr Angela Tillett is the interim Chief Medical Officer with Dr Crawford Jamieson as the Medical Director with responsibility for Workforce and Education. Dr Martin Mansfield was appointed as Responsible Officer in January 2019 and is supported by Dr Sean MacDonnell, Lead Appraiser and Dr Catherine Brosnan, Mr Robert Brierly and Mr Gautam Banerjee as Senior Appraisers for the organisation.

14. The Revalidation Support Team for ESNEFT has now been established with a Revalidation Manager and two Revalidation Support Officers. Support Officer roles have developed further to provide a dedicated named support for Divisions in line with the HR Transformation Plan.

15. For the year 2018/19, appraisal processes at Ipswich and Colchester hospitals have remained separate and unchanged whilst work has been undertaken to merge 2 different systems. A new ESNEFT-wide appraisal process has begun for 2019/20.

16. Due to different processes at Ipswich and Colchester, it has been necessary to adjust the appraisal cycle. The appraisal cycle at Colchester was between 1st September and 21st December each year, whereas Ipswich had an all-year-round approach with allocated months for each individual's appraisal. This has now been unified for ESNEFT to provide a 6-month appraisal window starting on the 1st July and running to 31st December each year. Following advice taken from NHS England Revalidation Support Team the local team has moved all doctors into the new cycle in one tranche, rather than implementing a phased approach. This has meant that many doctors have seen a change in their allocated month for appraisal and some doctors will end up having 2 appraisals in 2019 to align dates properly going forward. When necessary, appropriate extensions for completion have been granted to all affected doctors to ensure there has been no adverse effect on their appraisal compliance due to this necessary realignment of processes.

17. The main issue faced by the Appraisal & Revalidation team during this transitional period has been a significant delay in the implementation of the appraisal software: Allocate. Ipswich doctors have previously used SARD software, with Colchester doctors having used the MAG (Medical Appraisal Guide) form since the inception of revalidation in 2012. The expectation was that Allocate software would be in place for the start of 2019 but in fact a 5-month delay has had a significant impact on ensuring that Allocate user accounts were implemented in a timely manner. We expect this delay to have a knock-on effect in producing some delayed appraisals initially and some user accounts have yet to be activated.

18. Allocate have provided a number of training days for all ESNEFT medical staff to familiarise them with the available modules relating to Appraisal and Job Planning. These have been held at both Colchester and Ipswich and were support by a member of the RST. Post implementation, further support is being provide by ad hoc and 1:1 sessions to ensure all medical staff have the appropriate knowledge and support in using the new software.

Medical Appraisal

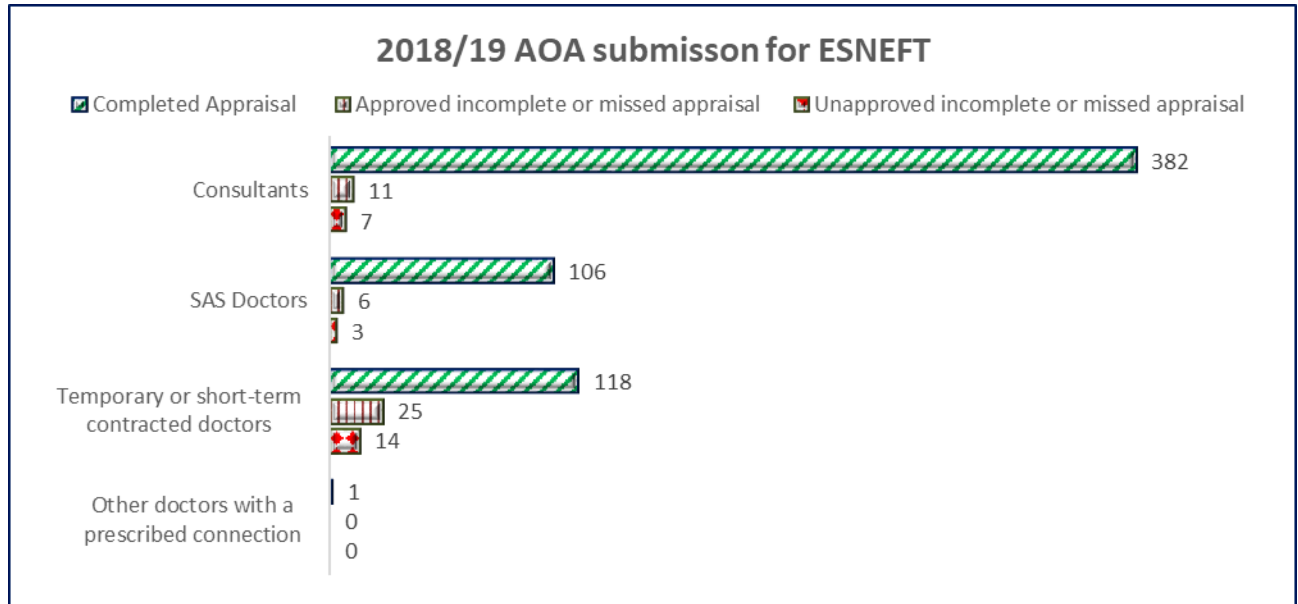
Appraisal and Revalidation Performance Data

19. On 31st March 2019, 672 doctors had a prescribed connection with the Trust. In addition the RO is currently appointed as the alternate RO for one doctor due to a recognised conflict of interest (medical director) at a neighbouring Trust. Therefore the data below is based on 672 Trust employed doctors and for the purposes of the AOA the Trust is required to report on <u>all 673</u> doctors with a prescribed connection to the Trust.

20. Table 1 below represents the year end compliance. In summary the Trust can report 607 doctors had completed their annual appraisal providing an overall compliance rate

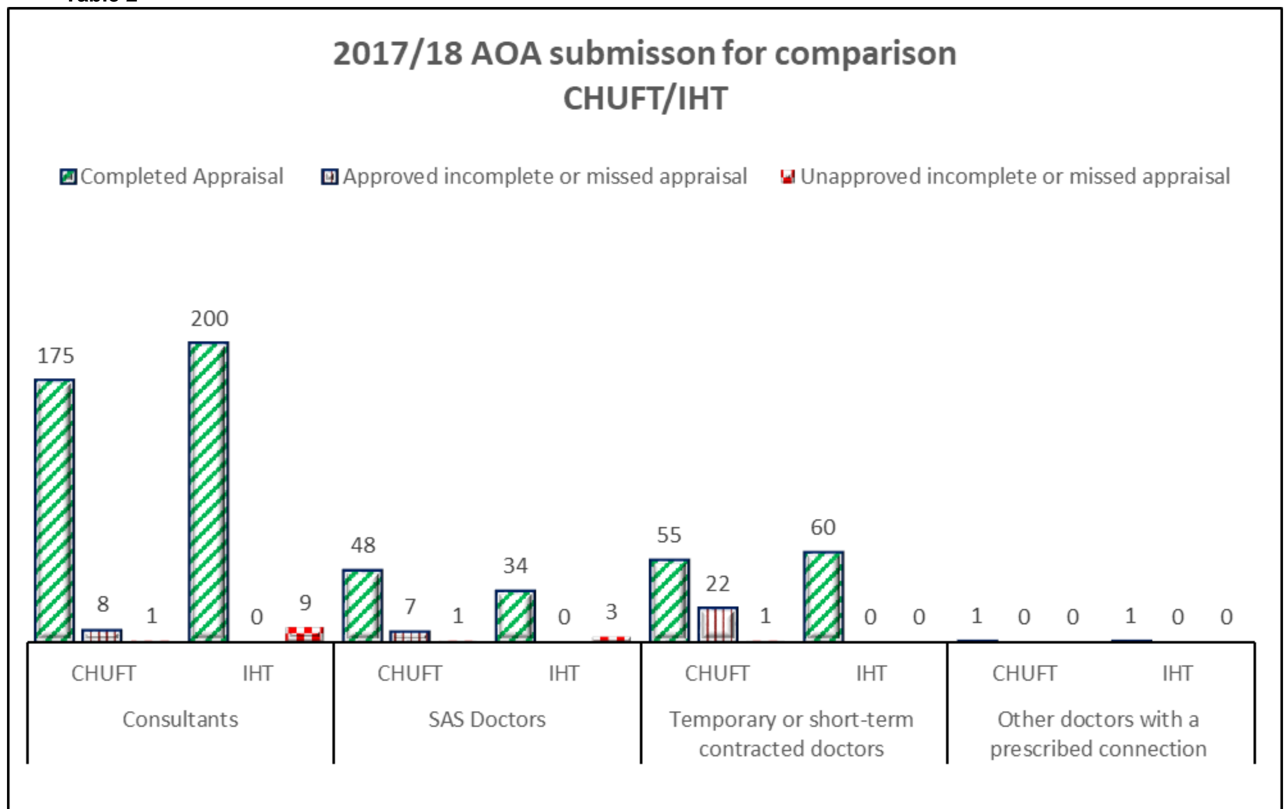
for 2018/19 of 90%. This rate is comparable with other trusts in the region which are reporting completion rates of between 87% and 95%.

Table 1



21. Table 2 below provided a data comparison of the 2017/18 submission for both Colchester and Ipswich pre-merger. With compliance rates declared at 87% for Colchester and 96% for Ipswich, it is encouraging to report 90% for ESNEFT for the 1st appraisal year post merger.

Table 2



22. Missed or incomplete appraisals are an important occurrence which could indicate a problem with the appraisal system or non-engagement with appraisal by an individual

doctor which will need to be followed up. Whilst the Trust has declared 42 missed appraisals, the majority of these are due to the realignment of appraisal processes for ESNEFT.

23. In addition, the “appraisal lite” previously provided by the Revalidation Manager for all short term contracted posts for locally employed doctors (LEDs) at Ipswich has now ceased. A new process of appraisal for LEDs at F1 & F2 level has been introduced utilising the education portfolio HORUS. These doctors will each be allocated an Educational Supervisor to ensure their developmental needs are met through a more educationally based process rather than our standard appraisal process. All other short term contracted doctors have been moved onto Allocate for our standard medical appraisal.

24. Table 1 above shows that 24 doctors were recorded as non-compliant with the ESNEFT appraisal process for 2018/19. A factor in mitigation of the non-compliance is the move to a new system of appraisal for LEDs as mentioned above. Once this group of doctors had been moved on HORUS they were asked to meet with their Educational Supervisor to ensure their competencies were completed on the system and a supplementary ePortfolio sheet was completed, verified and returned to the RST for recording. 13 of the 14 outstanding forms for LEDs have now been received and provide the necessary assurance. The remaining doctor advised of an appraisal she had undertaken privately and outside Trust control. Whilst this provides her with annual appraisal compliance she has been advised that future appraisals must be undertaken using Allocate according to ESNEFT requirements. The 3 Speciality Doctors have been provided with additional support and a plan of action to ensure engagement with their next appraisal. Lastly, of the 7 outstanding Consultants, 3 have now completed their appraisal, 1 is currently on long-term sickness, 2 are currently part of a local process and 1 requires additional support from the Senior Team.

Quality Assurance

30. Quality assurance mechanisms have always been embedded throughout the appraisal and revalidation systems used at Colchester and Ipswich prior to the merger. At Ipswich all appraisals were audited annually whereas Colchester audited approximately 20% plus those individuals approaching their revalidation.

31. During 2018/19 290 audits were conducted at Ipswich with 72 appraisals reverted back to the appraisee as unsatisfactory and requiring further work. The main reason for the reversion of appraisals incomplete mandatory training; an element now removed from the process in line with the “soft re-boot” of appraisal by the GMC. At Colchester 20% of completed appraisals were reviewed, but historically appraisals have never been reverted to enable amendments to be made. Other common themes on appraisal audit are: a lack of detail in appraisal summaries by appraisees and appraisers; lack of detail in relation to the stage of the revalidation cycle and the evidence collected/still to be collected; and sufficient evidence of challenge in Personal Development Plans.

32. The appraisal audit process from 1st July 2019 for ESNEFT is changing to re-focus as a supportive process throughout the revalidation cycle and at times when we know more assistance/advice is required:-
    - All appraisals from new Appraisers in their first year in the role
    - An audit of every doctor’s appraisal in years 2 & 4 of their revalidation cycle
    - All new starters in their first year of appointment at ESNEFT
    - Doctors who are experiencing difficulty or require further support

33. The Revalidation Support Team will use an amended version of NHSE quality assurance tool, the ASPAT (Appraisal Summary and PDP Audit Tool) for all appraisals

fitting the above criteria. Audits will be performed by the Lead and Seniors Appraisers, as appraisals are completed and submitted on Allocate, with the audit outcome fed back to the Appraisee, Appraiser and the RO for information. All outcomes will be recorded by a member of the Revalidation Support Team on a central database.

Access, security and confidentiality

34. Whilst the detail of an appraisal meeting is confidential to the appraiser and appraisee, the RO, Lead Appraiser and Senior Appraisers do have access to the documentation through the Allocate system. All doctors are required to abide by Trust policies for confidentiality, data security and ensure that all patient identifiable information is removed prior to uploading any information into their appraisal folder.

35. The Trust has reported no information governance breaches in regard to appraisal for the reporting period.

Clinical Governance

36. Current appraisal processes require that doctors must self-declare involvement in any and all significant events or complaints received in the previous 12 months.

37. It is an aspiration of the Revalidation Support Team to be able to provide a governance report to doctors for their appraisal. This report would be populated with evidence relating to significant events, complaints, sickness and mandatory training. This report should ease the administrative workload on the Doctor and allow better focus on the actual appraisal. Whilst production of this report is still in the discussion stage with the Robotics Team it is hoped a positive outcome can be achieved before the 2020/21 appraisal cycle.

Revalidation Recommendations to GMC

38. During the last 12 months, 148 recommendations have been made to the GMC. 122 of these were positive recommendations to revalidate the doctor and 26 were a request for a deferral of the impending revalidation.

39. A recommendation to defer can be made when a doctor is engaged in the appraisal process but there may be incomplete information on which to base a positive recommendation. Alternatively a doctor may have entered into a local investigation/disciplinary process and therefore the revalidation should be deferred until such a process is concluded. Deferral is a completely neutral act and does not impact on the doctors standing or medical practice.

40. Table 3 below show the status of all deferrals made during the 2018/19 appraisal year:-

Table 3

Number of deferrals made	Outcome/update on current position
Of the 26 deferrals made (2 for the same doctor), 15 have since received a positive recommendation and those doctors have been revalidated	
7 Deferrals have been made for Insufficient evidence	1st Deferral until March 2019 Deferred until July 2019 Deferred until October 2019 Deferred until November 2019 Deferred until November 2019 Deferred until January 2020 2nd Deferral until March 2020

2 Doctors are currently under a local process	Deferral until September 2019 Deferral until January 2020
2 Doctors have since left the organisation	Recommendations will be managed by the Doctors new prescribed GMC connection.

41. No GMC non-engagement notices were issued during 1st April 2018 and 31st March 2019.

Recruitment and engagement background checks

42. Effective recruitment processes and on-going employment checks are essential, contributing to the highest standards of patient care and safety within the Trust. The Trust is committed to excellence in recruitment of its staff and recognises that carrying out the full range of pre and post-employment checks has a vital role to play in achieving this. Where statutory requirements dictate, the Trust has directly adopted the legally required checking procedure (e.g. Criminal record and barring checks).

43. The NHS Employment Check Standards apply to applications for NHS positions. This includes permanent staff, staff on fixed-term contracts, volunteers, students, trainees, contractors, highly mobile staff, temporary workers (including locum doctors), those working on a trust bank, and other workers supplied by an agency.

    There are 6 NHS Employment Checks Standards:
    - Identity Checks
    - Right to Work Checks
    - Professional Registration and Qualification Checks
    - Employment History and Reference Checks
    - Criminal Record and Barring Checks (DBS)
    - Work Health Assessment

44. These Standards have been developed to provide best practice guidance to Trusts in undertaking pre and post-employment checks to satisfy statutory requirements and those set by NHS regulatory bodies.

45. The Recruitment Services Team is responsible for the conducting and recording of pre-employment checks for all candidates on Electronic Staff Record (ESR) and the Trust's preferred online recruitment system.

46. The Trust has developed the following policies to support pre and post-employment checks:
- Recruitment and Selection Policy
- Employment Checks and Clearances for Applicants and Employees Policy
- Recruitment of Ex-offenders policy

47. The Recruitment Manager will monitor the effectiveness of the Trusts Employment Checks Policy by regular audit of the following:

- Recruitment Checklists
- Personnel files
- Spot checks on new starters' personnel files

Responding to Concerns and Remediation

48. The Trust ensures that all disciplinary matters are dealt with fairly and consistently. Minor lapses in performance or conduct will generally be dealt with as part of day to day management by verbal advice or counselling. Where lapses are more serious or persistent, the employee will be dealt with in accordance with the disciplinary procedure, however no disciplinary action will be taken until the matter is investigated fully.

49. The Decision Making Group for HR Matters was established to review concerns and the group meets on a weekly basis. Membership comprises of the Chief Medical Officer, Responsible Officer, Medical Director, Director of HR/Deputy Director of HR, Head of Employee Relations and the Senior ER Adviser (Medical). Additional advice is sought from PPAS (formerly NCAS) as soon as a concern arises and the GMC's ELA is contacted as appropriate. Any serious concerns are registered with the Chief Executive, Chief Medical Officer and Director of HR. A monthly report of current cases is submitted to Board providing analysis of on-going cases. A monthly report is provided to the People and Organisational Development Committee which provides an analysis of cases e.g. identifies any themes or trends. A monthly case report is also provided to the Designated Board Member.

50. The Maintaining High Professional Standards (MHPS), Disciplinary, Investigations and Remediation policies have been updated and approved by the Executive Management Committee. The Absence policy is currently being revised and will be completed by September 2019. The MHPS policy complies with the national MHPS framework.

51. The Remediation Policy supports the Medical Appraisal and Revalidation Policy in situations which relate specifically to the lack of capability of an employee to perform the work which they are employed to do. It provides a clear, formal framework to apply in order to address issues of remediation which arise in relation to an inability to perform to, and sustain, the required standard for a post. The policy is based on the NCAS document 'Back on Track' and is in line with the capability and remediation procedures for practitioners covered in the DH documents 'Maintaining High Professional Standards in the Modern NHS' and 'Tackling Concerns Locally'. The policy and its supporting procedures cover all doctors employed by the Trust, including those on honorary contracts. Junior medical staff will follow Health Education East of England's procedures regarding remediation.

52. During 2018/19 5 people underwent the NHSI two day case investigators training programme

53. There is an established process in place to transfer information and concerns quickly and effectively between the Trust's Responsible Officer and other Responsible Officers (or persons with appropriate governance responsibility about doctors connect to the Trust who also work elsewhere and doctors connected elsewhere who also work in our organisation). Examples include transferring information and/or concerns to the Responsible Officer at an agency and at Health Education East of England. The DMG discusses these cases and supports the Responsible Officer's decision to share this information.

54. Concerns about a doctor's practice, are fair and free from bias and discrimination the Trust has established the DMG. Members are required to declare any interest in a case and are not involved in the case discussion or any decisions made. Where appropriate, the case manager is supported by an independent panel who review and discuss the investigation report and will support the Case Manager with their decision on the next steps. The Trust involves PPAS as soon as a serious concern arises to discuss the case and seek advice on the appropriate approach/required actions.

55. Table 4 below indicates the number of cases during 2018/19

Table 4

Concerns about a doctor's practice - Number of doctors with concerns about their practice in the last 12 months;	**High level**	**Medium level**	**Low level**	**Total**
Capability concerns (as the primary category) in the last 12 months	1	0	0	1
Conduct concerns (as the primary category) in the last 12 months	5	2	1	8
Health concerns (as the primary category) in the last 12 months	1	0	0	1
TOTAL				10

Remediation/Reskilling/Retraining/Rehabilitation - Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2018 who have undergone formal remediation between the reporting period	
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)	0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)	0
TOTAL	0

Practitioner Performance Advice Service actions - Number of doctors about whom PPAS has been contacted between 1 April and 31 March:	
For advice	11
For investigation	0
For assessment (this also included advice)	1
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0
TOTAL	12

Other Actions/Interventions	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: *One doctor was excluded and then moved to restrictions, which has been recorded in this category to avoid double counting)*	5
Duration of exclusion: *3 – 5 months (some exclusions are still ongoing)*	
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	3
Were referred to the GMC between 1 April and 31 March (including those referred by the Trust and those the GMC advised the Trust.	9
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	3
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March *There is also one doctor currently suspended from the register*	3

Risk and Issues

48. There are currently no risks recorded on the risk register for medical appraisal and revalidation. However as discussed below, there is a risk that there will be insufficient appraisers to cover all the doctors with a Prescribed Connection. It has been requested

that the issue be added to the risk register until such a time a solution can be found to recruit and stabilise the Appraiser bank levels

Key Issues for 2019/2020

Appraisal "soft re-boot"

49. In 2016, the GMC commissioned Sir Keith Pearson to undertake an independent review of revalidation. The report that followed, "Taking revalidation forward", provided a valuable understanding of how appraisal and revalidation was working in practice. It also challenged organisations to consider how processes and systems could be refined and improved. In 2018, the GMC made improving the appraisal experience and reducing burdens for doctors, their top priority and introduced new overarching principles for all supporting information, based on quality not quantity in the evidence that doctors should collect. The emphasis going forward with appraisal will be about reflection on evidence that generates meaningful discussion and supports the doctor's development. In line with this update, compulsory information previously required for appraisal has now been removed from the list of evidence required for ESNEFT, such as the medical practice declaration form and mandatory training. Following a recent Revalidation Team away-day options are being considered to improve the training and development program for ESNEFT appraisers. The goal is to change the culture of appraisals to provide a more satisfying and worthwhile interaction between appraiser and appraisee, leading to better thinking about career progress and development.

Appraiser recruitment and retention

50. Since the merger, Ipswich Hospital site has experienced a 34% loss of appraisers. Whilst there have been a number of retirements and some change to various clinicians roles in ESNEFT, the reduction in the SPA allocation for Trust Appraisers has been cited as one of the main reasons for giving up the role. Unfortunately, without a significant increase in recruitment to the role, the Trust is at a high risk of not being compliant with appraisal at year-end 19/20. The RST currently has 72 doctors for whom we cannot allocate an appraiser due to lack of numbers. We expect the situation to deteriorate from August 2019 due to the increase in temporary bank staff, general recruitment and additional LED doctors that start at that time. Under current agreement with the LNC (Local Negotiating Committee) the RST can only allocate 6 appraisees per appraiser each year. The Revalidation Manger has been exploring options available to ESNEFT to mitigate this risk, such as engaging external appraisers or additional payments for current appraisers willing to take on additional appraisals. The options paper will be submitted to the JLNC and Board for consideration and agreement

Recommendations

51. Trust Board is requested to accept this report and to consider potential resource implications. The report will be shared, along with the Annual Organisational Audit, with the higher level Responsible Officer at NHSE.

52. Trust Board is requested to confirm that the Trust, as a designated body, complies with the Responsible Officer regulations and Quality Assurance Framework for Appraisal and Revalidation. This statement, on completion by the Managing Director, will then be submitted the Regional Medical Director, NHS England – Midlands and East by 30th September 2019.

Statement of Compliance:

East Suffolk and North Essex NHS Trust Board has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

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

Name: _ Neill Moloney _ _ _ _ __ Signed: _ _ _ _ _ _ _ _ _ _

Role: _ Managing Director _ _ _ _

Date: _ _August 2019_ _ _ _ _ _ _