ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Paper	**Agenda Item**	Agenda Pack B
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	27 November 2025

Suggested discussion points (two or three issues for the meeting to focus on)

The following report, received and discussed by the People and Organisational Development Committee, is presented today to be noted by the Board of Directors:

Medical Revalidation Report – The People and Organisational Development Committee and noted the good practice in the increased recruitment of appraisers.

Previous consideration (where has this paper previously been discussed – and what was the outcome?)

People and Organisational Development Committee held 22 October 2025.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE and CONSIDER the appended report for information

Alignment to strategic objectives (indicate those that the paper supports)	
SO2: Create equity of access, employment, and experience to address differences in outcome	X

Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

N/A

System / Place impact (advise which ICB or place that this matter relates to)

N/A

Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Refer to Agenda Pack B

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - 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 replying yes/no.

1A – General

The board/executive management team of

Rotherham, Doncaster and South Humber NHS Foundation Trust

can confirm that:

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

Action from last year:	10.06.2025 Paper – The Responsible Officer (RO) for RDaSH at the time of writing this report is Dr Diarmid Sinclair, Deputy Medical Director. Dr Sinclair subsequently was appointed as responsible officer in August 2024 due to Dr Mehta leaving the Trust Dr Sinclair did RO training on 10 Oct 2024
Comments:	Dr Sinclair was appointed as Chief Medical Officer is April 2025
Action for next year:	Dr Sinclair will continue to undertake appropriate CPD for the RO role

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

Yes	
Action from last year:	I am satisfied that the designated body continues to provide sufficient funding and resource for me to carry out my duties and responsibilities in relation to my RO role. Signed: Dr Diarmid Sinclair, date: 10.06.2025
Comments:	
Action for next year:	Ensure there is sufficient resource to support the role as well as there being appropriate systems in place such as L2P

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 list of prescribed connections is held on the GMC Connect website is regularly checked against staff lists held on the Electronic Staff Record (ESR) by a member of the Trust Revalidation Support Team who also receives notifications of staff changes from the Medical Staffing Team in the Workforce Directorate.
Comments:	
Action for next year:	Continue above processes, to regularly check the list of prescribed connections held on the GMC Connect website, against staff lists held on the Electronic Staff Record.

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

Action from last year:	10.06.2025 Paper – The Medical Appraisal Policy is active on the Trust's public website and has been agreed with the BMA via the Joint Local Negotiating Committee. The policy has been reviewed and is in the process of being reviewed by the LNC before being ratified. Review July 2025 completed by the Trust Revalidation Support Team and process for implementing changes is underway.
Comments:	The Medical Appraisal Policy has been submitted to People & Teams meeting on 10.06.25. The Policy has been approved is active on the Trust's public website.
Action for next year:	Continue to review the Medical Appraisal Policy in line with review schedule.

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

Action from last year:	The Regional Appraisal Network in Mental Health is attended by the RO; it forms a useful benchmarking and peer review system. Internally we hold annual reviews of our appraisal process and provide feedback to our appraisers.
Comments:	
Action for next year:	We will continue attendance at the RO network and have annual reviews of our appraisal process The RO will explore the possibility of a peer review from one of the neighbouring Trusts

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:	10.06.2025 Paper – We are guided by the GMC in terms of establishing RO responsibility. All of our doctors (locum and substantive) are invited to attend the monthly Consultants' meetings and the educational programmes for CPD activity, and such data will be provided to locums and where appropriate their Agency RO's if / when required. We supply relevant clinical governance information to their own RO e.g. complaints, serious incidents etc.
Comments:	
Action for next year	As above

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 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:	All doctors in this organisation are offered an annual appraisal that covers a doctor's whole practice, 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.

	Effective appraisals within the Trust are guided by our comprehensive Medical Appraisal Policy, they are monitored by 20% random sampling by the RO. Appraisals are predominantly undertaken in the period December-March remotely via Microsoft Teams or face-to-face. Centrally compiled data is used for individual doctors as a contribution to their supporting information. Information on Complaints, Serious Incidents and IR1's are provided to individuals directly into their L2P account (our current appraisal management software). The total number of employed doctors was 75 in the year 2024-2025. Out of 75, 72 had a completed RDaSH appraisal, all of which have been submitted to the Appraisal Team and signed off.
Comments:	
Action for next year:	As above

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	There were 3 instances of doctors not completing an appraisal: • 2 appraisal due end of 2025. • 1 did not engage with the appraisal and has been referred to the GMC for non-engagement, they have appealed a GMC decision to remove their licence to practice.
Comments:	
Action for next year:	Continue to monitor engagement with appraisal process.

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:	10.06.2025 Paper - I can confirm that this is the case, some minor amendments have been agreed by the local Trust Revalidation Support Team (12.08.2024), these are going to the Joint Local Negotiating Committee (10.06.2025) for their approval and then final policy revision should be agreed before September 2025 Board of Directors meeting in January where it can be given final approval.
Comments:	10.06.2025 Paper- I can confirm the revised policy has been approved in July 2025 and is active on the Trust public website.

Action for next year:	No action to be taken

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

Action from last year:	Appraiser refresher training takes place annually and is delivered by the Responsible Officer (Dr Diarmid Sinclair). In the year 2023-2024 period the Trust had 16 trained appraisers to cater to approximately 69 doctors. There has been no issue with our ability to carry out timely appraisals.
Comments:	In the year 2024-2025 period the Trust had 18 trained appraisers to cater to approximately 75 doctors.
Action for next year:	To offer new appraiser induction training and annual appraiser refresher training. The trust will continue to monitor how many appraisers it has versus the number of appraisees to ensure that there remains enough capacity.

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:	The Trust offers and monitors compliance with annual refresher training to ensure all appraisers are up to date and compliant, this is delivered by the Responsible Officer (Dr Diarmid Sinclair). Any appraisals undertaken by new appraisers are reviewed by the Responsible Officer and they are provided with feedback. Reminders are sent to all Appraisers that they demonstrate in their own appraisal how they keep up to date as an appraiser. In 2024-25 four doctors have been trained to become an Appraiser. The training was delivered by the Responsible Officer.
Comments:	The Trust to recruit Deputy Medical Director/Medical Appraiser Lead
Action for next year:	As above

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.

[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.

Action from last year:	The Trust Revalidation Support Team (TRST) meets quarterly and is part of the appraisal quality assurance process. The agenda includes the management of the system for appraisals, data flow including (complaints, SI's, appraisers matching, policy review, new starter assurance checks), changes to guidance and a formal discussion on IR1's which have been screened and categorised by the Revalidation Team. It reviews the appraisal feedback and spots any trends or cause for concern to be actioned. This also includes targeted feedback to the new appraisers. On an annual basis the RO reviews a sample of 20% of all appraisers for quality and consistency and feeds this back to TRST and the doctors involved.
Comments:	
Action for next year:	As above

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:	14 recommendations to the GMC were made during this appraisal cycle.
Comments:	
Action for next year:	The revalidation and appraisal team monitor when revalidation decisions are due and highlight this to the RO. Engagement is also monitored such that any requests to the GMC to bring forward revalidation decisions can be actioned

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:	In this appraisal cycle 2024-25 of our 75 doctors, 14 required revalidation.

	• 12 were recommended for revalidation on time and revalidation was approved by the GMC. • 1 was deferred due to non-engagement and subsequently referred to the GMC • 1 was deferred due to insufficient evidence.
Comments:	
Action for next year:	As above

1D – Medical governance

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

Action from last year:	The Trust has a system of governance and assurance that is approved by the Board of Directors. It includes a Board Assurance Framework, and formal sub committees of the Board which receives assurance regarding relevant areas such as serious incidents, complaints, audit activity and staff training. Relevant supporting information is supplied to doctors such as incident reports, complaints and SI's.
Comments:	
Action for next year:	The Trust has instituted learning half days for all staff to enhance learning opportunities For doctors with leadership positions there is also a leadership development programme in addition to the learning half days and regular CPD programme

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

Action from last year:	The Trust system relating to the conduct and performance of medical staff is in accordance with the MHPS framework and is explicitly mentioned in the relevant policies. Serious concerns about medical performance are and should be managed outside of the appraisal system. Relevant information is supplied to doctors for their appraisals, but doctors are expected to bring information of relevance that may not be known to the Trust e.g., complaints in relation to other parts of their whole scope of work.
Comments:	

Action for next year:	As above

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

Action from last year:	Relevant information is supplied to doctors for their appraisals, but doctors are expected to bring information of relevance that may not be known to the Trust e.g., complaints in relation to other parts of their whole scope of work.
Comments:	
Action for next year:	As above

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 have agreed policy and processes and follow the detail of Maintaining High Professionals Standards.
Comments:	
Action for next year:	Relevant policies will continue to be reviewed and followed.

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:	If the RO determines that there are serious concerns in relation to a medical practitioner, they are brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step. Any formal MHPS processes against a doctor are noted in the Private section of the Board of Directors.

	No formal MHPS processes were instigated against a Trust doctor in the 2024-2025 appraisal year. In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.
Comments:	
Action for next year:	If the RO determines that there are serious concerns in relation to a medical practitioner, they are brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step. Any formal MHPS processes against a doctor are noted in the Private section of the Board of Directors. No formal MHPS processes were instigated against a Trust doctor in the 2025-2026 appraisal year. In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.

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:	We supply relevant data when this is asked for in relation to revalidation and appraisal to other RO's. This includes when a doctor has a new prescribed connection (usually when they leave the Trust) or when a doctor has a different RO (e.g. agency doctor) but also works in our Trust. Where we have concerns that have arisen since the end of an appraisal cycle and that doctor leaves, we will identify their new RO (via the GMC) and if necessary, pass that information on to the RO; we will also inform the doctor that we have taken this action.
Comments:	
Action for next year:	We supply relevant data when this is asked for in relation to revalidation and appraisal to other RO's. This includes when a doctor has a new prescribed connection (usually when they leave the Trust) or when a doctor has a different RO (e.g. agency doctor) but also works in our Trust. Where we have concerns that have arisen since the end of an appraisal cycle and that doctor leaves, we will identify their new RO (via the GMC) and if necessary, pass that information on to the RO; we will also inform the doctor that we have taken this action.

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:	All staff must undergo relevant Mandatory/Statutory training e.g. Equality & Diversity, in addition the Trust must publish equality data in relation to certain protected characteristics (Race and Disability) every year. The organisation has developed an understanding with the Regional Appraisal Network, where concerns about a doctor is being assessed to consult an independent representative from with the Network.
Comments:	
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:	The Trust has systems in place to review national guidance such as NICE guidelines to ensure that the standards are reviewed against current practice in the Trust. There are forums for national reports to be reviewed such that the Trust can determine whether any actions are necessary.
Comments:	
Action for next year:	As above

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:	The Trust has policies in place to monitor performance of all staff against relevant professional standards. The Trust follows guidance from NHS improvement and operates a Just Culture.
Comments:	
Action for next year:	As above

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:	A checklist system for new starters is in place and monitored by the Medical Staffing Team, and further checks are carried out by the Revalidation Support Team. For Locums, the Agency will have their own framework but the doctor must be compliant with the Trusts own requirements and this information be provided by the agency and reviewed by the EMD. The Trust only uses national framework agencies accredited for supplying agency doctors.
Comments:	
Action for next year:	A checklist system for new starters is in place and monitored by the Medical Staffing Team, and further checks are carried out by the Revalidation Support Team. For Locums, the Agency will have their own framework but the doctor must be compliant with the Trusts own requirements and this information be provided by the agency and reviewed by the EMD. The Trust only uses national framework agencies accredited for supplying agency doctors.

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:	The Trust has introduced leadership training for all leaders within the organisation. There are learning half days for all staff. For medical staff there are regular weekly CPD sessions.
Comments:	
Action for next year:	The Trust has introduced leadership training for all leaders within the organisation. There are learning half days for all staff. For medical staff there are regular weekly CPD sessions.

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:	Equality and Diversity is mandatory part of Trust training for all employees. The Trust has implemented the principles of Just Culture and our HR processes are aligned to this. There are support networks to promote diversity and inclusion
Comments:	
Action for next year:	Equality and Diversity is mandatory part of Trust training for all employees. The Trust has implemented the principles of Just Culture and our HR processes are aligned to this. There are support networks to promote diversity and inclusion.

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

Action from last year:	The Trust has embedded PSIRF. The Trust has adopted the Just Culture framework. There is a Freedom to Speak up Policy and champions in place. Incident themes are regularly reviewed to look for patterns and learning.
Comments:	
Action for next year:	As above

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:	There is a complaints process which has an underlying policy in situ. Additionally the Trust regularly solicits feedback from service users to provide feedback to both practitioners and service design. The Trust ensures that formal 360 feedback is received by every doctor every 3 years.
Comments:	

Action for next year:	As above

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:	If the RO determines that there are serious concerns in relation to a medical practitioner, they are brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step. Any formal MHPS processes against a doctor are noted in the Private section of the Board of Directors. No formal MHPS processes were instigated against a Trust doctor in the 2024-2025 appraisal year. In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.
Comments:	
Action for next year:	**As above**

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:	The RO and Appraisal lead attends the appraisal and revalidation networks to allow for peer learning.
Comments:	
Action for next year:	As above and in addition the Trust will explore the possibility of organising a peer review from a neighbouring Trust.

Section 2 – metrics

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

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

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2025	75

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	72
Total number of appraisals approved missed	2
Total number of unapproved missed	1

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	14
Total number of late recommendations	0
Total number of positive recommendations	12
Total number of deferrals made	1
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	**0**
Total number of trained case managers	**0**
Total number of new concerns registered	**0**
Total number of concerns processes completed	**0**

Longest duration of concerns process of those open on 31 March	**0**
Median duration of concerns processes closed	**0**
Total number of doctors excluded/suspended	**0**
Total number of doctors referred to GMC	**0**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	23 (22.5wte)
Number of new employment checks completed before commencement of employment	23 (22.5wte)

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	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
- There has been one referral for non-engagement with appraisal, the GMC moved to remove this doctor's licence to practice as of 02/08/2024 but the doctor has appealed and is expected to provide evidence to the GMC for the appeal by the 23rd of September 2024. - The responsible officer role has changed from Dr Sunil Mehta to Dr Diarmid Sinclair. - Network and Development event held annually with the Appraisers to share experiences and problem solve. - The RO is satisfied that all other necessary appraisals have been conducted in the appraisal cycle.
Actions still outstanding
- None
Current issues

None to report.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Dr Sinclair the Trust's RO will continue to undertake appropriate CPD for the RO role.

We will continue to ensure there is sufficient resource to support the RO role as well as there being appropriate systems in place such as L2P.

We will continue the process of regularly checking the list of prescribed connections held on the GMC Connect website, against staff lists held on the Electronic Staff Record.

We will continue to review the Medical Appraisal Policy in line with review schedule.

We will continue attendance at the RO network and have annual reviews of our appraisal process. The RO will explore the possibility of a peer review from one of the neighbouring Trusts.

We will follow GMC guidance in terms of establishing RO responsibility. All of our doctors (locum and substantive) will continue to be invited to attend the monthly Consultants' meetings and the educational programmes for CPD activity, and such data will be provided to locums and where appropriate their Agency RO's if / when required. We will supply relevant clinical governance information to their own RO e.g. complaints, serious incidents etc.

We will continue to offer all doctors in this organisation an annual appraisal that covers a doctor's whole practice, 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.

We will monitor effectiveness of appraisals within the Trust by our comprehensive Medical Appraisal Policy, they are monitored by 20% random sampling by the RO.

Appraisals will be undertaken in the period December-March remotely via Microsoft Teams or face-to-face. We will supply centrally compiled data is used for individual doctors as a contribution to their supporting information. Information on Complaints, Serious Incidents and IR1's will be provided to individuals directly into their L2P account (our current appraisal management software).

We will continue to monitor engagement with appraisal process.

We will continue to review appraisal policy as per the schedule.

We will continue to offer new appraiser induction training and annual appraiser refresher training. The trust will continue to monitor how many appraisers it has versus the number of appraisees to ensure that there remains enough capacity.

We will continue to offer and monitors compliance with annual refresher training to ensure all appraisers are up to date and compliant, this is delivered by the Medical Appraisal Lead. Any appraisals undertaken by new appraisers are reviewed by the Medical Appraisal Lead and they are provided with feedback. We will send reminders to all Appraisers that they demonstrate in their own appraisal how they keep up to date as an appraiser

The Trust Revalidation Support Team (TRST) will meet quarterly and is part of the appraisal quality assurance process.

On an annual basis the RO will review a sample of 20% of all appraisers for quality and consistency and feed this back to TRST and the doctors involved.

The revalidation and appraisal team will monitor when revalidation decisions are due and highlight this to the RO. Engagement is also monitored such that any requests to the GMC to bring forward revalidation decisions can be actioned

The Trust has instituted learning half days for all staff to enhance learning opportunities
For doctors with leadership positions there is also a leadership development programme in addition to the learning half days and regular CPD programme. The effectiveness of these will be monitored.

The Trust will continue to ensure its system relating to the conduct and performance of medical staff is in accordance with the MHPS framework and is explicitly mentioned in the relevant policies. Serious concerns about medical performance will and should be managed outside of the appraisal system. Relevant information will be supplied to doctors for their appraisals, but doctors are expected to bring information of relevance that may not be known to the Trust e.g., complaints in relation to other parts of their whole scope of work.

Relevant information will be supplied to doctors for their appraisals, but doctors will be expected to bring information of relevance that may not be known to the Trust e.g., complaints in relation to other parts of their whole scope of work.

Relevant policies will continue to be reviewed and followed when responding to concerns about a medical practitioner's fitness to practice.

If the RO determines that there are serious concerns in relation to a medical practitioner, they will be brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step.
Any formal MHPS processes against a doctor will be noted in the Private section of the Board of Directors.

In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.

We will supply relevant data when this is asked for in relation to revalidation and appraisal to other RO's. This includes when a doctor has a new prescribed connection (usually when they leave the Trust) or when a doctor has a different RO (e.g. agency doctor) but also works in our Trust.
Where we have concerns that have arisen since the end of an appraisal cycle and that doctor leaves, we will identify their new RO (via the GMC) and if necessary, pass that information on to the RO; we will also inform the doctor that we have taken this action.

We will continue to require all staff undergo relevant Mandatory/Statutory training e.g. Equality & Diversity, in addition the Trust must publish equality data in relation to certain protected characteristics (Race and Disability) every year.

The Trust will use its links with the Regional Appraisal Network, where concerns about a doctor to consult an independent representative from with the Network.

The Trust has systems in place to review national guidance such as NICE guidelines to ensure that the standards are reviewed against current practice in the Trust and this will continue.
We will continue to use forums within the Trust for national reports to be reviewed such that the Trust can determine whether any actions are necessary.

The Trust has policies in place to monitor performance of all staff against relevant professional standards and these will continue to be utilised.

The Trust will continue to follow guidance from NHS improvement and operate a Just Culture.

We will continue to use a checklist system for new starters and this will be monitored by the Medical Staffing Team, and further checks will be carried out by the Revalidation Support Team.
For Locums, the Agency will have their own framework but the doctor must be compliant with the Trusts own requirements and this information be provided by the agency and reviewed by the EMD. The Trust only uses national framework agencies accredited for supplying agency doctors.

The Trust has introduced leadership training for all leaders within the organisation and we will monitor its effectiveness

There are learning half days for all staff. For medical staff there are regular weekly CPD sessions. Attendance and effectiveness will be monitored.

Equality and Diversity is mandatory part of Trust training for all employees and will continue to be monitored.

The Trust has implemented the principles of Just Culture and our HR processes are aligned to this. There are support networks to promote diversity and inclusion.

The Trust has embedded PSIRF and work will continue to ensure that this is effective in its implementation.

The Trust will continue to use the Just Culture framework.

We will continue to promote Freedom to Speak up, review its policy and ensure champions are in place. Incident themes will regularly reviewed to look for patterns and learning.

There is a complaints process which has an underlying policy in situ and this will continue to be reviewed.

We will regularly solicit feedback from service users to provide feedback to both practitioners and inform service design.

The Trust will ensure that formal 360 feedback is received by every doctor every 3 years.

The RO and Appraisal will lead attend the appraisal and revalidation networks to allow for peer learning. In addition the Trust will explore the possibility of organising a peer review from a neighbouring Trust.

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

We recognise that there is a shortfall of case investigators and case managers and are organising training to rectify this. We anticipate this being in place by the start of the next calendar year.

There are no current concerns about the management of governance of systems and processes in the Trust to deal with medical appraisal and revalidation with assurance provided to demonstrate that they operate effectively.
The feedback from the medical staff in relation to their appraisals 2024-2025 was very positive.

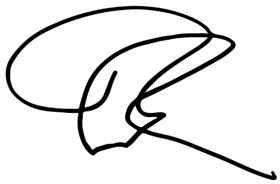
Section 4 – Statement of Compliance

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:	Rotherham, Doncaster and South Humber NHS Foundation Trust

Name:	Toby Lewis
Role:	Chief Executive Officer
Signed:	
Date:	10/11/2025