NHS England

# Information flows to support medical governance and responsible officer statutory function

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## Document Status

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# Information flows to support medical governance and responsible officer statutory function

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**Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:**

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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# 1 Purpose and relevance of this guidance

This guidance aims to promote improvements to clinical governance and appraisal of doctors by:

- setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow
- providing useful toolkits and examples of good practice

This guidance is relevant to all designated bodies in England. It is of particular importance to responsible officers, human resource, clinical governance, information governance departments, appraisers and doctors. It will also be of interest to patient and public representatives and other groups and bodies with an interest in the quality of healthcare.

# 2 Executive summary

## Purpose

This guidance sets out the main channels along which information about a doctor's medical practice may need to flow, in support of good medical governance and the statutory duties of the responsible officer and in support of patient safety and quality of care.

## Patient safety

The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. This priority must be balanced with data protection and confidentiality considerations.

## Consistency and networking

It is vital that all responsible officers in England adopt the same approach towards sharing information of this nature. As far as possible, the same principle must also be pursued cooperatively in all UK countries.

In making decisions about sharing information, a responsible officer may choose to confer with other responsible officers and colleagues in the responsible officer network and their higher level responsible officer. They may also take advice from other resources such as the local GMC Employer Liaison Advisor and other experts such as persons from Colleges and other professional bodies.

## Responsible officer duty to share

On a routine basis, the responsible officer is only required to share information about a doctor's fitness to practise with the GMC. The responsible officer is not under any duty, routinely, to share information about a doctor's fitness to practise with any other person. This contrasts with certain ad hoc situations where a responsible officer may

need to exchange information about a doctor’s practice with a range of other people in the interests of protecting patient safety.

## Cooperation with the responsible officer

The responsible officer requires access to such information as is required in the discharge of their statutory duties. Other persons and organisations have a corresponding duty of cooperation with the responsible officer to assist them in meeting these duties.

## Doctors in training

There is broad equivalence between revalidation arrangements for a doctor in postgraduate training connected to a dean and a doctor connected to a responsible officer elsewhere in the system. In this document, the term ‘appraisal’ equates to ‘Annual Review of Competency Progression’ (ARCP), the term appraiser to ‘educational supervisor’/’ARCP panel’, and ‘appraisal policy’ to ‘Gold Guide’.

## Information governance

All local and national information management processes must be adhered to when sharing information about a doctor’s practice. The arrangements for handling such information must be described in documents such as the designated body’s access statement.

## The flows

This guidance describes **18 distinct flows**, and the arrangements which apply for each in terms of:

- whether requested or provided proactively – ‘push or pull’
- the provider
- the recipient
- the nature of the information
- the timing of the information sharing
- the mechanism
- the status of the flow (whether existing or proposed)

The flows described are presented to support consistency of approach but do not comprise an exhaustive or restrictive list. A responsible officer has the prerogative to employ any suitable information flow necessary to discharge their statutory function and to protect patient safety.

## Appendices and toolkits to support the flows

An in-depth discussion of the background and rationale for this guidance is set out in Appendix A.

A summary analysis of each flow, including responsibility by each key role, is presented in Appendix B.

Toolkits follow the appendices to support the information flows described in this guidance. These include:

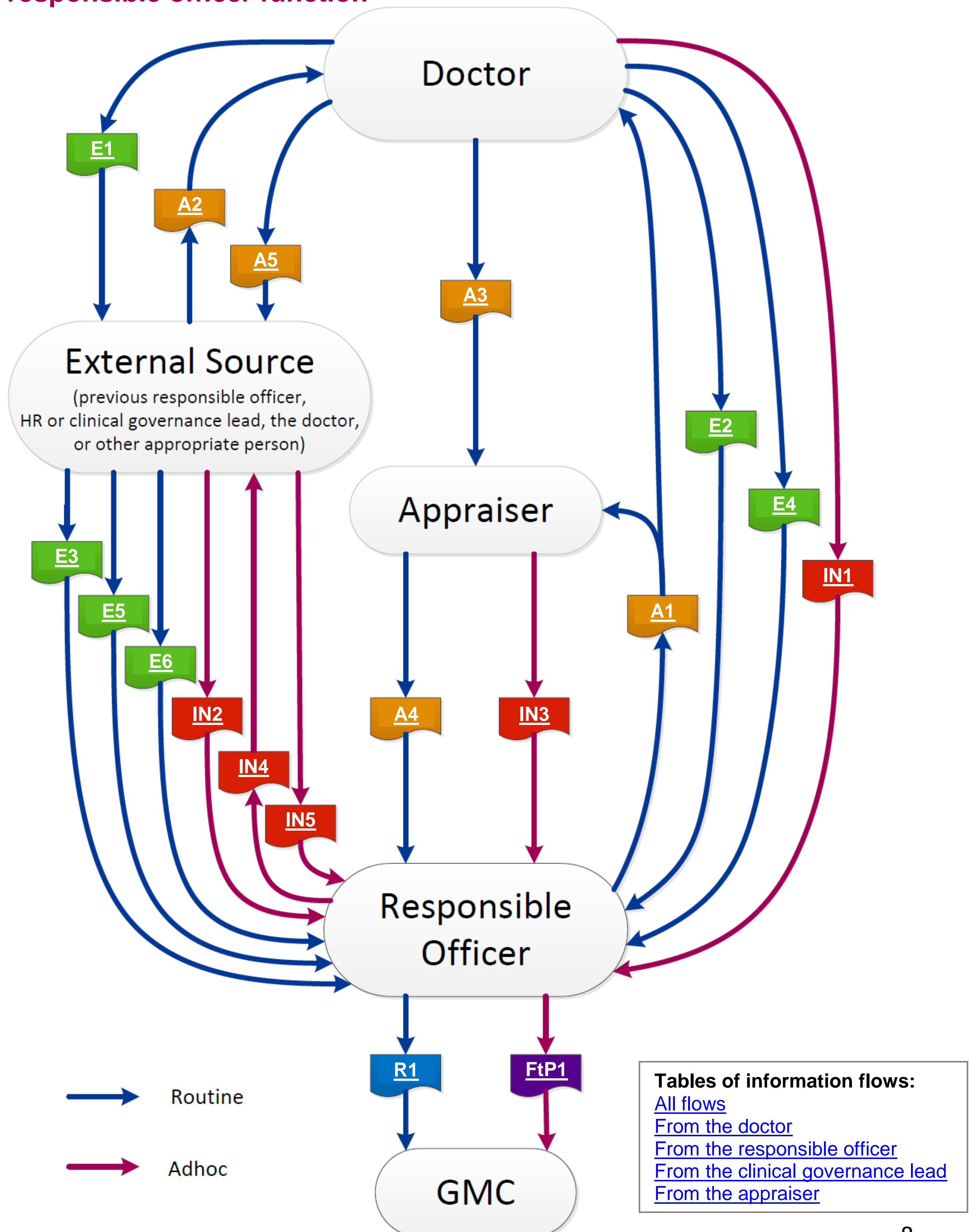
- a list of items suitable for inclusion in pre-employment checks

- an illustrative appraisal documentation access statement
- a standard format for informing a responsible officer that a doctor is taking up new employment
- a standard acknowledgement from a responsible officer to a doctor’s new employer or other person seeking information
- standard template versions of the existing Medical Practice Information Transfer (MPIT) form, suitable for use as email templates

## 3 Diagram of information flows

The information flows described in this guidance are shown schematically below in Figure 1. Each flow label links through to a more detailed tabular explanation of the flow in Section 4. High-level summary tables, broken down by key role responsibility, are also available in Appendix B.

**Figure 1: Information flows to support medical governance and responsible officer function**



# 4 Details of information flows

Use the diagram in Section 3 and summary tables in Appendix B to cross-reference each information flow as outlined below:

**Routine** sharing of information occurs:

- when a doctor takes up or ends employment
- at appraisal
- at revalidation

**Ad hoc** sharing of information occurs:

- When information of note arises
- When fitness to practise procedures are necessary

## Routine – When a doctor takes up or leaves employment:

| **Flow E1** | From: | **Doctor** |
|---|---|---|
| | To: | **New employer**, whether or not the new employment means a change in the doctor's prescribed connection |
| Push or pull? | **Pull**: the doctor's prospective employer should request this information. | |
| Information | Pre-employment information as determined by the doctor's prospective employer, in keeping with relevant prevailing regulations, and including self-declaration by the doctor of information of note as set out by the prospective employer. | |
| Timing | Prior to commencement of employment, in accordance with the human resource and other engagement processes of the doctor's prospective employer. | |
| Mechanism | As determined by the doctor's prospective employer (Human Resources (HR) department). | |
| Status | Existing - potential for improved consistency. | |
| Notes | A list of items which a prospective employing organisation might commonly require within this flow can be found in Toolkit 1.<br><br>Whether or not an employing organisation requires a doctor to make a self-declaration about information of note as a component of the pre-employment information in this flow is a matter for the organisation. It is good practice for this to happen. Should the employing organisation require a self-declaration of this nature by a doctor, as part of their pre-employment procedure, they may also choose to make clear to a doctor any consequences that may ensue, should information subsequently come to light that the doctor does not disclose, whether such consequences relate to the doctor's employment or the involvement of regulatory or other processes.<br><br>The term 'employer' in this document refers to any organisation employing, contracting or otherwise engaging the services of the doctor. This includes, for example, a private healthcare body offering practising privileges to a doctor.<br><br>See also General notes below. | |

Diagram of flows Table – All flows Table – From the doctor

| **Flow E2** | From: | **Doctor** |
|---|---|---|
| | To: | **Responsible officer**, when the new employing organisation will not be the doctor's designated body |
| Push or pull? | **Push**: the doctor should provide this information without prompting. | |
| Information | Confirmation that the doctor has taken up this new role. | |
| Timing | At the doctor's first medical appraisal following this new employment. | |
| Mechanism | By inclusion of the new role in the scope of work section of their next medical appraisal documentation. | |
| Status | Existing | |

Diagram of flows Table – All flows Table – From the doctor

| **Flow E3** | From: | **New clinical governance lead** of the doctor's new employing organisation with responsibility for the doctor[1] |
|---|---|---|
| | To: | **Responsible officer** of the doctor, when the new employing organisation will not be the doctor's designated body |
| Push or pull? | **Push**: the person of the doctor's new employing organisation with clinical governance responsibility for the doctor should provide this information without prompting. | |
| Information | Confirmation that the doctor has taken up this new role. | |
| Timing | No later than 12 weeks after commencement of the doctor's new employment. | |
| Mechanism | Electronically, preferably using a standard and secure template. | |
| Status | Proposed | |
| Notes | The responsible officer needs to be aware of all the places where a doctor is working, to allow the necessary channels of information to be established. The established mechanism for this information is via the doctor's scope of work declaration at their annual medical appraisal. This mechanism means that there is potentially a lapse of several months before a responsible officer becomes aware that a doctor has taken up new employment, should they do so shortly after completing an appraisal. It is therefore good practice for the person with clinical governance responsibility for the doctor in their new employing organisation to inform the doctor's responsible officer that they have engaged the doctor. The template letter in Toolkit 3 provides a suitable format for such a communication. | |

Diagram of flows Table – All flows Table – From the clinical governance lead

| **Flow E4** | From: | **Doctor** |
|---|---|---|
| | To: | **New responsible officer**, when the doctor's prescribed connection changes |
| Push or pull? | **Pull**: the new responsible officer should request this information. | |
| Information | • Name of previous responsible officer and designated body<br>• Dates of last and next revalidation<br>• Previous appraisal records (or Annual Review of Competence Progression (ARCP) supporting documentation if the doctor is exiting a training programme)<br>• Any existing/relevant information of note about the doctor's practice | |
| Timing | When the doctor establishes a prescribed connection to the new responsible officer – on date of commencement at new organisation. | |
| Mechanism | Electronically, on receipt of request, by secure email or other suitable mechanism, approved by the new responsible officer. | |
| Status | Existing - potential for increased consistency. | |
| Notes | See General notes below. | |

Diagram of flows Table – All flows Table – From the doctor

[1] In most situations this will be the organisation's responsible officer (although in this circumstance they are not the responsible officer of the doctor in question). In a small number of situations a doctor may provide medical services in an organisation which does not have a responsible officer. In this circumstance the information flows described in this document must be supported by a person with clinical governance responsibility for the doctor in the organisation.

| Flow E5 | From: | **Previous responsible officer** |
|---|---|---|
| | To: | **New responsible officer**, when the doctor's prescribed connection changes |
| Push or pull? | **Pull**: the new responsible officer should request this information. | |
| Information | • Date of last appraisal<br>• Most recent ARCP sign-off documentation (if the doctor is exiting a training programme)<br>• Existing information of note relating to the doctor's practice (Appendix A, Figure 2) | |
| Timing | At the point when the doctor establishes a prescribed connection to the new responsible officer – on the date of commencement at the new organisation. | |
| Mechanism | Electronically, using the Medical Practice Information Transfer (MPIT) form, or an abridged equivalent (e-MPIT) as appropriate (Toolkit 5). | |
| Status | Existing - potential for increased consistency. | |
| Notes | **Where a doctor loses their prescribed connection to a designated body but does not immediately register a new prescribed connection**, the responsible officer should prepare the information in this flow, ready for transfer when the doctor establishes a new prescribed connection. If, in this situation, the responsible officer is holding information of note about the doctor's practice, on the basis of which they were intending to take local action, but which does not cross the threshold for GMC fitness to practise procedures, the following considerations should apply:<br><br>• Patient safety is paramount. Whilst there are many legitimate reasons why a doctor may end their prescribed connection to a designated body and not subsequently establish a new connection, the responsible officer should re-evaluate the overall level of concern, in light of the fact that the prescribed connection has been broken and that local action will not now be possible. If this results in a judgement that the threshold for GMC fitness to practise procedures has now been reached, the information should be shared with the GMC as in Flow FtP1. In making this judgement, the responsible officer may wish to confer with others as described in Section 6 below.<br><br>• If re-evaluation results in the judgement that the threshold for GMC fitness to practise procedures has still not been reached, the responsible officer should hold the information, pending the doctor forming a new prescribed connection, at which point the information can be shared with their new responsible officer as in this flow. The responsible officer should also continue to make documented efforts to share the information in question with the doctor, advising them to share the information with their new responsible officer and to discuss at their next appraisal.<br><br>• The responsible officer should review the situation periodically, conferring appropriately and making suitable records, so as to remain clear that the information remains below the threshold for GMC fitness to practise. The interval between such reviews will be dependent on the level of concern. As a minimum benchmark, such | |

| | |
|---|---|
| | a situation should be reviewed on a three-monthly basis.<br>• Given the proactivity of the GMC in communicating with doctors who do not have a prescribed connection and that, as a result of the responsible officer regulations, healthcare organisations are increasingly effective in undertaking appropriate employment checks, it is both likely that a doctor in this situation will form a new prescribed connection in a timely fashion and unlikely that they will be able, legitimately, to undertake professional practise before doing so.<br>See also General notes below. |

Diagram of flows  Table – All flows  Table – From the responsible officer

| **Flow E6** | From: | **Clinical governance lead** with responsibility for the doctor in the doctor's employing organisation, which is not the doctor's designated body |
|---|---|---|
| | To: | **Responsible officer**, when the doctor leaves employment or completes a placement |
| Push or pull? | **Push**: the person of the doctor's new employing organisation with clinical governance responsibility for the doctor should provide this information without prompting. | |
| Information | Details of any information of note (Appendix A, Figure 2), or confirmation that there is no information of note. | |
| Timing | Within 2 weeks of end of employment or placement. | |
| Mechanism | Electronically, using the Medical Practice Information Transfer (MPIT) form, or an abridged equivalent (e-MPIT) as appropriate (Toolkit 5). | |
| Status | Existing – some locations. | |
| Notes | The challenge of this flow is greatest in the context of a doctor who undertakes multiple short term placements in several organisations, for example a doctor working as a locum in several places for short periods of time. While good practice in this regard to this flow does exist, there persists significant scope for the development of a widely used, effective, efficient, convenient, and proportionate mechanism for meeting this flow in such circumstances. A standardised mechanism would go a significant way to address this important matter, and it will be helpful for future work to focus on this challenge. | |

Diagram of flows  Table – All flows  Table – From the clinical governance lead

**General notes on flows relating to employment:**

- Flows **E1, E4** and **E5**: Transfer of information about a doctor's practice to the new responsible officer may commonly occur at the same time that **pre-employment procedures** are being completed, including the taking up of references.

  It is important to distinguish between pre-employment checks provided to a prospective employer **by a doctor** in Flow **E1** (and, if the prescribed connection is changing **E4**) and the transfer of information of note about the doctor's practice provided to the responsible officer of the employing organisation **by the doctor's previous responsible officer** (Flow **E5**). This distinction is chiefly in terms of whose responsibility it is to provide the information and the timing of the sharing of information:

- It is the responsibility of prospective employing organisation to obtain **pre-employment information** from the doctor (Flow **E1**). There is no existing legal basis for a responsible officer to transfer any information about a doctor to a prospective new responsible officer before the doctor's prescribed connection has changed.
- **Pre-employment checks** (Flow **E1**) should happen prior to a doctor's commencing practice in the new organisation and transfer of information from the previous responsible officer to the doctor's new responsible officer (Flow **E5**) should happen at the point of engagement of the doctor by their new designated body (see also '**responsible officer has an obligation to communicate'** bullet, below).

- Flow **E4** and **E5**: In these flows there is distinction between the sign-off information relating to appraisal or ARCP, and the supporting information behind this (the full appraisal documentation or the ARCP supporting documentation). It is the responsibility of the doctor to provide their responsible officer with the full documentation that will permit an assured recommendation about their revalidation and not the responsibility of their previous responsible officer to transfer this information on their behalf. It may be a breach of information governance rules to do so without the doctor's consent. For this reason it is set out in this document that the previous responsible officer shares the administration detail of the doctor's most recent appraisal/final ARCP output with the doctor's new responsible officer (Flow **E4**) and the doctor shares the supporting information (Flow **E5**). Describing the two flows in this manner does not preclude the possibility that a previous responsible officer may agree to share the appraisal/ARCP supporting information directly with the new responsible officer, provided this is with the consent of the doctor and within the capacity limits of the previous responsible officer to do.

  The situation in relation to flows **E4** and **E5** is slightly different for doctors whose prescribed connection is to NHS England, in that NHS England is a single designated body with a number of responsible officers. A doctor may therefore move between NHS England responsible officers, but in doing so will maintain their prescribed connection to the same designated body. It is therefore legitimate that all of their information transfers to the new NHS England responsible officer, as it is not moving outside the organisation's boundary. The NHS England Revalidation Management System (RMS) supports this process automatically by transferring access rights to the new NHS England responsible officer at the point of transfer.

- A doctor's **responsible officer has an obligation to communicate** on an ad hoc basis with the person responsible for clinical governance of the doctor in other organisations where a doctor is working, should they become aware of information of note relevant to the doctor's practice in those organisations (Flow **IN4**). However, there is currently no provision for a responsible officer to provide routine assurance to any person or body, other than the GMC, relating to a doctor's fitness to practise, whether as part of pre-employment checks, or as part of routine governance processes in places where a doctor may be working. If approached for routine information in this way, a responsible officer may respond in a manner similar to that set out in the template letter in Toolkit 4.

  This principle, that a responsible officer does not provide pre-employment reference or statement of fitness to practise, can create a difficulty when an employing organisation seeks a reference from a doctor's medical director. The large majority of designated bodies nominate their medical director as responsible officer, a logical and desirable

approach. However, it is possible for an individual to hold information as responsible officer, which they would not be privileged to as medical director, and which it would not be appropriate to include, refer to, or take into account as a component of a pre-employment reference. A responsible officer asked to provide a reference in their role as medical director may therefore need to consider carefully their response. If declining such a request, it is important to make clear that the reason is the conflict of confidentiality between the medical director and responsible officer roles, so as not to inadvertently disadvantage the doctor seeking employment.

## Routine – Appraisal:

**Before appraisal:**

| **Flow A1** | From: | **Responsible officer** |
|---|---|---|
| | To: | **Doctor** and **Appraiser** |
| Push or pull? | **Push**: where the information is agreed, the doctor's responsible officer should provide it without prompting. | |
| Information | Agreed expected information for presentation and reflection at appraisal. | |
| Timing | In a timely manner, prior to the doctor's appraisal. In practice this means no later than 28 days prior to the doctor's appraisal due date. | |
| Mechanism | Electronically, in a format suitable for the doctor to submit, reflect on and discuss with their appraiser as part of their appraisal portfolio. | |
| Status | Existing – some locations. | |
| Notes | 'Agreed expected information': As revalidation continues to develop, work is continuing to establish mechanisms whereby responsible officers and their doctors reach agreement about certain expected items of supporting information which the doctors will present for reflection at appraisal. This flow supports this emerging practice. More details of this approach can be found in the document: 'Improving the inputs to medical appraisal' (NHS England 2016), which also contains a template for providing this information to a doctor in a consistent and recognisable format.<br><br>It is helpful to the concept of transparency for the information in this flow to be shared simultaneously with the doctor's appraiser. | |

Diagram of flows    Table – All flows    Table – From the responsible officer

| **Flow A2** | **From:** | **Clinical governance lead** with responsibility for the doctor in other places where the doctor is working |
|---|---|---|
| | **To:** | **Doctor** |
| Push or pull? | **Push**: where local processes exist, the person with clinical governance responsibility for the doctor in the doctor's employing organisation should provide this information without prompting. | |
| Information | From all other organisations where the doctor is working: a summary, where it exists, of the outputs of the doctor's engagement with clinical governance processes in that organisation. | |
| Timing | In a timely manner, prior to the doctor's appraisal. In practice this | |

| | |
|---|---|
| | means no later than 28 days prior to the doctor's appraisal due date. |
| Mechanism | Electronically, in a format suitable for the doctor to submit, reflect on and discuss with their appraiser as part of their appraisal portfolio. |
| Status | Existing – some locations. |
| Notes | It is important that clinical governance processes in healthcare organisations are aligned so as to provide doctors with suitable details of their engagement with these processes. This will help doctors provide assurance of this engagement to their responsible officer via their annual appraisal and reflect on their engagement with their appraiser. This flow supports this process. A suitable in-role review template can be found in the document 'Improving the inputs to medical appraisal' (NHS England 2016) to assist organisations making developments in this area. Whilst it may be helpful for such information to be timed to coincide with a doctor's appraisal, it is recognised that this is not always logistically possible.<br><br>If information from clinical governance processes, in any of the places where a doctor is working, indicates a concern about the doctor's fitness to practise, this should be shared directly with the responsible officer in accordance with Flow IN2 as an ad hoc action at the time when it arises. The doctor's responsible officer can then note or take action as appropriate. The same information should also then be shared as a secondary action via Flow A2, to support the doctor's reflection at appraisal. |

Diagram of flows   Table – All flows   Table – From the clinical governance lead

| **Flow A3** | From: | **Doctor** |
|---|---|---|
| | To: | **Appraiser** |
| Push or pull? | **Push**: the doctor should provide this information to their appraiser without prompting. | |
| Information | The doctor's appraisal submission, in keeping with GMC requirements and taking into account other relevant considerations such as guidance from Colleges and expected information agreed with the responsible officer. | |
| Timing | In a timely manner, prior to the doctor's appraisal, as defined by the designated body's appraisal policy. | |
| Mechanism | As defined within the appraisal policy of the designated body. | |
| Status | Existing | |
| Notes | It is the doctor's professional obligation to present their appraisal submission to their appraiser, although many responsible officers support their doctors in this by way of reminders, local guidance and other means.<br>For a doctor in training, whose responsible officer is their postgraduate dean, the 'Form R' or equivalent, combined with the doctor's training portfolio, corresponds to the appraisal submission. | |

Diagram of flows   Table – All flows   Table – From the doctor

**After appraisal:**

| Flow A4 | From: | **Appraiser** |
|---|---|---|
| | To: | **Responsible officer** |
| Push or pull? | **Push**: the appraiser should provide this information without prompting. | |
| Information | The doctor's full appraisal record. | |
| Timing | Within 28 days of completion of the doctor's medical appraisal. | |
| Mechanism | As determined by the local appraisal policy and appraisal format. | |
| Status | Existing | |
| Notes | For a doctor in training, whose responsible officer is their postgraduate dean, the ARCP Outcome form corresponds to the appraisal record. The ARCP Outcome form also provides for the inclusion of information of note about a doctor in training for the responsible officer (Dean) to note or take action, and is therefore also the vehicle which supports Flows IN3 and IN4 4 below. | |

Diagram of flows Table – All flows Table – From the appraiser

| Flow A5 | From: | **Doctor** |
|---|---|---|
| | To: | **Clinical governance lead** with responsibility for the doctor in other places where they are working |
| Push or pull? | **Pull**: persons with clinical governance responsibility for the doctor in other places where the doctor is working should request this information, if appropriate. | |
| Information | The doctor's medical appraisal documentation as specified contractually, or otherwise, between the doctor and the organisation in question. | |
| Timing | Within the timescale agreed, or specified contractually, or otherwise, between the doctor and the organisation in question. | |
| Mechanism | As determined by the contractual, or other arrangements between the doctor and the organisation in question. | |
| Status | Existing - some locations. | |
| Notes | This flow only applies when the doctor and the person with clinical governance responsibility for them in an organisation where the doctor is working, other than their designated body, have agreed that this should happen, whether through contractual or other arrangements. This is a matter for the doctor and the person with clinical governance responsibility for the doctor in that organisation.<br><br>As referred to in the notes on the flows relating to employment, above, it is recommended that a doctor's responsible officer does not routinely provide any part of the doctor's appraisal outputs to any other person, regardless of whether the doctor has provided consent. (It should be noted that to share such information routinely and without the doctor's consent may breach existing data protection rules.) If approached for a doctor's appraisal information in this way, a responsible officer is therefore encouraged to respond in a manner similar to that set out in the template letter in Toolkit 4. | |

Diagram of flows Table – All flows Table – From the doctor

## Routine – Revalidation:

| Flow R1 | From: | Responsible officer |
|---|---|---|
| | To: | GMC |
| Push or pull? | **Push**: the doctor's responsible officer should provide this information without prompting. | |
| Information | The responsible officer's recommendation to the GMC about the doctor's revalidation. | |
| Timing | Prior to the doctor's recommendation due date, as notified by the GMC. | |
| Mechanism | As set out by the GMC via GMC Connect. | |
| Status | Existing | |
| Notes | **Communicating the recommendation decision to the doctor:** Whilst it is noted elsewhere in this guidance that it is good practice to inform the doctor about the information being shared, this is of special importance in this flow. This is because the GMC normally communicate promptly with the doctor about their decision. Forewarning the doctor about the nature of their responsible officer's recommendation will help avoid the doctor becoming concerned. This is particularly helpful if the responsible officer is making a recommendation of deferral or non-engagement. | |

Diagram of flows Table – All flows Table – From the responsible officer

## Ad hoc – Information of note:

| Flow IN1 | From: | Doctor |
|---|---|---|
| | To: | Responsible officer |
| Push or pull? | **Push**: the doctor should provide this information without prompting. | |
| Information | The information of note in question (Appendix A, Figure 2), for the doctor's responsible officer to note or take action. | |
| Timing | As soon as the information is identified. | |
| Mechanism | In reality, and in recognition of the likely stresses which may apply at the time, a responsible officer should be willing to accept such information from a doctor in any format. | |
| Status | Existing – potential for improved consistency. | |
| Notes | This flow is important as it reinforces the concept of professionalism: every doctor has a responsibility to continually review their own fitness to practise and raise the matter, if this is in question, in the interests of protecting patient safety. As a professional duty this applies to the doctor regardless of whether or not it is explicitly referenced in the doctor's contract with the engaging body or the body's other policies. The doctor is also expected to comply with ad hoc requests from their responsible officer in Flow IN5, should such requests arise. | |

Diagram of flows Table – All flows Table – From the doctor

| Flow IN2 | From: | **Clinical governance lead** with responsibility for the doctor in another place where the doctor is working |
|---|---|---|
| | To: | **Responsible officer** |
| Push or pull? | **Push**: the persons with clinical governance responsibility for the doctor in another place where the doctor is working should provide this information without prompting. | |
| Information | The information of note in question (Appendix A, Figure 2), for the doctor's responsible officer to note or take action. | |
| Timing | As soon as the information is identified. | |
| Mechanism | Various modalities may be appropriate, depending on the nature of the information. The Medical Practice Information Transfer (MPIT) form in Toolkit 5 has been designed to support the transfer of such information. Whichever mechanism is used, care is needed to ensure that the information is factual, and that the method of sharing complies with all relevant information governance, data protection and confidentiality rules. More detail can be found on this in Appendix A. A person considering sharing information of note in this way should consider whether to discuss the matter with the doctor's responsible officer before doing so.<br><br>The information in question should be shared with the doctor, unless there are compelling reasons not to do so. Whilst it is not essential to obtain consent from the doctor, it is regarded as good practice to inform the doctor, and to gain their consent if possible. | |
| Status | Existing – potential for improved consistency. | |

Diagram of flows Table – All flows Table – From the clinical governance lead

| Flow IN3 | From: | **Appraiser** |
|---|---|---|
| | To: | **Responsible officer** |
| Push or pull? | **Push**: the doctor's appraiser should provide this information without prompting. | |
| Information | New information of note arising from appraisal for the responsible officer to note or take action. | |
| Timing | On identification of the information. | |
| Mechanism | Via the appraisal documentation; other modalities may be appropriate, depending on the nature of the information. | |
| Status | Existing | |
| Notes | It should be an uncommon scenario that new information of note arises for the first time in an appraisal. Nevertheless, it is appropriate to include this flow as the appraiser maintains a continuous professional responsibility to protect patients and take action at any time, should information come to light which may compromise patient safety.<br><br>For a doctor in training, whose responsible officer is their postgraduate dean, the ARCP Outcome form corresponds to the appraisal documentation in this flow. | |

Diagram of flows Table – All flows Table – From the appraiser

| Flow IN4 | From: | **Responsible officer** |
|---|---|---|
| | To: | **Clinical governance lead** with responsibility for the doctor in other places where the doctor is working |
| Push or pull? | **Push**: the doctor's responsible officer should provide this information without prompting. | |
| Information | The information of note in question (Appendix A, Figure 2), which is of sufficient significance that it needs to be brought to the attention of the person with clinical governance responsibility for the doctor in places where the doctor works, or has worked, for them to note or take action. | |
| Timing | In a timely manner, appropriate to the information in question, once the information is identified and verified. | |
| Mechanism | The Medical Practice Information Transfer (MPIT) form (see Toolkit 5) has been designed to support the transfer of such information, although various modalities may be appropriate, depending on the nature of the information and the context of the situation. For example, for a doctor in training, the ARCP Outcome form can be a suitable vehicle for the information in this flow, whether or not as an attachment to an MPIT form.<br><br>Whichever mechanism is used, care is needed to ensure that the information is factual, and that the method of sharing complies with all relevant information governance, data protection and confidentiality rules, as described in Appendix A. A doctor's responsible officer considering sharing information of note in this way should consider whether to take suitable advice before doing so.<br><br>The information in question should be shared with the doctor unless there are compelling reasons not to do so. Whilst it is not essential to obtain consent from the doctor, it is regarded as good practice to inform the doctor, and to gain their consent if possible. | |
| Status | Existing – potential for improved consistency. | |

Diagram of flows Table – All flows Table – From the responsible officer

| Flow IN5 | From: | **Clinical governance lead** with responsibility for the doctor in other places where a doctor is working |
|---|---|---|
| | To: | **Responsible officer** |
| Push or pull? | **Pull**: the doctor's responsible officer should request this information. | |
| Information | Details of any information of note (Appendix A, Figure 2) of which the responsible officer, in a place where the doctor is working other than the designated body, is aware, and which may inform the enquiry which the doctor's responsible officer is making. | |
| Timing | In a timely manner, appropriate to the nature of the request, but normally within two weeks of receipt of the request. It should be noted that in the context of this flow, positive confirmation that there is no other information of note itself constitutes 'information of note' for the doctor's responsible officer. | |
| Mechanism | The Medical Practice Information Transfer (MPIT) form (see Toolkit 5) has been designed to support the transfer of such information, although various modalities may be appropriate, depending on the nature of the information. The abbreviated version of the MPIT form in | |

| | |
|---|---|
| | Toolkit 5 (also known as the e-MPIT form) may also provide a suitable vehicle in the context of this flow, especially when the responder is simply confirming that they have no information of note to share with the doctor's responsible officer.<br>Whichever mechanism is used, care is needed to ensure that the information is factual, and that the method of sharing complies with all relevant information governance, data protection and confidentiality rules, as described in Appendix A, particularly when the information being shared is significant. A person considering sharing information of note in this way should consider whether to take suitable advice before doing so.<br><br>The information in question should be shared with the doctor, unless there are compelling reasons not to do so. Whilst it is not essential to obtain consent from the doctor, it is regarded as good practice to inform the doctor, and to gain their consent if possible. |
| Status | Existing - some locations. |
| Notes | There are two main scenarios when a doctor's responsible officer may make an enquiry about a doctor's practice in this way:<br><br>• **In response to a concern about the doctor's practice** which has arisen. Depending on the arrangements for investigating the concern and the role of the doctor's responsible officer in the investigation (for example as the case manager), the request for information may come from a person other than the responsible officer, for example the case investigator, acting with delegated responsibility.<br><br>• **To support the responsible officer's recommendation to the GMC** about the doctor's revalidation. Revalidation has been designed in such a way as to minimise the need for a doctor's responsible officer to routinely seek assurance from responsible officers in other places where the doctor is working. However, because a doctor's responsible officer relies on clinical governance information submitted by the doctor at appraisal to help assure their recommendation, a responsible officer may need to make use of this flow to request information from organisations which have not provided sufficient clinical governance information already for the doctor to submit at their appraisal.<br><br>Doctors should note that they may be expected to provide information via this flow, as they have a duty to present all required information necessary to inform their responsible officer's recommendation. While many responsible officers have systems in place to gather and store this information over time, a situation which is mutually convenient for both responsible officer and the doctor, ultimate responsibility in this regard rests with the doctor. |

Diagram of flows   Table – All flows   Table – From the clinical governance lead

**General notes on flows relating to information of note:**

- As indicated in Appendix A, Figure 2, information of note may be positive, indicating excellence of practice which the sender wishes to bring to the attention of the doctor's

responsible officer, in order to gain recognition for the doctor and to help disseminate learning.

## Ad hoc – Fitness to practise:

| **Flow FtP1** | From: | **Previous Responsible officer** |
|---|---|---|
| | To: | **GMC** |
| Push or pull? | **Push**: the doctor's responsible officer should provide this information without prompting. | |
| Information | Information supporting the responsible officer's concerns about the doctor's fitness to practice for the GMC. | |
| Timing | As soon as the responsible officer is aware that the threshold for GMC fitness to practise procedures has been reached. | |
| Mechanism | Using the GMC referral form or in other format acceptable to the GMC. | |
| Status | Existing | |
| Notes | The responsible officer will normally confer with their GMC Employment Liaison Advisor (ELA) before deciding to make a formal Fitness to Practice referral to the GMC as set out in this flow, where it is appropriate to do so and circumstances permit. | |

Diagram of flows     Table – All flows     Table – From the responsible officer

# 5 Appendices and Toolkits

In this section, background information is given and toolkits are provided which are designed to help doctors, responsible officers and persons with clinical governance responsibility for doctors in their places of work to make operational the principles of this guidance. It is highly desirable that all designated bodies use the same documentation to support consistency and confidence in the arrangements. They have been developed in conjunction with the Responsible Officer Network in England to ensure their suitability and usefulness as much as possible.

Responsible officers are therefore encouraged to adopt the tools provided here, or modify their existing tools to match those in this document as closely as possible. Where the adoption of a tool may be disruptive to local processes, this should be communicated to the responsible officer's higher level responsible officer, so that the matter can be assessed and resolved.

The **appendices to support this guidance** are:

Appendix A: Information flows to support medical governance and responsible officer statutory function – background, rationale, list of flows and references

Appendix B: Details of information flows

The **toolkits to support this guidance** are:

Toolkit 1: Items suitable to include in pre-employment checks

Toolkit 2: Illustrative appraisal documentation access statement

Toolkit 3: Standard notification to responsible officer from a new employer

Toolkit 4: Standard response from responsible officer to new employer or person making enquiry

Toolkit 5: Medical Practice Information Transfer (MPIT) pdf form and email templates

Stand-alone versions of these toolkits are available via the NHS England, medical revalidation web pages.

# Appendix A: Information flows to support medical governance and responsible officer statutory function –background, rationale, list of flows and references

## i. Background

### Responsible officer regulations

The Medical Profession (Responsible Officers) Regulations 2010 and the Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (‘the regulations’) require each body designated under the regulations to appoint a responsible officer who must monitor and evaluate the fitness to practise of doctors with whom the designated body has a prescribed link.

### Revalidation

Revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise. On the basis of information available to the responsible officer from local clinical governance and medical appraisal systems, the responsible officer makes a recommendation to the GMC, normally every five years, about the doctor’s revalidation. The GMC will consider the responsible officer’s recommendation and decide whether to continue the doctor’s licence to practise.

### Statutory duty of the responsible officer, delegated authority, responsible officer autonomy and calibration of decisions

Depending on the scale and nature of a designated body, a responsible officer may delegate certain duties to others whist retaining overall statutory responsibility as set out in the regulations. This may include, for example, delegating an associate director to manage day-to-day revalidation activity, or delegating relevant activities to effective human resource or clinical governance departments.

Additionally, some doctors do not hold a prescribed connection to a designated body, and therefore do not have a responsible officer. Such doctors may, with the agreement of the GMC, have their revalidation managed by a GMC-approved ‘suitable person’.

A small number of doctors have neither a responsible officer nor a ‘suitable person’. These doctors have their revalidation managed directly by the GMC.

In this guidance therefore, where the term ‘responsible officer’ is used, this should be taken to mean ‘responsible officer or other person with appropriately delegated authority’, or GMC-approved ‘suitable person’.

In many aspects of the revalidation process, including those set out in this guidance, the responsible officer has discretion to make decisions based on their professional judgement. In doing so a responsible officer may confer with other responsible officers and colleagues in the responsible officer network, and their higher level responsible officer. They may also take advice from other resources such as the local GMC Employer Liaison Advisor and other experts such as persons from Colleges and other professional bodies. Conferring in this way helps ensure that decisions are based on current national thinking, and are in step with other responsible officers.

## ii. Rationale

As the person with statutory responsibility for making a recommendation to the GMC about a doctor's revalidation, the responsible officer is the focal point for information relating to a doctor's fitness to practise. This may be relatively straightforward in the main organisation where a doctor works. However, information also needs to be obtained from each of the organisations in which the doctor works. When a doctor works in more than one organisation, or has roles which are otherwise supervised distinctly, there needs to be pathways for sharing relevant information about the doctor's work with their responsible officer.

The same information should be submitted and reflected upon by the doctor at appraisal. These pathways must be aligned across all designated bodies in order for the system to work in a consistent manner. For this to happen in a reliable and efficient manner, it is necessary for all doctors and responsible officers to adopt the same processes and, as far as possible, use standard forms and templates.

### Why share information about a doctor's practice?

The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when it is required to support the responsible officer's statutory duties or to maintain patient safety.

### Information governance/confidentiality/consent

The reasons to share information about a doctor's practice are balanced with the rights of the doctor as set out in data protection rules. This is discussed in detail in 'The Information Governance Review' (Department of Health, 2013). The NHS Revalidation Support Team published relevant guidance in 2014, and guiding principles have also been set out by NHS Employers and the Independent Healthcare Advisory Service (IHAS).

Information transferred in these circumstances must be held in confidence and viewed only by those with the proper authority to do so. Those sharing information should take care to ensure all the information shared is factual and support it as much as possible with objective evidence.

Whilst it is not necessary to gain the consent of the doctor to share information when this is required to ensure patient safety, it is preferable that the doctor is informed and to provide them with the information being shared. A doctor can ask their responsible officer for sight of information being shared and, in all but the most exceptional circumstances, has the right to view all information that exists relating to their practice. Sharing such information with the doctor in question is usually very helpful as it often helps to involve the doctor in the matters in question and also represents useful supporting information for them to reflect on at their appraisal.

All local and national information management processes must be adhered to when sharing information about a doctor's practice. The arrangements for handling such information must be described in documents such as the designated body's access statement. An illustrative appraisal documentation access statement can be found in Toolkit 2.

The information flows described in this document relate to the sharing of information which falls within the professional duties of the persons described. This is distinct from the process of whistle blowing, where information of relevance to patient safety may arise from any source and not just those listed in this document.

## Doctors in training

The revalidation process for a doctor in postgraduate training, whose prescribed connection is to Health Education England via a Local Education and Training Board, is broadly parallel to those for doctors who are no longer in training. For a doctor in training, the Annual Review of Competency Progression (ARCP) equates to medical appraisal as set out in the Medical Appraisal Guide, the ARCP panel and in particular the educational supervisor performs the function of the medical appraiser, and the Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide) is the equivalent to a designated body's medical appraisal policy. Information is available here about meeting the revalidation requirements of doctors in postgraduate training where scope of practice extends outside of their training programme.

## Sharing information between different designated bodies, sectors and countries

This document and its appendices are intended to support the flow of information about a doctor's practice between responsible officers in England, for all doctors regardless of the sector(s) they may be working in, or moving between. The flows described are primarily as a result of input and discussion in the Responsible Officer Network in England, of which all responsible officers in England are members. To achieve success, all responsible officers must follow the same approach, as much as possible. The resulting expectation is, therefore, that all doctors, responsible officers and organisations in England will cooperate with the information flows set out in this document, to enable not only the delivery of their statutory responsibilities but also those of their fellow responsible officers. Where a responsible officer finds that to do so causes particular difficulty, they are expected to debate this within the responsible officer network in order to find a commonly agreed solution. Such discussions will also support the revision of this document in future iterations.

Medical revalidation applies to all doctors with a UK licence to practise medicine and a doctor with a GMC licence may undertake work in more than one country within the UK. NHS England responsible officers are expected to cooperate with information sharing requests from responsible officers in other UK countries, provided these are in keeping with the flows set out in this document. It is outside the scope of this document to determine whether responsible officers in other UK countries will reciprocate, but it is hoped that through appropriate conversations and discussions, common information flows can be established, so as to ensure a high level of quality of care is delivered by all doctors with a UK licence.

# iii. List of flows

In accordance with the basis for sharing information, established in the preceding sections, it may be appropriate to share information about a doctor's practice on a routine or ad hoc basis.

**Routine** scenarios are:

- When a doctor takes up or ends **employment** or placement in a role
- At **appraisal**
- When a **revalidation** recommendation is due

**Ad hoc** scenarios relate to the sharing of information of note about a doctor's practice:

- When **information of note** (Figure 2) comes to light about a doctor's practice
- When a doctor's behaviour reaches the threshold for GMC **fitness to practise** procedures to be engaged

## Routine:

### Employment: when a doctor takes up or ends employment or placement in a role:

#### Whether or not the new employment means a change in the doctor's prescribed connection:

- Flow E1: From the doctor to their new employer

#### Where the new employing organisation will not be the doctor's designated body:

- Flow E2: From the doctor to their responsible officer
- Flow E3: From the person with clinical governance responsibility for the doctor within the doctor's new employing organisation to the doctor's responsible officer

#### When the doctor's prescribed connection changes:

- Flow E4: From the doctor to their new responsible officer
- Flow E5: From the previous responsible officer to the doctor's new responsible officer

#### When the doctor completes a period of employment or placement:

- Flow E6: From the person with clinical governance responsibility for the doctor within the doctor's employing organisation (which is not the doctor's designated body) to the doctor's responsible officer

### Appraisal:

#### Before appraisal:

- Flow A1: From the doctor's responsible officer to the doctor and their appraiser
- Flow A2: From persons with clinical governance responsibility for the doctor in other places where the doctor is working[2] to the doctor
- Flow A3: From the doctor to their appraiser

#### After appraisal:

- Flow A4: From the doctor's appraiser to the doctor's responsible officer
- Flow A5: From the doctor to the persons with clinical governance responsibility for the doctor in other places where they are working

[2] This person may or may not also be the responsible officer for the other organisation in in which the doctor will be working, but they will not be the responsible officer for the doctor in question.

### Revalidation:

**When a revalidation recommendation is due:**

- Flow R1: From the doctor's responsible officer to the GMC

## Ad hoc:

### Information of note (Figure 2) about a doctor's practice:

**When the information comes to light:**

- Flow IN1: From the doctor to their responsible officer
- Flow IN2: From the person with clinical governance responsibility for the doctor, in another place where the doctor is working, to the doctor's responsible officer
- Flow IN3: From the doctor's appraiser to the doctor's responsible officer
- Flow IN4: From the doctor's responsible officer to persons with clinical governance responsibility for the doctor in other places where the doctor is working

**When the responsible officer is investigating new information:**

- Flow IN5: From persons with clinical governance responsibility for the doctor, in other places where a doctor is working, to the doctor's responsible officer

**Figure 2: Information of note about a doctor's practice:**

1. Exemplar practice and significant achievements
2. Current restrictions on practice
3. Current GMC referral, or presence of GMC conditions or undertakings
4. Details of fitness to practise concerns, which require the responsible officer to note or take action
5. (On request from a doctor's responsible officer) confirmation that none of the above apply

### Fitness to practise:

**When a doctor's behaviour crosses the threshold for GMC fitness to practise procedures to be engaged:**

- Flow FtP1: From a doctor's responsible officer to the GMC

Depending on the flow, different details under the following parameters apply:

- **Push or pull** – whether the responsibility rests with the information provider to send the information without prompting, or with the final recipient to actively request it
- **Provider** – where the responsibility lies for providing the information. Following the principle that it is desirable to minimise the burden of documentation on doctors, it is for responsible officers and persons with clinical governance responsibility to shoulder as much of this responsibility as possible
- **Recipient** – the person who is the legitimate receiver of the information and accountable for its handling and storage
- **Information** – specific details of the information which is appropriate to that flow and by implication that which is not

- **Timing** – the point in time when sharing the information is legitimate and the flexibility or restrictions which might apply, according to prevailing rules and regulations
- **Mechanism** – the means by which the information in that flow may be passed to the recipient

Delineating the legitimate flows of information will clearly help the efficiency of processes and place limits on the volume and type of information to be shared, protecting capacity. It also reduces the risk of sharing information inappropriately, to maintain information sharing within the relevant rules and regulations. Being clear about the responsibilities for each flow will reduce demands on office staff by reducing the necessity to 'pull' information when in fact that flow is intended to be a 'push' from the sender without prompting.

Finally, and significantly, clarity about the flows allows the burden of documentation to be spread fairly and visibly. This will protect doctors from an unnecessary burden as much as possible and also will limit the risk of responsible officers inappropriately becoming 'on request' providers of assurance about the presence or absence of concerns about their doctors' fitness to practise.

Not all the flows described currently exist, and those that do are at varying stages of development. This guidance seeks to list those flows which are proposed, or in development in some parts of the system, so that all responsible officers can plan to adopt these in an incremental manner. The status of each flow as at the time of writing this document is noted in the tables in Section 4.

The list of flows described in this guidance is not exhaustive or restrictive. It is important that responsible officers are free to exchange information as required and by whatever means necessary to facilitate the discharge of their statutory duties and protect patient safety. The purpose of describing the flows listed is to facilitate an agreed and consistent approach to the common scenarios in which responsible officers rely on each other and other persons for the information they need.

Details of the parameters as they apply to the flows listed above are set out in Section 4, with explanatory notes.

## iv. References

1. A Framework of Quality Assurance for Responsible Officers and Revalidation (Department of Health, NHS England, 2014)

2. A guide for doctors to the General Medical Council (Licence to Practise and Revalidation) Regulations 2012 (GMC, 2012)

3. A Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide, 5th edition) (Conference of Postgraduate Medical Deans of the United Kingdom, 2014)

4. An introduction to revalidation (GMC)

5. Confidentiality NHS Code of Practice (Department of Health, 2003)

6. Data Protection Act 1988

7. Fair processing notice (NHS England)

8. Good Medical Practice (GMC 2013)

9. Guiding Principles for Sharing Information on Healthcare Workers (NHS Employers/IHAS, 2013)

10. Information Management for Medical Revalidation in England (version 4) (NHS Revalidation Support Team, January 2014)

11. Information: To Share or Not to Share? The Information Governance Review (Department of Health, 2013)

12. Medical Appraisal Guide: A guide to medical appraisal for revalidation in England, version 4 (NHS Revalidation Support Team, 2013 (reissued with updated hyperlinks September 2014))

13. Medical Appraisal Logistics Handbook (NHS England 2015)

14. Privacy notice for staff (NHS England)

15. Quality Assurance of Medical Appraisers: Engagement, training and assurance of medical appraisers in England, version 5 (NHS Revalidation Support Team, 2014)

16. Raising and acting on concerns about patient safety (GMC, 2012)

17. Specialty Guidance for Appraisal and Revalidation (Academy of Medical Royal Colleges)

18. Supporting information for appraisal and revalidation (GMC, 2012).

19. The Good medical practice framework for appraisal and revalidation (GMC, 2013).

20. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2010).

21. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013

22. The National Health Service (Performers Lists) (England) Regulations 2013.

ARCP (Annual Review of Competence Progression)
CG (clinical governance)
DB (designated body)
FTP (fitness to practice
GMC (General Medical Council)
HR (human resources)
MPIT (Medical Practice Information Transfer)
RO (responsible officer)

# Appendix B: Summary tables of information flows:

## All flows

**Information flows about a doctor's practice to support medical governance and responsible officer statutory functions.**

| | Scenario | Flow | Circumstances | From: | To | Push/Pull? | What? | When? | How? | Shared with doctor? |
|---|---|---|---|---|---|---|---|---|---|---|
| Routine | Where a doctor takes up or leaves employment ('E') | E1 | New employment | Doctor | HR | Pull by HR | Pre-employment information | Prior to employment | Following organisation's processes | N/A (from doctor) |
| | | E2 | New employment no change in DB | Doctor | RO | Push from doctor | Confirmation of new role | Next appraisal | In Scope of Work section of appraisal documentation | N/A (from doctor) |
| | | E3 | New employment no change in DB | CG Lead of employing organisation | RO | Push from new employer | Confirmation of new role | On commencement of employment | Electronically by secure mechanism using standard template | Yes - cc |
| | | E4 | New DB | Doctor | New RO | Pull by new RO | Details of previous RO/DB<br>Last and next revalidation dates<br>Appraisal documentation (unless trainee)<br>Information of note | On forming new prescribed connection | As agreed with the new responsible officer | N/a - from doctor |
| | | E5 | New DB | Previous RO | New RO | Pull by new RO | Date of last appraisal/ARCP<br>ARCP documentation (if trainee)<br>Information of note | On forming new prescribed connection | MPIT form or equivalent | Yes - cc |
| | | E6 | End of employment/ placement with organisation other than designated body | CG Lead of employing organisation | RO | Push from CG lead | Information of note or confirmation there is no information of note | Within 2 weeks of end of placement | MPIT form or abbreviated version (*e*-MPIT) | Yes in almost all circumstances |
| | Appraisal ('A') | A1 | Pre-appraisal | RO | Doctor and appraiser | Push from RO | Agreed expected information for inclusion at appraisal | Before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A2 | Pre-appraisal | CG lead of employing organisation | Doctor | Push from CG lead | Local CG outputs | When produced, preferably before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A3 | Pre-appraisal | Doctor | Appraiser | Push from doctor | Appraisal submission | Before appraisal | As defined by DB's appraisal policy | N/A (from doctor) |
| | | A4 | Post-appraisal | Appraiser | RO | Push from appraiser | Appraisal documentation | Within 28 days of appraisal meeting | As defined by DB's appraisal policy | N/A (doctor has copy) |
| | | A5 | Post-appraisal | Doctor | CG Lead of employing organisation | Pull by CG lead | If agreed, appraisal documentation | As agreed between doctor and employing organisation | As agreed between doctor and employing organisation | N/A (from doctor) |
| | Revalidation ('R') | R1 | Recommendation is due | RO | GMC | Push from RO | Revalidation recommendation | Prior to notified recommendation due date | Via GMC Connect | Yes (good practice is to inform doctor before GMC) |
| Ad hoc | Information of Note ('IN') | IN1 | Sharing new information of note with RO | Doctor | RO | Push from doctor | New information of note for the RO to note or take action | On identification of the information | As agreed with the responsible officer | N/A (from doctor) |
| | | IN2 | Sharing new information of note with RO | CG lead of employing organisation | RO | Push from CG lead | New information of note for the RO to note or take action | On identification of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN3 | Sharing new information of note with RO | Appraiser | RO | Push from appraiser | New information of note arising from appraisal for the RO to note or take action | On identification of the information | Appraisal documentation, MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN4 | Sharing new information of note with employing organisation | RO | CG leads in employing organisations | Push from RO | Confirmed information of note relevant to employing organisation | On confirmation of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN5 | RO seeking information of note to cross-refer with other information | CG lead of employing organisation | RO | Pull by RO | Information of note or confirmation there is no information of note | Within 2 weeks of request from RO | MPIT form or abbreviated version (*e*-MPIT) | Yes in almost all circumstances |
| | Fitness to Practise ('FtP') | FtP1 | When a doctor's behaviour crosses the threshold for GMC fitness to practise procedures to be engaged. | RO | GMC | Push from RO | Using the GMC referral form or in other format acceptable to the GMC | As soon as the threshold is reached | In the format set out in GMC FTP procedures | Yes in almost all circumstances |

## From the doctor

| | Scenario | Flow | Circumstances | From: | To | Push/Pull? | What? | When? | How? | Shared with doctor? |
|---|---|---|---|---|---|---|---|---|---|---|
| Information flows about a doctor's practice to support medical governance and responsible officer statutory functions. | | | | | | | | | | |
| Routine | Where a doctor takes up or leaves employment ('E') | E1 | New employment | Doctor | HR | Pull by HR | Pre-employment information | Prior to employment | Following organisation's processes | N/A (from doctor) |
| | | E2 | New employment no change in DB | Doctor | RO | Push from doctor | Confirmation of new role | Next appraisal | In Scope of Work section of appraisal documentation | N/A (from doctor) |
| | | E3 | New employment no change in DB | CG Lead of employing organisation | RO | Push from new employer | Confirmation of new role | On commencement of employment | Electronically by secure mechanism using standard template | Yes - cc |
| | | E4 | New DB | Doctor | New RO | Pull by new RO | Details of previous RO/DB<br>Last and next revalidation dates<br>Appraisal documentation (unless trainee)<br>Information of note | On forming new prescribed connection | As agreed with the new responsible officer | N/a - from doctor |
| | | E5 | New DB | Previous RO | New RO | Pull by new RO | Date of last appraisal/ARCP<br>ARCP documentation (if trainee)<br>Information of note | On forming new prescribed connection | MPIT form or equivalent | Yes - cc |
| | | E6 | End of employment/ placement with organisation other than designated body | CG Lead of employing organisation | RO | Push from CG lead | Information of note or confirmation there is no information of note | Within 2 weeks of end of placement | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Appraisal ('A') | A1 | Pre-appraisal | RO | Doctor and appraiser | Push from RO | Agreed expected information for inclusion at appraisal | Before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A2 | Pre-appraisal | CG lead of employing organisation | Doctor | Push from CG lead | Local CG outputs | When produced, preferably before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A3 | Pre-appraisal | Doctor | Appraiser | Push from doctor | Appraisal submission | Before appraisal | As defined by DB's appraisal policy | N/A (from doctor) |
| | | A4 | Post-appraisal | Appraiser | RO | Push from appraiser | Appraisal documentation | Within 28 days of appraisal meeting | As defined by DB's appraisal policy | N/A (doctor has copy) |
| | | A5 | Post-appraisal | Doctor | CG Lead of employing organisation | Pull by CG lead | If agreed, appraisal documentation | As agreed between doctor and employing organisation | As agreed between doctor and employing organisation | N/A (from doctor) |
| | Revalidation ('R') | R1 | Recommendation is due | RO | GMC | Push from RO | Revalidation recommendation | Prior to notified recommendation due date | Via GMC Connect | Yes (good practice is to inform doctor before GMC) |
| Ad hoc | Information of Note ('IN') | IN1 | Sharing new information of note with RO | Doctor | RO | Push from doctor | New information of note for the RO to note or take action | On identification of the information | As agreed with the responsible officer | N/A (from doctor) |
| | | IN2 | Sharing new information of note with RO | CG lead of employing organisation | RO | Push from CG lead | New information of note for the RO to note or take action | On identification of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN3 | Sharing new information of note with RO | Appraiser | RO | Push from appraiser | New information of note arising from appraisal for the RO to note or take action | On identification of the information | Appraisal documentation, MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN4 | Sharing new information of note with employing organisation | RO | CG leads in employing organisations | Push from RO | Confirmed information of note relevant to employing organisation | On confirmation of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN5 | RO seeking information of note to cross-refer with other information | CG lead of employing organisation | RO | Pull by RO | Information of note or confirmation there is no information of note | Within 2 weeks of request from RO | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Fitness to Practise ('FtP') | FtP1 | When a doctor's behaviour crosses the threshold for GMC fitness to practise procedures to be engaged. | RO | GMC | Push from RO | Using the GMC referral form or in other format acceptable to the GMC | As soon as the threshold is reached | In the format set out in GMC FTP procedures | Yes in almost all circumstances |

## From the responsible officer

**Information flows about a doctor's practice to support medical governance and responsible officer statutory functions.**

| | Scenario | Flow | Circumstances | From: | To | Push/Pull? | What? | When? | How? | Shared with doctor? |
|---|---|---|---|---|---|---|---|---|---|---|
| Routine | Where a doctor takes up or leaves employment ('E') | E1 | New employment | Doctor | HR | Pull by HR | Pre-employment information | Prior to employment | Following organisation's processes | N/A (from doctor) |
| | | E2 | New employment no change in DB | Doctor | RO | Push from doctor | Confirmation of new role | Next appraisal | In Scope of Work section of appraisal documentation | N/A (from doctor) |
| | | E3 | New employment no change in DB | CG Lead of employing organisation | RO | Push from new employer | Confirmation of new role | On commencement of employment | Electronically by secure mechanism using standard template | Yes - cc |
| | | E4 | New DB | Doctor | New RO | Pull by new RO | Details of previous RO/DB<br>Last and next revalidation dates<br>Appraisal documentation (unless trainee)<br>Information of note | On forming new prescribed connection | As agreed with the new responsible officer | N/a - from doctor |
| | | E5 | New DB | Previous RO | New RO | Pull by new RO | Date of last appraisal/ARCP<br>ARCP documentation (if trainee)<br>Information of note | On forming new prescribed connection | MPIT form or equivalent | Yes - cc |
| | | E6 | End of employment/ placement with organisation other than designated body | CG Lead of employing organisation | RO | Push from CG lead | Information of note or confirmation there is no information of note | Within 2 weeks of end of placement | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Appraisal ('A') | A1 | Pre-appraisal | RO | Doctor and appraiser | Push from RO | Agreed expected information for inclusion at appraisal | Before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A2 | Pre-appraisal | CG lead of employing organisation | Doctor | Push from CG lead | Local CG outputs | When produced, preferably before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A3 | Pre-appraisal | Doctor | Appraiser | Push from doctor | Appraisal submission | Before appraisal | As defined by DB's appraisal policy | N/A (from doctor) |
| | | A4 | Post-appraisal | Appraiser | RO | Push from appraiser | Appraisal documentation | Within 28 days of appraisal meeting | As defined by DB's appraisal policy | N/A (doctor has copy) |
| | | A5 | Post-appraisal | Doctor | CG Lead of employing organisation | Pull by CG lead | If agreed, appraisal documentation | As agreed between doctor and employing organisation | As agreed between doctor and employing organisation | N/A (from doctor) |
| | Revalidation ('R') | R1 | Recommendation is due | RO | GMC | Push from RO | Revalidation recommendation | Prior to notified recommendation due date | Via GMC Connect | Yes (good practice is to inform doctor before GMC) |
| Ad hoc | Information of Note ('IN') | IN1 | Sharing new information of note with RO | Doctor | RO | Push from doctor | New information of note for the RO to note or take action | On identification of the information | As agreed with the responsible officer | N/A (from doctor) |
| | | IN2 | Sharing new information of note with RO | CG lead of employing organisation | RO | Push from CG lead | New information of note for the RO to note or take action | On identification of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN3 | Sharing new information of note with RO | Appraiser | RO | Push from appraiser | New information of note arising from appraisal for the RO to note or take action | On identification of the information | Appraisal documentation, MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN4 | Sharing new information of note with employing organisation | RO | CG leads in employing organisations | Push from RO | Confirmed information of note relevant to employing organisation | On confirmation of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN5 | RO seeking information of note to cross-refer with other information | CG lead of employing organisation | RO | Pull by RO | Information of note or confirmation there is no information of note | Within 2 weeks of request from RO | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Fitness to Practise ('FtP') | FtP1 | When a doctor's behaviour crosses the threshold for GMC fitness to practise procedures to be engaged. | RO | GMC | Push from RO | Using the GMC referral form or in other format acceptable to the GMC | As soon as the threshold is reached | In the format set out in GMC FTP procedures | Yes in almost all circumstances |

## From the clinical governance lead or other external source

| Information flows about a doctor's practice to support medical governance and responsible officer statutory functions. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Scenario** | **Flow** | **Circumstances** | **From:** | **To** | **Push/Pull?** | **What?** | **When?** | **How?** | **Shared with doctor?** |
| Routine | Where a doctor takes up or leaves employment ('E') | E1 | New employment | Doctor | HR | Pull by HR | Pre-employment information | Prior to employment | Following organisation's processes | N/A (from doctor) |
| | | E2 | New employment no change in DB | Doctor | RO | Push from doctor | Confirmation of new role | Next appraisal | In Scope of Work section of appraisal documentation | N/A (from doctor) |
| | | E3 | New employment no change in DB | CG Lead of employing organisation | RO | Push from new employer | Confirmation of new role | On commencement of employment | Electronically by secure mechanism using standard template | Yes - cc |
| | | E4 | New DB | Doctor | New RO | Pull by new RO | Details of previous RO/DB<br>Last and next revalidation dates<br>Appraisal documentation (unless trainee)<br>Information of note | On forming new prescribed connection | As agreed with the new responsible officer | N/a - from doctor |
| | | E5 | New DB | Previous RO | New RO | Pull by new RO | Date of last appraisal/ARCP<br>ARCP documentation (if trainee)<br>Information of note | On forming new prescribed connection | MPIT form or equivalent | Yes - cc |
| | | E6 | End of employment/ placement with organisation other than designated body | CG Lead of employing organisation | RO | Push from CG lead | Information of note or confirmation there is no information of note | Within 2 weeks of end of placement | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Appraisal ('A') | A1 | Pre-appraisal | RO | Doctor and appraiser | Push from RO | Agreed expected information for inclusion at appraisal | Before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A2 | Pre-appraisal | CG lead of employing organisation | Doctor | Push from CG lead | Local CG outputs | When produced, preferably before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A3 | Pre-appraisal | Doctor | Appraiser | Push from doctor | Appraisal submission | Before appraisal | As defined by DB's appraisal policy | N/A (from doctor) |
| | | A4 | Post-appraisal | Appraiser | RO | Push from appraiser | Appraisal documentation | Within 28 days of appraisal meeting | As defined by DB's appraisal policy | N/A (doctor has copy) |
| | | A5 | Post-appraisal | Doctor | CG Lead of employing organisation | Pull by CG lead | If agreed, appraisal documentation | As agreed between doctor and employing organisation | As agreed between doctor and employing organisation | N/A (from doctor) |
| | Revalidation ('R') | R1 | Recommendation is due | RO | GMC | Push from RO | Revalidation recommendation | Prior to notified recommendation due date | Via GMC Connect | Yes (good practice is to inform doctor before GMC) |
| Ad hoc | Information of Note ('IN') | IN1 | Sharing new information of note with RO | Doctor | RO | Push from doctor | New information of note for the RO to note or take action | On identification of the information | As agreed with the responsible officer | N/A (from doctor) |
| | | IN2 | Sharing new information of note with RO | CG lead of employing organisation | RO | Push from CG lead | New information of note for the RO to note or take action | On identification of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN3 | Sharing new information of note with RO | Appraiser | RO | Push from appraiser | New information of note arising from appraisal for the RO to note or take action | On identification of the information | Appraisal documentation, MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN4 | Sharing new information of note with employing organisation | RO | CG leads in employing organisations | Push from RO | Confirmed information of note relevant to employing organisation | On confirmation of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN5 | RO seeking information of note to cross-refer with other information | CG lead of employing organisation | RO | Pull by RO | Information of note or confirmation there is no information of note | Within 2 weeks of request from RO | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Fitness to Practise ('FtP') | FtP1 | When a doctor's behaviour crosses the threshold for GMC fitness to practise procedures to be engaged. | RO | GMC | Push from RO | Using the GMC referral form or in other format acceptable to the GMC | As soon as the threshold is reached | In the format set out in GMC FTP procedures | Yes in almost all circumstances |

## From the appraiser

| Information flows about a doctor's practice to support medical governance and responsible officer statutory functions. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Scenario** | **Flow** | **Circumstances** | **From:** | **To** | **Push/Pull?** | **What?** | **When?** | **How?** | **Shared with doctor?** |
| Routine | Where a doctor takes up or leaves employment ('E') | E1 | New employment | Doctor | HR | Pull by HR | Pre-employment information | Prior to employment | Following organisation's processes | N/A (from doctor) |
| | | E2 | New employment no change in DB | Doctor | RO | Push from doctor | Confirmation of new role | Next appraisal | In Scope of Work section of appraisal documentation | N/A (from doctor) |
| | | E3 | New employment no change in DB | CG Lead of employing organisation | RO | Push from new employer | Confirmation of new role | On commencement of employment | Electronically by secure mechanism using standard template | Yes - cc |
| | | E4 | New DB | Doctor | New RO | Pull by new RO | Details of previous RO/DB<br>Last and next revalidation dates<br>Appraisal documentation (unless trainee)<br>Information of note | On forming new prescribed connection | As agreed with the new responsible officer | N/a - from doctor |
| | | E5 | New DB | Previous RO | New RO | Pull by new RO | Date of last appraisal/ARCP<br>ARCP documentation (if trainee)<br>Information of note | On forming new prescribed connection | MPIT form or equivalent | Yes - cc |
| | | E6 | End of employment/ placement with organisation other than designated body | CG Lead of employing organisation | RO | Push from CG lead | Information of note or confirmation there is no information of note | Within 2 weeks of end of placement | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Appraisal ('A') | A1 | Pre-appraisal | RO | Doctor and appraiser | Push from RO | Agreed expected information for inclusion at appraisal | Before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A2 | Pre-appraisal | CG lead of employing organisation | Doctor | Push from CG lead | Local CG outputs | When produced, preferably before appraisal | In suitable format for inclusion at appraisal | N/A (to doctor) |
| | | A3 | Pre-appraisal | Doctor | Appraiser | Push from doctor | Appraisal submission | Before appraisal | As defined by DB's appraisal policy | N/A (from doctor) |
| | | A4 | Post-appraisal | Appraiser | RO | Push from appraiser | Appraisal documentation | Within 28 days of appraisal meeting | As defined by DB's appraisal policy | N/A (doctor has copy) |
| | | A5 | Post-appraisal | Doctor | CG Lead of employing organisation | Pull by CG lead | If agreed, appraisal documentation | As agreed between doctor and employing organisation | As agreed between doctor and employing organisation | N/A (from doctor) |
| | Revalidation ('R') | R1 | Recommendation is due | RO | GMC | Push from RO | Revalidation recommendation | Prior to notified recommendation due date | Via GMC Connect | Yes (good practice is to inform doctor before GMC) |
| Ad hoc | Information of Note ('IN') | IN1 | Sharing new information of note with RO | Doctor | RO | Push from doctor | New information of note for the RO to note or take action | On identification of the information | As agreed with the responsible officer | N/A (from doctor) |
| | | IN2 | Sharing new information of note with RO | CG lead of employing organisation | RO | Push from CG lead | New information of note for the RO to note or take action | On identification of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN3 | Sharing new information of note with RO | Appraiser | RO | Push from appraiser | New information of note arising from appraisal for the RO to note or take action | On identification of the information | Appraisal documentation, MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN4 | Sharing new information of note with employing organisation | RO | CG leads in employing organisations | Push from RO | Confirmed information of note relevant to employing organisation | On confirmation of the information | MPIT form or other appropriate mechanism | Yes in almost all circumstances |
| | | IN5 | RO seeking information of note to cross-refer with other information | CG lead of employing organisation | RO | Pull by RO | Information of note or confirmation there is no information of note | Within 2 weeks of request from RO | MPIT form or abbreviated version (e-MPIT) | Yes in almost all circumstances |
| | Fitness to Practise ('FtP') | FtP1 | When a doctor's behaviour crosses the threshold for GMC fitness to practise procedures to be engaged. | RO | GMC | Push from RO | Using the GMC referral form or in other format acceptable to the GMC | As soon as the threshold is reached | In the format set out in GMC FTP procedures | Yes in almost all circumstances |

## Toolkit 1: Items suitable to include in pre-employment checks

This toolkit is a simple list of the items which may be appropriate to collect/establish at the point of employing or engaging a doctor. Organisations may find it helpful to refer to this list when establishing or reviewing their pre-employment criteria.

This list is offered as a guide only. It should be noted that not all the items need necessarily be included by all organisations, or in all contexts of employment. Equally, items not listed here may be appropriate, desirable or necessary in certain situations. Designated bodies are responsible for ensuring that their pre-employment processes are suitably designed for all relevant contexts. Particular care should be taken in all cases to ensure that the information presented as part of the pre-employment checking processes is authentic, for example by viewing original documentation not photocopies of the information required, and by checking information held on nationally managed databases where appropriate.

Further helpful information is available on the NHS Employers website.

## (cont.) Toolkit 1: Items suitable to include in pre-employment checks

| Item | Source | Timing |
|---|---|---|
| Identity check | • Doctor<br>• GMC List of Registered Medical Practitioners | Prior to commencement |
| Eligibility to work in the UK | • Doctor<br>• GMC List of Registered Medical Practitioners | Prior to commencement |
| DBS if required | • Doctor | Prior to commencement |
| Occupational health clearance | • Employing organisation | Prior to commencement |
| Qualifications check | • Awarding bodies<br>• GMC List of Registered Medical Practitioners | |
| References | • Referees | After offer, prior to commencement |
| Self-declaration of:<br>• GMC/Professional registration & license to practice<br>• status regarding<br>  ○ GMC referral or other regulatory investigations and their outcomes<br>  ○ GMC suspensions, conditions, undertakings or live warnings<br>  ○ local conditions<br>  ○ other information of note | • Doctor | Prior to offer |
| Corroboration of:<br>• GMC/Professional registration & license to practice<br>• status regarding GMC suspensions, conditions, undertakings or live warnings | • GMC List of Registered Medical Practitioners (may also be further corroborated with the last responsible officer (via MPIT) on commencement) | Prior to commencement |
| Corroboration of:<br>• Status regarding:<br>  ○ local conditions<br>  ○ other information of note | • Last responsible officer (via MPIT) | On commencement |
| Alert notice | • NCAS website | Prior to commencement |
| Language check | • In employment process/HR Department | Prior to commencement |

| Revalidation date | • Doctor | Prior to commencement |
|---|---|---|
| Contact details of previous RO | • Doctor<br>• GMC Connect | After offer |
| Last appraisal date from last responsible officer | • Last responsible officer (via MPIT) | On commencement |
| Last appraisal summary (if doctor is not exiting training) | • Doctor | On commencement |
| Final ARCP sign-off documentation | • Last responsible officer (Dean) (if doctor is trainee exiting training) (Via MPIT) | On commencement |

**References:**

1. GMC list of registered medical practitioners

# Toolkit 2: Illustrative appraisal documentation access statement

This toolkit is an illustrative appraisal documentation access statement which has been created by amalgamating access statements from different sources, including an NHS Hospital Trust and an NHS England local office. It is presented here to illustrate the matters which such a document should address, whether as part of a wider policy document, or as a standalone policy. As such, it may be of value to designated bodies establishing or reviewing their own access statements.

**It is not recommended that any designated body adopts this toolkit unchanged as their appraisal documentation access statement.** It is very likely that some local customisation will be necessary. In particular, the paragraph on the responsible officer and medical director functions will need amendment depending on whether or not the responsible officer role is held by the medical director. The paragraph on IT arrangements for appraisal will need to be reviewed, with the paragraph relating to NHS England being deleted by designated bodies other than NHS England, and the preceding paragraph deleted by NHS England offices. In addition, some parameters which are particularly likely to apply in some designated bodies, but not in others, are listed towards the bottom of the table in the statement and will need to be amended, included or deleted as necessary.

## i. The illustrative medical appraisal documentation access statement

### Introduction

The medical revalidation and appraisal processes have been designed so that the appraisal inputs are confidential between the doctor and their appraiser. In the vast majority of cases the appraisal outputs (appraisal summary, PDP and appraiser's statements) provide all the information that the responsible officer needs to make an assured recommendation to the GMC about a doctor's revalidation.

There are a number of circumstances when persons other than the appraiser may need access to appraisal documentation, including the inputs. This medical appraisal documentation access statement sets out these circumstances and the access arrangements for each, as they apply in [THIS ORGANISATION].

The Medical Appraisal Guide[3] recognises four purposes for appraisal:

1) To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in the GMC document Good Medical Practice and thus to inform the responsible officer's revalidation recommendation to the GMC.
2) To enable doctors to enhance the quality of their professional work by planning their professional development.
3) To enable doctors to consider their own needs in planning their professional development.

[3] 'Medical Appraisal Guide: A guide to medical appraisal for revalidation in England, version 4' (NHS Revalidation Support Team 2013 (reissued with updated hyperlinks September 2014))

4) To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in.

There is, therefore, an explicit link between appraisal, revalidation and clinical governance, necessitating and justifying the sharing of appraisal documentation with certain individuals and for certain reasons.

In addition, the responsible officer has certain statutory duties in relation to a doctor's practice, in addition to revalidation, set out in the Medical Profession (Responsible Officer) Regulations. The responsible officer's duties can be summarised as follows:

- to ensure that a doctor meets the criteria to undertake a post that they are proposing to take up
- to make a periodic recommendation to the GMC about the doctor's revalidation
- to ensure the provision of appraisal for the doctor
- to ensure that the doctor's practice is properly monitored
- to ensure that any concerns about the doctor are properly investigated and appropriate action taken

As set out in Information Management for Medical Revalidation in England, the responsible officer needs access to various forms of information, including appraisal information, in the discharge of these duties.

### The importance of context

The context determines who may view a doctor's appraisal documentation, and what may be viewed. These include:

- providing an accurate record for those involved
- quality assurance, supervision and support of appraisers
- addressing concerns highlighted in the appraisal interview
- having capacity to highlight themes that might need to be addressed by the organisation as a whole
- reviewing appraisal documentation as part of the process of making a revalidation recommendation
- supporting clinical governance, job planning, supervision of doctors and direct support to doctors at directorate level
- as part of the process of investigating a concern about a doctor's practice
- when a doctor wishes to complain about their appraisal
- complying with regulatory and other legal processes

### The responsible officer's team and delegated authority

Bearing in mind that the responsible officer and appraisers work in a team which supports them, other members of that team will need to handle and view part or all of a doctor's appraisal record. Such people and their roles may vary from time to time, but they include administrative staff, lead appraiser and senior appraiser. Any named individual who has been given delegated authority by the responsible officer to undertake the responsible officer's duties on an operational basis will have the same access to documentation, including appraisal documentation, as the responsible officer for the duties in question.

### The responsible officer and medical director functions

In this organisation the responsible officer role is held by the medical director. For certain individual doctors, an alternative responsible officer may be appointed for certain reasons such as conflict of interest of appearance of bias. Where this is the case, the medical director retains right of access to appraisal documentation under certain circumstances in the discharge of their medical director function, as set out in this access statement.

### Sharing information with other persons

The responsible officer may, on occasion, need to share information about a doctor's practice with other persons, including persons responsible for the quality and safety of care in other organisations where the doctor is working, or with those in other bodies such as the GMC, in the interests of protecting patient safety, or legal persons, including the police. It is the policy of this organisation that on such occasions and with very few exceptions (for example where doing so would compromise the investigation of criminal proceedings), we share the same information with the doctor in question, so that the doctor knows what is being shared. The exact information will depend on the matter at hand, but it may, on occasion, include documentation from appraisal.

Notwithstanding the above ad hoc requirement and in keeping with the NHS England guidance document 'Information flows to support medical governance and responsible officer statutory function', it is the policy of this organisation that appraisal information is not shared routinely with anyone in other places where a doctor is working. The sharing of such routine information is a matter between the doctor and that organisation. Any doctor who works in an outside organisation which requires access to their medical appraisal documentation, as part of the organisation's governance processes, is therefore responsible for sharing that information with the organisation themselves.

### Consent

Any doctor who wishes to object to any aspect of this access statement should raise their concern with the responsible officer in writing. Withholding consent to aspects of this statement may have an impact on the ability of the organisation to provide high quality appraisal and may restrict ability of the responsible officer to make a recommendation of a doctor's revalidation to the GMC.

In addition, when information is shared in the interests of protecting patient safety, consent by the doctor is not required. However, this organisation works to the principle that it is good practice to inform a doctor when information is shared about their practice on an 'if needed' basis (set out in Table A below). This information would be shared as a matter of course, whether or not consent is necessary, in the spirit of transparency, notwithstanding the potential restrictions on this as referred to in the section on 'Sharing information with other persons' above.

All persons with potential access to appraisal documentation have confidentiality clauses written into their terms of engagement and it would be a gross breach to reveal anything out of turn.

### Personal identifiable information in appraisal documentation

An appraisal portfolio must not contain personally identifiable information (whether patient, colleague or any other person). To do so is a breach of information governance rules. It also increases the risk of being compelled to disclose appraisal documents to a third party in a legal challenge. It may sometimes be appropriate to present some supporting information separately to protect confidentiality of individuals.

### Professional language in appraisal documentation

Doctors should be aware that if they include anything in their appraisal documentation which raises a concern about their fitness to practise, their appraiser has a professional duty to address this, which may, on occasion, require breaking the confidentiality of the appraisal without the doctor's consent. Care should therefore be taken to write the appraisal submission in appropriately professional terms.

### IT arrangements for appraisal

This organisation uses the [XXXX] appraisal documentation. Information held in electronic format complies with the organisation's data security and confidentiality policy.

### NHS England IT arrangements for appraisal

NHS England uses an organisation-wide NHS England Revalidation Management System (RMS) to manage the appraisal and revalidation processes for its doctors. RMS is a system owned by NHS England, based on tools previously developed in PCTs, prior to the formation of NHS England. RMS provides many functions which support appraisal and the responsible officer function, including a revalidation dashboard for the Responsible Officer and a secure facility to upload and store appraisal documents. Annex H of the NHS England Medical Appraisal Policy sets out the process when uploading documents to RMS, in order to protect information in transit. Information transferred between doctor, appraiser and organisation should be via secure NHS email accounts or secure memory stick.

### Access arrangements for medical appraisal documentation

A summary of the access arrangements to medical appraisal documentation, according to the purpose in question, is set out in Table A below. The circumstances and arrangements are not intended to be exhaustive or restrictive. Should it be necessary, for example, to protect patient safety or comply with due legal process, information may be shared in different ways and with different individuals than are listed here.

Table A describes those with access in terms of their roles, as individuals in post will change from time to time. An up to date list of the individuals in each post is available on request from the responsible officer's office.

## (cont.) Toolkit 2: Illustrative appraisal documentation access statement

### ii. Table A: Access arrangements for medical appraisal documentation

| Reason | Who can access | What can be accessed |
|---|---|---|
| 1. Appraisal | • Appraiser | • Normally: Full current year's documentation, last year's appraisal outputs (appraisal summary, PDP and appraiser's statements)<br>• If needed: full past documentation |
| | • Appraisal lead<br>• Senior appraiser<br>• Responsible officer | • If needed: Full current year's documentation, to respond to a query or concern from the doctor or appraiser about the doctor's submission, or to clarify an uncertainty arising from the appraisal outputs |
| 2. To support revalidation recommendation | • Responsible officer<br>• Lead appraiser<br>• Senior appraiser<br>• Members of the responsible officer's decision support group | • Normally: Appraisal outputs since last revalidation<br>• If needed: Full appraisal documentation, past and present. This may need to be supplied by the doctor directly, for example historic appraisal documentation from appraisals at another designated body |
| 3. Quality assurance of appraisal | • Lead appraiser<br>• Senior appraiser | • Normally: Relevant part of appraisal documentation, normally the appraisal outputs (appraisal summary, PDP and appraiser's statements)<br>• If needed: Full documentation of appraisal being reviewed |
| | • Administrative/support staff | • Full documentation of appraisal being reviewed, mainly for handling, but may be access to content to support completion of the review |
| | • Responsible Officer | • If needed: Full documentation of appraisal being reviewed |

Cont…

| Reason | Who can access | What can be accessed |
|---|---|---|
| 4. To support organisational clinical governance, including organisational analysis of learning needs in PDP | • Lead appraiser<br>• Senior appraiser | • Full appraisal documentation in the year relevant to the learning needs assessment |
| | • Medical director<br>• Responsible officer | • If needed: Full appraisal documentation in the year relevant to the learning needs assessment |
| 5. Concern about the doctor's practice | • Responsible officer<br>• Lead appraiser<br>• Senior appraiser<br>• CEO<br>• Medical director<br>• HR director<br>• Persons with clinical governance responsibility for the doctor all the places where they are working<br>• Other persons involved with the investigation and handling of the matter in hand | • If needed: full appraisal documentation, past and present, to be judged on a case by case basis. This information may be provided by the doctor directly, especially if not already held by the responsible officer, e.g. historic appraisal documentation from appraisals at another designated body |
| 6. Complaint by the doctor about the appraisal process | • Responsible officer<br>• Lead appraiser<br>• Senior appraiser | • Normally: Whole of appraisal documentation for the appraisal in question<br>• If needed: Appraisal documentation from other appraisals, including those for other doctors who have had appraisal with the same appraiser |

Cont…

| Reason | Who can access | What can be accessed |
|---|---|---|
| 7. Regulatory and legal processes | • GMC personnel<br>• Legal personnel, including courts<br>• Police | • Normally, and if legally appropriate: The specific appraisal documentation relating to the matter in question<br>• If needed and legally appropriate: Full appraisal documentation, past and present. This information may be released more appropriately by the doctor than by their responsible officer<br>• The circumstances in which it may be appropriate to release information in this context are varied and the decision whether or not to release the documentation will be made on a case by case basis, normally after consultation with the organisation's Caldicott Guardian. We will normally inform the doctor of such a request, but on rare occasions this may not be possible. There may be circumstances when it is required to release appraisal information without the doctor's consent |
| 8. Supporting the above processes | • Administrative/support staff | • Handling/uploading documentation; no permitted access to content unless under specific instruction |
| **Parameters which may apply in some designated bodies/responsible officer offices, but not in others:** | | |
| 9. Job planning | • Clinical Director | • PDP element only of appraisal form for doctors in their directorate |
| 10. To review compliance with Health Education England requirements for the appraisal of educators | • The Director of Postgraduate Education | • Normally: For relevant doctors, sections of appraisal documentation relating to education and to review "appraisal of educators" supporting information. In practice, because of the logistics of separating out this information, this normally requires access to whole of appraisal documentation |

# Toolkit 3: Standard notification to a doctor's responsible officer from a new employer

This toolkit provides a template for a standard communication to a doctor's responsible officer from the person with clinical governance responsibility for the doctor in an organisation where the doctor is taking up new employment or engagement.

## i. Helpful hints

When using this template, you will find it useful to save a version of it to your local system, part-completed with the local office details (Sender Field 3). By doing so it will then be necessary only to add the name and GMC number of the doctor in question for each request (Sender Fields 1 and 2).

If you are using an email system such as Outlook, which includes the facility to create automatic signatures, you may find it convenient to create automatic signatures which incorporate the templates. This will save the need to cut and paste the templates from another programme such as Word.

When using the templates, you may prefer to cut and paste the sentence beginning: 'CONFIDENTIAL: Notification to responsible officer …' from the template into the 'Subject' line of the email requesting the information.

## (cont.) Toolkit 3: Standard notification to a doctor's responsible officer from a new employer

### ii. The template

Date as email

Dear Colleague

CONFIDENTIAL: Notification to responsible officer of new employment or engagement of Doctor's name: [SENDER FIELD 1: OVERWRITE WITH DOCTOR'S NAME]; GMC No: [SENDER FIELD 2: OVERWRITE WITH DOCTOR'S GMC NUMBER]

The doctor named above is taking up a new position at this organisation and we have verified that that you are their responsible officer on the GMC website. I am writing to let you know this so that you can update your information about their scope of work. I understand that the doctor will also now include this new role in their scope of work declaration at their medical appraisal.

| Doctor's new position : | |
|---|---|
| Details of person with clinical governance responsibility for the doctor in this role (if different from the sender of this message): | |

If, whether now or in the future, you have any enquiries to make in relation to their fitness to practise, or any information of note to share about their practice in relation to patient safety please address these to the person named in the table above:

**Information of note about the doctor's practice**

In the process of applying for this position the doctor has declared the following:

| I have information of note to share about my practise | Yes / No |
|---|---|
| Details: | |

If the doctor answered 'No' this specifically means they have indicated that they are not referred to the GMC, are not subject to GMC conditions or undertakings, and are not subject to any local restrictions on their practice.

If this declaration is at variance with any information which you hold I would be grateful if you would let me know as soon as possible.

**Communication with the doctor**

| The information in this communication has been shared with the doctor. | Yes / No |
|---|---|
| Note: If I have indicated 'No' this is for the reason in the box below and I ask that you contact me before sharing this message with the doctor. | |
| Details: | |

Yours sincerely,
[SENDER FIELD 3: OVERWRITE WITH SENDER'S ADDRESS BLOCK]

# Toolkit 4: Standard response from a responsible officer to a doctor's new employer or person making an enquiry

This toolkit provides a template for a standard communication from a doctor's responsible officer to the person with clinical governance responsibility for the doctor in an organisation where the doctor is taking up new employment or engagement. It may also be useful in response to any other person making an enquiry about a doctor's practice.

## i. Helpful hints

When using the template, you will find it useful to save a version of it to your local system, part-completed with the local office details (Sender Field 3). By doing so it will then be necessary only to add the name and GMC number of the doctor in question for each request (Sender Fields 1 and 2).

If you are using an email system such as Outlook which includes the facility to create automatic signatures you may find it convenient to create automatic signatures which incorporate the template. This will save the need to cut and paste the templates from another programme such as Word.

When using the templates you may prefer to cut and paste the sentence beginning: 'Re: CONFIDENTIAL: Doctor's' name: …' from the template into the 'Subject' line of the email requesting the information.

## ii. The template

Dear Colleague — Date as email

CONFIDENTIAL: Doctor's name: [SENDER FIELD 1: OVERWRITE WITH DOCTOR'S NAME]; GMC No: [SENDER FIELD 2: OVERWRITE WITH DOCTOR'S GMC NUMBER]; Responsible Officer:

Thank you for your communication about this doctor. It has been noted that they are undertaking professional practice at your organisation and they will be expected to make reference to this in the scope of work section in their medical appraisal documentation from now on. Please note, that if information of note about their practice in relation to patient safety should arise at any point, you and the doctor are required to notify this office.

It may be appropriate to inform you about matters relating to this doctor's practise on occasion when this is required in the interests of patient safety. Please note, however, that, in keeping with the guidance document 'Information flows to support medical governance and responsible officer statutory function', information about a doctor's status is not provided routinely by their responsible officer on request. Specifically, we do not routinely provide copies of appraisal documentation such as the appraisal summary or PDP to other persons. Should you require such information, as part of your local clinical governance processes, this is a matter for you to arrange with the doctor directly and not through this office.

Yours sincerely,
[SENDER FIELD 3: OVERWRITE WITH SENDER'S ADDRESS BLOCK]

# Toolkit 5: Medical Practice Information Transfer (MPIT) Form - Abbreviated template for email use

This toolkit provides abbreviated versions of the interactive pdf Medical Practice Information Transfer (MPIT) form. It is designed to facilitate easier exchange of information using standard email, instead of a separate form which must be saved and attached separately. This may be of particular help when the respondent is providing simple confirmation that there is no information of note to share.

## i. MPIT form

The MPIT form actually contains several embedded distinct forms. Each of these is presented in a separate template in this appendix, suitable for insertion into an email:

**MPIT Scenario 1:** Information of note about the doctor's medical practice.

**MPIT Scenario 2:** Handover information for the new responsible officer.

**MPIT Scenario 3:** Notification of information relating to a doctor's practice from a doctor's responsible officer to other organisations where the doctor practises.

Whilst it is highly desirable to have a standardised format for the sharing of this information, there is considerable technological challenge in developing email-based templates capable of being shared and deployed across the many email programmes in use in the healthcare system. To address this, pragmatically simple templates are provided here, for organisations to cut and paste into their email systems locally. In keeping with the principles set out in the document 'Information flows to support medical governance and responsible officer statutory function', all designated bodies are strongly encouraged to use the fields in these templates, and only these fields, when requesting and sharing information about a doctor's practice in these scenarios.

## ii. Helpful hints

When using the templates, you will find it useful to save a version of each to your local system, part-completed with the local office details (Sender Fields 3 and 4). By doing so it will then be necessary only to add the name and GMC number of the doctor in question for each request (Sender Fields 1 and 2).

If you are using an email system such as Outlook which includes the facility to create automatic signatures you may find it convenient to create automatic signatures which incorporate the templates. This will save the need to cut and paste the templates from another programme such as Word.

When using the templates you may prefer to cut and paste the sentence beginning: 'CONFIDENTIAL: Medical Practice Information Transfer request for…' from the template into the 'Subject' line of the email requesting the information.

It is important to include the explanatory notes and associated links as part of the templates. This helps ensure that both the requester and the recipient have access to this guidance and these resources when participating in this information exchange process.

Simply using these templates is not in itself a guarantee of remaining within information governance rules. In particular, diligence is needed to ensure that the

exchange occurs between secure email addresses. Judgement is also needed to be clear that any information shared is appropriate in the context of protecting patient safety and the information is handled and stored appropriately. The information should normally be shared with the doctor. Please read the guidance in the templates for more detail on these matters.

As mentioned above, these templates are provided as a convenient vehicle for most instances of information transfer. Where there is complex information to share, it may be preferable to use the formal pdf MPIT form.

## (cont.) Toolkit 5: Medical Practice Information Transfer (MPIT) Form - Abbreviated template for email use

### iii. MPIT Template 1 – information of note about a doctor

Dear Colleague

CONFIDENTIAL: Medical Practice Information Transfer request for [SENDER FIELD 1: INSERT DOCTOR'S NAME], GMC No: [SENDER FIELD 2: INSERT DOCTOR'S GMC NUMBER], Responsible Officer: [SENDER FIELD 3: INSERT NAME OF DOCTOR'S RESPONSIBLE OFFICER]

Thank you for completing this form for the doctor named above.
Please complete and return it by replying to this message and **completing the five sections** of the structured response below.

Please respond as soon as possible and **no later than 2 weeks** after the sending of this message.

If you have no information of note to share, it is helpful if you indicate this and return the form as requested.

I confirm that I have the appropriate delegated authority to make this request.
If you are unsure as to whether you have the appropriate authority to respond to this request, please discuss this with me or your line manager before responding.

Yours sincerely,

[SENDER FIELD 4: INSERT SENDER'S ADDRESS BLOCK]

#### 1. Information of note relating to the doctor's practice

| I have information of note for the Responsible Officer to note or take action: | Yes / No |
|---|---|
| Note: If answering 'Yes', please give details in the box below. Information of note may be positive or negative. Specifically, you must provide details if the doctor is referred to the GMC, is subject to GMC conditions or undertakings, or is subject to any local restrictions. | |
| Details: | |

#### 2. Supporting documentation

| I have supporting information to describe/share: | Yes / No |
|---|---|
| Note: If 'Yes', list in the box below and attach to your reply where possible and appropriate | |
| Details: | |

### 3. Communication with the doctor

| I am sharing a copy of this information with the doctor: | Yes / No |
|---|---|
| Note: If answering ‘No’, please give reason in the box below. It is good practice to share information of note with the doctor (copying them into this message is the most straightforward way of doing so). The doctor can request to see the information shared in this message and, in all but the most exceptional circumstances, is entitled to do so. | |
| Details: | |

### 4. Additional comment

| Any further detail or comment: | |
|---|---|

### 5. Responder’s declaration and signature

| By including my name here I confirm that I have read the ‘Explanatory notes’ below and that I have the authority to transfer this information: | |
|---|---|
| Name: | |
| Designation: | |
| Address and contact details: | (You may leave this box blank if these details are included in your email signature to this message) |

**Explanatory notes:**

This form is designed to support the appropriate transfer of information about a doctor’s practice to the doctor’s responsible officer, or other person(s) with appropriate delegated authority.

Use of this simple e-form is appropriate for most exchanges of information about a doctor’s practice, but you should take care to ensure it is sent only to those to whom it is appropriate, and from a secure email address of a person who has the authority to send it. It must also be sent in a secure manner, in keeping with current information governance rules and regulations.

In certain circumstances, it may be more appropriate to use the standard pdf-format MPIT form. If you are uncertain about which format to use, you should discuss this with the doctor’s responsible officer before sending the information.

This form is designed to be used to share information with the doctor’s responsible officer in the following situations:

- when a doctor’s prescribed connection changes
- when a concern arises about the doctor’s practice in any place where the doctor is practising

It may also have a role:

- in providing routine information about the doctor’s practice

The responsible officer regulations[1, 2] and GMC guidance[3] make it clear that there is an obligation to share information about a doctor when it is required to maintain

patient safety. This is balanced with the rights of an individual set out in data protection rules[4, 5]. This is discussed in detail in the Department of Health's Information Governance Review 2013[6]. The NHS Revalidation Support Team has published relevant guidance[7], and guiding principles have also been set out by NHS Employers and the Independent Healthcare Advisory Service (IHAS)[8].

Information entered on this form will be held in confidence and viewed only by those with the proper authority to do so. You should take care to ensure all the information you enter is factual and support it as much as possible by providing objective evidence.

While it is not necessary to gain the consent of the doctor to share information, when this is required to ensure patient safety, it is good practice to inform the doctor that you are sharing information about them. You should bear in mind that they have the right to request sight of the content of this form from their responsible officer. In most circumstances, sharing the content of this form with the doctor in question will be very helpful, as it represents useful supporting information for them to provide at their appraisal. One way to do this is to copy them into this email trail, provided they have a secure email address. Please also note that in all but the most exceptional of circumstances, the doctor is entitled to have access to any information shared about them.

When sharing this form, all local and national information management processes must be adhered to.

## (cont.) Toolkit 5: Medical Practice Information Transfer (MPIT) Form - Abbreviated template for email use

### iv. MPIT Template 2 – handover information for the new responsible officer

Dear Colleague

CONFIDENTIAL: Medical Practice Information Transfer request for [SENDER FIELD 1: INSERT DOCTOR'S NAME], GMC No: [SENDER FIELD 2: INSERT DOCTOR'S GMC NUMBER], Responsible Officer: [SENDER FIELD 3: INSERT NAME OF DOCTOR'S RESPONSIBLE OFFICER] – Doctor exiting training

Thank you for completing this form for the doctor named above, for whom I understand you have, until recently, been responsible officer and who has now exited training.

Please complete and return it by replying to this message and **completing the six sections** of the structured response below.

Please respond as soon as possible and **no later than 2 weeks** after the sending of this message.

If you have no information of note to share, it is helpful if you indicate this, and return the form as requested.

I confirm that I have the appropriate delegated authority to make this request.
If you are unsure as to whether you have the appropriate authority to respond to this request, please discuss this with me or your line manager before responding.

Yours sincerely,

[SENDER FIELD 4: INSERT SENDER'S ADDRESS BLOCK]

#### 1. Appraisal details (or ARCP details if applicable)

| Date of last appraisal/ARCP: | |
|---|---|
| Note: It is the doctor's responsibility to provide the documentation from their appraisals to their new responsible officer directly.<br>Conversely, it is agreed that, where a doctor is exiting training, their dean will routinely provide the doctor's final ARCP sign-off documentation to the new responsible officer. | |

#### 2. Information of note relating to the doctor's practice

| I have information of note for the Responsible Officer to note or take action: | Yes / No |
|---|---|
| Note: If answering 'Yes', please give details in the box below. Information of note may be positive or negative. Specifically, you must provide details if the doctor is referred to the GMC, is subject to GMC conditions or undertakings, or is subject to any local restrictions. | |
| Details: | |

### 3. Supporting documentation

| I have supporting information to describe/share: | Yes / No |
|---|---|
| Note: If 'Yes', list in the box below and attach to your reply where possible and appropriate.<br>Notwithstanding the note in Section 1, it may be appropriate to include the doctor's full appraisal documentation (or supporting ARCP documentation) as supporting documentation for information of note. | |
| Details: | |

### 4. Communication with the doctor

| I am sharing a copy of this information with the doctor: | Yes / No |
|---|---|
| Note: If answering 'No', please give reason in the box below. It is good practice to share information of note with the doctor (copying them into this message is the most straightforward way of doing so). The doctor can request to see the information shared in this message and, in all but the most exceptional circumstances, is entitled to do so. | |
| Details: | |

### 5. Additional comment

| Any further detail or comment: | |
|---|---|

### 6. Responder's declaration and signature

| By including my name here I confirm that I have read the 'Explanatory notes' below and that I have the authority to transfer this information: | |
|---|---|
| Name: | |
| Designation: | |
| Address and contact details: | (You may leave this box blank if these details are included in your email signature to this message) |

**Explanatory notes:**

This form is designed to support the appropriate transfer of information about a doctor's practice to the doctor's responsible officer, or other person(s) with appropriate delegated authority.

Use of this simple e-form is appropriate for most exchanges of information about a doctor's practice, but you should take care to ensure it is sent only to those to whom it is appropriate, and from a secure email address of a person who has the authority to send it. It must also be sent in a secure manner, in keeping with current information governance rules and regulations.

In certain circumstances, it may be more appropriate to use the standard pdf-format MPIT form. If you are uncertain about which format to use, you should discuss this with the doctor's responsible officer before sending the information.

This form is designed to be used to share information with the doctor's responsible officer in the following situations:

- when a doctor's prescribed connection changes
- when a concern arises about the doctor's practice in any place where the doctor is practising

It may also have a role:

- in providing routine information about the doctor's practice

The responsible officer regulations[1, 2] and GMC guidance[3] make it clear that there is an obligation to share information about a doctor when it is required to maintain patient safety. This is balanced with the rights of an individual, set out in data protection rules[4, 5]. This is discussed in detail in the Department of Health's Information Governance Review 2013[6]. The NHS Revalidation Support Team has published relevant guidance[7], and guiding principles have also been set out by NHS Employers and the Independent Healthcare Advisory Service (IHAS)[8].

Information entered on this form will be held in confidence and viewed only by those with the proper authority to do so. You should take care to ensure all the information you enter is factual and support it as much as possible by providing objective evidence.

While it is not necessary to gain the consent of the doctor to share information, when this is required to ensure patient safety, it is good practice to inform the doctor that you are sharing information about them. You should bear in mind that they have the right to request sight of the content of this form from their responsible officer. In most circumstances, sharing the content of this form with the doctor in question will be very helpful as it represents useful supporting information for them to provide at their appraisal. One way to do this is to copy them into this email trail, provided they have a secure email address. Please also note that in all but the most exceptional of circumstances, the doctor is entitled to have access to any information shared about them.

When sharing this form, all local and national information management processes must be adhered to.

## (cont.) Toolkit 5: Medical Practice Information Transfer (MPIT) Form - Abbreviated template for email use

### v. MPIT Template 3 - Notification from a doctor's responsible officer to other organisations where a doctor practises, of information relating to the doctor's practice

Dear Colleague

CONFIDENTIAL: Information about the medical practice information of [SENDER FIELD 1: INSERT DOCTOR'S NAME], GMC No: [SENDER FIELD 2: INSERT DOCTOR'S GMC NUMBER], Responsible Officer: [SENDER FIELD 3: INSERT NAME OF DOCTOR'S RESPONSIBLE OFFICER]

I understand that this doctor practices or has practised at your organisation. This notification contains information relating to their fitness to practise and, if appropriate, I have attached supporting information about this matter. You should decide whether this has any implications for the governance and/or practice of this doctor in your organisation and take any actions necessary to safeguard patient safety.

**1. Information of note relating to the doctor's practice**

| Details: | |
|---|---|

**2. Communication with the doctor**

<table>
<tr><td colspan="2">The information in this communication has been shared with the doctor:</td><td>Yes / No</td></tr>
<tr><td colspan="3">Note: If I have indicated 'No', this is for the reason(s) given in the box below and ask that you contact me before sharing this message with the doctor.</td></tr>
<tr><td>Details:</td><td colspan="2"></td></tr>
</table>

I confirm that I have the authority to share this information.
If, on review of the information you decide that you have further information relevant to the matters in question, or you have any queries in relation to this information, please contact me.

Yours sincerely,

[SENDER FIELD 4: INSERT SENDER'S ADDRESS BLOCK]

**Explanatory notes:**

The responsible officer regulations[1, 2] and GMC guidance[3] make it clear that there is an obligation to share information about a doctor when it is required to maintain patient safety. This is balanced with the rights of an individual, set out in data protection rules[4, 5]. This is discussed in detail in the Department of Health's Information Governance Review 2013[6]. The NHS Revalidation Support Team has published relevant guidance[7] and guiding principles have also been set out by NHS Employers and the Independent Healthcare Advisory Service (IHAS)[8].

This information must be held in confidence, and viewed only by those with the proper authority to do so. Care has been taken to ensure all the information is factual and supported as much as possible by objective evidence.

When sharing this form, all local and national information management processes must be adhered to.

**References:**

1. The Medical Profession (Responsible Officers) Regulations 2010

2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013

3. Raising and Acting on Concerns about Patient Safety (GMC, 2012)

4. Confidentiality NHS Code of Practice (Department of Health, 2003)

5. Data Protection Act 1988

6. Information: To Share or Not to Share? The Information Governance Review (Department of Health, 2013)

7. Information Management for Medical Revalidation in England (NHS Revalidation Support Team, 2014)

8. Guiding Principles for Sharing Information on Healthcare Workers (NHS Employers/IHAS, 2013)

# 6 Stakeholder consultation and Reference group

This guidance has been developed after consultation with and input from all major stakeholder organisations. This included a reference/working group, convened in November 2015 to support the development of this guidance. Particular thanks for their contribution includes:

| Name | Organisation |
|---|---|
| Alistair Baker | Consultant Paediatric Hepatologist, King's College Hospital and Responsible Officer, MAAR Gateway Ltd and Responsible Officer Appraiser, NHS London |
| Vicky Banks | Associate Medical Director Revalidation, Quality & Appraisal Lead and Regional Medical Directorate, NHS England (South) |
| Susi Caesar | Associate Dean, Appraisal and Revalidation Service, Health Education Wessex |
| Ruth Chapman | Regional Appraisal Lead, NHS England (London) |
| Liz Clarke | Appraisal Lead, NHS Trafford CCG |
| Mark Cohen | Project Manager, NHS England Professional Standards Team |
| Maurice Conlon | National Appraisal Lead, NHS England |
| Jack Cornish | Responsible Officer Support Officer, Health Education England |
| Alex Crowe | Consultant nephrologist and Clinical Service Lead for Appraisal and Revalidation, Wirral University Teaching Hospital NHS Trust |
| Davina Deniszczyc | Medical Executive Director, Nuffield Health |
| Ian Gell | Regional Appraisal Lead, NHS England (Midlands and East) |
| Lene Gurney | Practice and Policy Advisor, Association of Independent Healthcare Organisations |
| Nathan Jones | Nathan Jones, Head of Assessment and Revalidation, Health Education England – East Midlands Office |
| Tom Kane | Consultant in radiology & nuclear medicine, Blackpool Teaching Hospitals NHSFT and Alliance Medical PETCT Centre, Preston |
| Debra King | Consultant Physician and Associate Medical Director for Appraisal and Revalidation, Wirral University Teaching Hospital |
| Jenny Kirk | Project Manager, NHS England Professional Standards Team |

| | |
|---|---|
| Yvonne Livesey | Revalidation and CPD Programme Manager, Academy of Medical Royal Colleges |
| Rory Lawton | Training Support Service & Revalidation Manager, Health Education England: Kent, Surrey and Sussex Local Team |
| David Macdonald | Appraisal Lead, Spire Healthcare |
| Sol Mead | Patient/Public Representative |
| Ian McKay | Chair, Independent Sector Responsible Officer Committee (ISROC) |
| Helena McKeown | Revalidation and Appraisal Lead, GP Committee - Education Training and Workforce Subcommittee, British Medical Association |
| Alexander Ottley | Senior Policy Executive, NHS Primary Care Division, Policy Directorate, British Medical Association |
| Sarah Parsons | Medical Workforce Manager, NHS Employers |
| Kiran Patel | Medical Director, NHS England (West Midlands) |
| Ian Starke | Chair, Revalidation and Professional Development Committee, Academy of Medical Royal Colleges |
| Kate Tansley | Policy and Projects Manager, Academy of Medical Royal Colleges |
| Marc Terry | Head of Foundation Workforce (HEKSS) and Co-Chair of COPMeD Revalidation Operational Group |
| Paul Twomey | Joint Medical Director, NHS England-North (Yorkshire and the Humber) |
| Andrew Wardman | Consultant Physician, Wrightington, Wigan and Leigh NHS Foundation Trust |
| Julia Whiteman | Lead Dean for Revalidation, Health Education England |
| Fahed Youssef | Consultant Surgeon, The Ipswich Hospital NHS Trust, Colchester Hospital University NHS Foundation Trust, Athona Ltd |