Board of Directors

Date:	25 September 2019	**Attachment:**	**12(iii)**
Title of Report:	**Guardian of Safe Working Annual Report as necessitated by 2016 Terms and Conditions of Service**		
Purpose of the report and the key issues for consideration/decision:	To outline the working hours of trainee doctors within the Trust, looking at rotas and exception reports and actions taken.		
Prepared by:	Dr Martin Kelsey, Guardian of Safe Working		
Presented by:	Mr Karl Mainprize, Executive Medical Director		

Strategic Objective(s) supported by this paper:

Financial Sustainability		**Empower & Engage Staff**	✓
Quality of Care	✓		

Is this on the Trust's risk register:

No	✓	**Yes**		**If Yes, Score**	

Which CQC Standards apply to this report:	Safe, Effective, Caring, Responsive, Use of Resources, Well Led		

Have all implications related to this report been considered: (please X)

Finance Revenue & Capital		**Equality & Diversity**	X
National Policy/Legislation	X	**Patient Experience**	
Human Resources	X	**Terms of Authorisation**	
Governance & Risk Management (BAF)		**Other:**	

Action Required: (please X)

Approve		**Discuss**	X	**Receive for information**	X	**Decision**	

Previously Considered By:		**Date:**	
Recommendations:	To receive and note the report.		

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Executive summary

Many rotas have carried gaps thoughout the year although the impact of the gap on trainee experience and patient care will vary from rota to rota and ward to ward. Care must be taken when interpreting numbers.

We remain understaffed in some areas, particularly the medical and surgical junior tiers (F1. F2 equivalent) which impacts on doctor workload and can lead to exhaustion and stress related sickness.

Our 2 remaining 6 person rotas are of particular concern with regards to trainee burnout and limited access to education and training opportunities and I would ask the board to consider a commitment to expanding these rotas, where possible, through recruitment to trust positions.

Introduction

In accordance with Schedule 6 of the new contract the Guardian of Safe Working should provide the Board with a Guardian of Safe Working Report not less than once per quarter. This report should include details of 'all rota gaps on all shifts' and shall also be provided to the LNC and newly formed Junior Doctors Forum. In addition, the guardian shall produce a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps.

Annual data summary

This section outlines the total number of rota gaps across all specialties and all grades over the year. It does not differentiate between gaps due to training gaps (trainee doctors rotating to Airedale from Health Education England) or gaps due to inability to fill trust grade post.

Specialty	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
Emergency Medicine	Junior	**2**	**2**	**2**	**4**	**2.5**	-	**-**
	Middle	**1**	**1**	**0.4**	**1WTE**	**0.85**	-	**-**
General Medicine / Geriatric Medicine	Junior F1 / F2	**2.5**	**2.5**	**2**	**0.4**	**0.7**	-	**-**
	CT / GPST	**-**	-	**1**	**2**	**-**	-	-
	Middle	**1**	**1**	**1**	**1**	**1**	-	-
General Surgery / Ortho / Urology	Junior	**0**	**0**	**2**	**1**	**0.75**	-	-
	CT1	**0**	**2**	**0**	**2**	**1**	-	-
	Middle (Gen Surg)	**0**	**0**	**0**	**0**	**0**	**-**	**-**

	Middle (urology)	**0**	**0**	**0.8**	**0**	**0**	**-**	**-**
	T&O Middle Grade	**0**	**0**	**0**	**0**	**0**	**-**	**-**
Paediatrics	Junior	**0**	**0**	**0**	**0.8**	**0**	**-**	**-**
Obstetrics and Gynaecoloy	Junior F2 / CT1 / GP-ST	**0.5**	**0.5**	**2**	**0**	**0.75**	**-**	**-**
Obstetrics and Gynaecoloy	Middle Grade	**2.5**	**2.5**	-	-	**0.1**	**-**	**-**
Anaesthetics	Junior	**1**	**1**	**-**	**2**	**1**	**-**	
	Middle Grade	**2.5**	**2.5**	**-**	**-**	**0.1**	**-**	**-**

Comments

1. Crude numbers of rota gaps are difficult to interpret in isolation due to different working practices within specialties. For example, The Emergency Department has had junior rota gaps throughout the year. Whilst this incurs a financial cost for the trust in terms of locum procurement it does not impact on trainees educational experience, workload or shift finish time. Conversely, a single rota gap in a smaller ward based speciality eg: O&G can significantly limit trainee access to mandatory training, make access to annual leave more difficult and result in a challenging day to day workload if a locum cannot be procured.

2. Obtaining up to date information on staffing and rota gaps has historically been challenging as departments have managed staffing in isolation. This has led to a situation where it has been very difficult to say with certainty how many doctors work for the trust and where they are working. As of 2019 recruitment has been, to a large part, centralized. This will result in a greater ability to forward plan to fill gaps and higher quality data.

3. Rota gaps should be interpreted with caution. For example, whilst the junior medical rota only carries, on average, 0.7 gaps across the year, it is known that even when we have full complement of junior doctors in this rota, once annual leave etc is taken into consideration a "full" complement of doctors is insufficient to staff the wards without reliance on locums. We receive regular exception reports and complaints from junior doctors about working with less than the minimum safe number of doctors on wards or else being swapped away from their base ward to cover gaps. Doctors regularly need to stay late to complete routine work. This leads to trainee dissatisfaction, exhaustion and stress related sickness. It can also delay patient care and lead to delayed discharges.

4. On average, there are around 20-30 "winter pressure" beds open within the trust. As a rule of thumb, 15 inpatients equates to a days work for 1 x junior doctor which means that we need at least 2 additional doctors above calculated minimal staffing

5. In many instances, but particularly in medicine (esp respiratory, cardiology, gastroenterology) and general surgery the minimum number of doctors required on the ward remains an underappreciation of the actual manpower needs of the hospital.

6. We still have 2 x 6 person rotas (O&G junior, Surgery CT1). Experience tells us that 6 person rotas are exhausting, provide little scope for swaps and limit the education and training opportunities afforded by a post.

7. Obtaining data relating to weekly / annual shift gaps and locum use remains challenging. Once the trust moves to an e-rostering system I will be able to provide this data.

8. **Issues arising**

The trust remains largely reliant on training rotations to staff the junior and middle grade rotas. Whilst not unusual this can provide challenges when we are sent rotation "gaps". Sometimes we are given little notice of when we will be sent a "gap". In addition, the number of trainees working less than full time continues to rise, particularly in GP trainees but also trainees in Emergency Medicine. This particularly impacts smaller rosters that have a high proportion of GP trainees such as O&G, paediatrics and Emergency Medicine.

Recruitment to trust grade positions has improved since this was centrally co-ordinated via the medical workforce group although the trust, as of yet, has no novel fellowship posts that other trusts are successfully utilizing to attract and retain trust grade doctors such as education / simulation / quality improvement fellows.

Recruitment of experienced trust grade doctors able to work at a level beyond foundation in many specialities is challenging. The surgical team has appointed 2 overseas doctors to work on the CT 1 rota. Unfortunately both have required a prolonged period of induction and supervision and are currently working on the junior rota.

We have had meetings with the O&G team who have agreed, in principle, to expand their junior rota from 6 to 7. Unfortunately there have been issues with the business case and disappointingly this has not progressed.

Actions taken to resolve issues

- Recruitment to trust grade positions has been centrally co-ordinated. In addition, a centralized freely accessible spreadsheet of all rosters within the hospital over the next 12 months has been produced which allows us to identify gaps and forward plan. I can provide a copy of the spreadsheet to board members on request.

- We continue to review and, where possible, attempt to optimize rotas in order to provide the most appropriate medical cover to meet the needs of our patients whilst also ensuring that rotas are sustainable and supportive of access to education and training. A significant change to the medical junior rota is currently being designed which will hopefully provide stability across the base medical wards. This rota is being designed and will be introduced in full compliance with the trust policy on amending medical rosters.

- The trust policy on amending medical rosters should prevent the longstanding practice of writing a rota based primarily on the number of trainees available. Instead, the starting point

for rota design is the number of clinicians needed to safely staff the ward whist also allowing for access to education and training.

- There has been a successful round of trainee Advanced Care Practitioner recruitment. 3 trainee ACP's have been recruited into medicine. Planned start in September. In the first instance they will spend time on AAU before being deployed to support the medical teams on ward 7 (respiratory), Cardiology (ward 1) and Oncology / Haematology (ward 19)

  1 trainee ACP has been recruited into general surgery with a further interview planned for later in July.

  6 trainee ACP's are already working within the Emergency Department

These recruitments are a positive and important step in moving towards a sustainable blended workforce. Having discussed with the Trust ACP Lead she is satisfied that Medicine have a robust plan for ensuring that the trainee ACP's are adequately supervised and have a clear plan for training and progression. She has concerns that the same level of support and supervision will not be available to those trainee ACP's that have been recruited to support the surgical teams.

It should also be noted that trainee ACP's will be supernumerary until they are qualified and cannot be used to fill rota gaps.

- From September Physicians Associates recruited to primary care will work on AAU one day per week. This will allow the trust to appraise their potential role across the trust.

Summary

1. Medical staffing is improving in terms of numbers and in terms of co-ordination of recruitment. As a trust we have a better picture of present and expected rota gaps than we did 3 years ago and centralized recruitment of trust grade doctors appears to be an effective tool for filling rotation gaps. From August 2019 the accuracy of data relating to rota gaps will be much better.
2. Whilst actual number of doctors is improving, there are still areas of concern, particularly in medicine where workload is unacceptably high on certain wards, particularly over the winter months, general surgery and on our 2 remaining 6 person rotas (O&G junior / surgery ST).
3. The trust is actively pursuing a blended workforce including ACP's in medicine and surgery (already in place in orthopaedics / AAU and, in part, A&E) and will have the opportunity to appraise the value of physicians associates form September
4. Without a trustwide e-rostering system it is difficult to provide accurate numbers for locum usage and unfilled shifts

Questions for consideration

The Guardian of Safe Working would like the board to consider a commitment to expanding the 2 remaining 6 person rotas – O&G junior and surgery CT1 - to 7 person in order to make working patterns more sustainable and improving access to education and training opportunities.

In addition, recognition of the need to expand the junior workforce across the trust (F1 / F2 equivalent) particularly in medicine but also in surgery through the use of further trust appointments should be considered.