Attachment 1

Executive Summary

- This paper summarises progress to the year end 31 March 2021 in providing assurance that non-consultant (junior) doctors at Great Ormond St Hospital (GOSH) are safely rostered and enabled to work hours that are safe and compliant, with opportunity to access training and education.

- Robust medical workforce management during the COVID pandemic provided a safe and effective response.

- An ongoing medical workforce improvement programme has continued to ensure GOSH is safely staffed. Improved data intelligence has enabled the Trust to fully understand the dependencies and requirements of the junior medical workforce and deliver financial efficiencies

- Compliance with 2016 TCS: Implementation of the New Amendments October 2019
  - Critical care rotas achieved compliance in the fourth quarter 2020-21
  - Rest facilities continue to require improvement.
  - CAMHs rota remains under review
  - The implementation of the 5th nodal salary point' has resulted in a significant cost pressure at GOSH due to the seniority of many of our junior doctors in 2020

- Exception reporting (ER) requires more integration and is a risk for monitoring assurance and compliance with 2016 contractual obligations of the Trust as doctors continue to struggle with many aspects of the reporting process. Integration into medical culture and systems enabling process regulation continue to be addressed. Exception reporting (ER) experience, rota gaps and vacancies for junior doctors across the Trust are described with actions taken to address them are described.

- GOSH vacancy rates has varied between 6.8 and 12.1% over 2020/21 and continue to be below the national average

- One fine has been levied with current ERs to date. Fines would only apply for doctors on the 2016 TCS on formal training programs (35% of GOSH junior medical workforce). All doctors at GOSH can ER.

1. Purpose

This paper provides assurance to the Board on progress being made to ensure that doctors working hours are safe for the year ending March 2021.

The Board is asked to report information on rota gaps and the plan for improvement in the Trust's Quality Account and publish the details of Guardian fines in the Trust's annual accounts.

COVID related response for the medical workforce in first and second surges is also reported for assurance purposes.

2. Introduction

2.1. The 2016 Terms and Conditions of Service (TCS) highlight the importance of appropriate working hours and attendance at training and education opportunities for junior doctors. Both issues have a direct effect on the quality and safety of patient care with increasing recognition on the negative effect of rota gaps on junior doctor training and wellbeing.

2.2. The 2016 TCS set firm limits to the number of hours trainee doctors can spend on duty and provided a process for:

- reporting safety concerns in the workplace which reach senior management level
- trainees to record if they worked beyond their scheduled hours
- fining departments directly for the most serious breaches of working hours
- providing work schedules to doctors before starting a job and in more detail than previously
- trainees to inform if they are not able to attend education and training opportunities
- the establishment of a junior doctors forum (JDF) to discusses work and training issues

2.3. Contractually every Trust has a Guardian of Safe Working (GoSW), a senior appointment who ensures that issues of compliance with safe working hours are addressed and provides assurance to the Board of the employing organisation that doctors' working hours are safe.

3. COVID-19 Medical Workforce

3.1. **COVID Rotas March 23rd – June 22nd 2020 (Appendix 1)**

As part of the Major Incident Planning the Medical Director's Office structured a bronze medical workforce group to establish key processes and infrastructure to ensure a medically and surgically competent workforce 24/7. A rapidly responsive decision arm with medical oversight built and co-ordinated a rota system that provided a flexible, timely approach to safe staffing based on patient need. A novel senior leadership network was created from the Medical Director's Office to nominated Medical Workforce Leads with clear lines of accountability and responsibility on clinically led decisions about the allocation of junior doctor resource.

3.1.1. Medical and surgical expertise was distributed equitably across the organisation based on need, eradicating the artificially created silos that had previously formed based on clinical units, directorates and locations, resulting in a networked system of care at value delivering a full service without additional staff. By continually reviewing the numbers of doctors, the skill set of the team and the clinical workload, the hospital was kept safe and well-staffed throughout the pandemic

3.1.2. COVID rotas supported a 'stand by system' for absence cover for 30% predicted reduction in junior doctor workforce. All COVID rotas were compliant with TCS 2016 with 12.5 hour shift patterns; banded 1a

3.2. **Return to Specialty based Rotas June 22nd – Changes to out of hours (OOH) rotas post COVID (Appendix 2)**

3.2.1. GOSH stepped on to new, fully compliant rotas on June 22nd. These rotas have effectively utilised the junior medical workforce to its full capacity and created the opportunity to have improved safety and a higher quality of patient care alongside a flexible team approach to 'step up' out of hours and potentially reduce bank spend.

3.2.2. The COVID 19 pandemic exposed additional risks relating to the lack of reliable data intelligence and a poor operational infrastructure to adequately address the OOH demands at GOSH. As part of the COVID recovery plan Medical Workforce Leads were appointed to continue to develop and improve out of hours working.

3.3. **Second Surge COVID December 2020 to March 2021**

3.3.1. The pandemic exposed significant workforce risk of a nature not seen before – high levels of unexpected absence and a changing patient demographic, with the requirement to continue clinical activity and upscale rapidly required a flexible, responsive and clinically capable medical workforce to meet the necessity for rapid change.

3.3.2. **Medical Workforce Leads (MWLs) appointed in November 2020 (Appendix 3)**, supported by the AMD workforce (GOSW) managed both COVID response and the need for improved infrastructure to create the resilience to match demand in a sustainable way. This included:

- Upscale and redesign of rotas – all tested for individual rota compliance
  - ICUs
  - General Paediatrics
  - PIMs TS
  - 'Shadow' rota development to rapidly expand service cover
- Daily situational awareness briefing and anticipatory plan
- Medical workforce redeployment management
- Wellbeing surveys pre and post second surge
- Wellbeing – 'check ins'
- Daily absence monitoring

3.4. **Medical Workforce Improvement Programme commenced November 2020: positive change and key areas of focus by the Medical Workforce Team include**

- Escalation level planning for the medical workforce pandemic response
- Cross directorate medical leadership OOH
- Active Rota Management
  - Situational decision making
  - Flexible Workforce – skills survey
  - Cost effective, managed bank spend
  - Daily clinician input throughout Covid-19
- Junior Doctor mentoring and leadership development
- Governance and risk infrastructure
- Hospital at Night: process, teamwork and leadership development
- Dashboard development: data reconciliation and capture
- Wellbeing assessment, pathways and integration

4. Implementation of 2019 New Amendments to 2016 TCS: Headlines

4.1. A referendum of the BMA Junior Doctor membership (August 2019) accepted the 2016 contract, including negotiated amendments. Implementation of the contract refresh have been fully implemented at GOSH in line with the required time line (completion August 2020).

4.1.1. Every rota has been line checked and updated for compliance with new amendments

4.1.2. PICU/NICU/CATS rotas were initially non-compliant for weekend frequency until November 2020 when the establishment was increased

4.1.3. Child and Adolescent Mental Health (CAHMs) rota remains under review with respect to safety and compliance. Shared with five other Trusts, it is currently a non-resident on call rota and may require changing to meet compliance for continuous rest. Trainees are currently auditing activity post COVID.

4.1.4. Access to appropriate rest facilities are inadequate for social distancing and numbers of clinicians requiring on site facilities. A more permanent solution is required; some improvement work is underway and more chair-beds for feet up rest are now ordered. Safety and rest limits now attract GOSW fines.

4.1.5. The implementation of the '5th nodal salary point' resulted in an unplanned cost pressure (approximately £0.6M) due to the seniority our junior doctors cohort.

4.2. The GoSW now has the authority to action any exception reports that have not been responded to. This is frequently required due to issues with understanding the software and the need to meet deadlines .

5. Patient Safety

5.1. During 2019/20 there have been no actual and immediate safety concerns reported directly through the exception reporting ER system (several have been created in error).

5.2. It is known that basic administrative and clinical tasks can negatively affect patient safety and quality of experience by detracting from time available for tasks that specifically require doctors. Implementation of an electronic patient record 'Epic' introduced in April 2019 may have improved some of the burden of administrative tasks undertaken by Junior Doctors although the impact of Epic on Junior Doctor working is yet to be fully evaluated.

5.3. **Rest provision** contributes to safe patient care by ensuring staff are making safe effective decisions. The 2016 TCS mandates the provision of adequate rest facilitates or alternative arrangements for safe travel home and includes provision of accommodation for non–resident on call and those 'too tired to drive home'. GOSH has increased bed availability on site from 12 to 21 beds. Rest facilities are currently housed on an unused ward. The facilities have received some upgrading supported by the 2019 Department of Health facilities fund (£60k) to support the BMA/ NHS 'Fatigue and Facilities Charter'. Current rest facilities provide adequate accommodation although costings and logistics to develop permanent rest facilities for junior doctors are required.

6. Work Schedules

6.1. NHS employers mandate that doctors in training should receive schedules of work that are safe for patients and safe for doctors and should be finalised and available 8 weeks prior to commencement of the new post. Working patterns of doctors in training are significantly influenced by rota gaps and changes in service requirements which in turn effects access to training and educational opportunities.

6.2. Due to the second COVID surge, rotational posts were deferred by Health Education England from February to March 2021. This impacted on work schedule deadlines.

6.3. Delayed international medical graduate recruitment due to COVID has caused rota gaps in haematology and oncology with trainees reporting additional duty hours through the exception reporting system.

7. High level Data* as of 31st March 2021

Number of trust doctors	223.6

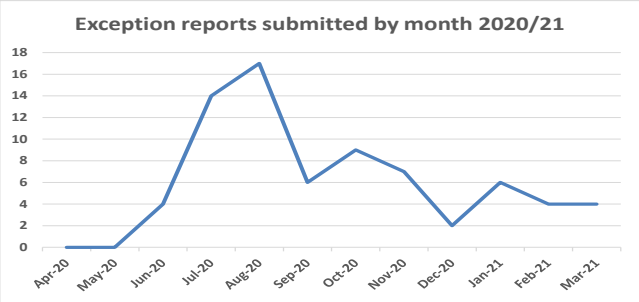
Number of training doctors	118.3
Number of vacant unfiled posts	18.7 out of a total of 307 rota slots (6%)

*Numbers indicate full time equivalent posts

8. Exception Reporting

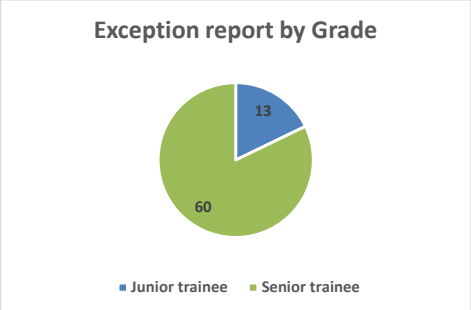
8.1. Exception reporting (ER) is the mechanism by which doctors are able to report safety concerns in the workplace and as such GOSH enables both Health Education England (HEE) trainees and non-training (trust) grade doctors to exception report at GOSH. All GOSH junior doctors can receive either financial compensation or time off in lieu for additional work performed if either preauthorised or when validated by a clinical manager.

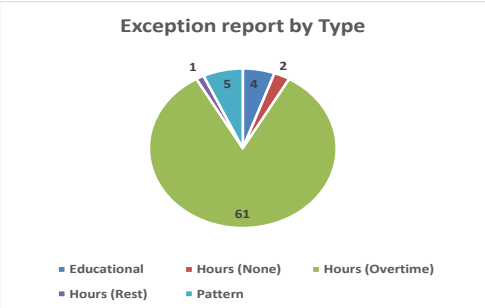
8.2. In 2020/21 GOSH received 73 exception reports submitted by a total of 24 individual doctors. There were no ERs from March until May 2020, and few December 2020 to March 2021, likely due to COVID pandemic disruption. There is an overall reduction from 149 reports submitted by 31 doctors in 2019/20.



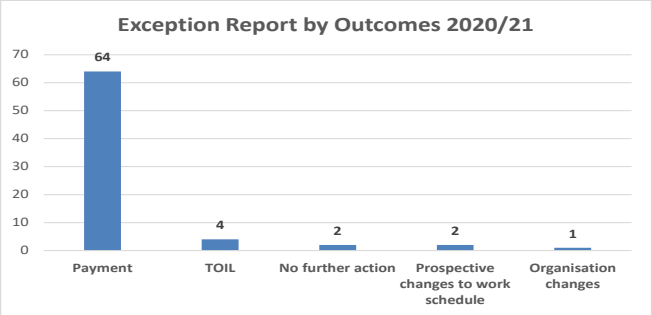
8.3. Presented monthly less than 1% of the junior doctor workforce are submitting ERs. This is a very small proportion of doctors but aligns with the national knowledge and our local ER survey in January 2020.

8.4. The majority of ERs are related to additional hours work and submitted by senior Trust grade (non-training) doctors.

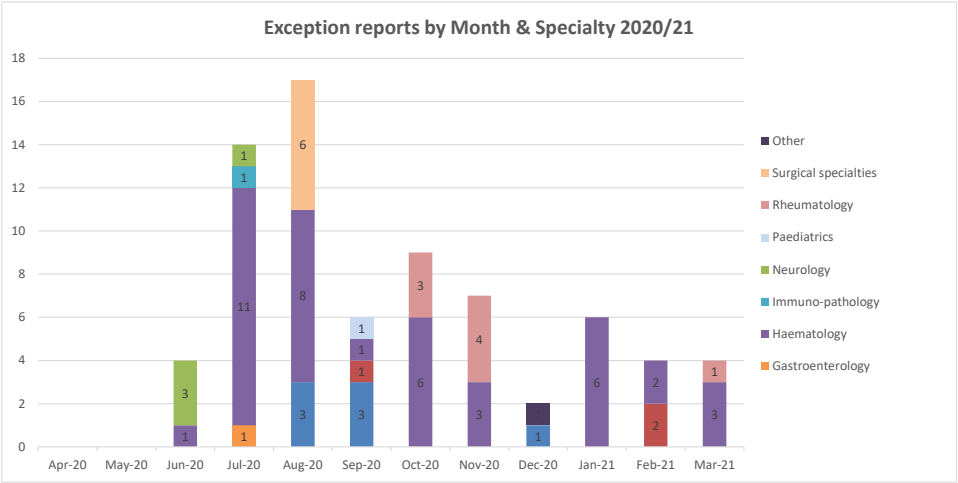




8.5. Most ERs resulted in financial compensation. One doctor has an outstanding work schedule review

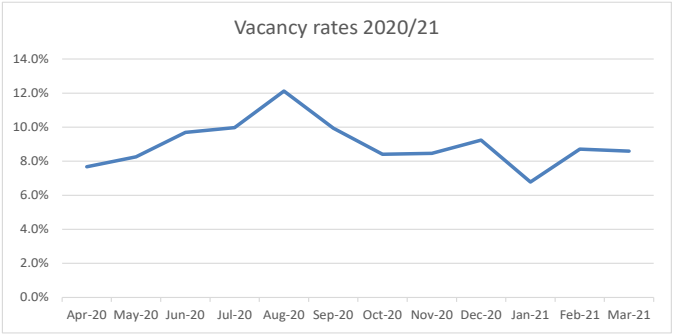


8.6. ERs have been presented by multiple specialties. Variation in reporting patterns are seen through the year. Incidence of reporting can be seen in some specialities that have experienced vacancies with subsequent high volume work flow resulting in additional hours as seen by a 30-40% reduction in baseline establishment in haematology/oncology which is reflected in ER numbers.



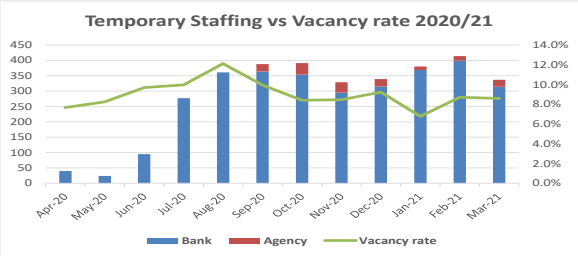
9. Rota Gaps and Vacancy Rates

9.1. GOSH vacancy rate has varied between 6.8% and 12.1% over 2020/21 (broadly similar to the previous year; range 6.8-12.8%) but continues to sit below the national average.



9.2. Vacancy rates and rota gaps reflect the end point of multiple workforce issues including:

- short term unplanned absence
- delays in recruitment process, particularly timeframes for on boarding international medical graduates
- long term structural rota problems and complex interdependencies
- variations in numbers of trainees sent to the Trust by the deanery
- national reduction in the medical paediatric workforce.



9.3. Rota gaps have been highlighted as an organisational pressure. Measures are being taken to mitigate the situation at GOSH include:

- appointing Medical Workforce Leads to closely support rota management
- increasing the number of doctors who are able to provide out of hours support applying equitable out of hours working principles to the medical workforce,
- establishing minimal numbers of doctors required to safely staff speciality areas
- devising new rotas that factor in minimum doctor numbers and hours for annual and study leave
- implementation of a standard operation procedure for rota gaps in medical specialities
- allocating managerial oversight providing cross organisation rota coordination and support

10. Fines

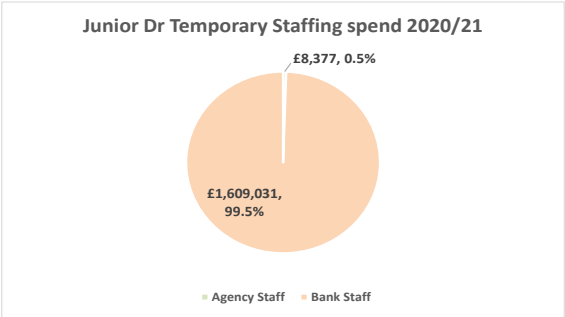
10.1. One fine has been levied with current ERs to date. This was associated with unintended additional bank duties for a surgical SHO. Fines only apply for the doctors on the 2016 TCS.

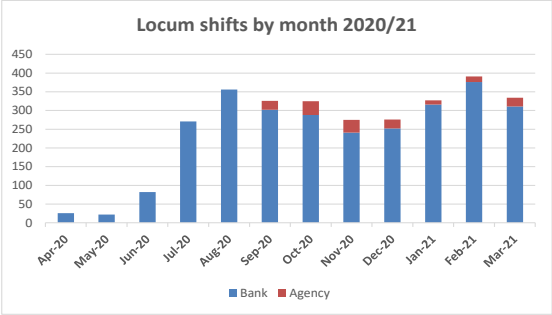
10.2. Current ER system does not automatically identify breaches as the system is dependent on the doctors to report breaches which they are often reluctant to do.

11. Bank Hours

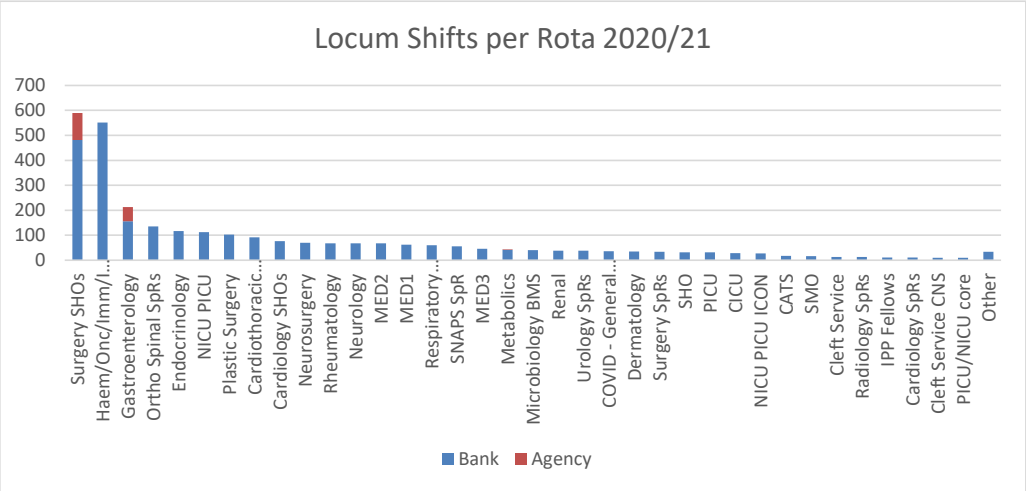
11.1. Bank shifts are filled 'in house' as opposed to locum agencies. There is significant reliance on internal 'bank' locums to cover both short and long term gaps in junior medical staff rotas across the Trust.

11.2. Year to Date spend is £1.61 million (of which Agency spend was £8,377 (0.5%). **This is £1.36 million lower than the previous year**.





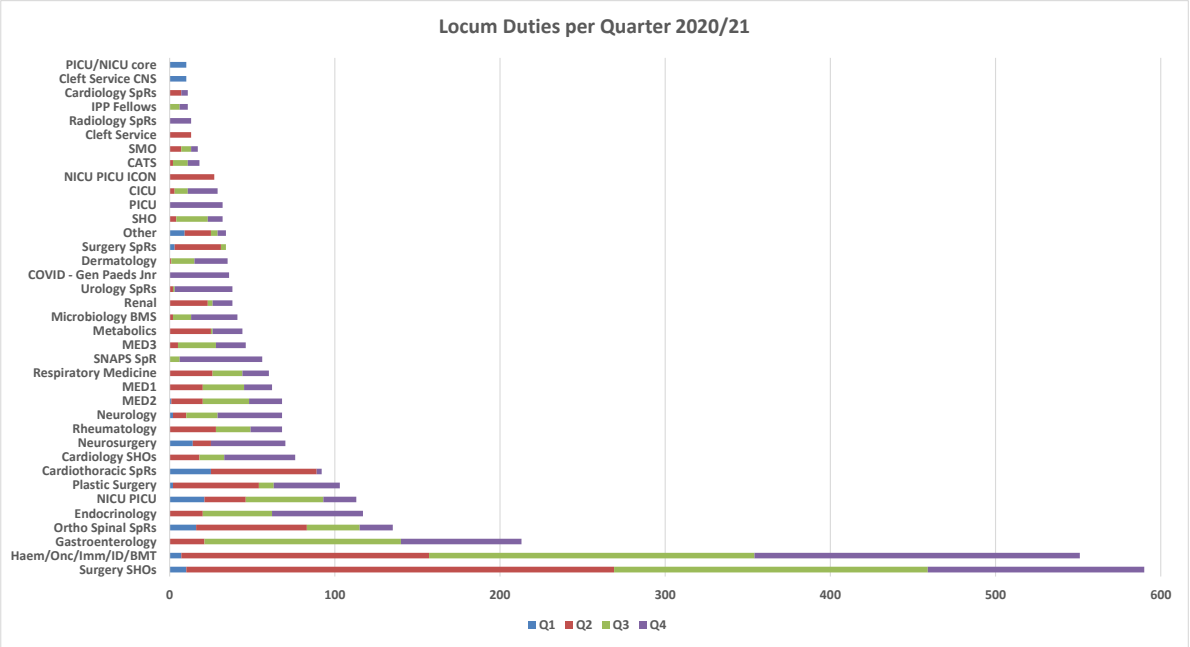
11.3. If non-consultant grade doctors wish to do work additional to their work schedule they must be aware of breaching safe working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation. Some organisational oversight is achieved through the rota coordinators. However, more robust systems and guidance are required.



11.4. Whilst Finance data reports spend against cost centres rather than rotas, when looking at shifts booked across the rotas, the Surgery SHO rota accounted for the largest number (19.6% of the total) followed by Haem/Onc/Imm/ID/BMT at (18.3%).

11.5. Vacancy was given as the most common reason (68%) of bookings followed by Short term staff sickness (6.5%) and COVID-19 (3.9%). Locum cost data must be triangulated with unfilled hours due to vacant posts and salary cost saving.

11.6. Detailed analysis of speciality areas requiring locum shifts is being undertaken monthly by the AMD workforce and MWLs. Clarification of dependencies and consideration for ways to provide clinical support is being considered.



12. Junior Doctors Forum (JDF)

12.1. The JDF was first established in spring 2017. On line meetings commenced in March 2020 and continue to run monthly with good attendance. Junior medical staff are represented as 'JDF Reps' in each directorate attending management meetings. Access to extended leadership training is currently being considered.

12.2. General engagement with the junior doctors across the organisation is good. Improvement in new messaging platforms, such as the new Rungway platform is likely to reach more junior medical staff.

13. Matters for the Board:

13.1. Significant achievements managing a safe and effective medical workforce during COVID pandemic.

13.2. Development of the Medical Workforce Lead role has provided excellent infrastructure and improvement to OOH working.

13.2.1. Clinical input to rota management and analysis of junior medical workforce bank costings has resulted in a significant saving to the Trust.

13.2.2. Risk related to poor compliance assurance offered by the exception reporting system should continue to be acknowledged. Most assurance is determined by good clinical leadership and infrastructure management by the MWLs and rota coordinators.

13.3. Awareness of requirement for better data intelligence to support clinical workforce planning

13.4. Consideration of a Junior Doctor representation at Executive and Board level.

Appendix 1:

COVID – 19 Medical Rota Proposal March 2020

GUIDING PRINCIPLES
• **Maintain safety of patients and staff**
• **Collaborative working across departments**
• **Wider situational awareness for risk assessment allowing informed and timely decisions**
• **Prioritisation of patient need**
• **Prioritisation of 24/7 clinical cover – pan Trust oversight**
• **Deployment based on clinical capability rather than current role**

The underlying approach to the COVID 19 clinical workforce planning has included:

- Planning must accommodate an unknown patient and staff demographic; we must be responsive and adaptable with structures in place to support rapid change
- Staff wellbeing is paramount – all rotas will have contingency staffing factored in to provide 30-50% back up on days and nights should someone call in sick/ be unable to work. Rotas will also have rest days that will be respected.
- All rotas will run 12.5 hour day and night shifts
- Depth and breadth of clinical workforce will need to be activated to ensure sharing of responsibilities
- Education and training will be delivered in parallel with upskilling /refreshing of staff skills and as an ongoing programme.
- We are ready to review, change and refine these plans as needed

In order to safely staff the trust in the face of potential staff shortages Workforce Bronze proposes the following structure.

Classification of Medical Staff

Doctors in the trust will be classified into the following categories:

Tier 3: Expert Clinical Decision Makers	Clinicians who have overall responsibility for patient care: consultants as well senior registrars / fellows who can 'act –up'
Tier 2: Senior Clinical Decision Makers	Medical & surgical registrars/CSPs/ ACPs: clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatments

Tier 1: Competent Clinical Decision Makers	Clinicians who are capable of making an assessment of the patient: includes SHOs (ST1-3); ANPs; CNS; ACPs*; redeployed clinicians

Note that these categories are context specific; so surgical registrar may, for example, be able to work at Tier 2 in their own specialty but at Tier 1 whilst covering medical patients. Following a review of ACP competencies in the trust by the Education Team, we have concluded that ANPs not currently on medical rotas will not be able to act above Tier 1. Some CNSs may be able to work at Tier 1 in their clinical areas, but this must be balanced against the potential need for them to support the nursing workforce.

The trust will have 5 rotas to maintain critical services and provide emergency provision

1. Specialist Medicine
2. Acute Surgery
3. Haematology, Oncology and BMT
4. Critical Care
5. Pelican (COVID-19), whilst these patients remain cohorted

All junior doctors on these rotas will be asked to work 12.5 hour shifts. We have used a survey to identify those doctors with critical care skills who could be offered training to move into critical care roles. The junior doctor workforce will then be classified into the following categories:

- Tier 2 Medical
- Critical care competent or competent following training
- Haem/Onc/BMT with EPIC Beacon training
- Tier 2 Acute Surgery
- High dependency Competent
- Tier 1

The individual rotas will be run as follows

Medicine

This rota will provide staffing for critical inpatient work which needs to continue despite restrictions to elective activity, for example critical inpatient infusions. Please note that we think this work will continue to delineate a weekday vs. weekend day differentiation which has been accommodated. Most of the inpatient specialist medicine work will be provided by specialty consultants with support from the tier 2/1 pool.

This rota will provide:

Weekday	12 x Tier 2
	12 x Tier 1
Weekend day	8 x Tier 2
	8 x Tier 1

Nights	4 x Tier 2
	4 x Tier 1

This rota is designed with 4 x doctors on backup days and 2 x doctor on backup nights, which provides 50% contingency at night and 30% during the day. This rota will require 42 doctors to run from our current establishment of 48.7 at Tier 2, leaving us some contingency and the opportunity to redeploy some doctors to other areas.

Acute Surgery

The emergency surgery service will be staffed by Tier 2 Acute Surgery doctors, who will principally be those with general paediatric surgery experience, on the basis that reduced elective activity will significantly reduce patient numbers, in plastics, orthopaedics, urology and ENT.

The rota will provide:

Daytime	2 x Tier 2 Acute surgery
	2 x Tier 1
Nights	2 x Tier 2 Acute surgery
	1 x Tier 1

Additional cover will be required to run any elective lists which will be operating during this period. It is recommended that any elective lists are staffed by two surgical consultants

Specialty cover will be provided at Tier 3 by the Consultants.

Neurosurgery and Cardiothoracic Surgery represent critical urgent care services and their rotas will remain as they currently run. Contingency arrangements will need to be made to allow for potential staff sickness on these rotas.

Haematology, Oncology, Immunology, ID & BMT (Blood Cells Cancer rota) – Clinical Lead Lynne Riley

An increase in demand for these services is anticipated. Current staffing numbers are low. In order to meet the demand of this rota given the reduction in staff due to sickness, doctors from the Tier 2 pool will be redeployed and trained to deliver services via EPIC Beacon. These doctors will be offered additional induction and training during the week beginning 16th March.

This rota will provide:

Weekday

Haem	2 x Tier 2, 1 x Tier 1

Onc	2 x Tier 2, 1 x Tier 1
BMT	4 x Tier 2. 1 x Tier 1
Safari	2 x Tier 2, 3 x Tier 1

Weekend day	3 x Tier 2, 3 x Tier 1
Nights	2 x Tier 2
	2 x Tier 1

Pelican (COVID – 19)

This rota will be supported by the BCC rota and offered whilst patients with COVID-19 continue to be cohorted on Pelican. This rota will require

Day	1 x Tier 2 1 x Tier 1
Night	1 x Tier 21 x Tier 1

Critical Care

Staffing to allow 70 critical care beds to be achieved according to PICC standards can be delivered from existing staffing without allowing for sickness. This rota will be supported by provision from anaesthesia, with middle grade staff released by a decrease in elective activity. This workforce will be supplemented by other doctors with critical care experience who can act at Tier 2 with additional training.

The cardiology registrars will remain on their current rota with the cardiology fellows who are not on the current rota being drafted onto a 12.5 hour rota pattern.

Education Needed

ITU induction & training for doctors new to the system.

EPIC training for anaesthetic doctors rotating to ITU

EPIC Beacon training for those doctors joining Haem/Onc BMT

Staffing Hub

A staffing hub is being established by HR. This will need significant oversight by the clinical teams within each area. Success depends on knowledge of the skill set of the clinicians and a clear administration and communication process.

We suggest that the hub convenes on a daily at the end of the working day in order to confirm plans for the following 24 hours

Staff Wellbeing

The wellbeing of the clinical staff is paramount to the delivery of sustainable, quality care. We want to develop and deliver a wellbeing strategy which includes: a process that checks in on our staff who are self-isolating or are unwell; those who are far away from home and those who are feeling most vulnerable. This is the first time our generation have been faced with a work related mortality risk and we need to listen and respond to their fears and concerns.

Appendix 2:

H@N June 2020 – Stepping off COVID rotas- Medical Workforce Preparedness Bronze Workforce Group

COVID rotas were devised on the following principles:

- Maintain safety of patients and staff
- Collaborative working across departments
- Wider situational awareness allowing informed, timely decisions
- Prioritisation of patient need
- Prioritisation of 24/7 clinical cover – pan Trust oversight
- Deployment based on clinical capability rather than role

Underlying approach included:

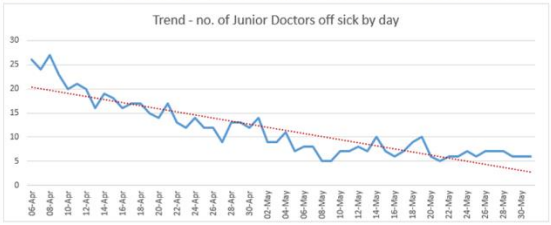
- Planning for unknown needs; rapid change needed
- Staff wellbeing paramount
- Clinical workforce activated to share responsibility
- Survey of ANPs/ CNS support for T1 rota – **unable to demonstrate medical level capability**

During April and May 2020

- COVID Absence rates 7 to 27% (non COVID baseline vacancy rate 7-16%)
- No gaps in COVID rotas –shifts internally covered with standby system:
- April 446 shifts; May: 197 shifts

Sickness absences (all rotas)

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total for week	Daily average
w/c 06/04/2020	26	24	27	23	20	21	20	161	23.0
w/c 13/04/2020	16	19	18	16	17	17	15	118	16.9
w/c 20/04/2020	14	17	13	12	14	12	12	94	13.4
w/c 27/04/2020	9	13	13	12	14	9	9	79	11.3
w/c 04/05/2020	11	7	8	8	5	5	7	51	7.3
w/c 11/05/2020	7	8	7	10	7	6	7	52	7.4
w/c 18/05/2020	9	10	6	5	6	6	7	49	7.0
w/c 25/05/2020	6	7	7	7	6	6	6	45	
Total	98	105	99	93	89	82	83	649	



COVID rotas – what has worked well?

- Rapid on - boarding, induction and training
- Cross specialty working: willingness for one team working from most
- System and process development:
- Centralised rota coordination 7 day service 07:30-21:00
- Establishing safecare system for doctors (sickness and absence tracking)
- Wellbeing support pathways (phone backs)
  Remote consultants checking 'real time' situational assessment and feeding back to workforce leads
- Engagement by team of consultants who have had operational oversight New work committed to handover process

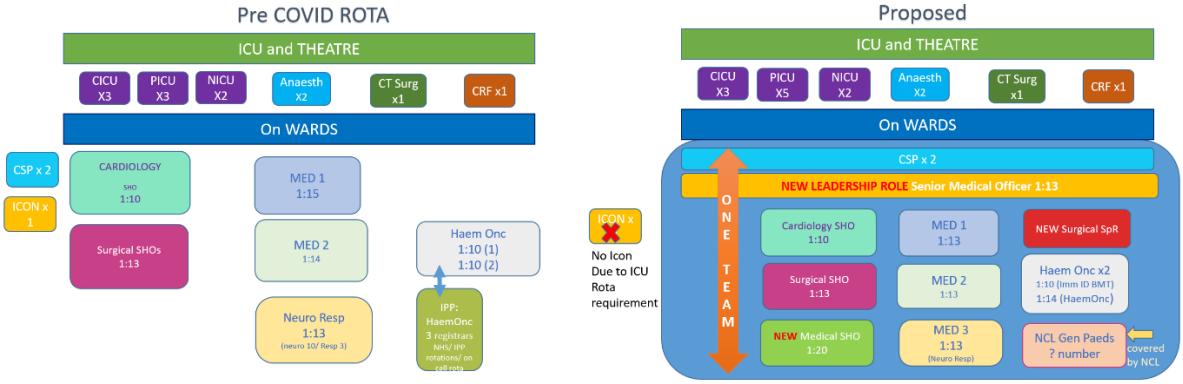
COVID rotas – what has been challenging?

- Establishing a safe and effective handover – space and logistics
- Old operational infrastructure to H@N
  - No managerial support

- No formalised lines of responsibility
- Lack of coordination from NCL for workforce numbers – need to constantly flex
- Frequent changes in dates and timeframes by NCL creates lack of trust
- Turning on other activity either by default or in a planned way but without medical workforce in place.
- No opportunity for consideration of wider individual doctor needs/ resilience at start
- Communication via email to JDs who prefer other platforms
    - Managing many with little resource – fuelled by commitment and good will

Approach to next step

- 24/7 Patient safety is paramount and must be everybody's business
- COVID rotas are not optimal for surgical and specialty restoration – they were devised for emergency short term cover and minimal regular activity
- Service needs to be resilient for second COVID wave and offer a 'step up' or flexible approach
- Preference to keep people in their base specialities
- Aim for safe H@N with increased absence and system for 'rota gap' management

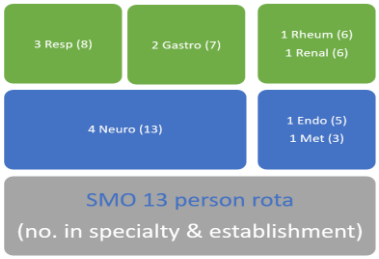


New Rotas development plan:

- Four 13 person medical rotas
- New leadership role Senior Medical Officer
- IPP Fellows join MED1 MED2
- Neuro Resp becomes MED 3
- 5 respiratory and 3 neurology fellows not doing nights go onto rota
- Medical SHO tier produces capability to 'act up'
- SNAPS & UROLOGY combine for resident surgeon

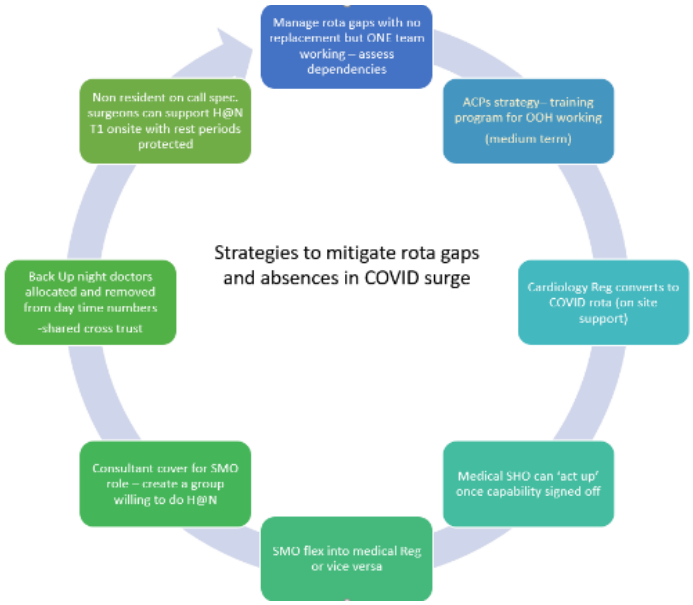
The Senior Medical Role:

- ST 7/8 or POST CCT fellows/ SPIN (APLS providers)
- Overnight leadership of entire medical team in conjunction with CSPs
- Supporting collaborative task based working
- Education & Training: Medical SHO capability development assessment and sign off
- Daytime/weekend cover remains within specialty
- Funded leadership & management program at GOSH
- Departmental identification of "step-up/transition" to consultant working in a supported way.
- Fits Shape of Training Model for 2021 – post CCT speciality training



Benefit: Improved Gap Management and Potential COVID Surge Capacity

- Meets requirement to step up for absence cover but maintain speciality cover
- Flexible and effective team accommodate rota gaps across specialities - broadens scope of gap cover (i.e MED3 neuroresp covered by any registrar as the team are working as ONE)
- Consultant on call is expert; Registrar is skilled
- Minimum number of H@N doctors to be established - need data for flow, acuity and capacity once new rota set up
- Intention for team to flex +/- 1 registrar; SHO post will not be backfilled. Intention is for this to create a pool of able doctors who can act up under supervision of SMO



Risks

Reduced day time medical capacity

- Every set of 7 nights takes 8 daytime service days away; this totals 16 day service days in 26 weeks – so 3 weeks and 1 day for 14 nights.
  - Neurology and respiratory 1:13 precovid rota; MED 1 and MED 2 were 1:14/15 precovid so negligible day time impact on MED1 and MED2

Areas affected:

1. Respiratory
   a. 5 out of 8 fellows now doing nights = 15 weeks and 5 day per 26 weeks
   b. 1 SHO doing 10 nights per 26 weeks = 12 days per 26 weeks
   c. Lung transplant fellow works alongside 0.8 consultant. No cross cover offered from respiratory or cardiology. Leaves service vulnerable

Action: Monday 1st June SS and DL agreed 9th fellow post to offset day time service loss. Lung transplant fellow will start on 8th rota line and when new fellow appointed will step off to long day and weekends only

2. Neurology
    a. 3 out of 10 additional fellows doing nights = 9 weeks and 3 days per 26 weeks.
    b. 4 SHOs doing nights (1 in 20) = 7 weeks per 26 weeks

    Action: Consider maintaining COVID arrangements for neurosurgical cover with ANP and Gen Paeds support neuro as third line back up
    Flow project to consider different approach (Advanced Clinical Practice/ Physicians Associates)

Appendix 3:

Medical Workforce Leads Duties and Responsibilities

- Work as a team alongside the AMD workforce, medical HR; rota coordinating team; OOH general manager, CSPs and service lead to shape clinical workforce leadership and management out of hours
- Remit to deliver further infrastructure improvement, of OOH working with an equitable cross Directorate approach with the focus of patient safety, junior medical workforce experience, training and education and the evolving GOSH response to an ongoing COIVD 19 threat.
- Support the medical pastoral and mentorship programme with a focus on OOH team working and support
- Promote learning excellence through focus on active learning from OOH experience, developing capability framework for SHOs and leadership programme for SMOs
- Integrate OOH performance into local faculty group review and educational supervision framework

Individual Areas of Responsibility

With the AMD as project lead, each medical workforce lead will have individual areas of responsibility that will contribute to:

1. **Safer Patient Care**

    - Active management of real time clinical decision making with situational knowledge of complex patient requirement in relation to workforce dependencies to ensure out of house cover is safe
    - Daily review of rota gaps and absence; risk assessing team capability in line with patient dependency; redeploying junior doctor workforce with equity into suitable roles
    - Ensure governance and safety issues have appropriate cross Directorate responses with clear lines of responsibility, reflection and learning from events out of hours
    - Active management of Datix linked to OOH working
    - Establish a monthly OOH clinical risk group

2. **Improved System Management**

    - Establish effective clinical communication strategies optimising existing resource and considering innovative systems

    - Development and application of EPIC based systems to support OOH working (specifically medical handover and clinical documentation)

- Medical Handover process improvement – training, oversight and evaluation
- Surgical handover process improvement – training and oversight and evaluation
- Develop trust wide SOP outlining general process for escalation pathways for unsafe staffing and expectations

- Work with departments to agree escalation pathway based on overall principles of safety and value

3. Accurate Data Information Systems

- Dashboard development to ensure key data is captured to support planning
- Facilitate and enable internal recruitment and retention including establishing development of career pathways within GOSH- monthly review

4. Improved Experience

- SMO weekly support and development meetings
- Establish feedback systems and work to improve the reputational issues that currently exist at GOSH related to OOH working

5. Focus on Education and Training

- Deliver systems intelligence development programme delivered to Senior Medical Offices- weekly
- SHO OOH clinical competency framework- assess baseline capability and delivery of weekly training
- Implement a training programme to induct current fellows/ registrars into out of hours working
- Feedback into local Faculty groups to ensure OOH performance is connected to junior doctor review