

PUBLIC – Board of Directors
31 March 2026

Report	Agenda Item 12.	Annual Report on Safe Working Hours				
Purpose of the Report	Decision		Ratification		Assurance	Information X
Accountable Executive	Dr Nigel Scawn			Medical Director		
Author(s)	Dr Rebecca Gale			Guardian of Safe Working		
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X X X X	Failure to maintain safety and prevent harm would result in poorer patient care and outcomes, inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust, Challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care and failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation, and our reputation.	
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health					X X
CQC Domains	Safe Effective Caring Responsive Well led					X X X
Previous considerations	JLNC March 2026					
Executive summary	<p>The purpose of this report is to provide assurance to the Board that the doctors' working hours within the Trust are monitored and managed appropriately.</p> <p>The role of the Guardian of Safe Working (GOSW) is to ensure that compliance with safe working hours is addressed both by the doctors themselves and the Trust hosting them.</p>					

	<p>This 2025 annual report includes data relevant to the safe working hours of resident doctors including but not limited to, exception reports, locum costs and information obtained from the quarterly resident doctors forums.</p> <p>The current main issue is the impact that staffing levels are having on resident doctors being able to adhere to their scheduled hours and breaks. The common themes seen throughout the exception reports are a mismatch in volume of workload and staffing numbers. There were five serious safety concerns raised in the last quarter of 2025 (Oct to Dec) with four referencing understaffing as a main contributor. One explanation given for this may be related to the adherence to the regional locum rate card which was enforced from 1st October 2025. This was specifically raised at the resident doctor forum in October and JLNC in December to have had an impact on the number of rota gaps and highlighted the reliance of some specialties on locum staffing to fill known medium and long term gaps</p> <p>Going forwards the impact of the new exception reporting reforms, implemented nationally on the 4th February 2026 are being assessed. At the time of writing, there has not been a large increase in the number of exception reports submitted, however this needs to remain under close review as this appears at odds with the national picture. This may require additional resources in future, particularly regarding the workload of the medical staffing department who now handle the majority of reports that are submitted.</p> <p>Further actions to be taken include:</p> <ul style="list-style-type: none"> • To further consider the speciality specific actions as outlined in the paper, including the business case for the general surgery staffing model. • Departmental business managers and medical staffing need to work closely to highlight known rota gaps introduced by LTFT working patterns and long term leave and proactively work to recruit locally to mitigate the impact on remaining resident doctors. The introduction of the new rostering system may aid in the early identification of gaps.
Recommendations	The Board of Directors is asked to note the report and actions required.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	Risks related to the medical workforce and the governance around this.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

ANNUAL GUARDIAN OF SAFE WORKING REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING.

1. Executive summary

The key points to highlight are the impact that staffing levels are having on resident doctors being able to adhere to their scheduled working hours and breaks. The common themes seen throughout the exception reports are a mismatch in volume of workload and staffing numbers.

Going forwards the impact of the new exception reporting reforms, implemented nationally on the 4th February 2026 are being assessed.

2. Introduction

The purpose of this report is to provide reassurance to the Board that the doctors working hours within the Trust are safe. The safeguards built into the 2016 Junior doctors' contract are designed to ensure risk of fatigue is effectively mitigated thereby minimising any risk to patient safety. The role of the Guardian of Safe Working (GOSW) is to ensure that compliance with safe working hours is addressed both by the doctors themselves and the trust hosting them.

This yearly report includes data relevant to the safe working hours of resident doctors including but not limited to, exception reports, locum spends, and information obtained from the resident doctor's forums held quarterly on the 22nd January, 30th April, 16th July and 15th October 2025.

3. High level data (data from 8/12/25)

Number of doctors / dentists in training (total): 135

Number of locally employed doctors / dentists on 2016 TCS (total): 93

Number of Foundation doctors: 60

Annual vacancy rate among this staff group: Not known.

4. Annual data summary

The introduction of the new patchwork eRostering system that the trust has invested in, should make the availability of rota gap data much easier to obtain. Going forwards there is a requirement for the Guardian of Safe Working to report on all rota gaps to provide context to the exception reporting data. In lieu of current vacancy data I have included the locum spend per specialty for the year as it is felt to be partially reflective of rota gaps.

Locum bank booking costs per specialty for Resident doctors within the Trust (F1 to ST8) for 2025.

Row Labels	Count of Speciality gap/doctor being covered	Sum of Total spend
ACCIDENT & EMERGENCY	2097	£1,208,277.41
Accident & Emergency2	78	£55,975.30
ACUTE INTERNAL MEDICINE	478	£272,153.92
ANAESTHETICS	112	£104,862.00
Bank Medical Team	10	£3,951.67
CARDIOLOGY	135	£81,664.56
CRITICAL CARE MEDICINE	133	£119,355.50
DERMATOLOGY	4	£5,948.00
DIABETIC MEDICINE	225	£140,787.58
ENT	317	£171,566.61
EPH	15	£6,010.00
GASTROENTEROLOGY	162	£101,052.75
GENERAL MEDICINE	1128	£558,597.14
GENERAL SURGERY	282	£205,511.96
GERIATRIC MEDICINE	489	£257,531.17
HAEMATOLOGY	75	£35,109.75
OBS & GYNAE	175	£130,716.75
OPHTHALMOLOGY	34	£43,410.50
ORAL & MAXILLO FACIAL SURGERY	189	£96,088.33
PAEDIATRICS	150	£114,576.40
PLASTIC SURGERY	342	£214,704.08
RESPIRATORY MEDICINE	106	£63,884.00
RHEUMATOLOGY	2	£1,560.00
SDEC	62	£35,391.50
TRAUMA & ORTHOPAEDICS	212	£141,534.13
UROLOGY	188	£127,351.52
UTC	497	£368,522.00
VASCULAR	129	£86,949.43
Grand Total	7826	£4,753,043.94

Overall locum spend was £4,753,034.94. This is a £10,049 increase on the 2024 figures.

There were 222 exception reports submitted in 2025 which is a reduction by 14 from the 236 reports submitted in 2024. COCH allows all doctors in training and all locally

employed doctors who are appointed on a contract that mirrors 2016 Terms and Conditions of Service to access the exception reporting system.

Exception reports by Department

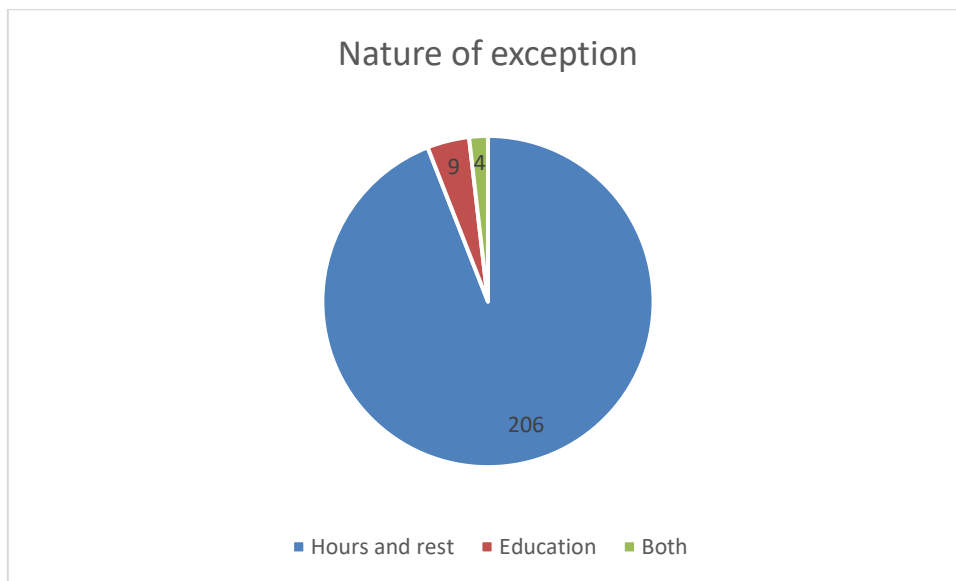
Department	Number of Exception reports 2025
Accident and Emergency	14
Acute Medicine	24
Breast	0
Cardiology	4
Care of the Elderly	16
Diabetes	6
Gastroenterology	39
General Surgery	15
Haematology	1
Medical on call	19
Obstetrics and Gynaecology	6
Ophthalmology	0
Paediatrics	2
Plastics	4
Respiratory	33
Surgical on call	12
Trauma and Orthopaedics	5
Urology	18
Vascular	4
Unknown	1

Grade of reporter

Grade	
F1	126
F2	26
ST1-2	49
ST3-5	20
ST6-8	1

The F1 doctors are the highest reporters, accounting for 57% of all reports submitted. This is in line with national trends in exception reporting where foundation tiers account for the greatest number of reports submitted.

Nature of exception reported



The vast majority of the exceptions reported related to excessive hours worked and lack of rest with only 4% attributed to missed educational opportunities. In 1.8% of reports both excessive hours and missed educational opportunities were reported. The commonest educational exception report related to inadequate clinical exposure, largely due to being moved from their planned rotational post to cover another area due to rota gaps. Over half of the educational reports occurred in the last quarter of 2025 with 7 of the 13 reports (54%) submitted in this 3 month period. Additional information on the educational exception reports submitted is available in appendix 2.

4. Issues arising

Reforms to exception reporting:

The main project throughout 2025 was the imminent introduction to the exception reporting process as a result of the updated Doctors and Dentists in training terms and conditions (England) 2016 Version 13. This was originally designed to be introduced nationally in September 2025, then November 2025 and finally set as an introduction date of 4th February 2026. This has been a significant piece of work to ready the trust for the introduction of the reforms as there have been a number of key changes to the previous process:

- Educational and clinical supervisors have now been removed from the process
- All educational exception reports are sent directly to the director for Medical Education (DME)
- All exception reports for 2 hours or less are actioned directly by Medical Staffing
- Exception reports for 2 hours or over are investigated and actioned by the GOSW

- Exception reports are now subject to confidentiality fines if anyone other than the named individuals listed on the DRS exception reporting system are informed of the report without the express consent of the doctor submitting the report.
- The doctor submitting the report can choose whether they wish to have payment or time back in lieu of additional hours (TOIL).
- All doctors must be provided with access to the exception reporting system within 10 days (reducing to 7 days in August) of starting in the trust or a fine can be levied.

10-point plan

There was a national 10-point plan published by NHS England in August 2025 which laid out 10 key areas that each trust had to evaluate and score themselves against. An action plan then had to be provided at the end of a 12-week period to look for improvement. All the points included were designed to improve and enhance the working lives of resident doctors and point 7 specifically related to ensuring that resident doctors are able and encouraged to exception report if working beyond their contracted hours.

Less than Full Time (LTFT) Work schedules:

Timely provision of LTFT work schedules was raised at the residents doctor forum in April as being a particular issue with work schedules not being sent with the contractual notice period required. The key issue raised by the medical staffing team was that all LTFT work schedules are bespoke to the individual doctor and require input from departmental rota masters in addition to medical staffing and awaiting agreement was felt to be contributing to the delay in being able to provide these.

Serious safety concerns:

There were 6 serious safety concerns raised in 2025. Five of the six reports occurred within the final quarter of the year (Oct to Dec 2025) and 4 of these were directly felt to have been due to rota gaps or inadequate staffing. One explanation given for this may be related to the adherence to the regional locum rate card which was enforced from 1st October 2025. This was specifically raised at the resident doctor forum in Oct and JLNC in Dec to have had an impact on the number of rota gaps and highlighted the reliance of some specialties on locum staffing to fill known medium and long term gaps.

Specialty	Total	Nature of concern	Quarter occurred
Respiratory	1	Understaffing	2 nd (Reported 3 rd)
General Medical on call	2	Understaffing System error	4 th 4 th
General surgical on call	1	Understaffing	4 th
Acute Medicine	1	Understaffing	4 th

Endocrine	1	Understaffing	4 th
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Specialty specific information:

Emergency medicine:

Like 2024, Emergency medicine had the highest resident doctor locum costs with 26.6% of all locum payments. There were only 14 exception reports, but resident doctor forums highlighted concerns with taking of annual leave during emergency medicine placements due to requirements to adhere to minimum staffing numbers and the late granting of requested leave. Issues were also raised with the inability to take Self-directed learning time (SDT) during rotations. There has been a work schedule review for the F1 tier in ED as working hours did not reflect work schedule. A consultation on change of hours has been put forward to the department for agreement. Additional payment for the additional hours was provided retrospectively to the doctors affected.

Acute internal medicine:

Locum payments for acute medicine made up 5.7% of the total locum bill and they had the third highest number of exception reports with 24. There was a serious safety concern raised due to a rota gap and excessive workload for one doctor covering SDEC. In addition, there was an open letter penned by the resident doctors and ACPs on MAU highlighting the frequency of rota gaps and the frequent need to cover more than one role due to this.

General medicine:

Second highest for locum costs and had 19 exception reports. The on-call medicine rota has been regularly flagged in the resident doctors forum as a rota with frequent gaps. There have been 2 serious safety concerns raised, one because of understaffing on an out-of-hour shift and a further one related to a systems error which required a resident doctor to stay over their designated shift to clerk a patient.

General Surgery:

There have been significant issues raised throughout the year regarding the general surgical staffing, particularly with very high workload for the number of doctors on call. There have been 27 exception reports for general surgery (12 for on call). There has been a serious safety concern raised when a consultant was required to be resident on call overnight to cover for a resident doctor gap which left the post take ward round without an available consultant the following morning.

Gastroenterology:

There were 39 exception reports submitted for gastroenterology, the highest of all the specialties. These were largely received in the second half of the year from August to December 2025. Approximately a third of reports referenced excessive workload while two thirds referenced the ward running at or below minimum staffing. This was highlighted to the education lead and the business manager for

gastroenterology and matched with the significant staffing challenges the gastroenterology department had with two unfilled posts in the Aug to Dec rotation.

Respiratory:

The second highest specialty for number of exception reports was Respiratory with 33 reports. There was also one serious safety concern raised in respiratory for understaffing due to a daytime consultant gap. The commonest reasons for exceeding hours were acutely unwell patients (the Respiratory Support Unit is a high acuity area) and understaffing.

Urology:

There were 18 reports for Urology, a proportion of these highlighted the additional hours the on-call doctors were spending resident in the hospital at weekends due to high workload. These were raised with medical staffing and the Urology department, and a work schedule review was undertaken.

Fines for breaches in safe working hours:

There has been a significant issue with collecting the payment of fines issued due to the lack of a functional system to allow GOSW fines to be administered. This was initially flagged in October 2024 and a report detailing the reasoning and requirement for a GOSW fines account was written by the Guardian in March 2025. A fine account was finally established in December 2025 and is now in place to allow for effective administration and collection of relevant fine monies going forwards.

Overall, there were 9 exception reports which breached safe working hours. These 9 reports actually incurred 14 fines as all incidents were due to exceeding the maximum 13-hour shift length and on 5 of these occasions this led to a reduction of <11 hours rest between shifts in addition. A summary of the fines is given below:

Specialty	Grade	Breach	Number of incidences	Reason
On call surgery	F2	>13 hours	1	Understaffing
On call surgery	F1	>13 hours	4	Workload
On call surgery	F1	< 11 hours rest	3	-
On call Medicine	F1	>13 hours	4	Workload
On call Medicine	F1	< 11 hours rest	2	-

5. Actions taken to resolve issues.

Exception reporting reforms:

The software used for exception reporting (DRS5) has been updated by the software developers and relaunched to ensure compliance with the exception reporting reforms. An updated PowerPoint presentation detailing the steps required to submit an exception report was given at induction for doctors rotating to COCH in February 2026 and that was then circulated to all doctors already within the trust via email. There is a plan to embed the presentation on the GOSW page on the medical education webpage to allow for easy reference in future. The Guardian has also written an exception reporting guideline which embeds all the updated terms and conditions as referenced in Version 13. This has been reviewed and agreed at the Resident Doctors Forum in Jan 2026 and reviewed and agreed at JLNC in March 2026. The current trust position is that geolocation data is not required to verify exception reports due to the lack of an accurate and intuitive solution for resident doctors to provide this. This will be reviewed if a national or regional solution is found.

10 point plan:

In order to comply with the 10-point plan, a resident doctor representative was appointed, and a working group was established. At the 12-week review point, COCH compliance improved from 61% to 71%. There are ongoing action plans for the areas where COCH has not yet achieved compliance.

Less than Full Time (LTFT) work schedules:

The medical staffing team now have a system in place to contact all doctors 12 weeks prior to starting when the names are provided by the lead employer and ask if they are LTFT and specific information relating to non-working days. The rota master for the specialty the doctor is joining is copied in to try and streamline the process and reduce delays.

Specialty specific information:

Emergency medicine

The lead clinician confirmed that to improve delays in approving annual leave, a new medical staffing coordinator had been appointed for the ED plus one of the consultants had taken on the medical role of rota coordinator. There had been a change in the “minimum staffing” requirements at the Core trainee tier to include ACPs in the minimum numbers so there would be more opportunity to take leave. Going forwards there was a plan to allocate the SDT into the rota in advance of each new rota cycle starting to minimize the chance of not being able to take this time. A new Trust annual leave policy that incorporates resident doctors is currently being reviewed prior to implementation.

General Medicine:

The serious safety concern has been raised with the Associate Medical Director for medicine. There has been a minimum safe staffing document constructed which clearly outlines the minimum staff required to run the medical on-call tier and which, if not met, will trigger a dynamic risk assessment and potential need to act down by the medical consultant on call. This is being disseminated within the directorate. A

standard operating procedure (SOP) to support this is being constructed which specifies that, even if minimum staffing is met, additional locum cover will be authorized and sought to allow for optimal staffing due to the known high workload of the medical on call service.

General Surgery:

The General Surgery division have constructed and submitted a comprehensive business plan designed to increase the consultant and resident doctor staffing within the department with the introduction of an additional tier at the foundation/CT level for out-of-hours on call cover. The current staffing has been placed on the trust risk register (with a high risk assigned) due to the concerns raised regarding the sustainability of the current rota. Following an innovation week in which the current staffing model was bolstered with an additional doctor there is agreement for funding for an extra daytime resident doctor to cover on call surgical admissions and SDEC for 12 months. The serious safety concern within general surgery was escalated widely, via the DME, the GOSW and via the trust incident reporting system. The new business case plans for an additional consultant to be present in daytime alongside the on-call consultant to allow for additional supervision of resident doctors, undertaking emergency reviews and improving patient flow. This additional consultant would hopefully mitigate further incidents of inadequate supervision.

Gastroenterology:

The education lead was very proactive in trying to address the staffing gaps for gastroenterology. Locum cover was requested for days when the staffing was below the minimum requirements (although often not filled) and there was appropriate senior support with daily consultant ward rounds. They introduced weekly teaching and improved access to clinics. They had also constructed a rota for the registrar grade doctors to return to the ward at 4pm to aim to try and ensure all doctors can leave on time. There remains one long term rota gap for gastroenterology from December 2025.

Respiratory:

The serious safety concern was reviewed and was felt to be due to an unexpected and exceptional circumstance. Going forwards there are now 3 consultants covering the respiratory ward areas following recruitment at the consultant tier. The educational lead for respiratory highlighted that there is a long-term rota gap at the registrar level and due to LTFT working patterns at the Foundation/CT level there is also a 1.6FTE gap leading to an appreciable impact on staffing levels. There are also an additional 12 medically optimized patients under the care of the respiratory consultants. The staffing model is for a locally employed additional doctor to cover these patients, however gaps in this cover lead to the resident doctors for respiratory covering these additional patients in addition to their own bed base.

Urology:

Following a work schedule review and the recruitment of 2 additional Urology doctors at the registrar tier, there was an increase in the number of predictable hours within

the work schedule at weekends and there is now weekday Urology on call registrar cover.

6. Summary

While the numbers of submitted exception reports remain consistent, there was an increase in serious safety concerns raised in the final quarter of the year which aligns to the concerns highlighted at the December JLNC meeting. It was felt that the adherence to the Northwest locum rate card may have contributed to this with a reduction in the number of locum shifts being undertaken. It also highlighted the issues of running with a high locum burden and the need to proactively manage medical establishment numbers to reduce reliance on locum doctors going forwards. The impact of long-term rota gaps within smaller specialties can be clearly demonstrated with the exception reporting data for respiratory and gastroenterology. The adoption of the new rostering system may aid in early identification of gaps.

The adoption of the new exception reporting reforms in February 2026 appears at present, to have proceeded uneventfully. National templates for the updated quarterly and annual reports are awaited. There may be further changes to the provision of geolocation evidence required for submission of exception reports when a national or regional option is developed to provide reliable geolocation data.

7. Questions for consideration:

While it is acknowledged that the trust currently has significant financial constraints, I feel the general surgical business case for additional staff needs to be strongly considered as the current staffing model is resulting in finable breaches in safe working hours and a serious safety concern related to rota gaps. The GMC survey contained feedback on the unsafe workload for general surgical on calls. Consequently, the general surgical rota is on the risk register with a high-risk grading.

The importance of proactively identifying and managing long term rota gaps has been demonstrated by the exception reporting data this year. Known rota gaps are transferring workload to the remaining team members with the subsequent impact on their hours, ability to take breaks and annual leave and overall wellbeing. Departmental business managers and the medical staffing team need to proactively identify and look to recruit to vacant posts or to cover rota gaps introduced as a result of LTFT working patterns.

8. Conclusion

The Board of Directors is asked to **note** the report and actions required.

Appendices

Appendix 1:

Locum booking by grade:

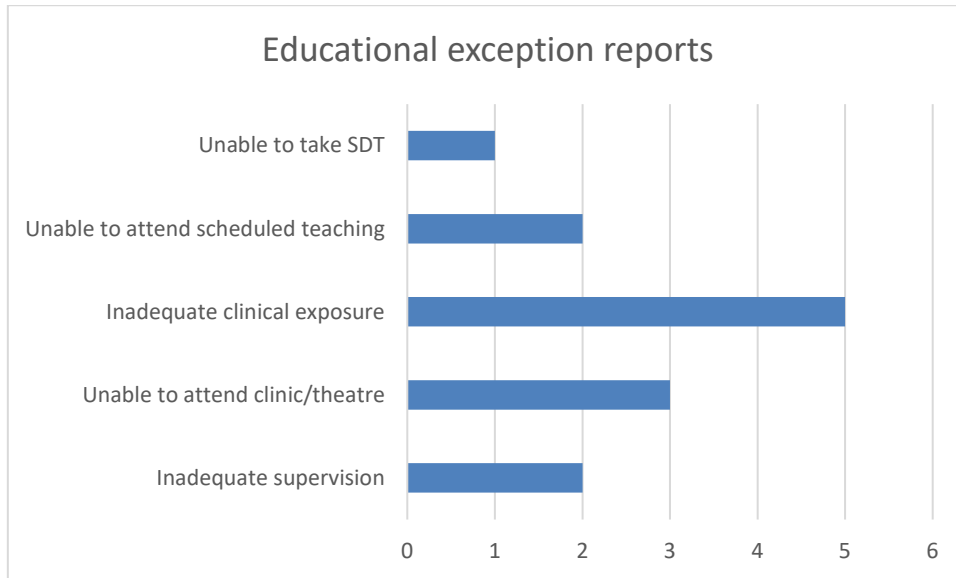
Row Labels	Count of Grade
Foundation Y1	64
Foundation Y2	485
Registrar ST1-2	5845
Registrar ST3 (+)	1432
Grand Total	7826

Locum booking by reason:

Row Labels	Count of Reason
A&E - A/L	301
CoCH Vacancy	2368
Cover for Induction	46
ECA - Cover for Colleagues	1
Extra Work Pressures	355
Fadlalmula	1
Induction/Mandatory Training	25
J Ablewhite	1
LTFT	396
Maternity / Paternity	16
Maternity/Paternity Cover	148
Medicine - Day 2's	667
No On Call (Health/Pregnancy)	26
No on-call (Health/Pregnancy)	128
Other	2
Other (see extra detail)	1072
SH & K Vacancy	6
SH&K Vacancy	117
Shadow Cover	6
Shadowing Cover	96
Sickness	777
Special Leave	11
Special Leave (see extra detail)	26
Strike	960
Ward Based Cover	274
Grand Total	7826

Appendix 2:

Reasons for educational exception reports



Number of exception reports by division

<i>No of Exception Reports by Division</i>	
Urgent Care	156
Planned Care	58
Womens & Childrens	8
Diagnostics	0

Type of exception reported:

<i>Type of Exceptions</i>	
72 hours work in 168 hours	0
Difference in work pattern	16
Early start	6
Exceeded the maximum 13-hour shift length	9
Late finish	179
Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours	0
Request a work schedule review	9
Teaching cancelled	0
Unable to achieve breaks	72
Unable to attend clinic/theatre/session	4
Unable to attend scheduled teaching/training	3

Outcome of exception reports:

<i>Resolution of Exception Reports</i>	
Open	4
Agreed - no action	42
Payment	121
TOIL	44
Disagreed	0