Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Guardian of Safe Working Hours Quarterly Report, Q4 25-26**

Status:	**For Information**
History:	**Quarterly report**

Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This Guardian of Safe Working Hours (GoSWH) report covers the period 1 January to 31 March 2026 (Q4 2025–26). It is provided to the Trust Board for assurance regarding the oversight and management of Resident Doctor safe working hours at Oxford University Hospitals NHS Foundation Trust.
2. This quarter represents a significant transition point in both contractual governance and local processes. January 2026 operated under the pre-existing contractual framework and legacy exception reporting system, while from February 2026 Version 13 of the Terms and Conditions of Service came into effect alongside national exception reporting reforms and the transition to the DRS5 exception reporting platform. As a result, this report reflects a hybrid operational period, and quantitative comparisons should be interpreted with appropriate caution.
3. **Work Schedules and Duty Rosters:** Work schedules continue to be centrally produced to ensure contractual compliance. However, there remains no formal mechanism for monitoring whether work schedules and duty rosters are issued within contractual timelines or whether subsequent local changes remain compliant with the Terms and Conditions of Service. This continues to limit assurance.
4. **Exception Reporting:** Exception reporting remains the primary formal mechanism through which Resident Doctors raise concerns about working hours. During Q4, 298 exception reports were closed, the majority relating to hours and rest. From February 2026, strengthened contractual duties were introduced regarding access to exception reporting, confidentiality protections, and employer responsibilities. These reforms, alongside the move to DRS5, represent a material change in governance and are expected to improve confidence, accessibility and data credibility over time.
5. **Fines and Regulatory Breaches:** Twenty-two exception reports submitted during the quarter are potentially associated with a contractual breach requiring a fine. The implementation of the new contractual framework and reporting platform necessitated the development of revised fining processes, which were not fully operational at the time of writing. Reported breaches continue to reflect high workload, rota gaps, and service pressure rather than individual non-compliance.
6. **Rota Gaps and Locum Usage:**
   Significant reliance on resident doctor locum work persists, predominantly driven by vacancies and sickness. There remains no central collation of vacancy data or oversight of individual locum working hours, limiting assurance that locum activity is compliant with safe working hours regulations.
7. **Resident Doctor Engagement and Governance:** This quarter also reflects significant progress in the implementation of national exception reporting reforms and the NHS England 10 Point Plan, strengthening the governance foundations for

safe working hours despite the recognised limitations of this hybrid reporting period.

8. This is the final Guardian of Safe Working Hours quarterly report produced in the current local format. From the subsequent quarter, reporting will move to the nationally mandated quarterly template aligned to the reformed contractual and oversight framework.

Recommendations

9. The Trust Board is asked to receive this report for information.

Guardian of Safe Working Hours Quarterly Report, Q4 25-26

1. Purpose

1.1. This quarterly report of Safe Working Hours (Q4: January-March 2026) is presented to the Trust Board with aim of providing context and assurance around safe working hours for OUH Resident Doctors.

2. Report Limitations

2.1. This report should be read in the context of recognised limitations in providing definitive assurance on safe working hours. As in previous quarters, assurance is constrained by reliance on voluntary feedback, limited data integration, and the absence of dedicated corporate administrative support for the Guardian role.

2.2. This reporting period is also a hybrid quarter. January 2026 operated under the pre-existing contractual framework and legacy exception reporting system, while February 2026 saw the implementation of Version 13 of the Terms and Conditions of Service, national exception reporting reforms, and transition to the DRS5 platform. This limits comparability of data within the quarter.

2.3. Apparent changes in activity or outcomes may therefore reflect changes in contractual and reporting frameworks rather than underlying changes in working patterns. The absence of reported non-compliance should not be interpreted as evidence of compliance, and the report should be interpreted with appropriate caution.

3. Background

3.1. The Guardian of Safe Working Hours (GoSWH) role is established under the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, which place specific duties on both the employer and the Trust Board in relation to safe working hours, rota management, and assurance.

3.2. During the reporting period January - March 2026, there were significant national changes to the contractual and governance framework within which this role operates. These included the implementation of Version 13 of the Terms and Conditions of Service, incorporating substantive reforms to exception reporting, and the active delivery phase of the NHS England 10 Point Plan to Improve Resident Doctors' Working Lives. Together, these changes represent a transition from legacy arrangements towards a

reformed national oversight framework for resident doctor working conditions.

3.3. This reporting period represents a transitional and hybrid quarter in both practice and reporting. During January 2026, the management of exception reporting and safe working hours processes remained unchanged from previous quarters and operated under the pre-existing contractual framework and DRS4 exception reporting platform.

3.4. From February 2026, Version 13 of the Terms and Conditions of Service came into effect, together with the implementation of national exception reporting reforms and a transition from the DRS4 to the DRS5 exception reporting system. As a result, there were substantive changes to exception reporting governance, processes, and system architecture within the quarter.

3.5. This report therefore spans two distinct operating frameworks within a single quarter. Comparisons across the reporting period should be interpreted with caution, as observed differences may reflect changes in contractual requirements and reporting mechanisms rather than underlying changes in resident doctor working patterns alone.

3.6. This report is the final Guardian of Safe Working Hours quarterly report produced in this local format. From the subsequent quarter it is expected that reporting will transition to the nationally mandated quarterly reporting template, aligned with the reformed contract and NHS England oversight framework.

Table 1: High level data

Area	**Number**
Number of OUH employees (approx. total)	12,000
Number of OUH Resident Doctors (approx. total)	1,400
Number of doctors in training: Total Deanery posts	1048
Number of doctors in training: not currently in post (Parental leave/long-term sick/out of programme)	61
Number of doctors in training: Fulltime / Less than fulltime	783/265
Locally employed 'resident' doctors	450
Number of resident doctor rosters (approx.)	200
Foundation year 1	114
Foundation year 2	139
Core Trainees	38 (20 surgical)
Internal Medicine Training	74
Dental	5
General Practice	45

Specialty Trainees	633
Job planned time for Guardian	8 hours / week
Job planned time for Deputy Guardian	4 hours / week
Dedicated admin support for Guardian Role, the Resident Doctor Forum and issues arising related to safe working hours (requested 1 WTE)	0 hours / week
Amount of job planned time for educational supervisors	0.25PA / trainee

4. Context: Transition, Reform and Progress (2025–2026)

4.1. The 2025–2026 year has taken place against a challenging national backdrop. Resident Doctors in England have continued to experience uncertainty related to industrial action, unresolved pay issues, and persistent pressures linked to working conditions, rota fragility and workforce sustainability. NHS trusts have also been operating under sustained financial constraint.

4.2. Against this context, progress in improving Resident Doctors' working lives might reasonably have been expected to slow. However, from the perspective of the Guardian of Safe Working Hours (GoSWH), 2025–2026 has instead been a period of meaningful structural improvement at OUH. This has been driven by sustained senior leadership, cross organisational collaboration, and a clearer recognition of the importance of the Resident Doctor workforce to safe patient care.

4.3. Several developments are particularly pertinent to this reporting period.

4.4. For several years, OUH experienced significant limitations with the legacy DRS4 exception reporting system, which were sufficiently material to be recorded on the Trust risk register. During 2025–2026, DRS4 was replaced by DRS5, a supported and reform-compliant platform aligned with the national Framework Agreement, strengthening exception reporting as a core component of safe working hours governance and patient safety at OUH.

4.5. OUH has also been an active adopter of the NHS England 10 Point Plan to Improve Resident Doctors' Working Lives. Delivery has been coordinated through the Improving Working Lives Group with executive sponsorship and multidisciplinary involvement. Progress has included improved oversight of rota and work schedule information, targeted improvements to rest facilities and wellbeing support, strengthened payroll

and mandatory training governance, and clearer Trust level accountability for Resident Doctor experience.

4.6. Alongside this, strengthened Resident Doctor leadership and engagement, together with the transparent use of fatigue, facilities and fine funds agreed with the Resident Doctors' Forum, has supported practical improvements to the working environment.

4.7. Taken together, these developments position this quarter as a clear transition point between legacy arrangements and a reformed national framework. While operational pressures remain, the foundations for more credible, sustainable and accountable safe working hours governance at OUH have been significantly strengthened.

5. Work schedule assurance.

5.1. A work schedule is a structured plan that outlines the distribution of a doctor's contracted hours, balancing service delivery requirements with training needs. It is designed to ensure safety for both patients and doctors, adhering to national guidance and forming the basis for a personalised schedule during a training placement.

5.2. At OUH, work schedules are produced by the central medical staffing team. The information relating to contracted hours is generated using DRS compliance software, ensuring full adherence to the Terms and Conditions of Service (TCS). Educational and training opportunities, provided by individual departments, are incorporated into the work schedule document by the medical staffing team before being shared with Resident Doctors.

5.3. The TCS allows for certain variations to the work schedule in specific circumstances, provided there is a clearly identified clinical reason approved by the relevant clinical director and deemed appropriate by the GSWH. Such rotas must be co-produced, approved by the affected doctors, agreed upon through the Resident Doctors Forum (RDF), and reviewed annually. At OUH, no work schedules with such variations have been submitted to the GSWH or RDF for approval to date.

5.4. The TCS stipulates that a generic work schedule must be provided to a doctor at least 8 weeks before the start of a placement to ensure they are fully informed of the expected work and duties. At OUH, performance against this requirement is not formally monitored. However, the GSWH has received informal feedback suggesting that this target is not consistently met. The primary reason cited is delays in obtaining necessary information from the external Resident Doctor recruitment process, which affects the medical staffing team's ability to complete the work schedules within the required timeframe.

6. Duty roster assurance

6.1. A duty roster, in contrast to a work schedule, outlines the timetabled duties of the resident doctor, including the specific day, date, time, location, and type of work.

6.2. It is assumed that these timetabled duties are derived from and mirror the corresponding work schedule, ensuring full compliance with the TCS. At OUH, there is currently no formal process for reporting on the compliance of duty rosters with either the corresponding work schedule or the TCS.

6.3. Changes to the duty roster are frequently required due to factors such as capacity within the pool of resident doctors or service demands. These adjustments are made at the service level without oversight or scrutiny from the central medical staffing team. Consequently, there is no assurance that these changes consistently comply with the TCS.

6.4. The TCS stipulates that the duty roster must be provided to a doctor at least 6 weeks before the start of a placement to ensure the doctor is informed of the work and duties they are expected to undertake. At OUH, it is uncertain whether this target is consistently met. The GSWH has not received reports on compliance with this deadline, and there is no clear process in place to monitor adherence to this requirement.

7. Exception reports (with regard to working hours) – Appendix 1

7.1. Exception reporting is the contracted process for Resident Doctors (all doctors in training under the 2016 TCS, as well as locally employed doctors with contracts that mirror the 2016 TCS). It enables doctors to report discrepancies between their work schedule and actual hours worked, ensuring that any issues related to safe working hours can be addressed promptly and allowing for timely adjustments to work schedules when necessary.

7.2. The GSWH continues to be contacted by Resident Doctors who report difficulties accessing the exception reporting system. Historically, the exact proportion of Resident Doctors with access has been unclear, and the causes of access delays have not been consistently visible to the Guardian.

7.3. From February 2026, Version 13 of the Terms and Conditions of Service introduced strengthened and explicit employer duties in this area. Employers must provide remote access to exception reporting within 7 calendar days of a doctor starting work, changing employer, work site, or rota.

7.4. The contract also requires employers to provide a simple and clear mechanism for doctors to raise access issues with HR and the Guardian

after this initial seven-day period. Where access issues preventing submission of an exception report are not resolved within a further seven calendar days of being raised, the Guardian is contractually required to levy a fine on a recurring seven-day basis until the issue is resolved.

7.5. A total of 298 exception reports were closed, and 7 exception reports remain open from Q4 (quarterly average = 210, range: 47 – 392). This is down from the 352 ERs submitted in Q3. 94% of ERs are for 'hours and rest' with the remainder being educational exception reports.

7.6. Five 'immediate concerns' were raised in Q4. The threshold to submit such concerns is subjective.

7.7. The default agreed action for hours and rest exception reports is time off in lieu (TOIL) in 78% of cases (167 out of 268 agreed ERs for hours and rest), with additional payment agreed in 88 cases.

8. Fines

8.1. Under the Terms and Conditions of Service, the Guardian of Safe Working Hours (GSWH) is responsible for levying fines where an exception report demonstrates a breach of safe working hours regulations or contractual requirements. Most exception reports arise from Resident Doctors working beyond their scheduled hours; however, where defined regulatory thresholds are breached, a financial penalty must be applied.

8.2. During this reporting period, the operation of the fining process was affected by the implementation of Version 13 of the Terms and Conditions of Service and the transition from the legacy DRS4 exception reporting system to the DRS5 platform. As a result, established fining workflows were not directly transferable, and a revised operational process for levying fines is required and is currently being established.

8.3. A total of 22 exception reports submitted during the quarter are potentially associated with a fine, based on the nature of the reported breaches. These predominantly relate to late finishes resulting in:

- exceeding the maximum 13-hour shift length
- failure to achieve the minimum 11 hours rest between resident shifts
- breaches of the 72-hour limit within a 168-hour period
- breaches arising during non-resident on-call (NROC) work

8.4. The qualitative content of these reports consistently describes high clinical workload, rota gaps due to sickness or vacancies, unanticipated patient acuity, and the need to remain beyond rostered hours to maintain patient safety. Many reports note appropriate escalation to senior decision-makers

and awareness at registrar or consultant level, indicating that these breaches reflect system pressure rather than individual practice.

8.5. At the time of writing, fines associated with these reports have not yet been formally levied, pending completion of the revised fining process under the new contractual framework and exception reporting platform. Once established, the GSWH will review eligible reports and apply fines in accordance with Schedule 5 of the Terms and Conditions of Service

8.6. As in previous quarters, the pattern of reported breaches highlights the limitations of relying on the fining mechanism alone to address underlying rota fragility. Recurrent breaches, particularly in busy acute specialties, suggest structural workforce and rota design pressures that require broader operational review in addition to contractual enforcement.

9. Work Schedule Reviews

9.1. There were no formal work schedule reviews in this quarter.

10. Rota Gaps / Vacancies

10.1. Vacancies or rota gaps, ranging from a single unfilled shift due to sickness to longer-term unfilled posts, can increase the work intensity for remaining Resident Doctors. This added pressure may lead to longer working hours or even breaches of the TCS and working hours regulations, as doctors may be required to cover additional shifts to maintain service delivery.

10.2. Contractually, this report "will include data on all rota gaps on all shifts."

10.3. There is no central collation of trainee vacancy data. The management of vacancies is largely devolved to individual managers who are responsible for more than 200 Resident Doctor rotas.

10.4. It is not possible to provide assurance regarding the effective management of vacancies or rota gaps at OUH. Without consistent oversight and reliable data, the impact on working hours and regulatory compliance cannot be accurately assessed.

11. Locum Bookings / Locum work carried out by Resident Doctors – Appendix 2

11.1. The use of Resident Doctors covering vacancies by working as locums can help mitigate the risk of breaching TCS/working hours regulations and ensures safe staffing levels at the service level.

11.2. It is important to note that any locum work undertaken by Resident Doctors, in addition to their regular work schedule, must be counted within

the working hours limits set by the TCS/working hours regulations. Mutual agreements between a department and a Resident Doctor to exceed these limits for locum work, either within the same organisation or across different hospitals, are not permitted. In practice, it is challenging to monitor and enforce compliance with this aspect of the TCS, and it is not currently known whether such breaches are occurring at OUH.

11.3. The total number of Resident Locum Doctor shifts in this quarter was 2,845 **(quarterly average = 3,250 / range 1,356 – 4,992**). The top reason for locum usage was 'vacancy' for 1640 shifts (quarterly average = 2,370 / range 772 – 4,069).

11.4. As noted in Section 10, there is no central collation of trainee vacancy data, making it difficult to assess whether the use of locums is an effective or sustainable solution. Additionally, without oversight of individual doctors' locum commitments, it is unclear whether reliance on locum work is contributing to breaches of safe working hour regulations. This lack of transparency means assurance cannot be provided that locum work is being managed in compliance with the TCS, nor that it is a viable long-term solution to rota gaps.

12. Resident Doctor Forum (RDF)

12.1. Funds generated through Guardian of Safe Working (GOSW) fines are required to be used solely for the benefit of resident doctors, specifically to support education, training, and improvements to the working environment. The Guardian of Safe Working Hours oversees the allocation of this budget in collaboration with the Resident Doctors' Forum (RDF), in accordance with the provisions of the 2016 Resident Doctor Contract. The overarching aim remains to enhance the working environment and overall experience of resident doctors and dentists across the Trust.

12.2. During the financial year 2025-2026 a range of initiatives were approved and funded through the Guardian Fund, all aligned with the overarching aim of enhancing junior doctors' working conditions and wellbeing. Individual applications were approved through the quarterly RDF meetings.

12.3. A total of £14,604.28 was spent during the financial year, benefiting a broad range of departments including surgery, radiology, palliative care, histopathology, and medicine, in addition to funding improvements to the mess facilities at the John Radcliffe and Churchill. Applications broadly fell into three categories: practical improvements, wellbeing initiatives, and educational resources.

12.4. In addition, significant progress has been made during this financial year in utilising the Fatigue and Facilities Fund, with the support of Professor Andrew Brent (Chief Medical Officer), Amy McDermott (Business Manager to Professor Brent), and Dr Ola Kriks (Resident Doctor Peer Lead). This fund formed part of the Government's £10 million national investment in 2018, from which OUH received an allocation of £61,685. In 2022, £5,580 was used to install lockers in the JR mess, leaving a remaining balance of £56,105. The purpose of the funding is to support the expansion and enhancement of rest facilities for resident doctors undertaking on-call duties.

12.5. During 2025–2026, approximately £34,000 of the remaining fund has been utilised, although some applications are still being processed and final figures will be confirmed in the next report. Expenditure has focused on upgrading communal rest areas across all four hospital sites. A small number of proposed initiatives could not be completed during the financial year due to logistical or operational constraints and will continue to be explored during 2026–2027. These included requests for water coolers, which could not be accommodated within the Trust's water cooler policy, and vending machines for mess facilities. Discussions with the Estates team regarding a potential pilot vending machine scheme are ongoing in order to assess demand and inform longer-term planning.

12.6. The RDF will next meet in June.

13. Conclusion

13.1. This quarter marks a clear transition in the governance of safe working hours for Resident Doctors at OUH. The implementation of Version 13 of the Terms and Conditions of Service, national exception reporting reforms, and the move to the DRS5 platform represent a substantive shift from legacy arrangements towards a reformed national framework with strengthened employer accountability.

13.2. Alongside these limitations, the Trust has made tangible progress during this period in strengthening exception reporting systems, governance arrangements, and resident doctor engagement.

13.3. As in previous reports, this report prioritises assurance on processes and governance rather than over-interpretation of quantitative exception reporting data. The hybrid nature of this quarter, combined with known data and system limitations, means that apparent trends must be interpreted with caution. The absence of reported non-compliance should not be taken as evidence of compliance.

13.4. The exception reporting narratives presented during this period consistently describe high workload, rota fragility, and unanticipated patient acuity, with appropriate escalation to senior clinicians. These reports point to structural service and workforce pressures, reinforcing the limitations of reliance on exception reporting and fines alone as mechanisms for improvement.

13.5. Looking forward, the challenge for the Trust is to ensure that the benefits of contractual reform and improved reporting systems are translated into earlier, more effective operational oversight at directorate and divisional level, while respecting the confidentiality protections embedded in the new framework. The transition to nationally standardised reporting provides an opportunity for improved consistency and benchmarking, but local governance and accountability will remain essential.

13.6. From a Guardian perspective, this quarter closes a period dominated by legacy system constraints and opens the next phase of work focused on embedding safe working hours intelligence into routine governance, improving assurance, and supporting sustainable working practices for Resident Doctors.

14. Recommendations

14.1. The Trust Board is asked to receive this report for information.

Appendix 1: Exception Reporting Summary Data

Summary of OUH exception reports: Jan/Feb/Mar.2026					
		Jan	Feb	Mar	**Total**
Reports (*all reports submitted within 2 weeks of quarter ending)*	Total	121	68	109	298
	Closed	121	63	107	291
	Open	-	5	2	7
The data below relates to the 291 closed exception reports only					
Individual doctors / specialties reporting	Doctors	52	29	45	93
	Specialties	20	17	19	30
Immediate concern		3	-	2	5
Nature of exception	Hours & Rest	117	58	106	281
	Education	7	6	6	19
Additional hours *('Hours & Rest' exception reports only)*	Hours (plain time)	141.2	56.5	145.8	343.5
	Hours (night-time)	23.7	23.5	15.3	62.5
	Total hours	164.8	80.0	161.2	405.9
	Hours per exception report	1.4	1.4	1.5	1.4
Response	Agreed	109	56	103	268
	Not Agreed	12	7	4	23
Agreed Action *('No action required' is the default action for 'education' exceptions)*	Time off in lieu	91	27	49	167
	Payment for additional hours	10	24	54	88
	No action required	8	5	0	13
Grade	FY1	61	29	32	122
	FY2	32	7	7	46
	CT1	-	-	6	6
	CT2	-	-	9	9
	CT3	-	9	11	20
	IMT1	-	-	1	1
	IMT3	-	-	1	1
	SHO	-	-	2	2
	ST1/ST2 Trust Grade	-	6	-	6
	ST2	-	2	4	6
	ST4	1	4	20	25
	ST5	-	-	1	1
	ST6	10	2	7	19
	ST6-ST8 Trust Grade	1	1	-	2
	ST7	-	1	2	3
Hospital Site	John Radcliffe Hospital	80	41	74	195
	Churchill Hospital	16	8	8	32
	Nuffield Orthopaedic	9	6	16	31
	Horton General Hospital	12	8	8	28
	(blank)	4	0	1	5
Exception type *(more than one type of exception can be submitted per exception report)*	Late finish	39	134	142	315
	Unable to achieve breaks	5	27	14	46
	Early start	-	27	3	30
	Exceeded the maximum 13-hour shift length	4	3	7	14
	Difference in work pattern	5	5	-	10
	Request a work schedule review	3	-	5	8
	Minimum 11 hours rest between resident shifts	3	1	1	5
	Unable to attend scheduled teaching/training	-	2	3	5
	72 hours work in 168 hours	-	2	-	2
Specialty *(Top 10)*	General Internal Medicine	20	14	17	51
	Acute Internal Medicine	12	11	12	35

	Trauma and Orthopaedics	16	10	8	34
	General Surgery	7	8	12	27
	Haematology	5		11	16
	Medical Oncology	11	2	1	14
	Cardiology	11		1	12
	Geriatric Medicine	5		6	11
	Paediatrics	2	1	8	11
	Clinical Haematology		3	7	10

Appendix 2: Locum Bookings / Locum work carried out by Resident Doctors

Summary of OUH Locum Filled Shifts: Jan/Feb/Mar 2026					
		Jan	Feb	Mar	**Total**
Locum Shifts	**Total**	935	914	996	**2845**
	Bank	908	860	944	**2712**
	Agency	27	54	52	**133**
Grade	Specialty	496	460	462	**1418**
	Core	374	425	493	**1292**
	Foundation	20	37	64	**121**
Specialty *(top 20 specialties only)*	Acute Medicine	186	177	238	**601**
	Orthopaedic and Trauma Surgery	140	147	180	**467**
	General Surgery	132	97	116	**345**
	Obstetrics and Gynaecology	51	49	49	**149**
	Cardiothoracic Medicine	64	40	41	**145**
	Cardiothoracic Surgery	27	54	52	**133**
	Paediatrics	34	36	37	**107**
	Hepatobiliary Surgery	27	23	28	**78**
	Paediatric Surgery	30	19	21	**70**
	Respiratory	24	25	18	**67**
	Urology	19	22	23	**64**
	Neonatal Intensive Care	15	28	20	**63**
	Haematology	17	17	21	**55**
	Care of the Elderly	18	17	14	**49**
	Neurology	26	7	9	**42**
	Renal Medicine	10	18	14	**42**
	Oral and Maxillofacial surgery	5	16	15	**36**
	Transplant Surgery	16	9	8	**33**
	Rheumatology	3	7	20	**30**
	Neurosurgery	10	14	5	**29**
Reason	Vacancy	532	524	584	**1640**
	Sick	175	179	196	**550**
	Other	127	136	143	**406**
	Exempt from On Calls	43	27	31	**101**
	Pregnancy/Maternity Leave	22	12	21	**55**
	Compassionate/Special Leave	16	20	4	**40**
	Study Leave	13	12	10	**35**
	Annual Leave	6	4	7	**17**
	COVID-19	1	-	-	**1**
Division	Medicine Rehabilitation and Cardiac	336	329	366	1031
	Neurosciences Orthopaedics Trauma and Specialist Surgery	290	312	342	944
	Surgery Women and Oncology	300	260	274	834

	Clinical Support Services	9	10	10	29
	Not Mapped	-	3	4	7