Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 14 May 2025

TB2025.43

Title:	**Guardian of Safe Working Hours Quarterly Report, Q4 2024-25**

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

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

Executive Summary

1. This report provides an overview of safe working hours assurance for Resident Doctors at OUH, highlighting key challenges in work scheduling, exception reporting, rota gaps, and locum usage.
2. **Work Schedule and Duty Roster Assurance:** Work schedules are centrally issued to comply with contractual obligations. Adjustments to schedules can be made locally, without oversight, creating uncertainty over actual compliance with the Terms and Conditions of Service.
3. **Exception Reporting and Compliance:** Exception reporting remains the main route for Resident Doctors to raise concerns about unsafe hours. However, access and utilisation remain inconsistent, and implementation of agreed outcomes (e.g. time off in lieu) is not routinely monitored. The quality of data remains poor due to input errors and categorisation issues, limiting its interpretability. These challenges are mirrored nationally, and consequently exception reporting reform will be introduced in September 2025.
4. **Fines and Regulatory Breaches:** High numbers of breaches triggering fines, particularly those exceeding 13 hours per shift, continue to reflect persistent rota design issues rather than isolated incidents. Breaches are often recurrent and structurally embedded. The absence of real-time monitoring of total hours or minimum rest further constrains compliance assurance.
5. **Rota Gaps and Locum Usage:** There is no centralised tracking of rota gaps, but ongoing high locum usage and feedback from Resident Doctors suggest significant vacancy pressures. During Q4, 2,668 shifts were covered by Resident Doctor locums. There is no assurance that locum allocations meet safe working hour limits, due to the lack of integration between rostering and exception reporting systems.
6. **Resident Doctor Forum (RDF):** The RDF continues to support Resident Doctors in raising systemic issues, including facilities and access to exception reporting. The Forum also reviewed plans to distribute funds for wellbeing and the development of wellbeing and Schwartz Rounds. Collaboration with the Guardian of Safe Working Hours and the Improving Working Lives group remains active.
7. **Conclusion and Recommendations:** Structural and data-related barriers continue to hinder effective oversight of safe working hours. In response, a shift is underway toward a governance-based model that empowers divisional teams, supported by divisional and medical HR, to monitor compliance and lead improvements. The Guardian of Safe Working Hours recommends that OUH further invest in digital infrastructure, rota design support, and divisional accountability to ensure regulatory and contractual compliance.

Recommendations

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

Guardian of Safe Working Hours Quarterly Report, Q4 2024-25

1. Purpose

1.1. This quarterly report of Safe Working Hours (Q4: January-March 2025) 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. It is important to recognise the limitations that challenge the capacity to offer dependable assurance. These encompass the dependency on sporadic and voluntary feedback, compounded by the absence of dedicated corporate administrative support, resulting in limited readily accessible information on this issue.

2.2. The absence of reports of non-compliance does not necessarily indicate compliance, and the Guardian suggests interpreting the report with caution due to these limitations.

3. Background

3.1. The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 state:

3.1.1. The Guardian reports to the Board of the employer (and host organisation, if appropriate), directly or through a committee of the Board, as follows:

- The Board must receive a Guardian of Safe Working Report no less than once per quarter. This report shall also be provided to the JLNC, or equivalent. It will include data on all rota gaps on all shifts.
- A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account, which must be signed off by the Trust Chief Executive. This report shall also be provided to the JLNC, or equivalent.
- Where the Guardian has escalated a serious issue in line with Terms and Conditions paragraph 10(d) and the issue remains unresolved, the Guardian must submit an exceptional report to the next meeting of the Board.
- The Board is responsible for providing annual reports to external bodies as defined in these terms and conditions, including Health

Education England (Local office), Care Quality Commission, General Medical Council and General Dental Council.

- There may be circumstances where the Guardian identifies that certain posts have issues that cannot be remedied locally and require a system-wide solution. Where such issues are identified, the Guardian shall inform the Board. The Board will raise the system-wide issue with partner organisations (e.g., Health Education England, NHS England, NHS Improvement) to find a solution.

Q4 Report

4.1. Throughout Q4, the reliability of exception reporting data has remained compromised due to ongoing issues with the electronic reporting system. These issues, specifically the incorrect attribution of specialty and supervisor details, continue to undermine data integrity and have been formally recognised on the Trust's risk register (Ulysses risk: 2698). Despite some local workarounds, a Trust-wide solution has not yet been implemented, and the data presented in this report remains unvalidated. It should therefore be interpreted with caution. Meanwhile the medical staffing team are working with the software provider to optimise the current software platform.

4.2. The Guardian of Safe Working Hours (GSWH) continues to emphasise that assurance regarding compliance with safe working hours cannot rely solely on exception reporting data, even if system functionality is fully restored. There continues to be a systemic over-reliance on this dataset, which at best provides assumed assurance. Broader triangulation with rota monitoring, work schedule reviews, contractual compliance checks, and Resident Doctor feedback remains essential.

4.3. In view of these concerns, and in alignment with upcoming national reforms to exception reporting and safe working hours governance, this report prioritises assurance relating to contractual compliance with the 2016 Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England). This report therefore focuses on structural and cultural improvements to the oversight of safe working hours. This shift recognises the need for a more reliable and proactive model of assurance and prepares OUH for the implementation of national reforms in 2025.

Table 1: High level data

Area	Number
Number of OUH employees (approx. total)	12,000
Number of OUH Resident Doctors (approx. total)	1,450
Number of doctors in training: Total Deanery posts	1,016
Number of doctors in training: not currently in post (Parental leave/long-term sick/out of programme)	60
Number of doctors in training: Fulltime / Less than fulltime	765/251

Locally employed 'resident' doctors	450
Number of resident doctor rosters (approx.)	200
Foundation year 1	114
Foundation year 2	128
Core Trainees	40 (18 surgical)
Internal Medicine Training	78
Dental	4
General Practice	37
Specialty Trainees	615
Job planned time for Guardian	8 hours / week
Job planned time for Deputy Guardian (vacant for most of this quarter)	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

4. Work schedule assurance.

4.1. 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.

4.2. At OUH, work schedules are produced by the Medical HR 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 HR team before being shared with Resident Doctors.

4.3. 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, and there is no evidence of variations to work schedules requiring GSWH/RDF approval for them to be compliant. There are examples of duty rosters not matching work schedules. Work schedules are produced by the central medical HR team and are therefore compliant.

4.4. 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.

5. Duty roster assurance

5.1. 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.

5.2. 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.

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

5.4. 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.

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

6.1. 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.

6.2. The GSWH is often contacted by Resident Doctors have reported not having access to the exception reporting system. However, the exact

percentage of Resident Doctors who have access is unknown, and the reasons for any shortfall in access have not been clarified.

6.3. A total of 530 exception reports were closed, and 9 exception reports remain open from Q4 (quarterly average = 198, range: 47 – 530).

6.4. Four ‘immediate concerns’ were raised in Q4 by three doctors across two specialties. As in previous quarters, the threshold for raising an immediate concern is subjective and based on individual judgement.

6.5. The reported concerns highlighted significant and recurring workforce pressures. Doctors described working with minimum staffing levels, including occasions where a single junior doctor was responsible for a large number of unwell patients, with delays in securing out-of-hours support. There were examples of handovers starting late due to lack of available staff, acute clinical responsibilities falling disproportionately on junior staff, and insufficient capacity to attend mandatory teaching sessions. Attempts to escalate concerns and secure additional support were often unsuccessful, and several doctors reported staying significantly late to complete clinical duties. The reports indicate that the level of clinical demand exceeded agreed staffing thresholds and raised concerns about both patient safety and trainee wellbeing.

6.6. The default agreed action for hours and rest exception reports is time off in lieu (TOIL) in most cases (428 out of 498), with additional payment agreed in 45 cases. In the remaining 25 cases no action was required. However, many doctors report difficulties in actually taking TOIL. In Q3, 97 doctors reported being unable to take their agreed TOIL even four weeks after it was approved, while only 30 confirmed they had taken it. The remainder have not provided feedback. This highlights potential challenges in ensuring TOIL is a viable and accessible option for Resident Doctors.

6.7. The fulfilment of agreed exception report outcomes (TOIL or additional payment) is assessed solely through ad hoc feedback from Resident Doctors. As a result, there is no systematic method to monitor whether doctors receive their agreed TOIL or payments. This lack of oversight means assurance cannot be provided either to doctors regarding the completion of agreed actions or to the Trust regarding the financial impact of exception reporting.

6.8. Where TOIL is granted, it is typically taken as standard day shifts, even when the additional work was undertaken out of hours, potentially leading to further rota gaps.

7. Fines

7.1. As per the TCS, the GSWH is responsible for levying fines when an exception report identifies a breach in the TCS or working hours regulations. Typically, most exception reports are filed when Resident Doctors work beyond their scheduled hours, but these are usually not significant enough to breach regulations. However, if a breach occurs, a financial penalty may be imposed.

7.2. The fining process for exception reports is limited due to several challenges. If a doctor doesn't have access to the exception reporting system, regulation breaches may go unnoticed. The reporting software is also not linked to the work schedule or duty roster, so it only shows excess hours worked. Without the work schedule context, it's unclear if those hours breach regulations. Additionally, some breaches may involve working excess hours over multiple shifts, such as exceeding the 72-hour maximum within a 168-hour period or the 48-hour average working week. The software's tick-box options do not include violations of the 48-hour average working week.

7.3. Thirty-two of the 498 exception reports from ten specialties, submitted by 19 doctors, reported a possible fine. The most common reason for a breach is reported as "Exceeded the maximum 13-hour shift length" (28/32 reports).

7.4. Nineteen of the 32 exception reports indicating a fine were submitted by doctors working in General Medicine. As 13-hour shifts are routinely rostered in this specialty, any exception report related to exceeding shift length automatically results in a fine. This indicates that the breaches may result from the underlying rota design, rather than individual non-compliance, highlighting the need for broader review rather than reliance on the fining process alone.

7.5. The GSWH has levied 18 fines from 14 Q4 exception reports, totalling £2,076 (£779 paid to reporting doctors and £1,298 paid to the RDF). The GSWH requires and has requested information for the remaining 11 exception reports before a fine can be levied. Five resident doctors have not provided additional information despite five requests to each.

7.6. The GSWH is given financial oversight relating to fines via an Excel spreadsheet held in an MS Teams folder. At the time of writing, the approximate balance in the cost centre is £32,000(=Q3 / Q4 figure requested).

8. Work Schedule Reviews

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

9. Rota Gaps / Vacancies

9.1. 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.

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

9.3. 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.

9.4. 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.

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

10.1. 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.

10.2. 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.

10.3. A total of 2,668 locum shifts were undertaken by Resident Doctors in Q4 (quarterly average = 3,316 / range 1,356 – 4,992). The top reason stated for locum usage was ‘vacancy’ for 1,841 shifts (quarterly average = 2,465 / range 772 – 4,069).

10.4. As noted in Section 9, 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 to demonstrate that

locum work is being managed in compliance with the TCS, nor that it is a viable long-term solution to rota gaps.

11. Resident Doctor Forum (RDF)

11.1. A hybrid Resident Doctors Forum (RDF) meeting was held in January 2025, chaired by the GSWH.

11.2. Resident Doctors raised several key issues:

- Rota Compliance: There was a call for more proactive oversight to ensure that duty rosters align with contractual work schedules. It was suggested that Educational Supervisors remind doctors to verify compliance during induction.
- Honorary Contracts: Concerns were raised about delays in processing honorary contracts for Public Health registrars placed with UKHSA. Suggestions were made to streamline this process with support from HR.
- Development of structured 'training-adjacent' roles for locally employed doctors:
  A substantial discussion focused on the creation of “training-adjacent” roles (e.g. “Foundation year 3 (F3) and Locally Employed Doctor (LED) roles to:
  - Improve retention, wellbeing, and career progression
  - Provide structured experience between foundation and specialty training
  - Enable locally employed doctors to remain in departments longer and gain competencies

  While challenges were acknowledged — including the lack of a formal national framework or dedicated funding — examples of local initiatives (e.g., in Schwartz rounds in Gynaecology) were noted. There was also discussion about the feasibility of using RDF funds to support such roles.

- Wellbeing and Schwartz Rounds:
  The value of Schwartz Rounds was discussed, with suggestions to expand them beyond current availability in Oncology and Obstetrics.

11.3. Three actions were agreed at the meeting:

1. To follow up on honorary contracts for Public Health placements
2. To explore training-adjacent roles for locally employed doctors in more detail
3. To look into broader adoption of Schwartz Rounds across departments

12. Monitoring Resident Doctor Working Hours Procedure

12.1. In June 2024, the HR Manager – Policies and Procedures requested a review and update of the "Monitoring Resident Doctor Working Hours"

procedure. The update was initially paused to await details of the Resident Doctor pay settlement. In Q4, the agreed reforms to exception reporting were published as part of that settlement (NHS Employers summary; framework agreement PDF).

12.2. These changes will have a significant impact on both the procedure and the systems needed to support it. As a result, the update to the procedure remains paused while a local implementation process develops. This is likely to involve engagement from the Trust Management Executive (TME), the Joint Local Negotiating Committee (JLNC), and other stakeholders, given the procedural, financial, and cultural implications of the reforms.

13. Conclusion

13.1. This report continues the core theme established in previous quarters: that while exception reporting data is available, the lack of system integration, inconsistent access for doctors, and absence of reliable monitoring processes mean it cannot currently be used to provide robust assurance on safe working hours. The apparent differences in data between quarters are difficult to interpret reliably and are open to subjective judgement. Therefore, this report prioritises assurance on processes – such as work schedules, duty rosters, exception reporting mechanisms, and rota gap management – over quantitative comparisons.

13.2. Looking ahead, the forthcoming national reforms to exception reporting will represent a major cultural and procedural shift. These reforms aim to make reporting easier and more purposeful for Resident Doctors, with clearer compensation mechanisms and a greater emphasis on accountability. However, they also carry significant implications for the Medical HR team's workload, cost management, and the nature of the employer-doctor relationship. The success of these reforms at OUH will depend on how proactively and inclusively they are implemented.

14. Recommendations

14.1. In light of national reforms to exception reporting and the safe working hours framework, it is recommended that OUH strengthens its local governance arrangements by embedding a more robust structure within existing divisional teams. This structure should leverage the operational expertise within each division to monitor, interpret, and respond to its own safe working hours data. Divisional teams should report performance to the GSWH and Trust Board, enhancing local accountability and improving organisational oversight.

14.2. To this end, the GSWH recommends that OUH engages early and widely with relevant stakeholders—including Resident Doctors—to co-develop a local implementation plan that responds to the national changes. The scale of the work ahead must not be underestimated. A collaborative, transparent, and well-resourced approach will be essential to ensure contractual compliance, sound financial governance, and a sustainable, positive working culture for Resident Doctors.

14.3. 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.2025					
		Jan	Feb	Mar	Total
Reports (*all reports submitted within 2 weeks of quarter ending)*	Total	185	195	150	530
	Closed	177	188	146	511
	Open	3	2	4	9
		The data below relates to the 385 closed exception reports only			
Individual doctors / specialties reporting	Doctors	55	51	48	**90**
	Specialties	20	19	19	**25**
Immediate concern		3	1	-	**4**
Nature of exception	Hours & Rest	168	186	144	**498**
	Education	13	10	6	**29**
Additional hours *('Hours & Rest' exception reports only)*	Hours (plain time)	204.0	361.9	172.7	**738.5**
	Hours (night-time)	33.8	59.2	38.3	**131.4**
	Total hours	237.8	421.1	211.1	**869.9**
	Hours per exception report	1.4	2.3	1.5	**1.7**
Response	Agreed	175	184	143	**502**
	Not Agreed	2	4	3	**9**
Agreed Action *('No action required' is the default action for 'education' exceptions)*	Time off in lieu	154	155	119	**428**
	Payment for additional hours	11	17	17	**45**
	No action required	10	12	7	**29**
Grade	F1	91	71	57	**219**
	F2	31	48	40	**119**
	SHO	29	26	20	**75**
	StR	11	17	10	**38**
	StR (CT)	2	11	9	**22**
	FStR	12	2	-	**14**
	FStR (CT)	-	7	6	**13**
	SPR	-	6	3	**9**
	FF1	1	-	-	**1**
	FSPR	-	-	1	**1**
Hospital Site	John Radcliffe Hospital	49	70	57	**176**
	Churchill Hospital	33	27	27	**87**
	Churchill	35	24	16	**75**
	JR2	13	17	13	**43**

	John Radcliffe	17	15	4	**36**
	John Radcliffe Hospital	9	8	9	**26**
	Katherine House	-	10	9	**19**
	(blank)	5	5	5	**15**
	Horton General Hospital	4	-	3	**7**
	Horton	-	5	1	**6**
	Chruchill	-	4	1	**5**
	Horton Hospital	3	2	-	5
	NOC	3	-	1	4
	JRH	3	-	-	3
	Radcliffe Hospital	2	-	-	2
	John Radcliffe & Horton	-	1	-	1
	Littlemore Hospital	1	-	-	1
Exception type *(more than one type of exception can be submitted per exception report)*	Late finish	154	174	124	452
	Unable to achieve breaks	31	41	48	120
	Exceeded the maximum 13-hour shift length	13	10	5	28
	Unable to attend scheduled teaching/training	12	6	5	23
	Difference in work pattern	3	5	5	13
	Minimum 11 hours rest between resident shifts	6	3	4	13
	Early start	3	1	3	7
	Request a work schedule review	2	-	-	2
	72 hours work in 168 hours	1	-	-	1
	Unable to attend clinic/theatre/session	-	1	-	1
	Late finish	154	174	124	452
	Unable to achieve breaks	31	41	48	120
Specialty *(Top 10)*	Renal medicine	28	30	20	78
	General Medicine	29	28	20	77
	Haematology	20	16	13	49
	Medical Oncology	19	9	10	38
	Neurology	-	17	18	35
	Gastroenterology	13	9	9	31
	Paediatric Surgery	13	14	4	31
	General Surgery	10	10	9	29
	Accident and emergency	11	10	6	27
	Cardiology	6	7	10	23

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

Summary of OUH Locum Filled Shifts: Jan/Feb/Mar.2025					
		Jan	Feb	Mar	**Total**
Locum Shifts	**Total**	891	852	925	**2,668**
	Bank	732	739	787	**2,258**
	Agency	159	113	138	**410**
Grade	Specialty	471	426	483	**1,380**
	Core	379	386	396	**1,161**
	Foundation	41	40	46	**127**
Specialty*(top 20 specialties only)*	Acute Medicine	169	154	209	**532**
	Orthopaedic and Trauma Surgery	142	138	136	**416**
	Spinal Services	89	85	93	**267**
	Cardiology	51	33	54	**138**
	General Surgery	55	34	42	**131**
	Respiratory	42	26	12	**80**
	Cardiothoracic Surgery	20	26	31	**77**
	Urology	20	26	30	**76**
	Obstetrics and Gynaecology	25	20	29	**74**
	Paediatrics	20	32	18	**70**
	Renal Medicine	15	27	24	**66**
	Vascular	22	21	23	**66**
	Neurosurgery	27	16	19	**62**
	Neonates	14	25	23	**62**
	Care of the Elderly	23	20	16	**59**
	Hepatobiliary Surgery	22	17	20	**59**
	Oral and Maxillofacial surgery	9	20	17	**46**
	Colorectal Surgery	19	13	12	**44**
	Paediatric Surgery	17	15	11	**43**
	Gastroenterology	14	11	6	**31**
Reason	Vacancy	644	566	631	**1,841**
	Sick	126	150	149	**425**
	Elective Recovery Fund	41	31	58	**130**
	Compassionate/Special Leave	25	28	26	**79**
	On call	28	18	23	**69**

	Research time	4	26	20	**50**
	Study Leave	8	11	6	**25**
	Better Care Fund	8	7	10	**25**
	Annual Leave	5	15	2	**22**
	COVID-19	2	-	-	**2**
Division	Neurosciences Orthopaedics Trauma and Specialist Surgery	365	395	371	**1,131**
	Medicine Rehabilitation and Cardiac	339	294	353	**986**
	Surgery Women and Oncology	186	160	183	**529**
	Clinical Support Services	1	3	18	**22**