Improving the life of Doctors in Training - Gap Analysis

	NHS England Priorities (see attached letter from NHSE)	Current Position	Best Practice	Gap	Potential actions to close the gap
Better rota management and deployment:	•Provide work schedules at least 8 weeks in advance and finalised duty rosters 6 weeks in advance, as per the current contract.	We are not breaching this requirement currently. Medical Staffing aim to send generic rotas out with offer letters which are sent 12 weeks in advance with finalised rotas sent 6 weeks in advance in line with the nationally agreed timescales. The exception to this is the Hospital at Night rota. This is a 30 slot rota and can only be built when all slots have been filled by HEE. If HEE are late providing this information or we have gaps then we are able to meet the time requirements. This is not a common occurence. Late changes to this rota have on occasion also been requested by departments meaning a new rota will take around 1 week to build further delaying circulation.	Generic rotas sent with offer letters 3 months in advance and all finalised rotas sent 6 weeks in advance. This enables the individual to know their pay and for them to inform the employer of leave requirements. To fully move to this position we would need to implement an electronic rostering system.	We currently work within national timescales and rarely breach however this is managed with the current staff member working additional hours to ensure that this is completed . In order to make more substantive improvements to our system we would need to implement a rostering system.	A business case would need to be developed. The cost of such a system is not just the software and project support support for implementation. There would need to be dedicated rostering capacity in the Divisional teams to manage their rosters. Currently each division has their own systems some of which rely on junior doctors to manage them. Further consideration of the prioritisation of this is required.
	•Improve rota management	Currently rota management within departments is done by a variety of methods with no single oversight of all rotas meaning it is frequently difficult to establish where an individual should be at any one time. This was evidenced during the last 12 months of industrial action.	Doctors know their shift patterns up to a year in advance and can plan accordingly. Rotas are emailed directly to staff and sync to their online calendars. Shifts can easily be swapped via the app, without needing to go through rota co-ordinators. The same system is used by all. Management have complete overview.	We do not have an electronic rostering system and dedicated rostering support in the Divisions. Some departments have bought in their own systems but providers differ.	As above.
Reduce duplicative inductions and pay errors:	•Attention to payroll accuracy	In the last 2 years, we have seen 324 overpayments in the Trust, of which 45 were related to Junior Doctors. Therefore, 14% of overpayments related to Junior Doctors. Of these, 34 were caused by the Trust and 11 caused by SBS Payroll.	The Trust have one of the lowest overpayment to payslip ratios of all NHS SBS Payroll Clients, which shows we are in a positive place - there is always room for improvement though. More accountability is needed on the cause of errors so we can work to reducing overpayments and Payroll errors.	As a result of the following on occasion pay errors occur (a) Human error, (b) changes to contracts, © late amendments to work patterns etc. (d) Payroll input errors	Continue to work closely with the Payroll Team to avoid input errors. Continue to undertake work on overpayments to identify the main causes and how these can be reduced.
	•Develop SLAs to include timescales for dealing with payroll errors	We already have SLAs as part of the contract with NHS SBS	SLA met every month	SLAs are being achieved	Continue to monitor performance against SLAs in line with contractual perofrmance framework
	Reduce duplicative Trust inductions	Significant work has been undertaken to ensure that induction alligns with Core Skills Framework but is still easy to follow and avoids duplication.	Induction to happen over 1-2 days to include both general and local departmental induction.		Continue to gain feedback from trainees, LEDs and educators re recent inductions to ensure we address issues.
Create a sense of value and belonging for our doctors:	•Protected training time	Local department and hospital wide teaching is offered to junior doctors however this time is not protected and may be interupted. Self development time is offered variably to junior doctors with variation between specialities in what can be provided. **Foundation trainees-**Tuesday lunch time sessions- these may clash with MDTs, board rounds- can be difficult for juniors to attend. For Hub/Simulation days - trainees can usually attend provided not on call . **IMT-** Weekly sessions can clash with MDTs, board rounds - so may be difficult to attend. Trainees encouraged to attend regional training days. **Sp Trainees-**Lunch time sessions may be more difficult to attend. regional training days are given as study leave, unless on call committments. **LED-**may also find lunch time sessions/departmental teaching difficult to attend due to board rounds/MDTs	Junior doctors would have protected time to attend department and hospital wide teaching that is free of interuptions. Junior doctors would all have protected self development time. Ensure that all trainees and LEDs- can attend most of local teaching sessions delivered by local faculty or department. Aim for trainees and LEDs to be able to take study leave.		Ensure only essential bleeps/calls to junior doctors are made during these times. Explore where sessions clash with MDTs/board rounds- and how this can be avoided.
	•Address issues caused by rotations	Not aware of issues caused by rotations locally.			
	•Aligning to Core Skills Training Framework	We are fully aligned to the CSTF and part of the national conversation about alignment in the future.	Induction to happen over 1-2 days to include both general and local departmental induction.	Significant work has been undertaken to ensure that induction alligns with Core Skills Framework but is still easy to follow and avoids duplication.	Remain part of the conversation with NHEe and partners. Continue to gain feedback from trainees, LEDs and educators re recent inductions to ensure we address issues.
	•Using e-learning for healthcare	We make regular use of eLFH modules that are delivered through our local systems. Optimised use eLFH for eligible mandatory training requirements, including transfer of competence between trusts where available. There are Papworth specific training that we ask to be completed which is not via eLFH. junior doctors (Foundation trainees) have access to virtual	Seamless transference of in date competencies between trusts meaning that eLearning does not need to be repeated.	Differences between some organisation allocation of competence refresh requirement versus CSTF standards meaning manual person by person review. Some competencies, eg level 3 resus certificate require individual staff to submit own evidence.	Ongoing collaboration with Workforce Education Team to ensure compliance is transferred across.
	•Adopting the NHS Digital Staff Passport	This is not fully rolled out yet.	A service that allows NHS employees to use their smartphones to share employment, education, training and OH information. This should be used widely once in operation within the Trust.	Not available presently	Currently 0 Trusts in the Eof E are registered - a rollout plan for EoE is needed as it requires all Trusts to be using it to deliver the benefits.
	•Take action to improve the experience of trainees by ensuring the NTES and GMC survey are treated in the same way as National Survey	NTES and GMC survey results are reviewed by educators and scrutinised to assess what needs to be improved. Action plans are developed. Both surveys are reported to the Trust Board and Workforce Committee. .	Report to the Trust Board and Workforce Committee. Acton plans developed and delivery tracked through the Workforce Committee.	None noted	Further review of action plans during year to identify blocks
	•Identifying a senior named individual to oversee and implement these actions	Presently this is addressed between the GoSW and DME	None noted	None noted	No action proposed.
	•Implement the BMA wellbeing guidance	**On-call designated parking-** this is available. **Self-directed learning time-** this is available for FY, IMT (as it is rostered),but variable between specialities as to whether this can be offered to LED. **The right to work from home for self-directed learning-** possible in some departments. **Mess, rest facilities and lockers-** this is being worked on. **Access to an out of hours menu 24/7-** hot drinks/milk is freely available and there are vending machines with hot and cold options available.	BMA wellbeing guidance: 1)On-call designated parking spaces 2)Self-directed learning time commensurate with the training needs of each individual 3)The right to work from home to undertake portfolio and self-directed learning. 4)Mess, rest facilities and lockers included in all hospitals including any new hospital builds 5)Access to an out-of-hours menu 24/7 that includes a hot meal and cold snacks for staff	Gaps in provision of self directed learning time. Mess facilities require improvement. The rest facilities will be improved by the implementation of the agreed actions from FoP.	**Self directed learning-** ensure further discussion with educators and clinical leads to increase their understanding of why this is important for junior doctors. Explore how this can be ensured for all junior doctors- but important to recognise that junior doctors remain productive and have guidance for self-directed learning. **Mess, rest facilities and lockers-** this is already being addressed.