Workforce information

Postgraduate Doctors in Training (PGDiT): Rostering guidance

RCPCH
Royal College of Paediatrics and Child Health
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Contents

Introduction

This document has been compiled by the College to provide clear guidance on rota planning and rostering for paediatric Postgraduate Doctors in Training (PGDiT) in England using information derived from a number of sources including the BMA[1, 2] , the RCPCH trainee toolkit[3] and the RCPCH paediatrician of the future guidance[4].

PGDiT incorporates Foundation Doctors (FY1 and FY2) and Specialty Trainees (ST1-8) specifically, but the principles within this document can be translated to doctors in equivalent non-training roles including Clinical Fellows and SAS doctors sharing the same rota pattern.

This PGDiT Rostering Guidance sits alongside the RCPCH Trainee Toolkit[3] and RCPCH Thrive Paediatrics Roadmap for Transforming Working Lives of Paediatricians[5]. The RCPCH Trainee Toolkit has been compiled by PGDiT and trainers as a comprehensive guide on what to expect from a training post; please refer to this document for issues that extend beyond the job planning remit of the current guidance. The Thrive Paediatrics Roadmap consolidates "**what good looks like**" in terms of working practices for paediatric clinicians to ensure staffing for a sustainable and high-quality paediatric service. Job and rota planning are key components of Thrive's objectives and in conjunction with our job planning guidance, we aim to support working lives and well-being of paediatric doctors in training.

Rostering best practice

What should trainees expect?

To be provided with their rota at least six weeks before they start their job and from thereon, six months into the future.

To be facilitated in taking annual and study leave provided six weeks' notice has been given.

To be supported in exception reporting or hours monitoring.

Rotas that account for adequate rest and recovery during and between shifts.

Education on healthy lifestyle, sleep and risks of fatigue as part of inductions and education programmes.

Provision of appropriate rest facilities when working resident on-call night shifts or if feeling unsafe to travel.

A positive culture towards taking contractual rests and breaks; and access to hot food and hydration on all shifts.

Junior Doctor Contract 2016: Work Scheduling (T&Cs Sch. 4)

1. The employer will design work schedules that are safe for patients and doctors, and shall ensure that they are adhered to in the delivery of services.
2. Work scheduling allows employers to plan and deliver clinical services while delivering appropriate training.
3. Educational planning and clinical work scheduling are interlinked, reflecting the interdependence of training and service commitments of doctors.
4. The employer will ensure that a generic work schedule that takes into account expected service commitments, and relevant parts of the training curriculum; this will form the basis for a personalised work schedule.
5. A work schedule shall normally apply for the duration of a training placement, and will identify the number and distribution of hours for which the doctor is contracted.
6. A work schedule may be subject to review from time to time.
7. Work schedules should be designed to balance the service delivery needs of the organisation and the education and training needs of the doctor; referring to the national guidance on good rostering practice.

The working week

Clinical hours

Both the New Junior Doctor Contract and the older 2002 contract stipulate a 40 hour working week, which can be extended to a maximum of 48 hours.

During sub-specialty training at least 70% of time should be dedicated to the chosen speciality, with up to 30% providing acute unscheduled care[3]. Out-of-hours care should be shared between general and sub-specialty PGDiT, with no more than 33% of hours on the delivery of emergency out of hours care.

Recommendations for Supporting Professional Activities (SPA) is eight hours per month for ST1-3 and 16 hrs per month for ST4+ . When calculating average total hours, the number of days' leave across the length of the rota cycle will be deducted and the remaining hours will be divided by remaining weeks (including part-weeks). For example, in an eight-week cycle with six days' leave deducted, the total remaining hours would be divided by 6.8 weeks. The number of continuous hours worked should not exceed 13 and every period of work over five hours requires a 30 minute paid break.

Out of Hours Working

Full shift rota on-call can be worked from home (non-resident on-call) or the hospital (resident on-call). On-call requires doctors to be available to return to work or give advice by telephone but not generally working on site for the whole period.

When calculating on-call working patterns employers should make a prospective estimate of average work carried out while on-call and then use feedback, exception reporting and schedule review to adapt this.

Calculating on-call hours

- Identify total number of on-call hours across a typical week within rota reference period.
- Calculate average work for each weekday and each weekend day.
- Divide total hours by the number of on-call shifts for average on-call duration.

- Identify busy (max hours) and quiet (min hours) times for each period.
- Assess extent of deviation from max and min hours.

- Communicate hours in advance of starting work with 72 hours max and roster below this.
- Clarify average number of hours, time of day and indicate the amount of unpredictable work before and after 9:00pm.

Work schedules should include an average amount of time for expected predictable and unpredictable work. Predictable work refers to routine activities that occur at specific times, such as, ward rounds or clinical handovers , which should be within working hours and

exception reported if they overrun; this information alongside allocated times should be specified within the workplan. Unpredictable work is unscheduled activities that occur at unspecified times, such as telephone calls or awaiting urgent results; the average amount of unpredictable on-call work must be estimated as part of the workplan for on-call shifts.

Full shift rota on-call

Consecutive shifts

- A maximum of four 'long shifts' (ten hours+) on consecutive days with a minimum of 48 hours rest rostered immediately following the fourth long shift.
- By agreement of the doctors on a rota, this limit can be increased to a maximum of five consecutive long shifts.
- A maximum of four long shifts finishing after 23.00, with a minimum of 48 hours rest rostered immediately following the fourth long shift.
- A maximum of four long shifts where at least three hours of work fall between 23.00 and 6.00 on consecutive days.
- Where night shifts are rostered singularly, or consecutively, then there must be a minimum 46-hour rest period rostered immediately following the conclusion of the shift(s).

Exemptions

- PGDiT can work the day after on-call, but no longer than five hours if busy on-call.
- Working patterns should be reassessed where PGDiT are repeatedly able to come in after on-call.
- Due consideration should be given to continuity of patient care prior to taking a full day's break.

Non-resident on call (NROC)

On rare occasions, PGDiT may be asked to perform NROC duties as part of their rotation. When designing NROC shifts on rotas, consider issues mentioned above in addition to start and end times to incorporate travel to and from home and between sites; and variability in frequency of returning to work. If busy, PGDiT may be given a rest day following due consideration for patient safety.

Partial Shifts

Partial shifts are appropriate where it has not been possible to take eight hours' rest during the on-call period, but the work is not full-shift intensity. Partial shifts should generally not exceed 16 hours, but up to 24 hours is permitted with adequate rest. This type of shift is advantageous when training, to reduce stretch of nightshifts and for more weekends off.

For flexible working, the number of full time shifts should be pro-rated accordingly, contributing proportionally to out-of-hours working with night shift patterns taking into consideration fixed working day patterns and off days.

Education and Training

Training units should foster a positive working environment to work alongside the multi-professional team with regular junior-senior meetings, supportive of regular PGDiT meetings and involving PGDiT in monitoring and improving educational quality within the department.

PGDiT can expect to attend relevant local and regional teaching, leaving clinical staffing at weekend levels where necessary. They can also expect adequate time within their work schedule to complete SPA which may include audit, leadership and ePortfolio and personal development; if outside of rostered hours, exception reporting is encouraged. It is recommended that time allocated for supporting professional activities should be a minimum of eight hours a month for ST1-3 and 16 hours a month for those ST4 and higher, pro rated for less than full time working (LTFT), in addition to departmental teaching and clinical admin time.

Provision of time for bleep-free training should also be included with assigned clinical cover clearly documented. In conjunction with Heads of School and Training Programme Directors, PGDiT should have access to a breadth of different training environments and opportunities across each level of training, to evidence each curriculum domain in RCPCH Progress+ [6].

Agreed Work Plan

Whether starting in a new role or moving between six-monthly rotas, it is important to meet with your Clinical Supervisor following inductions with both the Health Board / Trust and department. The purpose being to discuss the working week, expectations and training opportunities. This should include identifying time for completion of work-based assessments, clinic attendance, access to clinical supervision and SPA in addition to out of hours working. Where PGDiT are asked to backfill clinical activity during clinic/SPA time exception reporting is advised and PGDiT should expect that clinic/SPA time will be returned and/or receive reimbursement payment.

Exemplar Work Duties and Rota: Tier 1 Neonatal Intensive Care Unit (NICU)

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		8:30 - 21:30	8:30 - 21:30	8:30 - 21:30
2			8:30 - 21:30	8:30 - 21:30	8:30 - 17:30		
3	8:00 - 16:30	8:00 - 16:30	8:00 - 16:30	8:00 - 16:30	8:00 - 16:30		
4	8:30 - 21:30	8:30 - 21:30			20:30 - 24:00	00:00 - 9:30, 20:30 - 24:00	00:00 - 9:30, 20:30 - 24:00
5	00:00 - 9:30		9:00 - 17:00	9:00 - 17:00	9:00 - 17:00		
6	20:30 - 24:00	00:00 - 9:30, 20:30 - 24:00	00:00 - 9:30, 20:30 - 24:00	00:00 - 9:30, 20:30 - 24:00	00:00 - 9:30		
7	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		
8	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:00 - 16:30	8:00 - 16:30
9			9:00 - 17:00	9:00 - 17:00	9:00 - 17:00		
10	8:30 - 17:00	8:30 - 17:00	8:30 - 17:00	8:30 - 17:00	8:30 - 17:00		
11	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		
12	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		

Duty	Name	Type	Start	Finish	Days	Duration
A	NWD	Shift	8:30	17:30	1	9:00
B	Long	Shift	8:30	21:30	1	13:00
C	Night	Shift	20:30	9:30	2	13:00
D	SCBU	Shift	8:30	17:00	1	8:30
E	PN / TC	Shift	8:00	16:30	1	8:30
F	Clinic	Shift	9:00	17:00	1	8:00
G	Floater/Admin	Shift	8:30	17:30	1	9:00
H	Admin	Shift	9:00	17:00	1	8:00

Duties and time assigned for Tier 1 NICU (NWD- normal working day, SCBU- special care baby unit, PN- post natal ward, TC -transitional care); using BMA recommended OOH working.

Exemplar Work Duties and Rota: Tier 2 General Paediatrics

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	8:30 - 17:30	8:30 - 17:30	9:00 - 17:00	9:00 - 17:00	9:00 - 17:00		
2	9:00 - 17:00	9:00 - 17:00	14:30 - 22:30	14:30 - 22:30	14:30 - 22:30		
3	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		
4	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		8:30 - 21:30	8:30 - 21:30
5			8:30 - 21:30	8:30 - 21:30	8:30 - 21:30		
6	20:30 - 24:00	00:00 - 8:30, 20:30 - 24:00	00:00 - 8:30, 20:30 - 24:00	00:00 - 8:30, 20:30 - 24:00	00:00 - 8:30		
7	8:30 - 21:30	8:30 - 21:30	8:30 - 17:30		20:30 - 24:00	00:00 - 8:30, 20:30 - 24:00	00:00 - 8:30, 20:30 - 24:00
8	00:00 - 8:30		9:00 - 17:00	9:00 - 17:00	9:00 - 17:00		
9	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		
10	14:30 - 22:30	14:30 - 22:30		8:30 - 17:30	8:30 - 17:30	8:30 - 21:30	8:30 - 21:30
11			8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		
12	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30	8:30 - 17:30		

Duty	Name	Type	Start	Finish	Days	Duration
A	NWD	Shift	8:30	17:30	1	9:00
B	Long	Shift	8:30	21:30	1	13:00
C	Night	Shift	20:30	8:30	2	12:00
D	Late Shift	Shift	14:30	22:30	1	8:00
E	SPA	Shift	9:00	17:00	1	8:00
F	PAU	Shift	8:30	17:30	1	9:00
G	Floater/Admin	Shift	8:30	17:30	1	9:00
H	Admin	Shift	9:00	17:00	1	8:00

Duties and time assigned for Tier 2 General Paediatrics (NWD- normal working day, SPA – Supporting Professional Activities, PAU – paediatric assessment unit); using BMA recommended OOH working.

Overview: rota design and rostering

The roster should consider patient, staff and organisational needs alongside staff levels necessary to deliver high quality service, quality improvement, training and development.

Rota design and rostering is a two-stage process. First, a generic rota template is created, then it is converted into a live workable roster detailing daily staff deployment and resource allocation. The roster should reflect a realistic and safe assessment of service compiled with engagement from the wider team and agreed between PGDiT and managers, ensuring an even balance of shift types that account for full annual and study leave allowances. A flexible approach is key particularly where PGDiT have caring responsibilities or health needs.

An operational live roster should be regularly checked and updated where necessary with a clear process for implementing changes. This is particularly important in the case of rota gaps and where workload exceeds capacity; it is the responsibility of the organisation to manage demand or increase workforce via recruitment.

Rostering good practice: Aims

- Open and transparent consultation to ensure best possible use of resources while meeting service and training requirements.
- Staff take ownership of working patterns facilitating work-life balance and quality of service.
- Accommodate additional hours and greater flexibility by rostering below contractual limits.
- Ensure full access to leave.
- Provide sufficient time for mandatory training and induction, teaching and assessment, e-learning, quality improvement, and reflective practice with fairness and consistency.
- Maximise training time across six-month rotation block and out-of-hours work proportionate to less than full time working.
- Greater utilisation of technology and e-rostering solutions.
- Partnership working and communication of service innovations.

Rostering good practice: Outcomes

- Safe and appropriate staffing levels.
- Improved oversight and monitoring to align staffing levels with service needs, training opportunities, and budgets.
- Better management and oversight of educational opportunities to meet outcomes required for progression at the Annual Review of Competence Progression (ARCP).
- Staff are able to complete all aspects of their role within working hours.
- Improved planning and management of leave.
- Increased opportunities for doctor involvement in roster design, development and management.
- Better management and oversight of resources; reducing reliance on temporary staffing.
- Improved outcome in terms of quality of working lives and well being.

The Rostering Process

The NHSE School of Paediatrics release rotation placements at least 12 weeks in advance of the start of a rotation. New rotas should be developed at least three months in advance to allow time for validation and approval; the final rota should then be distributed six to eight weeks in advance.

Develop and evaluate core components of template rota

- Consider WTE allocation, annual budget and required staffing
- Determine optimum number of staff for each duty and shift type
- Incorporate feedback and ensure contract compliance
- Satisfy education and training requirements, QI, patient safety, formal study, audit and e-portfolio
- Be responsive to different working arrangements; health and safety considerations; and workload fluctuations
- Leave planning and short-terms sickness contingency
- Ensure adequate time for handover

Create draft roster

- Use local processes and management system to identify vacancies
- Ensure sufficient staffing numbers

Validate and authorise draft roster

- Include sufficient information to allow safety and efficacy approval
- Departmental approval plus JDF and local TU representation
- Review safety, contractual compliance, balance of training and service needs, leave entitlement
- Escalate where there is disagreement

Publish and communicate finalised and approved roster

- Publish minimum six weeks before becoming operational
- Provide necessary information to understand roster
- Avoid changes where possible

Review and maintenance

- Update routinely to reflect changes from exception reporting or review with senior and junior medical staff; and staffing reps
- Assess any changes against contractual safety and pay
- Safe staffing audit recommended every three months
- Annual sign off as safe, effective and financially viable
- Rota management should be collaborative

Rostering checklist

Run your rota through the BMA's rota checker tool - is it compliant with the rules?

Questions for the first junior-junior meeting post-induction

1. Did you receive your rota with sufficient notice as defined by the Code of Practice (8 weeks for the rota template and 6 weeks for the duty roster)?
2. Have you been given a copy of your employer's policy (or equivalent) stating the requirements of the roster manager and doctors working under the roster that has been agreed by the local negotiating committees?
3. Were you consulted on the design of this rota? If not, do you know which doctors were involved, and how to contact them with any questions?
4. If this is a change to an existing rota, have you been given 6 weeks' notice?
5. If you're LTFT, has this rota taken into account any set working days you have? If not have you been able to negotiate working arrangement
6. Is the rota template as a whole balanced, with different types of shifts (on-calls/ weekends, nights, long shifts) evenly distributed?
7. Is there a straightforward process for swapping shifts if you need to?
8. Is it possible to take annual leave when you need to rather than leave being fixed in the rota, particularly on long days and nights? Is there flexibility to have annual leave for longer periods if needed?
9. Have you received guidance on exception reporting at induction?

During placement and exit interview

Training:

10. Does the rota provide opportunity to complete all mandatory training and inductions?
11. Is it possible to take supervisor approved study leave?
12. Are all training needs as per Progress+ able to be met in this rota as it currently stands?
13. Is there opportunity to get time off in lieu for mandatory training, study days and courses attended on non-working days?
14. Are long-term and short-term rota gaps being adequately covered for NROC

Working Hours:

15. Is there enough time for handover and admin work within your rostered shifts ?
16. Was any exception reporting feedback in the last 6 months / current rotation shared with PGDiT and the rostering team?

Staffing:

17. Were long- and short-term rota gaps adequately covered for standard shifts?
18. Were long- and short-term rota gaps adequately covered for on-call shifts?
19. Do you feel that the minimal staffing requirement is best on most days?

Please also see the NHS Employers: Rota Rules at a Glance [7]

Tips for resolving non-compliant rotas

- Identify nature of work
- Bleep policies
- Organisational changes e.g. more daylight hours, avoid task duplication
- Skill mix initiatives
- Alternative working patterns

Exception Reporting

Exception reporting ensures that training can be safeguarded, workloads are kept manageable and the health and safety of patients and PGDiT is protected. It is the right and responsibility of every PGDiT with no restriction on what should be reported or how many reports can be submitted; and no authorisation is required prior to submission.

Exception report for any variation from planned working hours or training opportunities in your work schedule within a maximum of 14 days (or 7 days when claiming payment) where possible. If extra hours cannot be authorised at the time, submit an exception report for retrospective authorisation. Where additional hours result in a breach of rest requirements this should be highlighted in the exception report and marked as urgent.

Exception report for the following:

- all scheduled and contractual NHS work
- activities required for successful ARCP completion including educational or development activities stated in schedule
- activities agreed between PGDiT and employer
- professional activities PGDiT is required to fulfil by employer

Exception report as issues arise:

- differences in hours worked from that set out in the work schedule
- being unable to take contractual rest breaks
- missed educational or training opportunities
- levels of support available during service commitments

This will facilitate timely adjustments to be made to working patterns where needed, as well as getting sign off for either TOIL or additional pay.

If clinic/admin time has been lost due to need to cover service, then PGDiT should exception report and plan alternative arrangements with supervisor/college tutor to receive missed clinic experience.

Roster Management

Rosters should be updated to reflect any changes related to leave, shift swaps, sickness, end and start time changes, and gaps requiring temporary staffing. Roster change policy should be sent to all doctors.

Every effort should be made to limit roster changes, but where there are alterations necessary they should be discussed with all affected staff members. If other doctors are affected, they should be consulted and be prepared for changes in cases of emergency/unforeseen circumstances with a minimum of six weeks' notice. In cases of wholesale changes, training requirements (ARCP) and individual circumstances should be considered including managing leave and other entitlements. In cases of dispute, seek input from the guardian of safe working or director of medical education.

When to amend a roster

- Average number of hours per week is close to or above 48 hours.
- Access to training and educational opportunities to fulfil curriculum requirements is unmet.
- High number of varied exception reports are submitted, with possible employer fines.
- Submission of work schedule review requests that impact roster.
- Guardian has raised concerns.
- Shift pattern close to breaching/has breached hours and rest requirements.
- Doctors unable to take leave, training or high rates of short-term sickness.
- Changes in service demand which require different staffing levels/rostering strategy.
- Significant concerns have been highlighted in junior-senior feedback meetings / exit interviews.

Implications of rota gaps include:

- Increased workload intensity
- Gaps in the delivery of patient care both during the day and for out of hours services
- A potential reduction in training opportunities is proposed to take place

The responsible consultant or clinical director should be alerted to uncovered activity due to rota gaps at the earliest opportunity. PGDiT may be asked to cover some duties and where this will improve patient care are encouraged to do so, as long as this does not impair ability to care for current patients and existing duties and working lives.

Emergency and short-term gaps

It is reasonable to be asked to cover brief colleague absence (48 hours' notice for sickness), late starts or in exceptional emergency scenarios. This should be recognised with either pay or TOIL. Additional commitments by academic PGDiT, sessional doctors or those with multiple employers should be protected and respected.

Long-term gaps

For long term gaps, the employer is required to engage internal or external locums to provide cover. PGDiT can increase hours to cover gaps, but the rota should be rewritten to account for

this and pay banding reassessed. Any resulting change in working pattern must take place in accordance with the Junior Doctor Contract and Department of Health guidance, with both post holder and College Tutor approval. If changes in working pattern impact the achievement of educational objectives, contact the educational /clinical supervisor or college tutor initially and/ or the programme director, or postgraduate dean as soon as possible. If regularly performing additional work as an internal or external locum, check cover with medical defence organisation.

Cover for on call duties/ out of hours

PGDiT can cover out-of-hour commitments or agree to self-roster as an internal locum. If an employer wishes to change to working patterns leading to an increase in the number of hours worked, the majority of the post-holders must be in agreement.

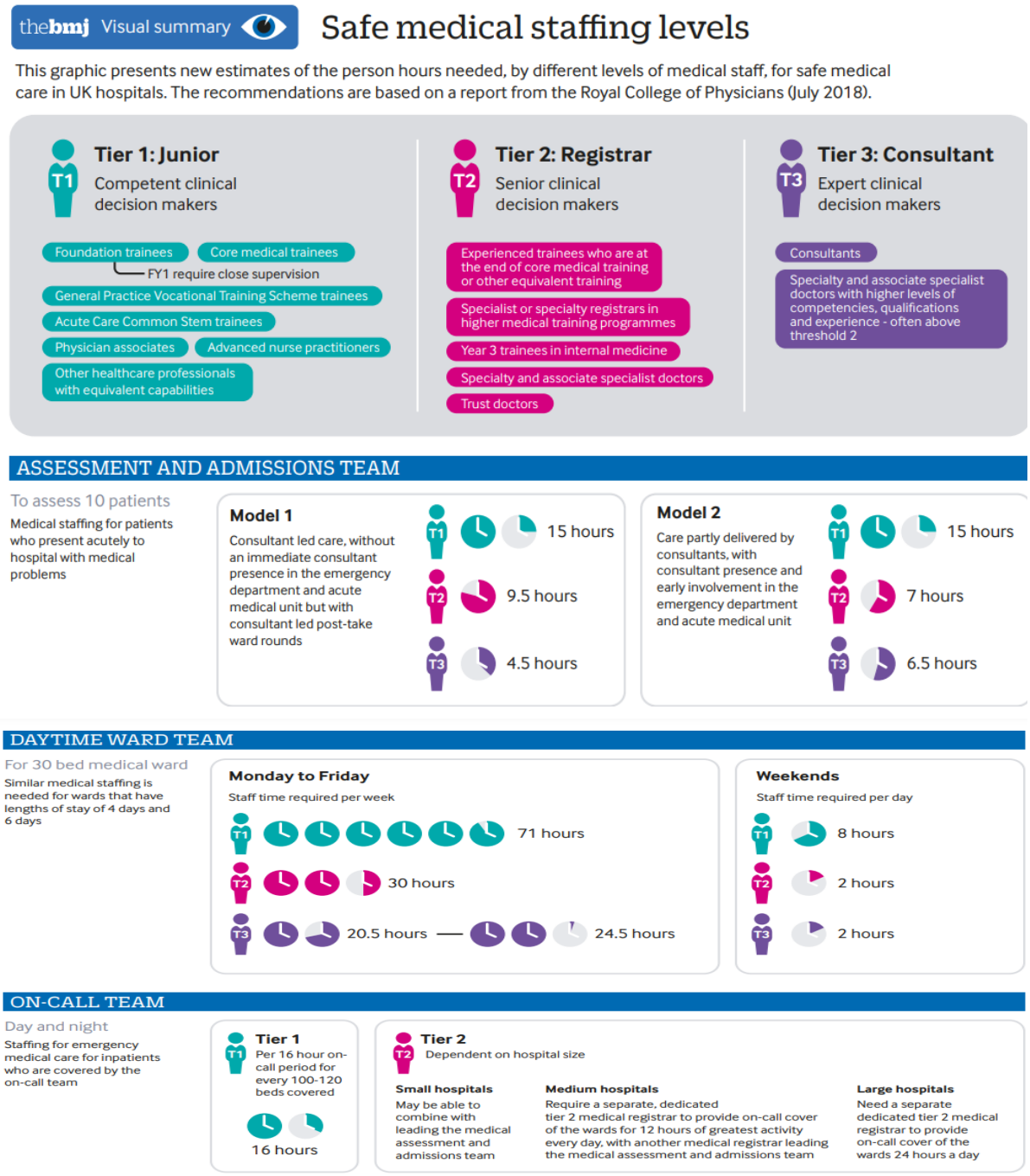
There is no obligation to work outside the job description or where patient safety may be jeopardised. If feeling pressurised into covering additional hours, PGDiT should contact the BMA.

Minimal staffing

Minimal staffing can be calculated according to previous figures with required leave taken by the end of the rota period and all approved leave requests for a new rota period honoured. Exit interviews between junior-junior and junior-senior staff are useful for understanding any minimal staffing issues.

The diagrammatic below has been created by the BMJ and is based on delivery of adult care rather than specifically for paediatric services, but provides a useful indication of minimal staffing levels.

British Medical Journal, Safe Staffing: This is how many doctors we really need [8]



Leave

12 Weeks Prior: Employers / doctors notified of placement

- Doctors submit leave requests with as much notice as possible

8 Weeks Prior: Doctors receive generic work schedule

- Employer recirculates request form and doctors request specific periods
- Share information re organising leave and shift swap

6 Weeks Prior: Doctors receive duty roster

- Doctors receive specific working pattern and leave approval

Start of placement: Doctors attend induction

- Further opportunity for training on managing rota and booking leave
- Develop informal mechanisms for arranging swaps

Halfway through placement: Review of leave entitlement

- Communicate to doctors how much leave has been taken and how much remains unallocated

Study Leave

Study leave includes periods of study linked to a course or programme, approved research, teaching, examinations, conferences and rostered training events or private study. All requests must be agreed prospectively with the educational supervisor and the PGDiT rota-co-ordinator/ college tutor. If study leave is refused or granted without pay or expenses, PGDiT can (i) appeal to the regional study leave committee (if one exists) or postgraduate dean (ii) approach the small claims court or (iii) engage the employer's grievance procedure.

Study leave application should follow Regional NHSE policy for both mandatory and discretionary study leave requests. Whereas mandatory study leave for regional teaching and course eg APLS may be automatically approved, discretionary study leave will need agreement from representative of School of Paediatrics eg TPD.

FY1 are not contractually entitled to take formal study leave, but the FTPD (foundation training programme director) should ensure access to a formal taught programme of education for professional elements of the curriculum up to three hours protected time per week.
FY2 doctors are eligible for 30 days study leave per year with a minimum of ten days for a formal

educational programme in generic professional training and other aspects of F2 training. Specialty training (including FTSTAs) are entitled to one day per week during university terms or a maximum of 30 days in a year plus examination study leave. ST2 PGDiT are entitled to up to 15 four-hour sessions of study leave in a six month post and ST3 PGDiT are up to 30 days in one year or 60 four-hour sessions.

Professional Leave

PGDiT are entitled to up to five days professional leave a year. Professional leave can be used for national roles representing professional bodies, including the RCPCH, GMC and NICE. Job interviews should be considered professional leave and should not require annual or study leave. Professional leave for overseas conferences etc is at employer discretion.

Annual leave

Leave requests should be submitted six weeks in advance of the start of the leave period and should be accepted (where possible). Requests that leave be carried over between rotations would need to be agreed by departments provided that the doctor remains in the employment of the same Health Board / Trust. Out-of-hours duties can be condensed to allow flexibility for longer periods of annual leave. Compassionate/special leave requests may be granted at the employer's discretion, in line with local policies.

Time off in Lieu (TOIL)

If a doctor chooses not to take compensatory rest within 24 hours, additional time worked can be taken as TOIL, although preference is for rest where safe working hours are threatened. Processes should be in place to ensure TOIL is properly monitored and all TOIL should be used within three months; if it is not possible to take the time in this period then payment should be made. Study leave is counted as working time and when undertaken on non-working days should be compensated for with TOIL. Days in lieu can also be taken for working on a bank holiday including rest day and night shift, and for mandatory training scheduled on off days (mandatory regional study days, APLS, NLS, safeguarding courses).

Flexible working

Identifying individual needs, facilitating flexible working patterns, and providing consistency and stability (with sufficient notice for changes) are key to good rota design and rostering. This may result in hours being carried over as a rota gap or being shared between other doctors. All reasonable attempts should be met to facilitate set working day patterns in line with the statutory rights of PGDiT to request flexible working provided that service needs can be met. PGDiT should discuss any plans to train LTFT or change percentage LTFT working with their Educational Supervisor and TPD well in advance of the planned start date of the next rotation in line with Regional NHSE LTFT policy. Once an application is submitted, the responsible TPD will confirm that this change in pattern of work can be accommodated in the training programme and the postgraduate or associate dean will then confirm approval. PGDiT can appeal in cases of refusal, but are encouraged to resolve any issues informally[9].

Less than Full Time (LTFT)

All reasonable requests to set working day patterns should be met in line with statutory rights to request flexible working provided that service needs can be met. If not possible due to service needs, a mutual agreement should be made so service needs are also met.

- LTFT PGDiT will have the same balance of daytime and out-of-hours as those working full time.
- Sufficient time must allow LTFT PGDiT to plan to maximise exposure to training.
- LTFT is dependent on how the week is structured e.g. four days a week at 80% is 32 hours in total.

Types of LTFT training post:

- Slot share - divided between doctors with all full time post duties covered; educational slot(s) shared with possible overlapping sessions.
- Job share - a full-time contract shared between two doctors, usually at 50% each; with half full-time salary, half working hours and 50% of the training opportunities.

There needs to be flexibility re shift swaps, where as much notice as possible should be provided and should be between doctors of equivalent grade to fulfill contractual hours and safety.

Less than Full Time Rota Design

- Plan LTFT contribution with PGDiT, department college tutor, educational supervisor
- Ensure personal and educational needs are met as well as departmental service needs.
- Ensure correct proportion of hours, shift types and pay for LTFT quota.
- Highlight pro-rata entitlement to study leave and annual leave.
- Ensure rota template spans length of the flexible working placement.
- Review regularly taking into account any highlighted variations.

When designing the rota:

- Count full time shifts of each type then pro-rate accordingly, ensuring each slot represents proportion of average weekly full time hours.
- Where working hours fall below LTFT percentage, ‘make up’ shifts should be on normal working days unless otherwise agreed.

- Factor in additional work, e.g. out-of-hours.
- Contribute proportionally to out-of-hours with night shift patterns taking into consideration fixed working day patterns and off days.
- Unless agreed, a normal day, long day or twilight shift should not be rostered on a non-working day.
- Encourage appropriate and consistent runs of twilight/night shifts and good forward rostering patterns to minimise fatigue.
- Preserve educational opportunities with clinic time prospectively included where possible.
- Strive for placement across multiple rotations, providing adequate notice of changes.
- Ensure opportunity to meet curriculum requirements and encourage exception reporting when not.
- Seek study leave where teaching falls on non-working days and compensate with TOIL.

Parental Leave

Maternity Leave

An employee working full time or part time is entitled to 52 weeks of maternity regardless of how long in employment.

- Maternity leave is made up of 26 weeks of ordinary leave and 26 weeks additional leave.
- Maternity leave can start at any time between the 11th week before expected week of childbirth and the expected week of childbirth.
- Notify employer of intention and date of maternity leave.
- Provide a MATB1 form from midwife or GP giving the expected date of childbirth.
- Notify employer of intention and date to return to work; if there is a change in start or return date, provide 28 days notice (or as soon as is practicably possible).
- The employer should confirm in writing paid and unpaid leave entitlements, expected return date based on her 52 weeks' based on this and any accrued annual or public holiday leave formal maternity leave period.
- Before going on leave, agree voluntary arrangements for keeping in touch (KIT) in terms of work developments.
- A risk assessment of working conditions should be carried out where an employee is pregnant, has recently given birth or is breastfeeding to ensure provision of suitable private rest facilities.

Paternity Leave

Employees who are new fathers or partners of a birth mother or primary adopter are entitled to two weeks paternity leave after birth or adoption if they have expected responsibility for the child's upbringing; this includes same-sex spouses and partners. PGDiT must have also worked continuously for the same employer for 26 weeks ending with the 15th week before the baby is due (or the adoption date) and continue in the same employment up to the date of birth. Paternity leave should be taken as either one week or two consecutive weeks of paternity leave and the employer informed of intention by the end of the 15th week before the expected week of childbirth, or if this is not possible, as soon as is reasonably practicable.

Prior to going on maternity or paternity leave, it is recommended that PGDiT should meet with their Educational Supervisor, college tutor, and TPD to discuss SuppoRTT / return to Training following their period of leave in relation to flexible working hours, training requirements, timing of ARCP and provision of a supernumerary period. It is also recommended to have a similar meeting just prior to return to work, including planning SuppoRTT (return to training).

Shared parental leave (SPL)

All employees will have the right to 50 weeks of SPL (minus maternity or adoption leave already taken) within one year. SPL can be taken in one go or in blocks between periods of work, at the same time as the other parent or staggering leave and pay. PGDiT should provide a minimum of eight weeks' notice to book a period of leave.

Adoption Leave

An adopter has 52 weeks leave entitlement that can begin either on the day of placement or on a pre-determined date no more than 14 days prior. Notice should be given within seven days of

the date of notification or as soon as is reasonably practicable; evidence relating to the adoption may be required.

Returning to work after 26 weeks or between 26-52 weeks entitles resumption of the previous role; if returning before the end 52 weeks, eight weeks notice is required. Adopters are entitled to paid time for up to five adoption appointments.

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9. British Medical Association. Rota and rostering guidance for LTFT doctors. 2022. https://www.bma.org.uk/pay-and-contracts/working-hours/work-schedule/managing-rotas-and-duty-rosters-for-junior-doctors-in-england/rota-and-rostering-guidance-for-ltft-doctors

Workforce information

Postgraduate Doctors in Training (PGDiT):
Rostering guidance

RCPCH
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