

European Working Time Directive Implementation

**Guidance on progressing
EWTD compliance**

17th October 2014

Purpose of document

This document sets out guidance on progressing EWTD compliance for HSE and HSE-funded Hospitals and Mental Health agencies with the requirements of the European Working Time Directive (EWTD). It includes guidance on measures to promote EWTD compliance, associated performance indicators and information on particular sections of the EWTD and related Irish legislation dealing with the issue.

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A. Performance indicators

The indicators below are to be used within each hospital / agency to assess performance in terms of EWTD implementation and compliance and will be used by the HSE at national level when evaluating hospital / agency performance. They represent a summary of the guidance in Sections B to F of this document.

Performance indicators		
Theme	Area	Performance indicator
Engaging staff in change	NCHD Committee	An NCHD Committee is in place
	Lead NCHD	A Lead NCHD is appointed (subject to sanction)
	EWTD Implementation Group	An EWTD Implementation Group is in place, includes named NCHDs and meets monthly
Safe rostering	NCHD Contract 2010	NCHDs work no more than 24 hours on-site on-call
		Employers are compliant with NCHD Contract 2010 with particular reference to: <ul style="list-style-type: none"> No split shifts Minimum notice periods for rosters NCHDs are not permitted to work in multiple employments if total working time exceeds 48 hours
	Start and finish times and breaks	Extent of use of staggered start and finish times where NCHDs are required to commence earlier than standard rostered hours e.g. for Handover
		The employer documents and ensures 30 minute breaks
		Training prior to normal start times is in line with guidance on protected training time and the associated payment arrangement
Staffing a 48 hour compliant roster	Extent to which rosters of 7 NCHDs or more are EWTD compliant	
Supporting the provision of training	Training Principles	Rostering in line with training needs
	Protected Training Time	Provision of protected training time
Transparency and accountability	Reporting and payment of hours worked	Publication of rosters as per agreed timeframes
		Regular review of rosters and payment arrangements
		Participation in process to introduce time and attendance systems (if not already in place)
	Accountability for NCHD rostering / working hours	A senior manager has been identified to liaise with NCHDs across 24/7 period
	Use of CompStat as a measure of performance and related sanctions	Reporting of EWTD compliance data via the monthly CompStat template in line with specified deadlines

Theme	Area	Performance indicator
Aligning work patterns to workload	Reducing tiers of on-call cover	Extent to which Registrar and sub-specialty cover is provided via off-site on-call
		Use of joint rosters or single levels of on-call cover at NCHD level to support reductions in NCHD hours
		Creation of a single Intern rota
		Use of a single layer of on-call cover at sub-specialty level where appropriate
		- reducing level of on-call cover on-site as activity reduces after 11pm / midnight
	Cross cover	Provide for single acute medical SHO rosters and single acute surgical SHO rosters
		Eliminate on-site 24/7 Registrar rosters outside Level 1 Hospitals
	Delivery of care by the most appropriate member of staff	Identify a specific senior, accountable non-medical staff member in each hospital to lead delivery of each of the tasks identified in Section 14
	Bleep policy	A formal Bleep Policy is in place, clearly displayed in each ward and updated as appropriate
		A named manager is responsible for and has signed the Bleep Policy together with the Clinical Director
	Handover	A formal, documented Handover process is built into 24/7 on-site on-call rosters
		Staggered starts and finish times are used to support Handover
		Handover is introduced in a way that does not extend existing shift or roster periods for either NCHDs arriving / going off-call or the NCHD who is rostered on-site at night

B - Engaging staff in change

1. Lead NCHDs and NCHD Committees

As part of a range of number of initiatives undertaken at national level to improve NCHD recruitment and retention in the Irish public health system, the HSE Human Resources Directorate in collaboration with the National Clinical Director Programme piloted an Lead NCHD role in eight acute hospitals beginning in January 2014. The key objective of the NCHD Lead role is to introduce a formal link at management level between NCHDs and Clinical Directors / Hospital Management, enabling improved engagement and communication between management and NCHDs.

This role will shortly be made available in a wider range of acute hospitals and other settings.

The Lead NCHD should be supported by an NCHD Committee. Key areas of focus for the NCHD Committee will include NCHD welfare, training, EWTD (responsibility for which is detailed at g) below) and executive decisions affecting NCHDs. The employer will make available resources to support the Committee and Lead NCHD in their role. This will include ensuring that NCHDs are able to attend meetings as required.

2. EWTD Implementation Group

In October 2013 each Hospital CEO / Manager was required to formally establish a Hospital-level EWTD Implementation Group to include the Hospital CEO / Manager, Clinical Director, NCHDs (nominated by IMO and others), lead Consultants, Director of Nursing and others as appropriate – meeting on a fortnightly basis. The Hospital EWTD Implementation Group is subject to direction and guidance from the National EWTD Verification Group and reports progress and information as required.

C - Safe Rostering

3. NCHD Contract 2010

Section 5 of NCHD Contract 2010 sets out a number of requirements for rostering of NCHDs to support safe service provision and exposure to appropriate training / activities that support the maintenance of professional competence. These include:

- The NCHD shall not be required to work for more than 24 consecutive hours on-site.
- The Employer will ensure that the NCHD is rostered to work on-site for a period of 24 hours on no more than a 1 in 5 basis other than in exceptional circumstances.
- Rosters must provide for a handover period between each shift. Handover periods must be of at least 30 minutes in duration.
- The NCHD may not be rostered to work a split shift¹.
- A minimum notice period of 2 weeks will apply for provision of initial rosters.

¹ A split shift is an employment schedule where the employee's normal work day is split in to 2 or more segments. For example an NCHD could not be rostered to work from 9 am to 2pm and then have a break until 8pm at which point they would be rostered to return to work until midnight.

- The NCHD shall not be required to attend on-site on a rostered day off (including leave) outside the 2 week minimum notice period where the requirement for such attendance can be reasonably anticipated by the employer.
- A minimum notice period will apply for changes to published rosters taking account of the need for shorter notice to respond to clinical need on an unplanned basis,
- Where the NCHD is provided with more than one rostered day off during a week, the Employer should endeavour to ensure such days are consecutive.
- Work outside the confines of this contract is not permissible if the combined working time associated with this employment taken together with any other employment exceeds the maximum weekly working hours as set out in S.I. No. 494 of 2004 European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004.

4. Start and finish times and breaks

Timing of clinics, theatre services, educational activities and ward rounds are key factors influencing when NCHDs attend onsite and commence or finish work. In this context, rosters should take account of the following:

- Where NCHDs are required to provide scheduled clinics, theatre services, to support Handover or other duties prior to 9am, staggered start times are used
- Only those NCHDs required for direct service delivery attend at the early start time
- NCHDs who start early only work a standard day and finish early
- Remaining NCHDs start only when required
- Compliance with a maximum 24-hour shift period may require that the NCHD rostered to work the 24 hour shift starts work later than colleagues the morning prior to the night on-call
- NCHD participation in educational and training activities prior to commencing clinical duties is in line with guidance regarding the provision of training time and use of protected training time as set out in Sections 7 and 8 of this document.
- The EWTD requires that NCHDs benefit from a 15 minute break for every 4 hours 30 minutes worked or a 30 minute break for every 6 hours worked. Irrespective of which is provided it is understood that the nature of clinical activity requires that the NCHD take such breaks as they become available rather than in a structured manner. A priority is that the hospital / agency have ensured that NCHDs receive breaks – and documented same via a signed overtime form or by other means.
- Use of 5/7 working – NCHD Contract 2010 provides that NCHDs may be rostered to provide 39 hours over any 5 days out of 7 in the week. In this regard use of 5/7 working may assist in reducing NCHDs hours and provide an alternative to staffing weekends on an on-call / overtime basis. For example, NCHDs could be rostered to work 4 days out of the Monday to Friday period and one of either Saturday or Sunday as their 5th day. Each NCHD on rota would rotate through these working arrangements and normal weekend premium payments would apply.

5. Staffing a 48 hour compliant roster

In 2003, the Report of the National Task Force on Medical Staffing indicated that 7 doctors were required to staff an EWTD compliant rota. In 2009, the Report of the EWTD National Implementation Group noted that the UK experience was that at least 7 doctors were required to achieve an average 48 hour week. It is noted that where the particular specialty rota is required to support a range of services simultaneously or deliver a high volume of activity that additional doctors may be required to meet EWTD requirements while maintaining required levels of service provision. Taking this into account, rotas with 7 or more NCHDs are regarded as capable of meeting EWTD requirements while providing safe, high quality patient care.

6. Factors to take account of in aligning rostering to service needs

A key priority in achieving sustainable EWTD-compliant rosters is to map roster patterns to service needs. When doing, hospitals should examine:

- the extent to which Consultant work patterns drive NCHD start and finish times and examine whether change in such Consultant work patterns is required to reduce NCHD hours.
- the extent of requirement to attend on-site during the Monday to Friday period;
- the extent of requirement to attend on-site on Saturdays and Sundays;
- periods when NCHDs are paid to be on-site but not required for clinical reasons (e.g. protected training time);
- start and finish times during the Monday – Friday period;
- times of ward rounds or other determinants of finishing / starting time;
- the requirement for NCHD to remain on-site following night on-call (and total length of period on-site);
- the potential for Saturday and / or Sunday to be covered by NCHD working Tuesday to Saturday or Sunday to Thursday as part of the roster;

D - Supporting the provision of training

7. Training principles

The ‘Training Principles to be incorporated into new working arrangements for doctors in training’ (available [here](#)) agreed by the Medical Education and Training Group with postgraduate training bodies some years ago include the following Training Principles for rosters:

- The primary consideration in constructing rosters is the provision of safe care for patients as agreed by the relevant local medical body;
- Rosters must be compiled to reflect the training needs and agreed principles;
- Rosters should in so far as possible be structured in such a way that the trainee is provided with the opportunity to follow patients in their journey through the hospital system e.g. through structuring in formal opportunities to see and/or review the patients involved during subsequent periods on duty;
- Trainees’ rosters should be structured to preserve the maximum possible association and contact with their designated trainers, as long as this is consistent with being exposed to the full spectrum of experience necessary for training in the specialty concerned, including extended hours and/or night work where appropriate;

- NCHDs should not be rostered for acute on-call and elective duties simultaneously, where possible.
- Rosters should facilitate scheduled on and off site education and training activities.

8. Use of Protected Training Time

Guidance on the delivery of protected training time agreed by the HSE, Forum of Postgraduate Training Bodies and the IMO is set out in a document entitled 'Supporting NCHD access to Protected Training Time – 11th July 2014' (available from the HSE MET Unit). It is intended to ensure that each NCHD benefits from protected training time appropriate to their grade and training status. The intent is to ensure that NCHDs receive - in general terms - between 123 and 328 hours of paid protected training time each year.

The document notes that rostered time engaged in training / educational activities will not be counted as working time for EWTD purposes if:

- the NCHD is off call, is not carrying a bleep or a mobile phone for the purposes of being contacted for work purposes and cannot be required to return to duty under normal circumstances prior to the end of the defined period;
- the time is recorded as spent participating in training / educational activities;
- In relation to category c), those specialties which require repeated exposure to and practice of specific clinical procedures time to allow trainees to observe and subject to Consultant approval, participate under supervision in certain planned procedures, the NCHD must have elected to attend the training opportunity and cannot be required by the employer to do so. The NCHD must be able to leave the procedure if necessary – and may choose to do so - and there must be sufficient staff to perform the procedure to completion without the NCHD being required. This will ensure that NCHDs in such specialties are able to gain exposure to appropriate procedures from a training rather than service perspective.

E - Transparency and accountability

9. Reporting and payment of hours worked

Central to NCHD participation in measures to reduce hours and progress EWTD compliance is the assurance that hours worked are properly recorded and appropriately paid. Taking this into account, hospitals should:

- publish NCHD rosters incorporating all required service hours (including hours currently unrostered) a month in advance;
- arrange for regular review / verification of compliance with and payment of same - led by the Clinical Director (under direction of the Hospital CEO / Manager and with support from the Medical Manpower Manager) and to include the NCHD Lead;
- ensure local documentation of compliance with the EWTD requirement for a 30 minute rest break for every 6 hours worked (within the existing contracted working day and working week) and of protected training time;
- report compliance regarding a maximum 24 hour shift, average 48 hour week, 30 minute rest breaks, daily rest and weekly / fortnightly rest via the monthly CompStat template following discussion / review of same by the EWTD Implementation Group referenced at Section 2 above;
- participate in the introduction of time and attendance systems (if not already in place) via the national process being led by Acute Hospital Division.

10. Accountability for NCHD rostering / working hours

At hospital level, accountability for rostering NCHDs ultimately lies with the Hospital CEO / General Manager. Currently, NCHD rosters are developed either by a Medical Manpower / HR Manager in consultation with relevant NCHDs, Consultants and the Clinical Director or, in some settings by NCHDs and / or Consultants themselves.

Accountability for how NCHDs are rostered to respond to service needs, can participate in training as appropriate, have access to leave and the working hours arising from such rostering must involve the relevant Consultant – as per the NCHD's reporting relationship – the Clinical Director and the Hospital CEO / General Manager. Taking the above into account:

- a) rosters should be developed in conjunction with the local hospital EWTD Implementation Group. The Hospital CEO / General Manager and Clinical Director are thereafter responsible for progressing and maintaining amended rosters;
- b) the Hospital CEO / General Manager should have identified a senior manager to liaise directly with NCHDs in relation to issues as they arise across the 24/7 period;
- c) it is the responsibility of the CEO / General Manager and Clinical Director to ensure ongoing compliance; plan for required changes and progress same.

11. Use of CompStat as a measure of performance and related sanctions

The CompStat system is used to assess hospital / agency performance regarding EWTD compliance under the following six headings:

- NCHD staffing by grade;
- compliance with a maximum 24 hour shift – by grade;
- Compliance with an average 48 hour working week – by grade;
- Compliance with the requirement for 30 minute breaks every 6 hours – by grade;
- Compliance with the requirement for 11 hours rest per day or equivalent compensatory rest – by grade;
- Compliance with the requirement for 35 hours rest per week, or 59 hours rest per fortnight or equivalent compensatory rest – by grade;

Separate guidance deals with the application of financial sanctions to hospitals / agencies which do not return monthly EWTD compliance data as required.

As of July 2014, CompStat data indicates national compliance as follows:

- Compliance with a maximum 24 hour shift: 94%
- Compliance with an average 48 hour week: 54%
- Compliance with a 30 minute break: 98%
- Compliance with 11 hours daily rest / equivalent compensatory rest: 95%
- Compliance with weekly / fortnightly rest / equivalent compensatory rest: 98%

A priority therefore are measures to promote compliance with the requirement that NCHDs work a maximum average 48 hour week.

F - Aligning work patterns to workload

12. Reducing the number of tiers of on-call cover

Significant progress has been made eliminating unnecessary tiers of on-call cover, where multiple tiers of NCHD are present on-site on-call without appropriate alignment to changing service needs over the 24/7 period. In general terms, best practice entails:

- In Level 1 Hospitals, retaining Emergency Medicine (in line with appropriate shift rostering), General Medical (SHO and Registrar level), General Surgical (at SHO level) and Anaesthetic (Registrar level) cover on-site at night and maintaining General Surgery at Registrar level and sub-specialties of Medicine and Surgery off-site on-call.
- Creation of joint Intern / SHO rosters or joint SHO / registrar rosters in Level 2 Hospitals where the next level of on-call cover is the Consultant;
- Creation of a single hospital wide Intern rota to replace separate, specialty based Intern rotas (e.g. a single Intern rota rather than separate Medical and Surgical rotas) subject to compliance with Medical Council requirements regarding Intern training;
- Reducing the level of on-call on-site after 11pm (for example) as activity reduces;
- Use of either a single layer of on-call cover (involving interns, SHOs and Registrars) at sub-specialty level (e.g. ENT) or cross cover at SHO level across multiple sub-specialties (e.g. General Surgery and Orthopaedic Surgery);

In each case, rostering should take account of decreases in the frequency and volume activity in the relevant specialty – particularly after midnight.

13. Expanding Cross-cover

A key aim of revised rostering arrangements over the past decade has been to eliminate unnecessary SHO rotas covering individual sub-specialties within General Surgery or within General Medicine e.g. separate SHO rotas for General Surgery and Orthopaedic Surgery and instead introduce cross-cover within the broader specialty where safe and appropriate to do so.

Cross-cover arrangements should be such as to ensure that the management of patients is of the highest standard and that the doctors involved are competent to provide cover.

One example of guidance on cross-cover is that approved by the RCSI relating to NCHDs in surgery² which states, under the heading 'Cross-cover between surgical sub-specialties':

- "Cross-cover between sub-specialties at HST level is not in the best interest of either patient or trainee. However, cross-cover between HSTs in vascular surgery and general surgery may be permitted as these individuals share a common training scheme.
- The RCSI has indicated that cross-cover within surgical sub-specialties is acceptable at more junior levels where:
 - the provision of cross-cover does not prevent an NCHD from achieving his or her learning objectives.
 - the working roster allows for continuity in training experience, and experience in specialty team management.

² Contained in a document entitled 'Statement by the Irish Higher Surgical Trainees Group and the Department of Health and Children regarding the implementation of the requirements of the European Working Time Directive for doctors in Higher Surgical Training Programmes'.

- the level of workload can be safely managed by the NCHD providing cross-cover.
- there are clear arrangements to ensure appropriate hand-over of information and clinical accountability.”

14. Delivery of care by the most appropriate member of staff

Patients benefit when service delivery is led by staff who, working within clear protocols and the scope of their professional practice, have demonstrable expertise, training and ongoing responsibility for such work. This is not a question of merely transferring tasks to other professionals. It is important that NCHDs develop and maintain skills in those procedures that they may be required to undertake.

A key means of ensuring that the patient receives care and procedures are undertaken by the staff member most appropriate to do so is identifying which staff member responds to the need for a task to be undertaken. It is key that where staff members have been trained to perform a task and are the most appropriate person to undertake the task that they are facilitated to do so.

Hospitals can address this by breaking down tasks into three broad categories:

- Direct patient care (Skills and activities that involve one to one contact with the patient, such as cannulation, admission, drug administration)
- Indirect patient care (Skills and activities that are necessary to progress patient care but do not necessitate contact with the patient, such as transfer letters, discharge letters, prescriptions, ordering diagnostics, accessing results)
- Inter-professional collaboration (How to manage the relationship of shared care, to include education/training, consultation, internal/external communications)

Hospitals should therefore identify which members of staff are most appropriate – taking account of the clinical condition of individual patients - to undertake the tasks identified on the illustrative list below and ensure that best use is made of staff training and experience to ensure delivery of the task by the most appropriate staff member at that time.

Direct patient care

- Venepuncture
- IV Cannulation
- Urethral Catheterisation
- Naso-Gastric Tube insertion
- Suturing
- Drug Administration
- ECG Recording
- Ordering tests - diagnostic, interventional or therapeutic

Indirect patient care

- Drug Prescribing
- Writing a discharge letter (post decision to discharge)
- Finding and delivering X-rays and radiological results / data (where PACs are not in place)
- Finding and delivering pathology results / data (where other reporting systems are not in place)

15. Bleep Policy

A key step in developing a Bleep Policy is the extent to which bleeps can be filtered or managed centrally. An example of a Bleep Policy is contained in the 'Report of the National Joint Steering Group on the Working Hours of Non-Consultant Doctors' – a joint IMO / Health Employer report published in 2001 (available [here](#)). Hospitals which have not introduced a bleep policy should take steps to introduce one immediately.

16. Handover

The Hospital Activity Analysis highlighted the extremely limited number of occasions on which formal handover takes place. Effective Handover procedures are associated with high levels of patient safety. Handover has also been found to support continuity of care, good team-working and provide valuable educational opportunities. In order for handover to work well the following elements are needed:

- There should be clarity about who is leading the handover
- All handover team members should attend insofar as staggered starts allow
- There should be a dedicated room for the handover
- Where NCHDs are required to support Handover staggered start times are used and NCHDs who start early should only work a standard day and finish early

Useful information and guidance on handover is contained in a document entitled 'Safe Handover: Safe Patients' published by the NHS Modernisation Agency and the BMA (available [here](#)). Similar documents have been published by the Australian Medical Association (available [here](#)), the Royal College of Surgeons of England (available [here](#)) and the Royal College of Physicians, London (available [here](#)).

This includes the following:

- "The ideal model includes all grades of staff from each included specialty, subspecialty or ward as appropriate. The senior nursing cover for the night period (and bed management if different) should be present.
- Daily involvement of senior clinicians is essential. This ensures that appropriate level management decisions are made and that handover forms a constructive part of medical education conveying the seriousness with which the organisation takes this process.
- There will always be work which is ongoing during the handover time, especially in the evening. Virtually all aspects of care can wait for 30 minutes to ensure continued safety overnight. Individuals need to be allowed to attend, subject to emergency cover being defined.
- The handover leader should ensure the team are aware of any new or locum members of the team and that adequate arrangements are in place to familiarise them with local systems and hospital geography."
- "Handover should be at a fixed time and of sufficient length.
- This period should be known to all staff and designated 'bleep-free' except for immediately life threatening emergencies.
- Shifts for all staff involved should be coordinated to allow them to attend in 'working time'. This is particularly important for the handover to, and from, the night team.
- Handovers will also be needed in the morning and at the change of other shifts (for example 5pm in some ward settings)."
- "The style of handover will vary depending on local need – whole hospital handovers to night teams, local handovers on specific units, community-based specialties or those covering several sites. However, all types need a predetermined format and structure to ensure adequate information exchange.

- Ad hoc handovers often miss out important aspects of care.
- Handover should be supervised by the most senior clinician present and must have clear leadership.
- Information presented should be succinct and relevant.
- Ideally, this can be supported by information systems identifying all relevant patients.”
- “Written (or IT based) handover should include:
 - current inpatients
 - accepted and referred patients due to be assessed
 - accurate location of all patients
 - operational matters, directly relevant to clinical care such as ICU bed availability
 - information to convey to the following shift
 - patients brought to the attention of the critical care outreach team (where appropriate)
 - patients whose ‘early warning scores’ are deteriorating (where in use).”

“The following, as well as being included in the written handover, should be discussed within the handover meeting. This verbal handover is vital to highlight these issues:

- patients with anticipated problems, to clarify management plans and ensure appropriate review
- outstanding tasks, associated with their required time for completion.”

G - Guidance

In addition to this document and appendices and documentation referenced in this document, further background information, examples of good practice and guidance may be found in the following documents:

- the Report of the National Joint Study Group on Working Hours of NCHDs (2001),
- Report of the National Task Force on Medical Staffing (2003),
- Report of the Hospital Activity Analysis (2005),
- European Working Time Directive and Non Consultant Hospital Doctors – Final Report of the National Implementation Group (December 2008)
- Guidance on implementation of the EWTD and LCR 19559 Vol I – 26th June 2009
- Guidance on implementation of the EWTD Vol II – use of compensatory rest – 9th September 2009
- Guidance to management on NCHD Contract 2010 – Vol I – 4th February 2010

Appendix I – requirements of the EWTD and Irish legislation

1. EU and Irish legislation

The EWTD referred to in this document and in the legislation is Directive 2003/88/EC, which took effect on 2nd August 2004. Should information be sought on the EWTD therefore, reference should be made to Directive 2003/88/EC of the European Parliament and Council of 4th November 2003 concerning certain aspects of the organisation of working time, available at: <http://www.health.gov.ie> or on the European Commission website at <http://www.europa.eu>

This Guidance also draws on clarification issued by the European Court of Justice on how the requirements of the EWTD should be interpreted. Two of the more relevant judgements are:

- a) SiMAP, European Court of Justice case C-303/98
- b) JAEGER, European Court of Justice case C-151/02

The Department of Health and Children's legislation transposing the EWTD into Irish law for doctors in training is entitled:

- 'The European Communities (Organisation of Working Time Act) (Activities of Doctors in Training) Regulations 2004' - issued as Statutory Instrument No. 494 of 2004;
- 'The European Communities (Organisation of Working Time) (Activities of Doctors in Training) (Amendment) Regulations 2010' - issued as Statutory Instrument No. 553 of 2010;

The legislation is available at <http://www.health.gov.ie> It should be read in conjunction with relevant Department of Jobs, Enterprise and Innovation legislation and the Organisation of Working Time Act 1997.

2. Scope of legislation - 'Activities of a doctor in training'

The legislation deals with the 'activities of a doctor in training' rather than 'doctors in training'. In effect, this includes the activities of all employed medical practitioners except qualified consultants, general practitioners, community ophthalmic physicians, public health doctors and other doctors who are entitled to be registered on the Register of Medical Specialists and who work without supervision in professional matters.

3. Definition of 'working time'

The legislation defines working time as "any period during which a doctor is working, at the employer's disposal and carrying out the activity or duties of his or her work, including on-call duty performed by a doctor where he or she is required to be physically present at his or her place of work".

This means all time spent on-site on-call counts as working time. Time spent on-site when off-call does not count as working time.

The following time does not count as working time where the NCHD is off-call:

- Scheduled and protected time off-site attending training as required by the training programme;

- on-site regular weekly/fortnightly scheduled educational and training activities including conferences, grand rounds, morbidity and mortality conferences;
- research, study etc.³

Time spent off-site on-call does not count as working time unless doctors are also required by their employer to perform a service while they are on-call off-site. Appendix III deals with the calculation of working time under the EWTD.

4. Daily breaks

A doctor cannot work for more than 4 hours 30 minutes without receiving a break of at least 15 minutes.

A doctor cannot work for more than 6 hours without receiving a break of at least 30 minutes. This break may include the 15-minute break referred to above.

Breaks cannot be taken at the end of the doctor's working day. Instead, they must be taken during the working day.

Alternatively, a doctor may be granted compensatory rest (see below)

5. Daily Rest

Each doctor is entitled to 11 consecutive hours rest every 24 hours OR compensatory rest (see below)

6. Weekly / Fortnightly Rest

Each period of weekly / fortnightly rest must follow an 11 hour rest period.

Each doctor is entitled to weekly / fortnightly rest as follows:

- a) 35 hours rest (11 hour rest period followed by 24 hours rest) once a week
OR
- b) 35 hours rest (11 hour rest period followed by 24 hours rest) twice a fortnight
OR
- c) 59 hours rest (11 hour rest period followed by 48 hours rest) once a fortnight
OR
- d) Compensatory rest (see below)

7. Compensatory rest

Compensatory rest must be given to a doctor who has not been granted his or her daily break, daily rest or weekly/fortnightly rest.

Compensatory rest is therefore given in lieu of:

³ The Collective Agreement agreed by the IMO and HSE on 22nd January 2010 refers

- a) A 30 minute break every 6 hours OR a 15-minute break every 4 hours 30 minutes
- b) 11 hours consecutive daily rest
- c) 35 hours continuous rest once a week or twice a fortnight OR 59 hours continuous rest once a fortnight

Compensatory rest must be equivalent to the break or rest which the doctor has not had. For example, if the doctor has received an 8 hour break instead of 11 hours, they require 3 hours. Such rest is not necessarily consecutive – it can be interrupted by time spent at work if the doctor is on-call at the time – however it must total the required rest period.

Compensatory rest must be taken before the doctor begins his or her next period of rostered work.

8. Maximum weekly working time

From 1st August 2009, an employer may not allow a doctor to work for more than 48 hours a week, averaged over the reference period described below.

9. Reference periods for average weekly working hours

A 'Reference Period' is a period of time over which a doctor's weekly working hours may be averaged.

The reference period includes all time for which the doctor has been paid, with the exception of:

- a) Annual leave
- b) Maternity leave
- c) Adoptive leave
- d) Sick leave
- e) Parental leave
- f) Carer's Leave
- g) Force majeure leave

The reference period is the doctor's term of employment or 12 months – whichever is the shorter. In no circumstances may the reference period exceed 12 months.

A reference period may begin when the contract begins. The reference period must also end when the contract ends or is terminated by the employer or 12 months have elapsed. There is no minimum reference period.

10. Night work and night workers

The legislation uses the same definition of "night time", "night work" and "night worker" as the Organisation of Working Time Act, 1997.

“Night time” means the period between midnight and 7a.m. on the following day; “night work” means work carried out during night time and a “night worker” is an employee:

- a) who normally works at least 3 hours of his or her daily working time during night time,
- AND
- b) the number of hours worked by whom during night time, in each year, equals or exceeds 50 per cent. of the total number of hours worked by him or her during that year;

It is considered unlikely that any doctor would be required to work in such a way that they would need to be designated as a night worker.

However, should a doctor be designated as a night worker, he or she may not work more than 8 hours in 24, averaged over a reference period of:

- a) 2 months
- OR
- b) a period of time specified by a collective agreement approved by the Labour Court.

The reference period should be composed of consecutive days or months, subject to the following categories of time not being included:

- a) Hours in excess of 24 hours in a weekly rest period
- b) Annual leave, unless it exceeds the minimum specified in the Organisation of Working Time Act, 1997.
- c) parental leave, *force majeure* leave or carer’s leave,
- d) Maternity, adoptive, or sick leave

“Special category night workers” are night workers who have undergone an assessment by their employer which has concluded that their work involves special hazards or a heavy physical or mental strain.

Doctors designated as special category night-workers may not work more than 8 hours in any 24-hour period.

It should be noted that health service employers are not aware of any circumstances where an NCHD is currently working in excess of 50% of their total annual working time between the hours of midnight and 7am. In that context it is understood that there are no NCHDs who currently fall into the category of ‘night workers’.

11. Shift work and shift workers

The legislation defines “shift work” as any method of organising work in shifts whereby employees succeed each other at the same work stations according to a certain pattern. The shift pattern may be continuous or discontinuous and require need for employees to work at different times over a given period of days or weeks.

A ‘shift worker’ is any employee whose work schedule is part of shift work.

Shift workers are afforded protection similar to that afforded to other workers. Any doctor who is considered to be a shift workers is entitled to equivalent compensatory rest (as set out in 4.8 above) when he or she changes shift and cannot take a daily rest period between the end of one shift and the start of the next one; or when he or she changes shift and cannot take a weekly rest period between the end of one shift and the start of the next one.

It should be noted that in the SiMAP case⁴, the European Court of Justice ruled that doctors working on-site on-call and off-site on-call work patterns were engaged in shift work and that such doctors were therefore shift workers. This does not affect existing payment structures in that NCHD Contract 2010 provides for payment of a shift allowance only to NCHDs working in Emergency Medicine departments arising from their respect of participation in a continuous rotating shift which requires delivery of the core 39 hours over a 24 hour, 7-day week cycle.

12. Records

Employers must maintain on-site a record of each doctor's normal schedule of work and actual:

- a) Daily hours of work and rest
- b) Rest breaks,
- c) Hours of night work
- d) Weekly hours of work and rest
- e) Hours on-call on-site
- f) Hours on-call off-site
- g) Periods of release from the activities or duties of his or her work, to engage in training, study leave or examination leave.
- h) Specialty and stage of training
- i) Annual leave and payment in respect of such leave
- j) Any additional day's pay

Records must take the form required by the legislation, be readily understandable and:

- a) be retained for at least 3 years
- b) be made available, on request, to the employee
- c) be made available, on request, to the Minister for Health and Children

13. Refusal by a doctor to co-operate with a breach of legislation

An employer cannot penalise a doctor for opposing, in good faith and by lawful means, an act which contravenes the legislation or the Organisation of Working Time Act, 1997.

If an employer, notwithstanding the requirement not to penalise a doctor in such circumstances, dismisses a doctor as a penalty; that doctor cannot obtain relief under both the legislation and the Unfair Dismissals Act.

⁴ European Court of Justice Case c303/98

14. Complaints to Rights Commissioner

A doctor or a trade union with the consent of the doctor concerned, may present a complaint to a Rights Commissioner that the doctor's employer has contravened one or more of the following provisions: compensatory rest, daily rest, breaks, weekly rest, maximum weekly working time, nightly working hours.

When this happens, the Rights Commissioner will give each party an opportunity to be heard by the Commissioner and to present any evidence relevant to the complaint. The Commissioner will then issue a written decision to the parties.

The Rights Commissioner may declare that the complaint or case was or was not well founded; require the employer to comply with the relevant provision; and/or require the employer to pay to the employee compensation not exceeding 2 years remuneration,

The Rights Commissioner will give a copy of the decision to the Labour Court.

Complaints will not normally be considered by a Rights Commissioner unless they are made within 6 months of the alleged contravention of the legislation. However, a Rights Commissioner may consider a complaint made up to 12 months after the alleged contravention if he or she is satisfied that the failure to present the complaint within that period was due to reasonable cause.

Complaints must be presented in writing and in a form specified by the DOHC.

A copy of the complaint as presented must be given to the employer by the Rights Commissioner.

Proceedings will not be conducted in public.

15. Appeals and enforcement of Rights Commissioner's decisions

Either party may appeal the decision of a Rights Commissioner to the Labour Court. When this happens, the Labour Court will give the parties an opportunity to be heard and present evidence. The Court will then issue a written decision in writing to the relevant parties.

Appeals to the Labour Court must be initiated within 6 weeks of the decision being made and must be in written form. Appeals must be in line with the requirements for appeals specified by the Labour Court.

Once the Labour Court receives an appeal, it will notify the other party to the complaint of the appeal.

The Labour Court will determine the procedures to be followed, including the times places of appeals and the representation of each party.

Decisions of the Labour Court may be appealed to the High Court on a point of law. The decision of the High Court will be final and conclusive.

If a decision of a Rights Commissioner has not been carried out by the employer and if no appeal has been made within the allotted time, a doctor may, no more than 6 weeks later after the end of the allotted time, send a written complaint to the Labour Court for decision.

16. Enforcement of Labour Court decisions

If an employer fails to carry out a decision of the Labour Court in relation to a complaint within 6 weeks of it being issued by the Labour Court; the Circuit Court may, on receipt of an

application from the doctor concerned or their trade union and without hearing the employer or any evidence, make an order directing the employer to carry out the decision.

The Circuit Court may direct the employer concerned to pay to the doctor concerned interest on any compensation in respect of the period beginning 6 weeks after the date on which the decision of the Labour Court was communicated to the parties and ending on the date of the order.

Applications to the Circuit Court should be made to a judge of the Court for the circuit in which the employer is located.

A document signed by the chairman or the registrar of the Labour Court stating that a named person was required to attend before the Labour Court at a specified time and place to give evidence or produce a document; that a sitting of the Labour Court was held at that time and place; and that the person did not attend before the Labour Court or having attended, refused to give evidence or refused or failed to produce the document, will be accepted as evidence without further proof.

17. Inspectors

The Minister for Jobs, Enterprise and Innovation may appoint inspectors to evaluate compliance with the legislation. Each inspector will have a Certificate of Appointment and should, if requested, produce the certificate or a copy of it. An inspector may:

- a) Enter premises – other than private dwellings
- b) Make relevant enquiries
- c) Require that records are produced
- d) Require current and former employees to provide information
- e) Require that employers or employees provide answers to questions
- f) Be accompanied by a member of the Gardai

18. Offences

Obstruction of an inspector

A person who obstructs or impedes an inspector, refuses to produce a record, produces false or misleading records, gives false or misleading information in any material respect knowing it to be so false or misleading, or fails or refuses to comply with any lawful requirement of an inspector, is guilty of an offence.

Failure to maintain records

Employers who fail to maintain records are guilty of an offence.

Double employment

Employees who are simultaneously employed by more than one employer (whether public or private) may not be required to work, in total, longer hours over the course of

- 24 hours,
- 7 days, or
- 12 months

than the legislation permits for those employees who have only one employer.

This means, for example, that an employee who is employed by more than one employer, cannot work, in total, more than an average of 48 hours per week on-call on-site over the course of a reference period. Total hours worked are a sum of the hours worked for each employer.

An employee who breaches this requirement is guilty of an offence

An employer who knowingly breaches this requirement is guilty of an offence unless they can prove they did not know or could not have found out that they were in breach.

Corporate offences

If an offence is committed by an employer and

- a) is proved to have been committed with the consent or connivance of a director, manager, secretary or other officer of that body corporate, or a person who was purporting to act in that capacity,

OR

- b) can be attributed to neglect on the part of on the part of a director, manager, secretary or other officer of that body corporate, or a person who was purporting to act in that capacity,

that individual shall also be guilty of the offence and be liable to be proceeded against and punished.

Appendix II – How to calculate ‘working time’ under the EWTD

1. Summary

- a) Identify the periods of time for which the NCHD has been paid that can be included in the ‘reference period’. The reference period shall not exceed 12 months and is determined by the doctor’s term of employment.
- b) Identify the periods of time within the reference period that count as ‘working time’
- c) Calculate the total hours of ‘working time’ and divide by the number of reference period weeks to obtain the weekly average.

2. The reference Period

The reference period is limited by contract. The maximum reference period is 1 year. There is no minimum. The reference period includes all time for which the NCHD has been paid, with the exception of:

- a) Annual leave
- b) Maternity leave
- c) Adoptive leave
- d) Sick leave
- e) Parental leave
- f) Carer’s leave
- g) Force majeure leave

Hint: List all time for which the doctor has been paid. Highlight the 7 categories above. They cannot be counted as part of the reference period. Once they are eliminated, calculate whether there are sufficient weeks of time paid to form a complete reference period.

3. What is Working time?

All time spent on-site on-call counts as working time. Time spent on-site when off-call does not count as working time. It should be noted that an NCHD who is on-site off-call and is required to resume the duties of work is regarded as reverting to on-call and such time is counted as working time. Time spent off-site on-call does not count as working time unless the doctor is also required by their employer to perform a service while they are on-call off-site (e.g. telephone advice). Study leave does not count as working time. In addition, time that cannot be included in the reference period (see above) does not count as working time.

For example: Take the weeks of time identified as part of the reference period. Highlight those periods of time that do not count as working time. Calculate the total working hours remaining. Divide by the number of weeks in the reference period being used.

Calculating the reference period			
Time	Paid Hours	Reference Period	Working Time
Source	NCHD Contract 2010	Legislation	
On-site on-call	Yes	Yes	Yes
On-site off-call (rostered off-call or bleep free)	Yes if rostered	Yes	No - unless required to resume work by employer
Off-site on-call	Yes	Yes	No
Required by employer to attend training	Yes	Yes	Yes
Required by training body to attend training	In line with guidance on 'Supporting NCHD Access to Protected Training Time' issued in July 2014	Yes	No
Annual Leave	Yes	No	No
Sick Leave	Yes	No	No
Maternity Leave	Yes	No	No
Adoptive Leave	Yes	No	No
Parental Leave	Yes	No	No
Paternity Leave	Yes	No	No
Educational Leave	Yes	Yes	No
Force Majeure Leave	Yes	No	No
Compassionate Leave	Yes	Yes	No

Working time and training activities			
Time	Paid Hours	Reference Period	Working Time
Source	NCHD Contract 2010	Legislation	
Unpaid Hours			
On-site on-call		Yes	Yes
All unpaid hours spent training / studying etc	No	No	No
Paid Hours			
On-site on-call	Yes	Yes	Yes
On-site off-call (rostered off-call or bleep free)	Yes if rostered	Yes	No - unless required to resume work by employer
Required <i>by employer</i> to attend training at a specific location (whether on-site or off-site)	Yes	Yes	Yes
Required <i>by training body</i> to attend training (whether on-site or off-site)	In line with guidance on 'Supporting NCHD Access to Protected Training Time' issued in July 2014	Yes	No
Off-site on-call			
Off-site on-call	Yes	Yes	No
From time bleeped / called and requested to return to work while off-site on-call	Yes	Yes	Yes
Paid Leave			
Educational Leave	Yes	Yes	No (0 hrs for EWTD purposes)

Appendix III – Meetings of local EWTD Working Group

A. Pro Forma Draft Agenda

1. Minutes of last meeting
2. Matters arising
3. Review of Performance of Hospital for current month
 - i. Any breaches in maximum 24 hour shift
 - ii. Areas of Concern in hospital for areas below 100%
 - iii. Update on any changes to rosters
 - iv. Progress and action on vacant posts
4. Actions on full EWTD Compliance
 - i. Review of actions agreed at last meeting
 - ii. New actions to be completed by next meeting
5. Industrial Relations Issues to be addressed
 - i. Payment of hours worked
 - ii. Returning of time sheets
6. Schedule of future meetings
7. AOB

B. LWG Meeting Guidelines

1. Notice to all participants of agenda, date, location and time of meeting at least 48 hours in advance
2. Draft minutes of previous meeting issued at least 48 hours in advance of meeting
3. Documents for discussion at the meeting to be circulated 48 hours in advance
4. AOB should only relate to smaller items that cannot be included in the agenda
5. Meetings should be attended by those listed below and should not proceed without appropriate representatives of each of the following Clinical management, Hospital Management and NCHDs ;
 - Hospital CEO / General Manager,
 - Clinical Director (Clinical Directors where more than one is in place),
 - Specialty leads where no Clinical Director is in place,
 - NCHD Representatives - 2 minimum (Medical and Surgical)
 - Lead NCHD
 - Director of Nursing,
 - Medical Manpower Manager / HR Manager;

European Working Time Directive Implementation

**Guidance on progressing
EWTD compliance**

17th October 2014

Purpose of document

This document sets out guidance on progressing EWTD compliance for HSE and HSE-funded Hospitals and Mental Health agencies with the requirements of the European Working Time Directive (EWTD). It includes guidance on measures to promote EWTD compliance, associated performance indicators and information on particular sections of the EWTD and related Irish legislation dealing with the issue.

Queries may be made by email to Andrew Condon, HSE Human Resources (andrew.condon@hse.ie) or Ciaran Browne, HSE Acute Hospitals Division (ciaran.browne@hse.ie).

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A. Performance indicators

The indicators below are to be used within each hospital / agency to assess performance in terms of EWTD implementation and compliance and will be used by the HSE at national level when evaluating hospital / agency performance. They represent a summary of the guidance in Sections B to F of this document.

Performance indicators		
Theme	Area	Performance indicator
Engaging staff in change	NCHD Committee	An NCHD Committee is in place
	Lead NCHD	A Lead NCHD is appointed (subject to sanction)
	EWTD Implementation Group	An EWTD Implementation Group is in place, includes named NCHDs and meets monthly
Safe rostering	NCHD Contract 2010	NCHDs work no more than 24 hours on-site on-call
		Employers are compliant with NCHD Contract 2010 with particular reference to: <ul style="list-style-type: none"> No split shifts Minimum notice periods for rosters NCHDs are not permitted to work in multiple employments if total working time exceeds 48 hours
	Start and finish times and breaks	Extent of use of staggered start and finish times where NCHDs are required to commence earlier than standard rostered hours e.g. for Handover
		The employer documents and ensures 30 minute breaks
		Training prior to normal start times is in line with guidance on protected training time and the associated payment arrangement
Staffing a 48 hour compliant roster	Extent to which rosters of 7 NCHDs or more are EWTD compliant	
Supporting the provision of training	Training Principles	Rostering in line with training needs
	Protected Training Time	Provision of protected training time
Transparency and accountability	Reporting and payment of hours worked	Publication of rosters as per agreed timeframes
		Regular review of rosters and payment arrangements
		Participation in process to introduce time and attendance systems (if not already in place)
	Accountability for NCHD rostering / working hours	A senior manager has been identified to liaise with NCHDs across 24/7 period
	Use of CompStat as a measure of performance and related sanctions	Reporting of EWTD compliance data via the monthly CompStat template in line with specified deadlines

Theme	Area	Performance indicator
Aligning work patterns to workload	Reducing tiers of on-call cover	Extent to which Registrar and sub-specialty cover is provided via off-site on-call
		Use of joint rosters or single levels of on-call cover at NCHD level to support reductions in NCHD hours
		Creation of a single Intern rota
		Use of a single layer of on-call cover at sub-specialty level where appropriate
		- reducing level of on-call cover on-site as activity reduces after 11pm / midnight
	Cross cover	Provide for single acute medical SHO rosters and single acute surgical SHO rosters
		Eliminate on-site 24/7 Registrar rosters outside Level 1 Hospitals
	Delivery of care by the most appropriate member of staff	Identify a specific senior, accountable non-medical staff member in each hospital to lead delivery of each of the tasks identified in Section 14
	Bleep policy	A formal Bleep Policy is in place, clearly displayed in each ward and updated as appropriate
		A named manager is responsible for and has signed the Bleep Policy together with the Clinical Director
	Handover	A formal, documented Handover process is built into 24/7 on-site on-call rosters
		Staggered starts and finish times are used to support Handover
		Handover is introduced in a way that does not extend existing shift or roster periods for either NCHDs arriving / going off-call or the NCHD who is rostered on-site at night

B - Engaging staff in change

1. Lead NCHDs and NCHD Committees

As part of a range of number of initiatives undertaken at national level to improve NCHD recruitment and retention in the Irish public health system, the HSE Human Resources Directorate in collaboration with the National Clinical Director Programme piloted an Lead NCHD role in eight acute hospitals beginning in January 2014. The key objective of the NCHD Lead role is to introduce a formal link at management level between NCHDs and Clinical Directors / Hospital Management, enabling improved engagement and communication between management and NCHDs.

This role will shortly be made available in a wider range of acute hospitals and other settings.

The Lead NCHD should be supported by an NCHD Committee. Key areas of focus for the NCHD Committee will include NCHD welfare, training, EWTD (responsibility for which is detailed at g) below) and executive decisions affecting NCHDs. The employer will make available resources to support the Committee and Lead NCHD in their role. This will include ensuring that NCHDs are able to attend meetings as required.

2. EWTD Implementation Group

In October 2013 each Hospital CEO / Manager was required to formally establish a Hospital-level EWTD Implementation Group to include the Hospital CEO / Manager, Clinical Director, NCHDs (nominated by IMO and others), lead Consultants, Director of Nursing and others as appropriate – meeting on a fortnightly basis. The Hospital EWTD Implementation Group is subject to direction and guidance from the National EWTD Verification Group and reports progress and information as required.

C - Safe Rostering

3. NCHD Contract 2010

Section 5 of NCHD Contract 2010 sets out a number of requirements for rostering of NCHDs to support safe service provision and exposure to appropriate training / activities that support the maintenance of professional competence. These include:

- The NCHD shall not be required to work for more than 24 consecutive hours on-site.
- The Employer will ensure that the NCHD is rostered to work on-site for a period of 24 hours on no more than a 1 in 5 basis other than in exceptional circumstances.
- Rosters must provide for a handover period between each shift. Handover periods must be of at least 30 minutes in duration.
- The NCHD may not be rostered to work a split shift¹.
- A minimum notice period of 2 weeks will apply for provision of initial rosters.

¹ A split shift is an employment schedule where the employee's normal work day is split in to 2 or more segments. For example an NCHD could not be rostered to work from 9 am to 2pm and then have a break until 8pm at which point they would be rostered to return to work until midnight.

- The NCHD shall not be required to attend on-site on a rostered day off (including leave) outside the 2 week minimum notice period where the requirement for such attendance can be reasonably anticipated by the employer.
- A minimum notice period will apply for changes to published rosters taking account of the need for shorter notice to respond to clinical need on an unplanned basis,
- Where the NCHD is provided with more than one rostered day off during a week, the Employer should endeavour to ensure such days are consecutive.
- Work outside the confines of this contract is not permissible if the combined working time associated with this employment taken together with any other employment exceeds the maximum weekly working hours as set out in S.I. No. 494 of 2004 European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004.

4. Start and finish times and breaks

Timing of clinics, theatre services, educational activities and ward rounds are key factors influencing when NCHDs attend onsite and commence or finish work. In this context, rosters should take account of the following:

- Where NCHDs are required to provide scheduled clinics, theatre services, to support Handover or other duties prior to 9am, staggered start times are used
- Only those NCHDs required for direct service delivery attend at the early start time
- NCHDs who start early only work a standard day and finish early
- Remaining NCHDs start only when required
- Compliance with a maximum 24-hour shift period may require that the NCHD rostered to work the 24 hour shift starts work later than colleagues the morning prior to the night on-call
- NCHD participation in educational and training activities prior to commencing clinical duties is in line with guidance regarding the provision of training time and use of protected training time as set out in Sections 7 and 8 of this document.
- The EWTD requires that NCHDs benefit from a 15 minute break for every 4 hours 30 minutes worked or a 30 minute break for every 6 hours worked. Irrespective of which is provided it is understood that the nature of clinical activity requires that the NCHD take such breaks as they become available rather than in a structured manner. A priority is that the hospital / agency have ensured that NCHDs receive breaks – and documented same via a signed overtime form or by other means.
- Use of 5/7 working – NCHD Contract 2010 provides that NCHDs may be rostered to provide 39 hours over any 5 days out of 7 in the week. In this regard use of 5/7 working may assist in reducing NCHDs hours and provide an alternative to staffing weekends on an on-call / overtime basis. For example, NCHDs could be rostered to work 4 days out of the Monday to Friday period and one of either Saturday or Sunday as their 5th day. Each NCHD on rota would rotate through these working arrangements and normal weekend premium payments would apply.

5. Staffing a 48 hour compliant roster

In 2003, the Report of the National Task Force on Medical Staffing indicated that 7 doctors were required to staff an EWTD compliant rota. In 2009, the Report of the EWTD National Implementation Group noted that the UK experience was that at least 7 doctors were required to achieve an average 48 hour week. It is noted that where the particular specialty rota is required to support a range of services simultaneously or deliver a high volume of activity that additional doctors may be required to meet EWTD requirements while maintaining required levels of service provision. Taking this into account, rotas with 7 or more NCHDs are regarded as capable of meeting EWTD requirements while providing safe, high quality patient care.

6. Factors to take account of in aligning rostering to service needs

A key priority in achieving sustainable EWTD-compliant rosters is to map roster patterns to service needs. When doing, hospitals should examine:

- the extent to which Consultant work patterns drive NCHD start and finish times and examine whether change in such Consultant work patterns is required to reduce NCHD hours.
- the extent of requirement to attend on-site during the Monday to Friday period;
- the extent of requirement to attend on-site on Saturdays and Sundays;
- periods when NCHDs are paid to be on-site but not required for clinical reasons (e.g. protected training time);
- start and finish times during the Monday – Friday period;
- times of ward rounds or other determinants of finishing / starting time;
- the requirement for NCHD to remain on-site following night on-call (and total length of period on-site);
- the potential for Saturday and / or Sunday to be covered by NCHD working Tuesday to Saturday or Sunday to Thursday as part of the roster;

D - Supporting the provision of training

7. Training principles

The ‘Training Principles to be incorporated into new working arrangements for doctors in training’ (available [here](#)) agreed by the Medical Education and Training Group with postgraduate training bodies some years ago include the following Training Principles for rosters:

- The primary consideration in constructing rosters is the provision of safe care for patients as agreed by the relevant local medical body;
- Rosters must be compiled to reflect the training needs and agreed principles;
- Rosters should in so far as possible be structured in such a way that the trainee is provided with the opportunity to follow patients in their journey through the hospital system e.g. through structuring in formal opportunities to see and/or review the patients involved during subsequent periods on duty;
- Trainees’ rosters should be structured to preserve the maximum possible association and contact with their designated trainers, as long as this is consistent with being exposed to the full spectrum of experience necessary for training in the specialty concerned, including extended hours and/or night work where appropriate;

- NCHDs should not be rostered for acute on-call and elective duties simultaneously, where possible.
- Rosters should facilitate scheduled on and off site education and training activities.

8. Use of Protected Training Time

Guidance on the delivery of protected training time agreed by the HSE, Forum of Postgraduate Training Bodies and the IMO is set out in a document entitled 'Supporting NCHD access to Protected Training Time – 11th July 2014' (available from the HSE MET Unit). It is intended to ensure that each NCHD benefits from protected training time appropriate to their grade and training status. The intent is to ensure that NCHDs receive - in general terms - between 123 and 328 hours of paid protected training time each year.

The document notes that rostered time engaged in training / educational activities will not be counted as working time for EWTD purposes if:

- the NCHD is off call, is not carrying a bleep or a mobile phone for the purposes of being contacted for work purposes and cannot be required to return to duty under normal circumstances prior to the end of the defined period;
- the time is recorded as spent participating in training / educational activities;
- In relation to category c), those specialties which require repeated exposure to and practice of specific clinical procedures time to allow trainees to observe and subject to Consultant approval, participate under supervision in certain planned procedures, the NCHD must have elected to attend the training opportunity and cannot be required by the employer to do so. The NCHD must be able to leave the procedure if necessary – and may choose to do so - and there must be sufficient staff to perform the procedure to completion without the NCHD being required. This will ensure that NCHDs in such specialties are able to gain exposure to appropriate procedures from a training rather than service perspective.

E - Transparency and accountability

9. Reporting and payment of hours worked

Central to NCHD participation in measures to reduce hours and progress EWTD compliance is the assurance that hours worked are properly recorded and appropriately paid. Taking this into account, hospitals should:

- publish NCHD rosters incorporating all required service hours (including hours currently unrostered) a month in advance;
- arrange for regular review / verification of compliance with and payment of same - led by the Clinical Director (under direction of the Hospital CEO / Manager and with support from the Medical Manpower Manager) and to include the NCHD Lead;
- ensure local documentation of compliance with the EWTD requirement for a 30 minute rest break for every 6 hours worked (within the existing contracted working day and working week) and of protected training time;
- report compliance regarding a maximum 24 hour shift, average 48 hour week, 30 minute rest breaks, daily rest and weekly / fortnightly rest via the monthly CompStat template following discussion / review of same by the EWTD Implementation Group referenced at Section 2 above;
- participate in the introduction of time and attendance systems (if not already in place) via the national process being led by Acute Hospital Division.

10. Accountability for NCHD rostering / working hours

At hospital level, accountability for rostering NCHDs ultimately lies with the Hospital CEO / General Manager. Currently, NCHD rosters are developed either by a Medical Manpower / HR Manager in consultation with relevant NCHDs, Consultants and the Clinical Director or, in some settings by NCHDs and / or Consultants themselves.

Accountability for how NCHDs are rostered to respond to service needs, can participate in training as appropriate, have access to leave and the working hours arising from such rostering must involve the relevant Consultant – as per the NCHD's reporting relationship – the Clinical Director and the Hospital CEO / General Manager. Taking the above into account:

- a) rosters should be developed in conjunction with the local hospital EWTD Implementation Group. The Hospital CEO / General Manager and Clinical Director are thereafter responsible for progressing and maintaining amended rosters;
- b) the Hospital CEO / General Manager should have identified a senior manager to liaise directly with NCHDs in relation to issues as they arise across the 24/7 period;
- c) it is the responsibility of the CEO / General Manager and Clinical Director to ensure ongoing compliance; plan for required changes and progress same.

11. Use of CompStat as a measure of performance and related sanctions

The CompStat system is used to assess hospital / agency performance regarding EWTD compliance under the following six headings:

- NCHD staffing by grade;
- compliance with a maximum 24 hour shift – by grade;
- Compliance with an average 48 hour working week – by grade;
- Compliance with the requirement for 30 minute breaks every 6 hours – by grade;
- Compliance with the requirement for 11 hours rest per day or equivalent compensatory rest – by grade;
- Compliance with the requirement for 35 hours rest per week, or 59 hours rest per fortnight or equivalent compensatory rest – by grade;

Separate guidance deals with the application of financial sanctions to hospitals / agencies which do not return monthly EWTD compliance data as required.

As of July 2014, CompStat data indicates national compliance as follows:

- Compliance with a maximum 24 hour shift: 94%
- Compliance with an average 48 hour week: 54%
- Compliance with a 30 minute break: 98%
- Compliance with 11 hours daily rest / equivalent compensatory rest: 95%
- Compliance with weekly / fortnightly rest / equivalent compensatory rest: 98%

A priority therefore are measures to promote compliance with the requirement that NCHDs work a maximum average 48 hour week.

F - Aligning work patterns to workload

12. Reducing the number of tiers of on-call cover

Significant progress has been made eliminating unnecessary tiers of on-call cover, where multiple tiers of NCHD are present on-site on-call without appropriate alignment to changing service needs over the 24/7 period. In general terms, best practice entails:

- In Level 1 Hospitals, retaining Emergency Medicine (in line with appropriate shift rostering), General Medical (SHO and Registrar level), General Surgical (at SHO level) and Anaesthetic (Registrar level) cover on-site at night and maintaining General Surgery at Registrar level and sub-specialties of Medicine and Surgery off-site on-call.
- Creation of joint Intern / SHO rosters or joint SHO / registrar rosters in Level 2 Hospitals where the next level of on-call cover is the Consultant;
- Creation of a single hospital wide Intern rota to replace separate, specialty based Intern rotas (e.g. a single Intern rota rather than separate Medical and Surgical rotas) subject to compliance with Medical Council requirements regarding Intern training;
- Reducing the level of on-call on-site after 11pm (for example) as activity reduces;
- Use of either a single layer of on-call cover (involving interns, SHOs and Registrars) at sub-specialty level (e.g. ENT) or cross cover at SHO level across multiple sub-specialties (e.g. General Surgery and Orthopaedic Surgery);

In each case, rostering should take account of decreases in the frequency and volume activity in the relevant specialty – particularly after midnight.

13. Expanding Cross-cover

A key aim of revised rostering arrangements over the past decade has been to eliminate unnecessary SHO rotas covering individual sub-specialties within General Surgery or within General Medicine e.g. separate SHO rotas for General Surgery and Orthopaedic Surgery and instead introduce cross-cover within the broader specialty where safe and appropriate to do so.

Cross-cover arrangements should be such as to ensure that the management of patients is of the highest standard and that the doctors involved are competent to provide cover.

One example of guidance on cross-cover is that approved by the RCSI relating to NCHDs in surgery² which states, under the heading 'Cross-cover between surgical sub-specialties':

- "Cross-cover between sub-specialties at HST level is not in the best interest of either patient or trainee. However, cross-cover between HSTs in vascular surgery and general surgery may be permitted as these individuals share a common training scheme.
- The RCSI has indicated that cross-cover within surgical sub-specialties is acceptable at more junior levels where:
 - the provision of cross-cover does not prevent an NCHD from achieving his or her learning objectives.
 - the working roster allows for continuity in training experience, and experience in specialty team management.

² Contained in a document entitled 'Statement by the Irish Higher Surgical Trainees Group and the Department of Health and Children regarding the implementation of the requirements of the European Working Time Directive for doctors in Higher Surgical Training Programmes'.

- the level of workload can be safely managed by the NCHD providing cross-cover.
- there are clear arrangements to ensure appropriate hand-over of information and clinical accountability.”

14. Delivery of care by the most appropriate member of staff

Patients benefit when service delivery is led by staff who, working within clear protocols and the scope of their professional practice, have demonstrable expertise, training and ongoing responsibility for such work. This is not a question of merely transferring tasks to other professionals. It is important that NCHDs develop and maintain skills in those procedures that they may be required to undertake.

A key means of ensuring that the patient receives care and procedures are undertaken by the staff member most appropriate to do so is identifying which staff member responds to the need for a task to be undertaken. It is key that where staff members have been trained to perform a task and are the most appropriate person to undertake the task that they are facilitated to do so.

Hospitals can address this by breaking down tasks into three broad categories:

- Direct patient care (Skills and activities that involve one to one contact with the patient, such as cannulation, admission, drug administration)
- Indirect patient care (Skills and activities that are necessary to progress patient care but do not necessitate contact with the patient, such as transfer letters, discharge letters, prescriptions, ordering diagnostics, accessing results)
- Inter-professional collaboration (How to manage the relationship of shared care, to include education/training, consultation, internal/external communications)

Hospitals should therefore identify which members of staff are most appropriate – taking account of the clinical condition of individual patients - to undertake the tasks identified on the illustrative list below and ensure that best use is made of staff training and experience to ensure delivery of the task by the most appropriate staff member at that time.

Direct patient care

- Venepuncture
- IV Cannulation
- Urethral Catheterisation
- Naso-Gastric Tube insertion
- Suturing
- Drug Administration
- ECG Recording
- Ordering tests - diagnostic, interventional or therapeutic

Indirect patient care

- Drug Prescribing
- Writing a discharge letter (post decision to discharge)
- Finding and delivering X-rays and radiological results / data (where PACs are not in place)
- Finding and delivering pathology results / data (where other reporting systems are not in place)

15. Bleep Policy

A key step in developing a Bleep Policy is the extent to which bleeps can be filtered or managed centrally. An example of a Bleep Policy is contained in the 'Report of the National Joint Steering Group on the Working Hours of Non-Consultant Doctors' – a joint IMO / Health Employer report published in 2001 (available [here](#)). Hospitals which have not introduced a bleep policy should take steps to introduce one immediately.

16. Handover

The Hospital Activity Analysis highlighted the extremely limited number of occasions on which formal handover takes place. Effective Handover procedures are associated with high levels of patient safety. Handover has also been found to support continuity of care, good team-working and provide valuable educational opportunities. In order for handover to work well the following elements are needed:

- There should be clarity about who is leading the handover
- All handover team members should attend insofar as staggered starts allow
- There should be a dedicated room for the handover
- Where NCHDs are required to support Handover staggered start times are used and NCHDs who start early should only work a standard day and finish early

Useful information and guidance on handover is contained in a document entitled 'Safe Handover: Safe Patients' published by the NHS Modernisation Agency and the BMA (available [here](#)). Similar documents have been published by the Australian Medical Association (available [here](#)), the Royal College of Surgeons of England (available [here](#)) and the Royal College of Physicians, London (available [here](#)).

This includes the following:

- "The ideal model includes all grades of staff from each included specialty, subspecialty or ward as appropriate. The senior nursing cover for the night period (and bed management if different) should be present.
- Daily involvement of senior clinicians is essential. This ensures that appropriate level management decisions are made and that handover forms a constructive part of medical education conveying the seriousness with which the organisation takes this process.
- There will always be work which is ongoing during the handover time, especially in the evening. Virtually all aspects of care can wait for 30 minutes to ensure continued safety overnight. Individuals need to be allowed to attend, subject to emergency cover being defined.
- The handover leader should ensure the team are aware of any new or locum members of the team and that adequate arrangements are in place to familiarise them with local systems and hospital geography."
- "Handover should be at a fixed time and of sufficient length.
- This period should be known to all staff and designated 'bleep-free' except for immediately life threatening emergencies.
- Shifts for all staff involved should be coordinated to allow them to attend in 'working time'. This is particularly important for the handover to, and from, the night team.
- Handovers will also be needed in the morning and at the change of other shifts (for example 5pm in some ward settings)."
- "The style of handover will vary depending on local need – whole hospital handovers to night teams, local handovers on specific units, community-based specialties or those covering several sites. However, all types need a predetermined format and structure to ensure adequate information exchange.

- Ad hoc handovers often miss out important aspects of care.
- Handover should be supervised by the most senior clinician present and must have clear leadership.
- Information presented should be succinct and relevant.
- Ideally, this can be supported by information systems identifying all relevant patients.”

- “Written (or IT based) handover should include:
 - current inpatients
 - accepted and referred patients due to be assessed
 - accurate location of all patients
 - operational matters, directly relevant to clinical care such as ICU bed availability
 - information to convey to the following shift
 - patients brought to the attention of the critical care outreach team (where appropriate)
 - patients whose ‘early warning scores’ are deteriorating (where in use).”

“The following, as well as being included in the written handover, should be discussed within the handover meeting. This verbal handover is vital to highlight these issues:

- patients with anticipated problems, to clarify management plans and ensure appropriate review
- outstanding tasks, associated with their required time for completion.”

G - Guidance

In addition to this document and appendices and documentation referenced in this document, further background information, examples of good practice and guidance may be found in the following documents:

- the Report of the National Joint Study Group on Working Hours of NCHDs (2001),
- Report of the National Task Force on Medical Staffing (2003),
- Report of the Hospital Activity Analysis (2005),
- European Working Time Directive and Non Consultant Hospital Doctors – Final Report of the National Implementation Group (December 2008)
- Guidance on implementation of the EWTD and LCR 19559 Vol I – 26th June 2009
- Guidance on implementation of the EWTD Vol II – use of compensatory rest – 9th September 2009
- Guidance to management on NCHD Contract 2010 – Vol I – 4th February 2010

Appendix I – requirements of the EWTD and Irish legislation

1. EU and Irish legislation

The EWTD referred to in this document and in the legislation is Directive 2003/88/EC, which took effect on 2nd August 2004. Should information be sought on the EWTD therefore, reference should be made to Directive 2003/88/EC of the European Parliament and Council of 4th November 2003 concerning certain aspects of the organisation of working time, available at: <http://www.health.gov.ie> or on the European Commission website at <http://www.europa.eu>

This Guidance also draws on clarification issued by the European Court of Justice on how the requirements of the EWTD should be interpreted. Two of the more relevant judgements are:

- a) SiMAP, European Court of Justice case C-303/98
- b) JAEGER, European Court of Justice case C-151/02

The Department of Health and Children's legislation transposing the EWTD into Irish law for doctors in training is entitled:

- 'The European Communities (Organisation of Working Time Act) (Activities of Doctors in Training) Regulations 2004' - issued as Statutory Instrument No. 494 of 2004;
- 'The European Communities (Organisation of Working Time) (Activities of Doctors in Training) (Amendment) Regulations 2010' - issued as Statutory Instrument No. 553 of 2010;

The legislation is available at <http://www.health.gov.ie> It should be read in conjunction with relevant Department of Jobs, Enterprise and Innovation legislation and the Organisation of Working Time Act 1997.

2. Scope of legislation - 'Activities of a doctor in training'

The legislation deals with the 'activities of a doctor in training' rather than 'doctors in training'. In effect, this includes the activities of all employed medical practitioners except qualified consultants, general practitioners, community ophthalmic physicians, public health doctors and other doctors who are entitled to be registered on the Register of Medical Specialists and who work without supervision in professional matters.

3. Definition of 'working time'

The legislation defines working time as "any period during which a doctor is working, at the employer's disposal and carrying out the activity or duties of his or her work, including on-call duty performed by a doctor where he or she is required to be physically present at his or her place of work".

This means all time spent on-site on-call counts as working time. Time spent on-site when off-call does not count as working time.

The following time does not count as working time where the NCHD is off-call:

- Scheduled and protected time off-site attending training as required by the training programme;

- on-site regular weekly/fortnightly scheduled educational and training activities including conferences, grand rounds, morbidity and mortality conferences;
- research, study etc.³

Time spent off-site on-call does not count as working time unless doctors are also required by their employer to perform a service while they are on-call off-site. Appendix III deals with the calculation of working time under the EWTD.

4. Daily breaks

A doctor cannot work for more than 4 hours 30 minutes without receiving a break of at least 15 minutes.

A doctor cannot work for more than 6 hours without receiving a break of at least 30 minutes. This break may include the 15-minute break referred to above.

Breaks cannot be taken at the end of the doctor's working day. Instead, they must be taken during the working day.

Alternatively, a doctor may be granted compensatory rest (see below)

5. Daily Rest

Each doctor is entitled to 11 consecutive hours rest every 24 hours OR compensatory rest (see below)

6. Weekly / Fortnightly Rest

Each period of weekly / fortnightly rest must follow an 11 hour rest period.

Each doctor is entitled to weekly / fortnightly rest as follows:

- a) 35 hours rest (11 hour rest period followed by 24 hours rest) once a week
OR
- b) 35 hours rest (11 hour rest period followed by 24 hours rest) twice a fortnight
OR
- c) 59 hours rest (11 hour rest period followed by 48 hours rest) once a fortnight
OR
- d) Compensatory rest (see below)

7. Compensatory rest

Compensatory rest must be given to a doctor who has not been granted his or her daily break, daily rest or weekly/fortnightly rest.

Compensatory rest is therefore given in lieu of:

³ The Collective Agreement agreed by the IMO and HSE on 22nd January 2010 refers

- a) A 30 minute break every 6 hours OR a 15-minute break every 4 hours 30 minutes
- b) 11 hours consecutive daily rest
- c) 35 hours continuous rest once a week or twice a fortnight OR 59 hours continuous rest once a fortnight

Compensatory rest must be equivalent to the break or rest which the doctor has not had. For example, if the doctor has received an 8 hour break instead of 11 hours, they require 3 hours. Such rest is not necessarily consecutive – it can be interrupted by time spent at work if the doctor is on-call at the time – however it must total the required rest period.

Compensatory rest must be taken before the doctor begins his or her next period of rostered work.

8. Maximum weekly working time

From 1st August 2009, an employer may not allow a doctor to work for more than 48 hours a week, averaged over the reference period described below.

9. Reference periods for average weekly working hours

A 'Reference Period' is a period of time over which a doctor's weekly working hours may be averaged.

The reference period includes all time for which the doctor has been paid, with the exception of:

- a) Annual leave
- b) Maternity leave
- c) Adoptive leave
- d) Sick leave
- e) Parental leave
- f) Carer's Leave
- g) Force majeure leave

The reference period is the doctor's term of employment or 12 months – whichever is the shorter. In no circumstances may the reference period exceed 12 months.

A reference period may begin when the contract begins. The reference period must also end when the contract ends or is terminated by the employer or 12 months have elapsed. There is no minimum reference period.

10. Night work and night workers

The legislation uses the same definition of "night time", "night work" and "night worker" as the Organisation of Working Time Act, 1997.

“Night time” means the period between midnight and 7a.m. on the following day; “night work” means work carried out during night time and a “night worker” is an employee:

- a) who normally works at least 3 hours of his or her daily working time during night time,
- AND
- b) the number of hours worked by whom during night time, in each year, equals or exceeds 50 per cent. of the total number of hours worked by him or her during that year;

It is considered unlikely that any doctor would be required to work in such a way that they would need to be designated as a night worker.

However, should a doctor be designated as a night worker, he or she may not work more than 8 hours in 24, averaged over a reference period of:

- a) 2 months
- OR
- b) a period of time specified by a collective agreement approved by the Labour Court.

The reference period should be composed of consecutive days or months, subject to the following categories of time not being included:

- a) Hours in excess of 24 hours in a weekly rest period
- b) Annual leave, unless it exceeds the minimum specified in the Organisation of Working Time Act, 1997.
- c) parental leave, *force majeure* leave or carer’s leave,
- d) Maternity, adoptive, or sick leave

“Special category night workers” are night workers who have undergone an assessment by their employer which has concluded that their work involves special hazards or a heavy physical or mental strain.

Doctors designated as special category night-workers may not work more than 8 hours in any 24-hour period.

It should be noted that health service employers are not aware of any circumstances where an NCHD is currently working in excess of 50% of their total annual working time between the hours of midnight and 7am. In that context it is understood that there are no NCHDs who currently fall into the category of ‘night workers’.

11. Shift work and shift workers

The legislation defines “shift work” as any method of organising work in shifts whereby employees succeed each other at the same work stations according to a certain pattern. The shift pattern may be continuous or discontinuous and require need for employees to work at different times over a given period of days or weeks.

A ‘shift worker’ is any employee whose work schedule is part of shift work.

Shift workers are afforded protection similar to that afforded to other workers. Any doctor who is considered to be a shift workers is entitled to equivalent compensatory rest (as set out in 4.8 above) when he or she changes shift and cannot take a daily rest period between the end of one shift and the start of the next one; or when he or she changes shift and cannot take a weekly rest period between the end of one shift and the start of the next one.

It should be noted that in the SiMAP case⁴, the European Court of Justice ruled that doctors working on-site on-call and off-site on-call work patterns were engaged in shift work and that such doctors were therefore shift workers. This does not affect existing payment structures in that NCHD Contract 2010 provides for payment of a shift allowance only to NCHDs working in Emergency Medicine departments arising from their respect of participation in a continuous rotating shift which requires delivery of the core 39 hours over a 24 hour, 7-day week cycle.

12. Records

Employers must maintain on-site a record of each doctor's normal schedule of work and actual:

- a) Daily hours of work and rest
- b) Rest breaks,
- c) Hours of night work
- d) Weekly hours of work and rest
- e) Hours on-call on-site
- f) Hours on-call off-site
- g) Periods of release from the activities or duties of his or her work, to engage in training, study leave or examination leave.
- h) Specialty and stage of training
- i) Annual leave and payment in respect of such leave
- j) Any additional day's pay

Records must take the form required by the legislation, be readily understandable and:

- a) be retained for at least 3 years
- b) be made available, on request, to the employee
- c) be made available, on request, to the Minister for Health and Children

13. Refusal by a doctor to co-operate with a breach of legislation

An employer cannot penalise a doctor for opposing, in good faith and by lawful means, an act which contravenes the legislation or the Organisation of Working Time Act, 1997.

If an employer, notwithstanding the requirement not to penalise a doctor in such circumstances, dismisses a doctor as a penalty; that doctor cannot obtain relief under both the legislation and the Unfair Dismissals Act.

⁴ European Court of Justice Case c303/98

14. Complaints to Rights Commissioner

A doctor or a trade union with the consent of the doctor concerned, may present a complaint to a Rights Commissioner that the doctor's employer has contravened one or more of the following provisions: compensatory rest, daily rest, breaks, weekly rest, maximum weekly working time, nightly working hours.

When this happens, the Rights Commissioner will give each party an opportunity to be heard by the Commissioner and to present any evidence relevant to the complaint. The Commissioner will then issue a written decision to the parties.

The Rights Commissioner may declare that the complaint or case was or was not well founded; require the employer to comply with the relevant provision; and/or require the employer to pay to the employee compensation not exceeding 2 years remuneration,

The Rights Commissioner will give a copy of the decision to the Labour Court.

Complaints will not normally be considered by a Rights Commissioner unless they are made within 6 months of the alleged contravention of the legislation. However, a Rights Commissioner may consider a complaint made up to 12 months after the alleged contravention if he or she is satisfied that the failure to present the complaint within that period was due to reasonable cause.

Complaints must be presented in writing and in a form specified by the DOHC.

A copy of the complaint as presented must be given to the employer by the Rights Commissioner.

Proceedings will not be conducted in public.

15. Appeals and enforcement of Rights Commissioner's decisions

Either party may appeal the decision of a Rights Commissioner to the Labour Court. When this happens, the Labour Court will give the parties an opportunity to be heard and present evidence. The Court will then issue a written decision in writing to the relevant parties.

Appeals to the Labour Court must be initiated within 6 weeks of the decision being made and must be in written form. Appeals must be in line with the requirements for appeals specified by the Labour Court.

Once the Labour Court receives an appeal, it will notify the other party to the complaint of the appeal.

The Labour Court will determine the procedures to be followed, including the times places of appeals and the representation of each party.

Decisions of the Labour Court may be appealed to the High Court on a point of law. The decision of the High Court will be final and conclusive.

If a decision of a Rights Commissioner has not been carried out by the employer and if no appeal has been made within the allotted time, a doctor may, no more than 6 weeks later after the end of the allotted time, send a written complaint to the Labour Court for decision.

16. Enforcement of Labour Court decisions

If an employer fails to carry out a decision of the Labour Court in relation to a complaint within 6 weeks of it being issued by the Labour Court; the Circuit Court may, on receipt of an

application from the doctor concerned or their trade union and without hearing the employer or any evidence, make an order directing the employer to carry out the decision.

The Circuit Court may direct the employer concerned to pay to the doctor concerned interest on any compensation in respect of the period beginning 6 weeks after the date on which the decision of the Labour Court was communicated to the parties and ending on the date of the order.

Applications to the Circuit Court should be made to a judge of the Court for the circuit in which the employer is located.

A document signed by the chairman or the registrar of the Labour Court stating that a named person was required to attend before the Labour Court at a specified time and place to give evidence or produce a document; that a sitting of the Labour Court was held at that time and place; and that the person did not attend before the Labour Court or having attended, refused to give evidence or refused or failed to produce the document, will be accepted as evidence without further proof.

17. Inspectors

The Minister for Jobs, Enterprise and Innovation may appoint inspectors to evaluate compliance with the legislation. Each inspector will have a Certificate of Appointment and should, if requested, produce the certificate or a copy of it. An inspector may:

- a) Enter premises – other than private dwellings
- b) Make relevant enquiries
- c) Require that records are produced
- d) Require current and former employees to provide information
- e) Require that employers or employees provide answers to questions
- f) Be accompanied by a member of the Gardai

18. Offences

Obstruction of an inspector

A person who obstructs or impedes an inspector, refuses to produce a record, produces false or misleading records, gives false or misleading information in any material respect knowing it to be so false or misleading, or fails or refuses to comply with any lawful requirement of an inspector, is guilty of an offence.

Failure to maintain records

Employers who fail to maintain records are guilty of an offence.

Double employment

Employees who are simultaneously employed by more than one employer (whether public or private) may not be required to work, in total, longer hours over the course of

- 24 hours,
- 7 days, or
- 12 months

than the legislation permits for those employees who have only one employer.

This means, for example, that an employee who is employed by more than one employer, cannot work, in total, more than an average of 48 hours per week on-call on-site over the course of a reference period. Total hours worked are a sum of the hours worked for each employer.

An employee who breaches this requirement is guilty of an offence

An employer who knowingly breaches this requirement is guilty of an offence unless they can prove they did not know or could not have found out that they were in breach.

Corporate offences

If an offence is committed by an employer and

- a) is proved to have been committed with the consent or connivance of a director, manager, secretary or other officer of that body corporate, or a person who was purporting to act in that capacity,

OR

- b) can be attributed to neglect on the part of on the part of a director, manager, secretary or other officer of that body corporate, or a person who was purporting to act in that capacity,

that individual shall also be guilty of the offence and be liable to be proceeded against and punished.

Appendix II – How to calculate ‘working time’ under the EWTD

1. Summary

- a) Identify the periods of time for which the NCHD has been paid that can be included in the ‘reference period’. The reference period shall not exceed 12 months and is determined by the doctor’s term of employment.
- b) Identify the periods of time within the reference period that count as ‘working time’
- c) Calculate the total hours of ‘working time’ and divide by the number of reference period weeks to obtain the weekly average.

2. The reference Period

The reference period is limited by contract. The maximum reference period is 1 year. There is no minimum. The reference period includes all time for which the NCHD has been paid, with the exception of:

- a) Annual leave
- b) Maternity leave
- c) Adoptive leave
- d) Sick leave
- e) Parental leave
- f) Carer’s leave
- g) Force majeure leave

Hint: List all time for which the doctor has been paid. Highlight the 7 categories above. They cannot be counted as part of the reference period. Once they are eliminated, calculate whether there are sufficient weeks of time paid to form a complete reference period.

3. What is Working time?

All time spent on-site on-call counts as working time. Time spent on-site when off-call does not count as working time. It should be noted that an NCHD who is on-site off-call and is required to resume the duties of work is regarded as reverting to on-call and such time is counted as working time. Time spent off-site on-call does not count as working time unless the doctor is also required by their employer to perform a service while they are on-call off-site (e.g. telephone advice). Study leave does not count as working time. In addition, time that cannot be included in the reference period (see above) does not count as working time.

For example: Take the weeks of time identified as part of the reference period. Highlight those periods of time that do not count as working time. Calculate the total working hours remaining. Divide by the number of weeks in the reference period being used.

Calculating the reference period			
Time	Paid Hours	Reference Period	Working Time
Source	NCHD Contract 2010	Legislation	
On-site on-call	Yes	Yes	Yes
On-site off-call (rostered off-call or bleep free)	Yes if rostered	Yes	No - unless required to resume work by employer
Off-site on-call	Yes	Yes	No
Required by employer to attend training	Yes	Yes	Yes
Required by training body to attend training	In line with guidance on 'Supporting NCHD Access to Protected Training Time' issued in July 2014	Yes	No
Annual Leave	Yes	No	No
Sick Leave	Yes	No	No
Maternity Leave	Yes	No	No
Adoptive Leave	Yes	No	No
Parental Leave	Yes	No	No
Paternity Leave	Yes	No	No
Educational Leave	Yes	Yes	No
Force Majeure Leave	Yes	No	No
Compassionate Leave	Yes	Yes	No

Working time and training activities			
Time	Paid Hours	Reference Period	Working Time
Source	NCHD Contract 2010	Legislation	
Unpaid Hours			
On-site on-call		Yes	Yes
All unpaid hours spent training / studying etc	No	No	No
Paid Hours			
On-site on-call	Yes	Yes	Yes
On-site off-call (rostered off-call or bleep free)	Yes if rostered	Yes	No - unless required to resume work by employer
Required <i>by employer</i> to attend training at a specific location (whether on-site or off-site)	Yes	Yes	Yes
Required <i>by training body</i> to attend training (whether on-site or off-site)	In line with guidance on 'Supporting NCHD Access to Protected Training Time' issued in July 2014	Yes	No
Paid Leave			
Off-site on-call	Yes	Yes	No
From time bleeped / called and requested to return to work while off-site on-call	Yes	Yes	Yes
Paid Leave			
Educational Leave	Yes	Yes	No (0 hrs for EWTD purposes)

Appendix III – Meetings of local EWTD Working Group

A. Pro Forma Draft Agenda

1. Minutes of last meeting
2. Matters arising
3. Review of Performance of Hospital for current month
 - i. Any breaches in maximum 24 hour shift
 - ii. Areas of Concern in hospital for areas below 100%
 - iii. Update on any changes to rosters
 - iv. Progress and action on vacant posts
4. Actions on full EWTD Compliance
 - i. Review of actions agreed at last meeting
 - ii. New actions to be completed by next meeting
5. Industrial Relations Issues to be addressed
 - i. Payment of hours worked
 - ii. Returning of time sheets
6. Schedule of future meetings
7. AOB

B. LWG Meeting Guidelines

1. Notice to all participants of agenda, date, location and time of meeting at least 48 hours in advance
2. Draft minutes of previous meeting issued at least 48 hours in advance of meeting
3. Documents for discussion at the meeting to be circulated 48 hours in advance
4. AOB should only relate to smaller items that cannot be included in the agenda
5. Meetings should be attended by those listed below and should not proceed without appropriate representatives of each of the following Clinical management, Hospital Management and NCHDs ;
 - Hospital CEO / General Manager,
 - Clinical Director (Clinical Directors where more than one is in place),
 - Specialty leads where no Clinical Director is in place,
 - NCHD Representatives - 2 minimum (Medical and Surgical)
 - Lead NCHD
 - Director of Nursing,
 - Medical Manpower Manager / HR Manager;