European Working Time Directive & Non Consultant Hospital Doctors

Final Report of the National Implementation Group

December 2008
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1. Chairman’s Foreword

I am pleased to present this final report on behalf of the National Implementation Group European Working Time Directive (NIG-EWTD). The NIG held its first meeting in September 2005 and met for the 28th and final time in December 2008. This report reflects the work of the NIG over the past three years, in collaboration with the nine Local Implementation Groups (LIGs).

The NIG’s deliberations were informed by the terms of reference agreed between the Irish Medical Organisation and the HSE Employers Agency, facilitated by the Labour Relations Commission, in February 2005. A key provision was ‘the continued provision of safe, high quality care to patients coupled with the provision of appropriate training to NCHDs during the EWTD implementation period’.

In addition the NIG was reminded to take cognisance of related published reports especially the ‘Report of the National Joint Study Group on the working hours of Non-Consultant Hospital Doctors’ (2001), the ‘Report of the National Task Force on Medical Staffing’ (Hanly, 2003) and Training Principles issued by the Medical Education & Training Group later incorporated into ‘Report of the Postgraduate Medical Education and Training Group’ (Buttimer Report, 2006).

The European Working Time Directive (EWTD) - 2003/88/EC - was transposed into Irish law by the European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004 (S.I. No. 494 of 2004). In addition to addressing working hours, the EWTD Regulations also contain certain provisions in relation to rest breaks, rest periods and compensatory rest. These include a 20 minute rest break for every 4 hours 30 minutes worked or a 30-minute rest break for every 6 hours worked, 11 hours daily rest or equivalent compensatory rest and 35 hours of consecutive rest every 7 days or two periods of 35 hours or one period of 59 of consecutive rest every 14 days. The EWTD stipulates since August 2007, that 56 hours be the average number worked by NCHDs. Reaching compliance with this limit has proven difficult but was achieved in some pilot projects. Conversely, meeting compensatory rest obligations, in the context of current service provision, has been virtually impossible.

In August 2009 the legal obligations regarding compliance with the terms of the EWTD will change such that the average number of hours worked by NCHDs cannot exceed 48 hours per week. As challenging as meeting the weekly working hours’ limits is and will be complying with the rest period provisions in the context of existing acute hospital service provision will be more daunting.

At the European level amendments to the current directive have been under consideration. The European Parliament’s Committee on Employment and Social Affairs has recently responded to the EU Council’s proposals (see Cercas Report). It is clear that differences of opinion remain and early legislative changes to 2003/88/EC seem unlikely.

The nine Local Implementation Groups submitted 46 Pilot Projects for the NIG-EWTD’s consideration. Nineteen were approved and 17 were completed. In terms of location and number the following is a breakdown of the 46 Pilot Projects submitted to the NIG (the 19 approved projects are in bold type): CUH 4/9, Crumlin 0/4, Galway 4/7, Holles Street 3/4, Letterkenny 3/4, Limerick 2/11, Longford-Westmeath, Mullingar 2/5, St. Loman’s Mullingar 1/1 and St. James’s 0/1. 17 pilot projects were completed during the past 3 years. A range of different solutions were piloted by the LIGs. These fell into three main categories:

a) the transfer of duties currently undertaken by NCHDs to other grades of staff; b) the recruitment of additional consultants and c) a move from on-call on-site to on-call off-site rotas.

Further details of the provisions of the EWTD as transposed into Irish law are to be found in the European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004 (S.I. No. 494 of 2004).
Executive summaries of all completed pilot projects are presented in Appendix H. An important aspect of the exercise was the need to ensure that standards of NCHD education and training be not adversely affected. With this in mind each local committee had their project independently evaluated by a consultant from the relevant specialty nominated by the appropriate postgraduate training body.

No hospital in Ireland is currently fully compliant with the provisions of the EWTD i.e. hours worked and rest break provisions. If current service levels are to be maintained, achieving EWTD compliance in hospitals where NCHDs work 1 in 5 (or more frequent) on-call rotas is not possible. It will be extremely difficult to achieve EWTD compliance in the medium-to-long term while maintaining current acute surgery, medicine and anaesthesia services in such hospitals. Paediatric and obstetric services in certain hospitals also face very significant challenges.

Factors to be considered when developing NCHD rosters include ensuring a) high quality and safe patient care, b) time for required training both on and off site and c) the maximum association with relevant consultants. Of particular importance is attendance at designated handover sessions once or twice daily, as per agreed protocols. For handover to work optimally there must be clarity about who is leading the handover and all relevant team members should attend (consultant & NCHD).

The vast majority of NCHDs in Ireland already work a form of shift. However, some of these shifts are up to 36 hours in duration for many on-call teams and sometimes longer. Clearly, periods on duty will have to be of much shorter duration in the future. Future working patterns must enable NCHDs to participate in the full spectrum of service provision and be provided with learning and training opportunities equal to their peers. This means that in busy specialties, NCHDs will need to work defined periods on a duty roster. Such rosters would cover a multitude of different working patterns.

A number of successfully completed Pilot Projects have improved patient care and patient satisfaction, have been enthusiastically endorsed by staff and in some instances have enhanced the NCHD education and training experience. Consequently an issue that has caused major concern to both the NIG and the LIGs is the failure, thus far, to have the benefits of those successful Pilot Projects implemented on a permanent basis. Rather in all cases the service has reverted back to what obtained before the pilots commenced. Several LIGs have conveyed their frustration to the NIG at this unsatisfactory situation. Accordingly, there is an urgency to address this matter if the goodwill and expectation generated over the past 3 years is not dissipated.

This Report is testament to the dedication and commitment of the members of National Implementation Group-EWTD and the Local Implementation Groups. I wish to record my personal thanks to my fellow NIG members, especially those who regularly attended our meetings. I commend them for their dedication and hard work, given voluntarily, for their contribution to the production of the NIG-EWTD Interim Report (September 2007) and this Final Report. I acknowledge too all LIG members and Pilot Project participants, I wish to record my personal thanks to all for their courtesy, dedication and hard work.

The NIG has been well served by its Joint Secretariat provided by the HSE-EA and IMO. I would especially like to thank Aoife O’Riordan, Mary Ruane and Lucy Grattan from the HSE-EA for their help in the production of this final report.

Míle buíochas agus go n-eirí liubh uilig.

Cillian Twomey, December 2008
2. Introduction

The establishment of the National Implementation Group–European Working Time Directive (NIG–EWTD) and the subsequent commencement of a number of EWTD pilot projects marked a significant stage in the implementation of the European Working Time Directive in Ireland. The European Directive on Working Time issued on 23 November 1993. The main provisions of the Directive are to limit maximum hours of continuous working, daily working and weekly working, and establish minimum entitlements to rest periods and paid annual leave for most workers in the EU. The EWTD applied to most sectors of activity with the exception of the activities of doctors in training and a small number of other categories or groups of workers.

On 22nd June 2000 the European Parliament and Council issued Directive 2000/34/EC. It amended the European Working Time Directive to cover sectors and activities previously excluded from that Directive. In particular, it extended the provisions of the EWTD to the activities of doctors in training. The EWTD was transposed into Irish law by the European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004 (S.I. No. 494 of 2004). The Regulations came into operation on 1st of August, 2004. The Regulations provide for a phased reduction in weekly working hours over a 5-year transition period, from 58 in 2004, to 56 by August 2007 and 48 by August 2009. The Regulations also contain certain provisions in relation to rest breaks, rest periods and compensatory rest. These include a 30 minute rest break for every 6 hours worked, 11 hours daily rest and 35 hours of consecutive rest every 7 days; or two periods of 35 hours or one period of 59 hours of consecutive rest every 14 days or equivalent compensatory rest.

In 2003, the European Commission initiated a review of the EWTD, (Directive 93/104/EC) as it applied to all employees, including ‘doctors in training’. This review took into account clarification issued by the European Court of Justice in a number of court cases on how the requirements of the EWTD should be interpreted. Two of the more relevant judgements are SiMAP, European Court of Justice Case C-303/98 and JAEGER, European Court of Justice Case C-151/02. In the “SiMAP” and “JAEGER” cases, the Court ruled on the definition of working-time, defining all time spent by a doctor on-site on-call, even if the doctor is resting, as working-time. The National Joint Steering Group on the working hours of Non-Consultant Hospital Doctors, published in 2001, showed very little difference in the workload between day and night. The JAEGER judgement also emphasised the need to grant immediate compensatory rest to an employee, following a period of work while on-call if they have worked more than 13 hours in any 24-hour period. This rest period must be taken before the employee begins another scheduled period of work.

On 15 September 2008 the Council of the European Union formally adopted a Common Position to amend the existing Directive. The proposal changes the provisions regarding the opt-out, ‘on-call time’, the reference periods for calculating the maximum working week, and the time limits for granting compensatory rest. Any amending Directive must be adopted by the Council and the European Parliament and is unlikely to come into effect for some time yet.

Further details of the provisions of the EWTD as transposed into Irish law are to be found in the European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004 (S.I. No. 494 of 2004).
This final report provides an overview of the work of the NIG–EWTD over the past 3 years. This work involved overseeing a number of pilot projects in various hospital sites across the country which aimed to develop innovative and effective local solutions to the challenges posed by the EWTD. The NIG–EWTD consulted a number of bodies including representatives of other health professionals and international experts with experience in addressing the implications of implementing the EWTD. The outcomes of the pilot projects and the learning derived from the consultation process are summarised in this report.

3.1 Establishment of National Implementation Group

The NIG–EWTD was established on the 7th February 2005 on the recommendation of the Labour Relations Commission (LRC) following discussions between the HSE Employers Agency and the Irish Medical Organisation (IMO). The Group was chaired by Prof. Cillian Twomey and comprised representatives from the Department of Health and Children, the HSE, (including the HSE – Employers Agency), the Irish Hospital Consultants Association, the Irish Medical Organisation, the Postgraduate Medical and Dental Board, the Medical Council, Postgraduate Medical Training Bodies, nursing representatives and representatives of other relevant healthcare professions (Appendix A – Membership of NIG-EWTD).

The role of the NIG-EWTD was to oversee the implementation of the European Working Time Directive by coordinating the work of Local Implementation Groups (LIGs) and assist them to identify the measures needed to achieve EWTD compliance while maintaining safe patient care and high quality NCHD training (Appendix B – Terms of Reference NIG-EWTD).

3.2 Establishment of Local Implementation Groups

Following a proposal by the Labour Relations Commission in September 2004, agreement was reached between employers and the Irish Medical Organisation to establish Local Implementation Groups (LIGs) in nine pilot sites. Pilot sites were chosen to reflect a range of regional demands and specialities. The nine sites are as follows:

- Cork University Hospital
- Galway University Hospitals
- Letterkenny General Hospital
- Midland Regional Hospital, Mullingar
- Mid-West Regional Hospital Group Limerick
- National Maternity Hospital, Holles Street
- Our Lady’s Hospital for Sick Children, Crumlin
- St. James’s Hospital
- St. Loman’s Psychiatric Hospital, Mullingar

The function of each LIG was to agree a template for local implementation of the EWTD. LIGs were asked to gather data on current compliance levels and to consider how the NCHDs hours might be reduced in line with the recommendations of a number of reports, including the Report of the National Joint Study Group on the Working Hours of Non-Consultant Hospital Doctors (2001); and the Report of the National Task Force on Medical Staffing (2003) in developing such a template. The LIGs have multidisciplinary membership, including representation from a range of health service staff including consultants, NCHDs, nurses, health and social care professionals, hospital management and health service unions (Appendix C – Guidance to and Membership of Local Implementation Groups).

3.3 Hospital Activity Analysis

The Hospital Activity Analysis (HAA) project involved an analysis of activity and tasks undertaken by NCHDs in the nine pilot sites over a two-week period in March–April 2005. The purpose of this Hospital
Activity Analysis was to collect information on the nature and organisation of the tasks undertaken currently by NCHDs with a view to identifying how attendance patterns might be reorganised to achieve compliance with the European Working Time Directive whilst maintaining high quality patient care.

The inspiration for the Hospital Activity Analysis came from the ‘Hospital at Night’ project which had been implemented in England as part of efforts to implement the EWTD in that context. The ‘Hospital at Night’ project had allowed the NHS Modernisation Agency, the British Medical Association and the Joint Consultants Committee (comprising representatives of the Academy of Medical Royal Colleges and the BMA) to redefine how medical cover is provided in hospitals during the whole out-of-hours period, including evenings, weekends and holidays. The National Joint Steering Group on the working hours of Non-Consultant Hospital Doctors referred to earlier undertook a similar exercise.

In cooperation with the IMO and under the auspices of the Labour Relations Commission, a template was agreed for the collection of information on NCHD activity and tasks over a two-week period at each site. The information was collected by medical students in the majority of cases, with a limited number of NCHDs completing the diary sheets themselves. Coding of the information on the diary forms was overseen by Medical Manpower Managers in cooperation with local NCHD representatives from the LIGs, using an agreed system.

Once coded, checked and rechecked for consistency and clarity, copies of the diary forms from each hospital were forwarded via the National EWTD Coordinator to the York Health Economics Consortium (YHEC). Data was entered by staff at the YHEC with 10% data verification undertaken. Statistical analysis of the total 49,069 tasks was carried out using an SPSS package.

A total of ten reports were prepared by YHEC – one summary report of patterns of NCHD activity in particular specialties in all 9 pilot sites and an individual report for each individual hospital. These reports were provided by YHEC in electronic format and printing was arranged locally. In addition, each pilot site was provided with their full database in electronic format for more detailed analysis.

The analysis found that:

- NCHDs spent 55% of time on duty performing tasks;
- Those tasks could be broken down into
  - Patient Care (48%)
  - Interactions with Others (35%)
  - Finding Stuff and Paperwork (17%);
- Five tasks took up 56% of doctors’ time. They were:
  - Reviewing a patient who had already been reviewed by a doctor (21.9%)
  - Giving advice to another clinician (9.6%)
  - Bleeps (9.2%)
  - Performing a minor procedure (8.1%)
  - Seeking advice (6.7%);
- The large majority of doctors (79%) considered their tasks as appropriate for them;
- Activity in major specialties such as A&E, Anaesthesia, General Medicine, General Surgery and Paediatrics declined significantly after midnight before rising again at 7-8am. The pattern of
recorded activity was greatest between 8am and 4pm when 44% of tasks were performed. This was followed by 42% in the period 4pm to midnight and 14% in the period midnight to 8am. Variations by specialty were evident, for example 93% of tasks in Radiotherapy were between 8am and 4pm. Such variations reflect differences in both the organisation and presentation of workload by specialty and variations in the monitoring periods;

• 24% of tasks were urgent. The remaining 76% of tasks were required within the hour or within the NCHDs’ time on duty;

• The proportion of urgent tasks rose after 4pm and was highest between Midnight and 8am;

• Less than 5% of patients had life or limb threatening conditions; and

• Less than 1% of time was reported as spent on training.

3.4 Development of Project Proposals by LIGs

The Hospital Activity Analysis reports provided the LIGs with valuable baseline data on which they could focus deliberations on potential solutions. In November 2005 the NIG-EWTD sent the LIGs guidance in relation to the process for submitting and approving potential projects and also gave advice on potential projects which the LIGs could consider. It was agreed at the outset that all submitted pilot projects would require final approval by the NIG-EWTD before commencement. In addition projects would receive approval for a limited time period and any changes in work practices during the pilots would be undertaken without prejudice to the industrial relations process. It was also agreed that the pay of NCHDs participating in the pilot projects would be protected for the duration of the pilots.

From the outset the LIGs were advised to adopt an open approach to their participation in the pilot exercise. The LIGs were encouraged to look at innovative and imaginative solutions, particularly those that involved a multidisciplinary approach and which began the process of changing work practices. The submitted pilot project proposals covered a wide range of specialties and included proposals achieving a varying range of NCHD working hours’ reduction from minimal to virtual complete compliance with the requirements of the EWTD.

The NIG-EWTD in undertaking its work was cognisant of HSE medical workforce policy that advocates the need for a substantial number of additional consultant posts and commensurate reduction of NCHD posts informed, inter alia, by the Report of the National Task Force on Medical Staffing (Hanly Report) (section 3.2.8, 3.4, 4.1.10, Appendix 5) and the Report of the Postgraduate Medical Education and Training Group (the Buttimer Report) (section 3.2 and 3.6). This policy presented significant challenges to the LIGs and it is noted that the IMO, whilst fully supporting the need for additional consultant posts, is not in agreement with the HSE’s policy that no additional Registrar or Senior House Officer posts be created.

Feedback from the LIGs confirmed significant imbalance in the number of NCHDs and Consultants in separate, though similar, hospital specialties/departments. There is significant variation in the numbers of doctors employed between larger and smaller hospitals and between hospitals of equal size and similar clinical activity levels. Achieving full EWTD compliance, while maintaining current levels of service, will not be possible without significant additional medical and other clinical staffing.
Research Registrars, on research bursaries/grants, were present in several hospitals and their participation in appropriate SpR/Registrar rotas acted to reduce excessive NCHD working hours in some locations. It has been suggested that Irish employment legislation could prohibit these arrangements; the EWTD allows for double employment but Ireland did not allow for this provision when transposing the EU legislation into Irish law.

The LIGs were required to submit proposals for potential pilot projects on an agreed template (Appendix D – Pilot Project Proposal Template). LIGs were also required to include current and draft illustrative NCHDs rosters with their proposal and a list of the names of staff that participated and signed off on the submitted proposal.

Following this communication inaugural site visits were held in November/December 2005 with all nine pilot hospitals by National EWTD Coordinator, Mr. John Bulfin and Prof. Cillian Twomey, Chair of the NIG-EWTD. Each LIG presented their initial observations, highlighted the perceived difficulties and discussed solutions under consideration. The LIGs were advised to prepare project plans for submission to the NIG on January 13th 2006. During this time there was extensive communication directly with the LIGs assisting with clarifications and ensuring the timely return of information.

A second series of site visits took place in the period May to July 2006 from a larger NIG-EWTD delegation including Mr. John Bulfin, Mr. Fintan Hourihan, then Director of Industrial Relations, IMO, Dr. Catherine Motherway, representing postgraduate education and training and Prof. Cillian Twomey. Issues discussed included specialty specific meetings, assisting with evaluation and assessment of NCHD education and training and meetings to clarify queries raised by NIG-EWTD members regarding individual project applications. Each pilot site, therefore, was visited on at least two occasions.

These project proposals were reviewed in detail and compiled into a summary format for evaluation at the NIG-EWTD meetings. Most projects required further clarification from the LIGs on matters such as current and proposed NCHD rosters, training and the roles to be undertaken by staff participating in the projects. Key personnel such as medical manpower managers joined the NIG-EWTD meetings either in person or by telephone link to clarify queries and issues in relation to individual proposals.
4. Consultation

4.1 Nursing and Midwifery Expert Group

A Nursing and Midwifery Expert Group was established in November 2004 to consider and coordinate the involvement of nurses and midwives in any altered/expanded roles to emerge following implementation of the EWTD for NCHDs. The Group is chaired by Ms Anne Carrigy, Director of the Serious Incident Management Team, HSE and is comprised of representation from the Department of Health and Children, the Irish Nurses Organisation, SIPTU, Psychiatric Nurses Association, Directors of Nursing and Midwifery, Health Service Executive, An Bórd Altranais and the National Council for the Professional Development of Nursing and Midwifery, a Director of Nursing and Midwifery Planning and Development (terms of reference are documented in Appendix E).

The Nursing and Midwifery Expert Group supports innovative nursing and midwifery practice including expanding roles which are responsive to service need and has stated that expansion of practice should occur for all nurses/midwives on the clinical career pathway from staff nurse and midwife to clinical nurse/midwife specialist to advanced nurse/midwife practitioners.

The Nursing and Midwifery Expert Group prepared guidance to assist Local Implementation Groups in their review of enhanced nursing and midwifery roles (Appendix F). The National Council for Nursing and Midwifery and An Bórd Altranais offered Local Implementation Groups assistance through the utilisation of existing nurse/midwife specialist/practitioner post-holders to give advice and assistance and a fast tracking process for proposals which require new specialist/practitioner posts. The assistance of the Nursing & Midwifery Planning and Development Unit (NMPDU) and representatives of the Centre of Nurse Education has also been much appreciated.

In 2006 a Conjoint Group was established composed of representatives from the NIG-EWTD and the Nursing & Midwifery Expert Group. The Conjoint Group has formally met on five occasions (24th February ’06, 18th October ’06, 7th November ’07, 1st April ’08 and 14th October ’08). These meetings ensured that the Nursing & Midwifery Expert Group was fully informed of the work and progress of the NIG-EWTD and, through it, the nine Local Implementation Groups and to discuss matters of mutual concern. In addition Prof. Twomey (Chair, NIG-EWTD) and Ms. Anne Carrigy (Chair, Nursing & Midwifery Expert Group) were in regular dialogue.

The upskilling of all registered nurses and midwives in venepuncture and intravenous cannulation was one area, in particular, which the Nursing and Midwifery Expert Group identified as key action which would assist the achievement of compliance with the European Working Time Directive. A survey of employers was carried out to assess the extent to which nurses and midwives in acute hospitals had received education and training on venepuncture and intravenous cannulation and use these skills in the course of their duties. The results of this survey and recommendations on increasing the number of nurses and midwives with clinical competence in venepuncture and intravenous cannulation are set out in a report carried out by the Director of Nursing Services, HSE entitled “Report of the Survey of Venepuncture and Intravenous Cannulation Education and Training among Nurses and Midwives Employed in Acute Hospitals” (May 2008).
The key findings of the report included:

- 20.3% nurses and midwives educated and trained in venepuncture and 19.6% educated and trained in intravenous cannulation.
- There was a difference between the numbers of nurses and midwives trained in venepuncture and IV cannulation and the numbers currently competent and using these skills.
- There is a significant variation in the training and education currently being offered with the length of classroom based study varying from 3 hours to 2 days.
- Competencies are not included in pre-registration education and training.
- Nurses and midwives with clinical competence could be influential in enabling implementation of the EWTD.
- There is a need to develop a national transferable learning education programme.
- Focus on PCCC as well as acute hospitals – supports Winter Initiative and residential care settings.

A project team has been formed to develop and implement a national training and education programme for venepuncture and intravenous cannulation, identify priority areas where nurses and midwives require this skill and schedule a number of nurses and midwives to be trained. The project team also aims to expand the curriculum of nursing and midwifery undergraduate education programmes to include training in venepuncture and intravenous cannulation.

### 4.2 The NHS Experience

Prof. Roy Pounder, Emeritus Professor of Medicine, University of London was invited to address the Group on 13th December 2007 to give a presentation on the efforts to meet EWTD compliance in the UK including the introduction of shift working and his research on the health and safety impact of such working patterns and the optimum design of rotas. Prof. Pounder has been closely involved with the implementation of the EWTD in the UK under the aegis of the Royal College of Physicians of London and the Department of Health and Social Security. He has produced a substantial body of research and guidance material on implementation of the Directive (Horrocks, N. & Pounder, R. (2006) “Working the night shift: preparation, survival and recovery”; Further food for thought on EWTD 2009 (RCP Lond College Commentary, June 2008 and Junior Doctors Working Hours: can 56 go into 48? (Clinical Medicine, Vol 8, No. 2 April 2008).

Two other reports from the Royal College of Physicians of London “Working the night shift: preparation, survival and recovery – a guide for junior doctors” and “Designing safer rotas for junior doctors in the 48-hour week” were published in 2006 and they promoted safer working practices for NCHDs. Research has shown that shorter shifts lead to less exhaustion and more efficient work. In the paper “Patterns of full shift working, using three nine-hour shifts to provide 24-hour care”, 3 x 9 hour rota models were evaluated. The model was shown to be compliant with cells of 7, 8, 9 or 10 doctors. However, the paper notes that, while the rotas were calculated for a maximum average work time of 48 hours per week, the rotas do not take account of annual and study leave. The paper concluded that one additional doctor is needed to provide such cover per 4-5 doctors in the cell if 24-hour on-site cover is to be provided.
5. Overview of the Approved Pilot Projects

5.1 The Approved Projects

The NIG-EWTD met for a total of 28 times between 29th September 2005 and the 16th December 2008. The Local Implementation Groups (LIGs) submitted a total of 46 Pilot Project proposals to the NIG for its consideration. Nineteen of these pilot project proposals received final approval on the basis that they met a number of key criteria including:

- the reductions in NCHD hours resulting from the project;
- value for money;
- the extent to which the project increased compliance with the rest break provisions of the EWTD;
- the extent to which the project will support full EWTD compliance;
- the impact of the project on medical education and training;
- the impact of the project on patient care; and
- the extent to which the project can act as a model for other specialities / areas.

The duration of the projects varied from three months (Mullingar and Letterkenny) to 12 months (Holles Street). The first project started in July 2006 and the last in September 2008. The full list of submitted proposals is included in the appendices, with the titles of the approved pilot projects written in bold type (see Appendix G). The approved projects were based in 7 of the 9 LIG sites.

Our Lady’s Hospital for Sick Children, Crumlin submitted pilot project proposals regarding paediatric surgical SHOs and paediatric medical SHOs which was predicated on the introduction of additional NCHDs in the Emergency Department. The project could not be approved as it ran contrary to the HSE’s position on the recruitment of additional NCHDs. The NIG-EWTD requested the LIG to look at other potential solutions including the recruitment of additional consultant posts but in the absence of additional NCHDs the LIG was unable to submit a revised proposal.

In 2006 St James’s Hospital-LIG submitted a project proposal related to the expansion of multidisciplinary team roles in 2 cardiology wards within the hospital. The project proposed a rather modest reduction in NCHD working hours (5 hours per SHO per week) which would have applied to only half the SHO cohort. This proposal was the subject of lengthy discussions between the NIG-EWTD and representatives of the LIG over the ensuing 2 years. In early 2008 the LIG was requested to consider presenting a revised proposal that would have involved a greater number of NCHDs achieving more significant compliance with the target EWTD obligations. Regrettably no further submission was received.

While some LIGs submitted Pilot Project proposals as early as January 2006, the requirement for further clarification and discussion and the resolution of some industrial relations issues meant that the first group of projects were not confirmed until May 2006. The first Pilot Project started on 1st July 2006. Most projects required a lead-in time following NIG-EWTD approval to recruit any additional staff required for the project. If such staff were seconded from within the hospital further delays ensued finding a locum for the temporarily vacated substantive post(s). Where training of recruited staff was necessary more delays were inevitable.
All projects were undertaken on the basis that ultimate clinical responsibility for each patient continued to reside with the admitting or treating consultant, with duties delegated to relevant staff, as appropriate.

Nine pilot projects commenced in 2006 - Letterkenny General Hospital (psychiatry) Midwestern Regional Hospital Limerick (ophthalmology), Galway University Hospitals (two related projects Concerning the specialities of haematology, oncology and radiation oncology and setting up a PICC line service and a third project introducing an IV Cannulation Team, Cork University Hospital (anaesthesia), St Loman’s Hospital, Mullingar (psychiatry) and the Midland Regional Hospital Mullingar (surgery and paediatrics). In 2007 a further seven projects commenced in Cork University Hospital (2 inter-related orthopaedic projects), in Letterkenny General Hospital (anaesthesia) and in Midwestern Regional Hospital Limerick (paediatrics). Two pilot projects commenced in the National Maternity Hospital, Holles St, in the specialties of anaesthesia and paediatrics / neonatology in January 2007 and a third project commenced there in obstetrics and gynaecology in July 2007. Due to the delay in sanctioning the required research officer post the Letterkenny-LIG project on the measurement and analysis of NCHD time dedicated to education and training did not commence until early September 2008. This 17th approved pilot project was completed in November 2008.

The remaining two approved projects - Cork University Hospital Plastic Surgery Project and Galway University Hospitals Surgical Intern Project - did not proceed. Although originally approved in February 2007 the senior management at Cork University Hospital decided, in February 2008, not to proceed with the Plastic Surgery project due to reported recruitment restrictions arising from HSE HR circular 1/2008 on employment ceilings. The Galway University Hospital surgical intern project was also abandoned due a reported ‘lack of engagement’ by the participants.

5.2 Evaluation
All approved pilot projects were subject to evaluation according to agreed criteria. Each LIG was asked to structure their reports with the following criteria in mind:

- The extent to which the pilot project achieves compliance with the EWTD;
- The acceptability of the piloted work practices to all participants;
- Project sustainability;
- Feedback of the patients’ experience of the pilot projects;
- Continuity of patient care;
- The protection, if not enhancement, of education and training (both formal and informal);
- The extent to which the pilot projects can be applied nationally;
- Effect on workload, including patient throughput (inputs/outputs), the effect of the pilot on the number of investigations undertaken such as laboratory, radiology etc;
- Value for Money / Costing; and
- Work Life Balance.

The evaluation was carried out by teams comprised of project participants, Local Implementation Group representation and nominee(s) from the relevant postgraduate training body (medical, surgical and/or paediatric etc) to provide independent adjudication of each project especially commenting on the projects’ impact on NCHD education and training.
The LiGs were required to submit a detailed report of each completed Pilot Project with an accompanying executive summary. These reports also included commentary from an independent external evaluator/consultant from the relevant specialty. The evaluator was asked to comment on the Pilot Project’s impact, if any, on participating NCHDs’ education and training. Specifically the extern was asked to compare the pre-pilot teaching programme and NCHD participation with that experienced during the pilot project itself.

These reports were discussed in some detail at NIG-EWTD meetings with live or telephone link with representatives from the relevant LiG. Invariably further clarification and amendments were required before the reports were formally signed off by the NIG-EWTD. The executive summaries of ALL approved Pilot Project Reports are set out in Appendix H. These summaries reflect the views of the LiGs and were formulated with reference to the criteria outlined at the beginning of this section (5.2).

5.3 Specialties

The approved projects encompassed a wide range of specialties. Those specialties are as follows:

- **Anaesthesia** – Cork University Hospital; Letterkenny General Hospital; National Maternity Hospital, Holles St;
- **General Surgery** – Galway University Hospitals and Midland Regional Hospital Mullingar;
- **Obstetrics and Gynaecology** – National Maternity Hospital, Holles St.;
- **Oncology / Haematology / Radiotherapy** - Galway University Hospitals;
- **Ophthalmology** – Midwestern Regional Hospital Limerick;
- **Orthopaedics** – Cork University Hospital;
- **Paediatrics** – Mid-Western Regional Hospital Limerick; Midland Regional Hospital Mullingar; National Maternity Hospital, Holles St.;
- **Psychiatry** – Letterkenny General Hospital and St. Loman’s, Mullingar.

A broad range of specialties was addressed by the pilot projects, but significant gaps remain especially in areas such as General Medicine, and several medical and surgical subspecialties. A pilot project proposal submitted by the Mullingar-LiG related to acute general medicine planned to introduce a programme of skill mix development and reconfiguration of the current service within the physician group. It promised full EWTD compliance for medical SHOs and the 48-hour working week target and partial rest break compliance for Registrars and Specialist Registrars. Rest break compliance at Registrar level was to have been reviewed as the skill mix within other grades and new SHO roster system were sufficiently established to support further changes.

The NIG-EWTD strongly supported this proposal and felt that it would have provided valuable information on the implementation of the 48-hour working week and the other obligations of the EWTD in the context of acute medical admissions. The NIG-EWTD sought senior HSE management support for this project however the HSE were unable to support it because of the substantial financial cost and reservations about its applicability to other hospitals.
5.4 NCHD Grades

A total of 126 NCHDs participated in the pilot projects. All NCHD grades have been involved in pilot site activity to some degree. The pilot projects mainly involved Senior House Officers (n= 75), with some involvement of Registrars (n = 35) in full and partial shift systems. Specialist Registrars (n = 12) have mainly been involved in limited hours reductions resulting from elimination of some unrostered hours and reduced requirement to attend the hospital from off-site call out-of-hours. A limited number of interns (n = 4) participated in projects in General Surgery and Orthopaedics.
<table>
<thead>
<tr>
<th>LIG</th>
<th>Project</th>
<th>No. Interns</th>
<th>No. SHOs</th>
<th>No. Registrars and SpRs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cork University Hospital Group</strong></td>
<td>1. The introduction of a shift system to the first on call Anaesthesia rota</td>
<td>0</td>
<td></td>
<td>7 BST trainees</td>
</tr>
<tr>
<td></td>
<td>2. <em>and</em> 3. Introduction of Trauma Co-ordinator and Clinical Specialist Physiotherapist Led Practitioner Fracture Clinic</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Galway University Hospital Group</strong></td>
<td>4. <em>and</em> 5. Introduction of Nurse led ‘PICC Line’ Service and Clinical Nurse Specialist Haematology/Oncology/Radiotherapy</td>
<td>0</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>6. IV Cannulation Team</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td><strong>National Maternity Hospital</strong></td>
<td>7. Proposal to achieve EWTD Compliance in Neonatology</td>
<td>0</td>
<td>0</td>
<td>3 Registrars and 3 SpRs</td>
</tr>
<tr>
<td></td>
<td>8. Proposal to achieve EWTD for Anaesthetic Registrars</td>
<td>0</td>
<td>0</td>
<td>4 Registrars and 2 SpRs</td>
</tr>
<tr>
<td></td>
<td>9. Proposal to achieve EWTD Compliance for NCHDs engaged in Obstetrics and Gynaecology</td>
<td>0</td>
<td>0</td>
<td>5 SpRs (two had part-time academic contract) and 4 Registrars</td>
</tr>
<tr>
<td><strong>Letterkenny General Hospital</strong></td>
<td>10. Review of onsite on call arrangements within the psychiatric specialty with object to convert to off-site working during out of hours periods.</td>
<td>0</td>
<td>11</td>
<td>1 Senior Registrar</td>
</tr>
<tr>
<td></td>
<td>11. Implementation of a full shift EWTD compliant rota in the Department of Anaesthesia.</td>
<td>0</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>12. Development of a model for measurement and analysis of NCHD time dedicated to education and training activities currently designated as training time.</td>
<td>N/a</td>
<td>N/a</td>
<td>N/a</td>
</tr>
<tr>
<td><strong>Midwestern Regional Hospital Limerick</strong></td>
<td>13. Ophthalmology Casualty Service</td>
<td>0</td>
<td>3</td>
<td>1 SpR and 2 Registrars</td>
</tr>
<tr>
<td></td>
<td>14. Paediatric Phlebotomy and reduction of working hours of neonatal SHOs.</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>Midlands Regional Hospital, Mullingar</strong></td>
<td>15. To achieve EWTD Compliance and enhance education and training in the Department of Surgery</td>
<td>2</td>
<td>5 SHOs (2 locums)</td>
<td>4 Registrars (1 locum)</td>
</tr>
<tr>
<td></td>
<td>16. To develop consultant provision of service, reduce NCHD hours and protect scheduled teaching in the Department of Paediatrics.</td>
<td>0</td>
<td>5</td>
<td>5 Registrars</td>
</tr>
<tr>
<td><strong>St Loman’s Hospital, Mullingar</strong></td>
<td>17. Achieving EWTD compliance at St Loman’s Mullingar</td>
<td>0</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total No. NCHDs</strong></td>
<td></td>
<td>4</td>
<td>75</td>
<td>47</td>
</tr>
</tbody>
</table>

*This project was research based project and did not involve a change in current NCHD working patterns.*
5.5 Solutions piloted by Local Implementation Groups

Solutions which were piloted by the LIGs fell into three main categories – i) transfer of duties to other grades of staff; ii) introduction of additional consultants and iii) introduction of on-call off-site rotas.

i) Improved skill mix and transfer of duties to other grades of staff

The Hospital Activity Analysis, just like the Report of the National Joint Steering Group on the Working Hours of Non-Consultant Hospital Doctors (2001), identified a number of areas which had potential for transfer of duties between different members of the multidisciplinary team. These areas included venepuncture, IV cannulation, urethral catheterisation, naso-gastric tube insertion, suturing, drug administration, drug prescribing, ECG recording, writing a discharge letter (post decision to discharge), finding and delivering X-rays and radiological results / data and finding and delivering pathology results / data. A number of projects began to address this area:

1. Ophthalmology - Nurse Triage of patients attending the Ophthalmology service at Midwestern Regional Hospital Limerick resulted in reduced NCHD hours.
2. General Surgery - the introduction of team secretaries to support surgical teams in the General Surgery Department at Midland Regional Hospital Mullingar contributed to enabling the unit to work with fewer SHOs on daytime cover by removing certain duties previously undertaken by NCHDs.
3. Orthopaedics - in the Orthopaedics Department at Cork University Hospital, the introduction of a Trauma Nurse Coordinator and Clinical Specialist Physiotherapist - led fracture clinic resulted in a modest reduction in NCHD hours.
4. Haematology/Oncology/Radiotherapy – the introduction of two additional Clinical Nurse Specialists, a Clinical Specialist-led PICC service and an IV Cannulation Team in University College Hospital, Galway. This removed certain duties from SHOs and enabled the introduction of a shift roster.
5. Paediatrics – the introduction of two paediatric phlebotomists who rotated between the Paediatric Department and the Emergency Department, in the Mid-Western Regional Hospital, Limerick, reduced the amount of time neonatal SHOs spent taking blood samples.

The transfer of routine duties and minor procedures such as those outlined above enhanced patient care by facilitating quicker NCHD access to patients. In addition NCHDs were able to concentrate on more complex cases thereby maximising their training opportunities.

Local Implementation Groups reported limited scope for changes in skill mix in some specialties, mainly due to existing staffing difficulties (for example, a lack of trained staff such as clinical nurse specialists or healthcare assistants) and/or concerns about their scope of practice. In particular, the lead-in time for training and sourcing these staff was problematic for pilot project purposes given the relatively short lead-in time. It is likely that this would have been proposed as a solution for a number of additional projects had the resource been more readily available.

ii) Introduction of additional consultants

A number of pilot projects included the recruitment of additional consultants as a potential solution. This included the National Maternity Hospital’s three pilot projects in Anaesthesia, Obstetrics and Gynaecology and Paediatrics, MRH Mullingar’s Surgical and Paediatric projects and Cork University Hospital’s Department of Anaesthesia project.
Where projects were successfully implemented the introduction of the additional consultants enabled the transfer of some clinical duties to the consultants thus facilitating the introduction of EWTD compliant work patterns. The increased consultant presence also improved the education and training opportunities in these specialties. For instance in the Neonatology Department in the National Maternity Hospital the introduction of three temporary consultants resulted in a significant increase in the quantity of research and project development. The new arrangements also allowed consultants to be present at teaching sessions every morning. The greater availability of consultants also meant that there was a consultant available at all times to support Registrars at all the emergencies and complex cases occurring in the hospital.

In the MRH Mullingar Paediatric pilot project the introduction of an additional two consultants increased the number of formal teaching sessions and supervision of NCHDs in the unit in addition to facilitating a significant increase in consultant-delivered services.

The introduction of additional consultants was not without its challenges. In the National Maternity Hospital’s Anaesthesia project the temporary nature of the additional consultants and the lack of integration of these posts within the normal career structure led to uncertainty of role for all staff, including the consultants and registrars.

iii) Move from on-call on-site to on-call off-site Rotas

Some of the pilot projects focused on changing working patterns of NCHDs from on-call on-site to on-call off site. Projects which adopted this type of solution included Letterkenny General Hospital’s Psychiatry Pilot Project and St Loman’s Hospital Mullingar’s Psychiatry Pilot Project. The introduction of an Ophthalmology Casualty service in the MWRH Limerick enabled the reduction of on-call on-site hours for the on-call registrar / SHO.

The implementation of on-call off-site working in these projects was found to be successful. For instance in Letterkenny General Hospital’s Psychiatry project NCHDs on-call were required on-site for an average of 1 hour 38 minutes per day, Monday to Friday, between the hours of 5pm and 9am the following morning. Attendance at weekends for each 48-hour period averaged only 5.5 hours in total, equating to 2.75 hours per day. In addition no additional clinical risks were noted with off-site working. However, the EWTD legislation does emphasise that being on call off-site cannot be simultaneously interpreted as a rest period.
### Table 2

**Solutions piloted by the Local Implementation Groups**

<table>
<thead>
<tr>
<th>LIG</th>
<th>Project</th>
<th>Type of Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cork University Hospital Group</td>
<td>1. The introduction of a shift system to the first on call Anaesthesia rota</td>
<td>A shift roster was introduced for NCHDs on first on call rota. Three temporary consultants were employed to counterbalance the lost working hours.</td>
</tr>
<tr>
<td></td>
<td>2. and 3. Introduction of Trauma Co-ordinator and Clinical Specialist Physiotherapist Led Practitioner Fracture Clinic</td>
<td>The introduction of a Trauma Coordinator and Physiotherapist-led fracture clinic to reduced NCHD working hours.</td>
</tr>
<tr>
<td>Galway University Hospital Group</td>
<td>4. and 5. Introduction of Nurse led ‘PICC Line’ Service and Clinical Nurse Specialist Haematology/Oncology/Radiotherapy</td>
<td>Introduction of CNS each in Haematology &amp; Oncology and a nurse-led PICC line service resulted in a transfer of some duties from NCHDs.</td>
</tr>
<tr>
<td></td>
<td>6. IV Cannulation Team</td>
<td>Transfer of IV cannulation duties to IV Cannulation team. More efficient discharge of patients.</td>
</tr>
<tr>
<td>National Maternity Hospital</td>
<td>7. Proposal to achieve EWTD Compliance in Neonatology</td>
<td>Recruitment of three additional temporary consultants resulted in the transfer of some clinical duties previously carried out by Registrars</td>
</tr>
<tr>
<td></td>
<td>8. Proposal to achieve EWTD for Anaesthetic Registrars</td>
<td>Recruitment of two additional temporary consultants (1WTE) resulted in the transfer of some clinical duties previously carried out by Registrars.</td>
</tr>
<tr>
<td></td>
<td>9. Proposal to achieve EWTD Compliance for NCHDs engaged in Obstetrics and Gynaecology</td>
<td>Recruitment of two additional temporary consultants resulted in the transfer of some clinical duties previously carried out by Registrars.</td>
</tr>
<tr>
<td>Letterkenny General Hospital</td>
<td>10. Review of onsite on call arrangements within the psychiatric speciality with object to convert to off-site working during out of hours periods.</td>
<td>Introduced a change from on-site on-call working to off-site on-call after 5pm Monday – Friday and all day at weekends.</td>
</tr>
<tr>
<td></td>
<td>11. Implementation of a full shift EWTD compliant rota in the Department of Anaesthesia.</td>
<td>Implementation of full shift rosters for NCHDS.</td>
</tr>
<tr>
<td></td>
<td>12. Development of a model for measurement and analysis of NCHD time dedicated to education and training activities currently designated as training time.</td>
<td>Investigation of the amount of NCHD time dedicated to education and training currently designated as working time.</td>
</tr>
<tr>
<td>Midwestern Regional Hospital, Limerick</td>
<td>13. Ophthalmology Casualty Service</td>
<td>Nurse triage of patients attending the Ophthalmology service at resulted in reduced NCHD hours</td>
</tr>
<tr>
<td></td>
<td>14. Paediatric Phlebotomy and reduction of working hours of neonatal SHOs.</td>
<td>Introduction of phlebotomist in Paediatric Department.</td>
</tr>
</tbody>
</table>

---

4 This project was research based project and did not involve a change in current NCHD working patterns.
<table>
<thead>
<tr>
<th>Midlands Regional Hospital, Mullingar</th>
<th>15. To achieve EWTD Compliance and enhance education and training in the Department of Surgery</th>
<th>Creation of two team structure of consultants, improved skill mix with nurses commencing IV cannulation and phlebotomy, the introduction of health care assistants and the creation of team secretaries for each of the consultant teams.</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. To develop consultant provision of service, reduce NCHD hours and protect scheduled teaching in the Department of Paediatrics.</td>
<td>Introduction of two additional consultant paediatricians to enhance EWTD compliance and improve training and education. Skill mix was addressed through addition of 2 paediatric phlebotomists and a CNS in Respiratory Medicine.</td>
<td></td>
</tr>
<tr>
<td>St Loman’s Hospital, Mullingar</td>
<td>17. Achieving EWTD compliance at St. Loman’s Mullingar</td>
<td>Introduced a change from on-site on-call working to off-site on-call after 5pm Monday – Friday and all day at weekends.</td>
</tr>
</tbody>
</table>

### 5.6 Extent of compliance

The challenges of achieving compliance with the provisions of the Directive are twofold. Firstly a reduction in NCHD working hours has to be implemented so that average weekly working hours are in line with the limits set out in the EWTD. These limits stand at 56 hours per week since 1 August 2007 and will drop to 48 hours by 1 August 2009. Secondly, NCHDs working patterns have to be altered so that they receive 11 hours daily rest or equivalent compensatory rest before the next period of work. This entails a fundamental change from the on call on-site pattern of working where currently many NCHDs can work up to 56-hour shifts at a time.

Compliance with EWTD provisions varied among the pilot sites and within the sites among specialities. A survey of on-site working hours in the pilot sites completed in August 2005 revealed that the average weekly hours worked was 64.1 hours for Interns, 60.5 hours for SHOs, 60.7 hours for Registrars and 58.6 hours for Specialist Registrars. The survey did not give information on compliance with the rest break or other EWTD provisions.

A more recent survey of employers gives more up to date information on the situation with regard to compliance with the provisions of the EWTD\(^5\). This survey was conducted in May/June 2007 with a reference period of 26 weeks from 1 July to 31 December 2006. The findings were based on records of on-site working hours submitted by NCHDs as part of payroll returns to each local employer. Each hospital collated these returns for all grades/specialties on a standard template for submission to the HSE EA. Returns from each hospital were collated into summary reports by grade/specialty by staff in the research office of the HSE EA.

The results indicated that the average on-site working hours\(^6\) for **interns** was 65.39 hours per week, 59.77 hours per week for **SHOs**, 59.01 hours per week for **registrars**, 40.31 hours per week for **senior registrars (psychiatry)** and 56.90 hours per week for **specialist registrars** over the reference period.

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5 HSE-Employers Agency – Medical Manpower Managers data 2007.

6 Average Weekly On-Site Hours claimed - all hours worked on site including rostered hours, hours worked when called in from on call off-site and unrostered overtime.
When asked about compliance with the rest break provisions of the EWTD it was reported that only 4.39% of interns, 16.05% of SHOs, 13.00% of registrars and 9.92% of specialist registrars were fully compliant with the rest break provisions of the EWTD. However it must be borne in mind that there was a low response rate for this question and that these percentages were calculated based on the minority who answered this particular question.

The LIGs attempted to address both these challenges in devising revised rosters for NCHDs. However, the numbers of NCHDs available on individual rotas have influenced the type of proposals submitted and this remains a fundamental difficulty in meeting full compliance. Recent literature suggests that a fully EWTD compliant 24-hour on-site roster of 48 hours per week including rest breaks can only be achieved with a cell size of between 7 – 10 medical staff with the addition of one additional doctor per 4-5 doctors to cover address annual and study leave requirements.

Notwithstanding the above full shift rosters were piloted for Registrars in Anaesthesia in the Cork University Hospital and Letterkenny General Hospital, as well as for Senior House Officers in the Haematology, Oncology & Radiotherapy pilot project in Galway. The rosters involved 7 Registrars in CUH, 8 SHOs in Letterkenny and 14 SHOs in University College Hospital, Galway. Conversely rosters with only 5 SHOs, such as in the National Maternity Hospital or in General Surgery at the Midland Regional Hospital Mullingar, were only able to demonstrate a move towards compliance with rest breaks.

In this scenario, the potential solution (as recommended in Report of the National Task Force on Medical Staffing, 2003) of combining two tiers of NCHD call into one tier (shared Registrar and SHO call) would require further study and was not piloted as part of this exercise. There is concern about the variable level of skill/experience available (i.e. difficulties might arise if inexperienced SHOs, who are currently supported by in-house registrars, were the only in-house doctor available). In some sites it is clear that any such change in NCHD call arrangements would have to be supported by increases in consultant manpower, including their availability over an extended working day.

Of the 17 completed pilot projects, five achieved 48-hour compliance with full rest break – Interns in General Surgery in MRH Mullingar, SHOs/Registrars in Psychiatry in St Loman’s Hospital and Letterkenny General Hospital, SHOs in Ophthalmology in MWRH Limerick and SHOs in Anaesthesia in Letterkenny General Hospital. Compliance was achieved in these projects through the introduction of shift working or on-call off-site working.
Table 3

NCHD current and proposed average weekly working hours in approved projects

<table>
<thead>
<tr>
<th>LIG</th>
<th>Project</th>
<th>Working Hours</th>
<th>Rest Breaks</th>
<th>EWTD Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cork University Hospital Group</td>
<td>1. The introduction of a shift system to the first on call Anaesthesia rota</td>
<td>71 hours to 52 hours per NCHD</td>
<td>Full rest break compliance</td>
<td>Compliance with August '07 working hours but not the August '09 limit. Full rest break compliance</td>
</tr>
<tr>
<td></td>
<td>2. and 3. Introduction of Trauma Co-ordinator and Clinical Specialist Physiotherapist Led Practitioner Fracture Clinic</td>
<td>Reduction from 70 to 60 hours per SpR, 76 to 66 hours per Reg, 73 to 63 hours per SHO and 82 to 72 hours per Intern</td>
<td>A move towards compliance with 11 hour rest periods</td>
<td>Working Hours reduced but still above current 56-hour limit &amp; a move towards compliance with rest breaks.</td>
</tr>
<tr>
<td>University College Hospital, Galway</td>
<td>4. 5 and 6 Introduction of Nurse led ‘PICC Line’ Service and Clinical Nurse Specialist Haematology/Oncology/Radiology Team/Radiotherapy and IV Cannulation Team</td>
<td>Reduction from 59 hours to 50 hours per SHO and full compliance with rest breaks</td>
<td>Full rest break compliance</td>
<td>Compliance with August '07 working hours but not the August '09 limit. Full rest break compliance</td>
</tr>
<tr>
<td>National Maternity Hospital, Holles Street</td>
<td>7. Proposal to achieve EWTD Compliance in Neonatology</td>
<td>Reduction from 65.17 hours per week to 48.62 hours per week per Registrar.</td>
<td>A move towards compliance due to limited numbers NCHDs</td>
<td>Compliance with August '09 48-hour limit &amp; a move towards rest break compliance</td>
</tr>
<tr>
<td></td>
<td>8. Proposal to achieve EWTD for Anaesthetic Registrars</td>
<td>Reduce NCHD working hours from an average of 64.40 to 49.46</td>
<td>A move towards compliance – incidence of 24 hour shifts reduced by 21%.</td>
<td>Nearly compliant with August '09 48-hour limit &amp; a move towards rest break compliance</td>
</tr>
<tr>
<td></td>
<td>9. Proposal to achieve EWTD Compliance for NCHDs engaged in Obstetrics and Gynaecology</td>
<td>Reduction from 62 hours per week to 54.47 hours per week.</td>
<td>A move towards Compliance – reduced length of shifts where possible</td>
<td>Compliance with August '07 working hours but not August '09 limit &amp; a move towards rest break compliance</td>
</tr>
</tbody>
</table>

25
| Letterkenny General Hospital | 10. Review of onsite on-call arrangements within the psychiatric speciality with object to convert to off-site working during out of hours periods. | Reduction from 55 hours per week to an average of 41.5 hours. | Full compliance – moved from 24 hour work pattern to off site during out of hours periods. | Compliance with August '09 48-hour limit. Full rest break compliance |
| Mid-Western Regional Hospital, Limerick | 11. Implementation of a full shift EWTD compliant rota in the Department of Anaesthesia. | Reduction from 56 hours per week to an average of 48 hours. | Full compliance – moved from 24 hour work pattern to full shift working. | Compliance with August '09 48 hour limit. Full rest break compliance |
| Mid-Lands Regional Hospital, Mullingar | 12. Development of a model for measurement and analysis of NCHD time dedicated to education and training activities currently designated as training time. | N/a | N/a | N/a |
| Mid-Western Regional Hospital, Limerick | 13. Ophthalmology Casualty Service | Reduction from 65 to 55 hours per Registrar, from 54 to 43.7 hours per SHO. a move towards compliance with 11 hour rest requirement | Full compliance for SHOs and a move towards rest break compliance for Registrars | Full compliance for SHOs and a move towards compliance with hours and rest break provisions for Registrars |
| Mid-Lands Regional Hospital, Mullingar | 14. Paediatric Phlebotomy and reduction of working hours of neonatal SHOs. | Reduction from 71 hours to 64 hours. | A move towards compliance with rest break provisions. | Working Hours reduced but still above current 56 hour limit and a move towards compliance achieved with rest breaks. |
| St Loman’s Hospital, Mullingar | 15. To achieve EWTD Compliance and enhance education and training in the Department of Surgery | Reduction from 52 to 42 hours per Intern, 63 to 62 hours per SHO and 73 to 66 hours per Registrar. | Full compliance with rest break provisions for Interns and SHOs; a move towards compliance for Registrar. | Working Hours reduced but still above current 56 hour limit for SHOs and Regs and full compliance achieved with rest breaks for interns and SHOs. |
| Mid-Lands Regional Hospital, Mullingar | 16. To develop consultant provision of service, reduce NCHD hours and protect scheduled teaching in the Department of Paediatrics. | Reduction from 73 to 54.1 hours per Registrar and from 73 to 55 hours per SHO. | Does not address 11-hour rest breaks | Compliance with August '07 working hours but not the August '09 limit; a move towards rest break compliance |
| St Loman’s Hospital, Mullingar | 17. Achieving EWTD compliance at St Loman’s Mullingar | Reduction from 51 to 43 hours per NCHD. | Full compliance with rest breaks | Compliance with August '09 48 hour limit and full rest break compliance |

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7 This project was a research based project and did not involve a change in current NCHD working patterns.
The majority of projects addressed just one tier of call. One exception was the full system change tested in the General Surgery Pilot Project at Midland Regional Hospital Mullingar. This project involved changed working practices for Interns, Senior House Officers, Registrars and Consultants. The results suggest that involving multiple tiers of NCHDs, consultants, nursing, administrative and other staff increases the likelihood of achieving department-wide cultural change which is essential in sustaining longer term changes in work practices.

5.7 Funding and Cost Implications
A total of €2.46m was spent funding approved pilot projects. There was a budget of €3 million in 2006 and a further €3 million in 2007. Of this money €1.07 million was spent on projects in 2006 and €1.352m in 2007. A further €42,500 was allocated to the research project carried out in Letterkenny General Hospital in 2008. This was not a rolling budget and money unspent in any given year was not carried forward.

The cost of the projects ranged from €3,500 for the introduction of shift working in the Department of Anaesthesia, Letterkenny General Hospital to €587,529 for the recruitment of three additional paediatric consultants and a researcher for the Neonatology project carried out by the National Maternity Hospital.

A core condition for agreement between employers and the IMO was that NCHD remuneration be fixed for the duration of the pilot. Taking this into account, remuneration for hours actually worked could, depending on the outcome of negotiations nationally, result in net savings in many of these projects. Health service employers and the IMO are currently engaged in negotiations under the auspices of the Labour Relations Commission on the issue of arrangements for a revised NCHD contract.
6. Discussion

6.1 Challenges to Achieving EWTD Compliance

Acute hospitals in Ireland vary in size and in staffing levels ranging from as low as 6 Consultant WTEs and 19 NCHD WTEs in one of the smaller hospitals to 127 Consultant WTEs and 269 NCHD WTEs in one of the country’s larger hospitals. The challenges to achieving full EWTD compliance are many but are virtually impossible to meet in smaller hospitals, with their lower medical staffing levels. Furthermore, as stated earlier, several hospitals of similar size and activity levels do not have equivalent Consultant or NCHD WTE staffing levels.

As indicated in section 5.6 of this report a national analysis of EWTD compliance reveals that the average weekly hours worked by NCHDs ranges from 40.31 to 65.39, according to grade. Since 1st August 2007 the upper legal limit has been an average of 56 hours per week and this will be 48 hours per week from August 2009.

The situation is even more pronounced when the EWTD rest requirements are considered. When the requirements of compensatory rest periods are included, the percentage compliance rates fall dramatically – to just 4.39% (Interns), 16.05% (SHOs), 13.00% (Registrars) and 9.92% (Specialist Registrars).

No hospital in Ireland is currently fully compliant with the provisions of the EWTD i.e. hours worked and rest break provisions. In our larger hospitals there are some rosters where the average hours worked is of the order of 52 to 60 hours per week; but even in these institutions there are notable exceptions, for example, in specialties such as obstetrics, paediatrics, neurosurgery, cardiothoracic surgery, and transplantation call teams (cardiac, liver and renal). If current service levels are to be maintained, achieving EWTD compliance in hospitals where NCHDs work 1 in 5 (or more frequent) on-call rotas is not possible. This is the current situation in the context of 56 hours per week in force since August 2007 and will be even more challenging from August 2009 when the 48 hours per week legislation comes into effect. A profile of existing acute hospitals in Ireland is present in Appendix 1.

It will be extremely difficult to achieve EWTD compliance in the medium-to-long term while maintaining current acute surgery, medicine and anaesthesia services in such hospitals. Paediatric and obstetric services in certain hospitals also face very significant challenges. Unless fundamental changes are introduced as to how these hospitals function, in collaboration with affiliated larger hospitals EWTD, compliance will not be achieved. A profile of existing acute hospitals in Ireland is presented in Appendix 1.

6.2 Report of the National Task Force on Medical Staffing

The Report of the National Task Force on Medical Staffing (2003) set out specific national measures for reducing the average working hours of NCHDs comprising:

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8 HSE-Employers Agency – Medical Manpower Managers data 2007.
1. removal of layered or tiered on-call;  
2. introduction of cross-cover arrangements;  
3. the introduction of new working patterns for NCHDs; and  
4. a defined set of measures aimed at reducing NCHDs workload, with special emphasis on areas in which other staff are better placed to deliver a quality service.

In relation to the reduction of tiered on-call, the Task Force noted that in many hospitals in Ireland, interns, senior house officers, registrars, specialist registrars/senior registrars and consultants participate in a tiered on-call system. If the appropriate clinical decision cannot be made by the first doctor on-call, the patient is referred to the next most senior doctor and the process continues until the appropriate diagnostic and treatment decisions are made. The Task Force recommended that the first tier of on-call should be appropriate to patient needs, noting that this would necessitate patient referral to, and in many cases on-site availability of, senior clinical decision-makers, including consultants, over an extended working day for many and on a 24/7 basis for certain emergency care specialties (such as acute medical call, busy emergency departments, Intensive Care Units and obstetrics). On-site clinical supervision of less experienced doctors in training must be assured wherever any reduction of tiered on-call is introduced.

The Task Force concluded that “there was scope within each specialty for the introduction of cross-cover arrangements at senior house officer and registrar levels. It noted that it was vital that all cross-cover arrangements must ensure that the doctors involved are competent to provide cover and that the safety and management of patients is not compromised. The increasing specialisation and complexity of patient care require that the provision of cross-cover should be a clinical decision”.

The Task Force further commented that the experience in other EU states indicated that the number of hours worked is not directly proportional to the quality of training and that it is possible to deliver training effectively in shorter working hours and with different types of working patterns. In a shorter working week, one of the best means of ensuring sufficient experience is to expose trainees to sufficient workload while appropriately supervised by senior clinicians, rather than requiring them to spend large amounts of time on the hospital site. The experience in some pilot sites reflected the findings that medical training, properly structured and organised, can be just as effective in shorter working hours.

The Report of the National Task Force on Medical Staffing (2003) emphasised that the retention of current on-call rotas will not reduce working hours. Implementation of the EWTD will require significant change in NCHD work patterns. The vast majority of NCHDs in Ireland already work a form of shift. However, some of these shifts are up to 36 hours in duration for most on call teams and often longer. Clearly, periods on duty will have to be of much shorter duration in the future. Future working patterns must enable NCHDs to participate in the full spectrum of service provision and be provided with learning and training opportunities equal to their peers. This means that in busy specialties, NCHDs will need to work defined periods on a duty roster. Such rosters would cover a multitude of different working patterns.

The Task Force noted that “all rosters must provide for a safe level of medical cover, allow for sufficient handover time, ensure that training can be delivered satisfactorily, and meet service needs and EWTD requirements while allowing NCHDs, consultants and other staff
a satisfactory quality of life. Each roster must take account of training needs, service needs, resources, tiers of cover, type and level of cover, distribution of workload amongst different grades or teams of staff, rest and break periods, frequency of duty, leave and compliance with EWTD requirements. Rosters should also be structured so as to maximise work life balance and ensure that rest period and days off are clustered together in so far as this is possible rather than fragmented to meet the minimum criteria of the EWTD. The minimum numbers required to deliver all these criteria are well documented.

6.3 Developing Rosters

When developing rosters for NCHDs therefore, employers should be mindful of the following:
1. ensuring high quality and safe patient care
2. time for required training both on and off site;
3. time for the delivery of training to others;
4. experience necessary to meet the relevant training programme requirements, including continuity of care and following a patient’s journey;
5. maximum association with relevant consultants within the full spectrum of experience required, including attendance at designated handover sessions once or twice daily, as per agreed protocols; for handover to work well there must be clarity about who is leading the handover and all relevant team members including consultants & NCHDs should attend;
6. rest days and time-off are structured to maximise work-life balance for the trainee;
7. available resources.

While it is technically possible to draft rosters that will meet the EWTD 48-hour week obligations, consideration must also be given to the impact such rosters may have on patient care and service delivery.

For some years now there has been much analysis undertaken by experts in the UK examining the challenges that achieving full EWTD compliance will present. Their suggested rosters were based on a maximum average work time of 48 hours per week. It is their considered view that a truly EWTD-compliant roster can only be achieved with a cell size of between 7 – 10 medical staff with the addition of one additional doctor per 4-5 doctors to address annual and study leave requirements. This is in stark contrast with an average roster cell size of 3-6 NCHDs in the majority of specialties as they are currently organised in Irish hospitals. In this context, a different approach to EWTD-compliance is required. The provision of round the clock rosters that are compliant with EWTD, the training needs of doctors, and service needs will require staffing levels that are impractical and unsustainable in smaller hospitals.

6.4 Implications for Training

The effect on NCHD education & training may be significant and will need some changes in the traditional apprenticeship model of training. The “Training Principles to be incorporated into New Working Arrangements for Doctors in Training”, set out in Appendix D (page 108-9) of the Report of the Postgraduate Medical Education and Training Group (Buttimer Report), states that “the postgraduate education and training environment will be attractive to all medical graduates, and deliver high quality schemes that will result in a sufficient
number of fully trained, competent doctors to deliver a patient-centred health service in this country”. The Buttimer Report also identifies a series of training principles which, when incorporated into new EWTD compliant rosters, will ensure the continued provision of high quality medical education and training. The general principles underpinning this vision are that:

- Educational and training opportunities in the workplace should be exploited and maximised;
- An artificial barrier must not be created between service and training;
- Because of the various working patterns between units and specialties there can be no one template roster;
- It is imperative that the training of NCHDs is of sufficient quality to safeguard the standards and continuity of patient care;
- The “prescription” as outlined in the Report of the National Task Force on Medical Staffing (Hanly Report) will “be implemented in full”.

A full shift system which will result in a reduction in NCHD daytime working hours, if applied to smaller hospital sites, with fewer NCHD WTEs, will pose a considerable challenge to effective training. This was highlighted by both trainers and trainees in some of the pilot project reports. In contrast the positive benefit of reduced hours on NCHD fatigue referred to in other pilot project reports is noteworthy.

This problem may be partly addressed by increased investment in off-site training, (currently provided by a number of training bodies using simulation technology), expanding video links to and between all training hospitals (large and small), developing national and international links with postgraduate training bodies and the development of competence based training. Protected training time to maximise training opportunities should be set aside to expose trainees to tasks specific to their training requirements. This can be achieved by reallocating some of the duties currently undertaken by NCHDs, by agreement, to other healthcare staff and by the more efficient organisation of non-emergency duties through maximising the use of agreed bleep policies by all members of the patient care team.

In a number of projects additional consultants were appointed leading to reduced working hours for NCHDs. While these temporary appointments did not involve a reduction in the NCHD numbers at each of these sites, the outcomes of these additional posts on patient care, NCHD supervision, EWTD compliance and NCHD training were consistently positive.

The proposed extension of on-site hours by trainers consequent to the revised consultant contract should increase consultant-provided supervision, education and training opportunities as was demonstrated in one project. Undoubtedly there will be a greater concentration of training on larger sites in the future to ensure the necessary knowledge and competencies are acquired in the anticipated reduced hours of exposure. A representative grouping of European surgeons, functioning under the umbrella of the Union Européenne des Médecins Spécialistes (UEMS) have called for a clearer distinction to be made between training time and working time, at least for some education. They have spoken of the 48 hours + 12 hours weekly schedule concept where the 12 hours would be guaranteed protected training time during which there would be NO employer requirement for service duties. It is only fair to point out that this proposal is not supported by the European NCHD representative body, the Permanent Working Group of European Doctors (PWG). Nevertheless this concept may be worthy of further consideration with the relevant parties in the Irish health service.
All the training bodies face a considerable challenge to ensure the continued high standard of training in the service but this challenge also provides opportunities to provide a more standardised and streamlined training structure to trainees.

6.5 Need for Innovation

Of particular importance therefore is progressing, as soon as possible, innovative, system-wide multidisciplinary solutions. Such solutions will be on the basis that the admitting or treating consultant continues to hold full clinical responsibility for patients under his or her care, potentially within the context of an agreed team of consultants as was examined in at least one of the pilot sites. In addition these solutions must ensure high quality, safe and preferably enhanced patient care. The key results from the individual pilot projects carried out under the guidance of the Local and National Implementation Groups point towards a number of specific actions which could be taken in relation to EWTD compliance:

- Provision of additional staffing/resources;
- Improved skill mix;
- Transfer of duties from medical to other more appropriate healthcare workers;
- Introduction of shift working and on-call off-site working.

Specific details of the methods used to reduce NCHD working hours in each of the pilot projects can be found in the executive summaries at Appendix H. It is essential that the methods tested in the pilot sites and proven to be successful in reducing NCHD working hours, are introduced on a national basis.

While it is acknowledged that there may be particular difficulties in achieving compliance in smaller hospitals and in certain specialities, the health system in Ireland cannot escape the wider obligations in achieving compliance with the statutory provisions and must address the consequent health and safety considerations for patients and staff alike.

It is seven months from the 48-hour average working week deadline of 1st August 2009. While the EWTD allows up to two further years for compliance to member states who encounter ‘difficulties’ and a further year for ‘special difficulties’ (2000/34/EC Article 1.6, amending Article 17(2) in 1993/104/EC), it should be noted that during these three years, doctors in training are restricted to an average of 52 hours work a week on-site. There is little or no difference in the service and operational implications for hospital and health services between a 52-hour as opposed to a 48-hour average working week. Rostering and rota requirements and the numbers of doctors needed to support either option are broadly identical.

At least six months before 1st August 2009, the Member States concerned must inform the Commission of their difficulties in meeting the timetable and their need for additional time. This allows the Commission to give an opinion, after appropriate consultations, within three months following receipt of such notification. If the Member State does not follow the opinion of the Commission, it must justify its decision. The notification and justification of the Member State and the opinion of the Commission shall be published in the Official Journal of the European Communities and forwarded to the European Parliament.
A major and repeated concern conveyed to the NIG by Local Implementation Groups has been the failure to apply on a permanent basis successfully completed Pilot Projects. This is based not only on the positive outcomes in respect of patient care and satisfaction, EWTD compliance and potentially more efficiency in use of resources, but also on the recognition that this success requires a fundamental cultural change in how services are delivered at each site. Such cultural change can only happen with significant time and communication with all participants. The Labour Relations Commission (LRC), in mid-2007, expressed the hope that the NCHD contract talks would be successfully completed by 1st November 2007 and furthermore that the widespread enforcement of the European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004 be in place by 1st January 2008. As of December 2008 the negotiations on the NCHD contract are ongoing.

The NIG-EWTD has not been party to industrial relations issues but would encourage all parties to ensure the successful conclusion of these talks. Ultimately whatever is agreed has to meet the obligations of the EWTD, must be satisfactory to NCHDs and their employers, must maintain or preferably enhance NCHD education and training and most important of all must ensure high quality and safe care to all patients.

The NIG-EWTD strongly encourages healthcare management and healthcare professionals, supported by the HSE and the Department of Health & Children centrally and the respective professional representative bodies to agree a strategy that will allow the required innovative practices to be introduced including providing such services over an extended working day. It is imperative that the lead-in time for training these professionals is considered, particularly where such training (e.g. advanced nurse practitioner) is currently in the early stages of development in some specialties.
7. Conclusions

1. The Pilot Project exercise has been enthusiastically embraced by most of the Local Implementation Groups. They are commended for their initiative, commitment and willingness to embrace change.

2. NCHDs in Ireland today are not compliant with the terms of the EWTD. This will be even more evident once the 48-hour week comes into effect in August 2009.

3. As NCHD rosters are currently structured any roster of 10 doctors or less is unlikely to comply with the EWTD either from the viewpoint of hours worked or availing of rest periods. In particular it will not be possible to achieve compliance in smaller acute units many of whom currently have duty roster cells consisting of 3-6 doctors. This also applies in several other specialties in larger hospitals.

4. Many innovative projects were undertaken by the Local Implementation Groups that
   i) were favourably supported in several patient satisfaction questionnaires undertaken,
   ii) improved patient care,
   iii) involved multi-professional collaboration and
   iv) achieved a modest reduction in NCHD working hours. Meeting rest period obligations has proven even more taxing, especially in those hospitals with fewer NCHDs.

5. Where pilot projects did achieve reductions in average hours worked by participating NCHDs these reductions were acknowledged positively by the NCHDs in terms of less fatigue, better work-life balance, better training opportunities in some instances and several examples of enhanced patient satisfaction during the period of the pilot.

6. In terms of education and training the experience was mixed – enhancement in some projects, not so in others. It is crucial that, regardless of reductions to NCHD working hours, such new working arrangements must not be at the expense of quality education and training programmes.

7. To achieve full compliance there needs to be a significant reorganisation of the existing acute hospital system and the way these services are provided. Any changes must:

   i) ensure high quality and safe care to patients,
   ii) promote multidisciplinary healthcare collaboration between healthcare professionals, including the redesignation of existing roles and
   iii) provide optimum educational and training opportunities for NCHDs and other healthcare professionals.

8. Additional consultant appointments in the context of new team-working arrangements should be given immediate consideration.

9. The delegation of non-medical duties to grades other than NCHDs can facilitate some reduction in NCHD working hours in addition to allowing NCHDs to focus on other aspects of medical care thereby improving efficiency of service delivery.
10. During the Pilot Projects NCHDs and other participating healthcare staff have shown both a willingness and flexibility to embrace changed work practices. Similar flexibility must continue to apply if new work practices are to be successfully implemented, especially the need to support the concept of service provision over an extended working day.

11. The challenge of EWTD compliance is not just meeting the total weekly hours’ target, but also complying with the rest period provisions.

12. Nobody should underestimate the challenges ahead and yet the Pilot Projects have shown that in larger hospitals at least (with their greater numbers of NCHDs) there is the capacity to achieve compliance with EWTD.

13. The NIG-EWTD is convinced that the challenge can be met and that the implementation of the EWTD can be attained if approached in a collaborative, coordinated and constructive manner. The outcome of such a partnership should ensure an enhanced service for patients and better educational opportunities and working conditions for NCHDs and all healthcare staff.
8. Bibliography


HSE – Employers Agency / Medical Manpower Managers data 2007.


Safe Handover: Safe Patients published by the NHS Modernisation Agency and the BMA. http://www.bma.co.uk

Appendix A

Membership of the NIG-EWTD

Chairperson
Prof. Cillian Twomey Consultant Physician in Geriatric Medicine, Cork University & St. Finbarr’s Hospitals, Cork

Group members
Mr. John Bulfin National Coordinator EWTD
Mr. Kevin Callinan IMPACT
Mr. Andrew Condon National Hospitals Office, HSE
Dr. Niall Considine Sligo General Hospital, IHCA representative
Mr. Joseph Cregan Department of Health and Children (DOHC) (replaced Mr. Larry O’Reilly in November 2005)
Mr. John Delamere HSE – Employers Agency
Mr. Eamonn Donnelly IMPACT (alternate)
Mr. Liam Doran Irish Nurses Organisation (INO)
Mr. Donal Duffy Irish Hospital Consultants Association (IHCA)
Ms. Gráinne Duffy Department of Health and Children (DOHC)
Mr. John Gloster Postgraduate Medical and Dental Board (PGMDB)
Dr. Róisín Healy Our Lady’s Hospital for Sick Children, IMO representative
Mr. Fintan Hourihan Irish Medical Organisation (IMO) (replaced Dr. McAleese in April 2006)
Mr. Asam Ishtiaq NCHD IMO representative
Mr. Des Kavanagh Psychiatric Nurses Association*
Dr. Anne Keane Medical Council
Mr. Dave Maguire DOHC (replaced Ms. Duffy in March 2006)
Mr. Tommie Martin Office of the CEO, HSE
Dr. Mick Molloy NCHD IMO representative
Dr. John Morris NCHD IMO representative (replaced Mr. Ishtiaq in March 2006)
Dr. Catherine Motherway College of Anaesthetists (replaced Dr. Surgeon in Nov 2005)
Mr. Brendan Mulligan HSE- Employers Agency
Mr. Brendan Murphy DOHC (replaced Mr. Maguire in May 2007)
Mr. Finbarr Murphy IMO (replaced Mr. Hourihan in September 2008)
Dr. Juliet McAleese Our Lady of Lourdes Hospital, Drogheda, IMO
Ms. Phil Ni Sheaghdha INO (replaced Mr. Doran in May 2008)
Mr. Gerry O’Dwyer Our Lady’s Hospital for Sick Children
Mr. Larry O’Reilly DOHC (attended the inaugural meeting in Sept ’05 only)
Ms. Louise O’Reilly SIPTU Nursing*
Dr. Margaret O’Riordan Irish College of General Practitioners (ICGP)
Dr. Nóirín Russell National Maternity Hospital, IMO representative
Dr. Matthew Sadlier NCHD IMO representative (replaced Dr. Russell in April 2008)
Dr. Bernard Silke Royal College of Physicians in Ireland
Dr. Ian Surgeon College of Anaesthetists (attended the first Sept ’05 meeting only)
Prof. Arthur Tanner Royal College of Surgeons in Ireland
Mr. Seán Tierney Tallaght Hospital, IMO representative

Joint Secretariat
Ms. Elizabeth Byrne Irish Medical Organisation (IMO)
Mr. Gavin Stanley IMO (replaced Ms. Byrne in May 2006)
Mr. Donal Moore IMO (replaced Mr. Stanley in October 2006)
Ms. Shirley Coulter IMO (replaced Mr. Moore in September 2008)
Ms. Aoife O’Riordan HSE - Employers Agency (HSE - EA)
Ms. Mary Ruane HSE - EA (replaced Ms. O’Riordan in October 2008)

* The PNA and SIPTU nursing have an alternating seat on the National Implementation Group.
Appendix B

Terms of Reference of NIG-EWTD as Provided in Labour Relations Commission Agreement February 2005.

Membership
The indicative membership of the National Implementation Group will be as follows; the Department of Health and Children (2), the Health Service Executive/Employers (5), IHCA (2), the Postgraduate Medical and Dental Board (1), the Medical Council (1), medical training colleges (4), the Irish Medical Organisation (6), nursing (2) and representatives of other relevant healthcare professions (1). The Group will be chaired by an independent Chairperson nominated by the Commission.

The Group will have a joint secretariat, i.e. Joint Honorary Secretaries - one of whom shall be nominated by the IMO. Their function will be to agree the agenda papers and meeting dates with the Chairperson.

Appropriate arrangements will be made for designated NCHDs to attend meetings of the implementation Body.

Functions
The primary consideration of the National Implementation Group is the continued provision of safe, high quality care to patients coupled with the provision of appropriate training to NCHDs during the EWTD implementation period. The National Implementation Group will:

a) Coordinate the work of the existing Local Implementation Groups and help them plan and support the implementation of the EWTD in line with the following three reports:

- The Report of the National Joint Study Group on the working hours of non-consultant hospital doctors
- The Report of the National Task Force on Medical Staffing
- Training principles issued by the Medical Education & Training Group

b) Issue of agreed guidance to health employers and other parties on issues related to the implementation of the European Working Time Directive

c) Assist in the development and evaluation of local implementation plans,

d) Initiate such research or data gathering exercises as are considered necessary,

e) Be responsible for communication with all national stakeholders on progress in the EWTD implementation process.

f) Review of the operation of the Body six months after the implementation of the Directive.
Appendix C

Guidance to and Membership of the Local Implementation Groups

Guidance issued to Local Implementation Groups (LIGs) was as follows:

Guidance to Local Implementation Groups-EWTD

Introduction

This document is divided into three sections, the first describing the role and terms of reference of the National Implementation Group-EWTD (NIG-EWTD); the second setting out measures recommended by key reports on EWTD implementation; and the third identifying areas which the Local Implementation Groups-EWTD (LIG-EWTD) should explore in detail and suggest proposals for change.

Implicit to the work of the NIG-EWTD is the need for a substantial number of additional consultant posts – as set out in detail in the Report of the National Task Force on Medical Staffing (Hanly Report). Equally, there is agreement that additional NCHD posts will not be created.

It should be noted that while individual patients will remain under the care of a named consultant, increasingly, consultants provide care as part of team of consultants and a wider multi-disciplinary team.

1. Role of National Implementation Group-EWTD

The primary consideration of the National Implementation Group is the continued provision of safe, high quality care to patients coupled with the provision of appropriate training to NCHDs. The terms of reference of the NIG-EWTD state that it should:

a) Coordinate the work of the existing Local Implementation Groups and help them plan and support the implementation of the EWTD in line with the following three reports:
   • The Report of the National Joint Study Group on the Working Hours of Non-Consultant Hospital Doctors
   • The Report of the National Task Force on Medical Staffing
   • Training principles issued by the Medical Education & Training Group

b) Issue of agreed guidance to health employers and other parties on issues related to the implementation of the European Working Time Directive

c) Assist in the development and evaluation of local implementation plans,
d) Initiate such research or data gathering exercises as are considered necessary,
e) Be responsible for communication with all national stakeholders on progress in the EWTD implementation process.

f) Review of the operation of the Body six months after the implementation of the Directive.
2. **How to proceed at local level**

Each Local Implementation Group now has the opportunity to use the data generated by the Hospital Activity Analysis to map out a series of steps towards EWTD implementation. Throughout this process, the primary consideration of each Local Implementation Group will remain the continued provision of safe, high quality patient care whilst ensuring the provision of appropriate training to NCHDs. An overall summary of the findings of the Hospital Activity Analysis for the nine pilot sites is available on request. You will already have received a detailed report of the analysis collected from your own hospital.

As a first step, Local Implementation Groups should have regard to the recommendations of two key reports - the 'Report of National Joint Study Group on Working Hours of Non-Consultant Hospital Doctors', 2001; and the 'Report of National Task Force on Medical Staffing', 2003. Recommendations on how hospitals can move towards compliance with the EWTD are set out at

- Section 4 - p60 onwards of the Report of the National Joint Study Group
- Section 3.2.9 – p33-38 of the Report of the National Taskforce on Medical Staffing.

These recommendations include:

a) Reducing the number of tiers of on-call cover

b) Expanding Cross-cover

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 surgery. The Royal College of Surgeons in Ireland (RCSI) encourages all surgical departments to refer to that guidance when developing – in conjunction with their Local EWTD Implementation Group – possible staffing rosters. A copy is enclosed.

Queries regarding cross-cover should be addressed to the National Implementation Group where they will be forwarded to and discussed with the relevant training body.

c) Changes in skill-mix and practice

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.

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9 This data is contained in an electronic database available to each Local Implementation Group, detailed reports on each of the nine sites studied during the Hospital Activity Analysis and a summary report describing activity across the nine sites.

This will involve identifying areas where health professionals could enhance their skills, improve their ability to undertake more complex tasks and/or broaden their range of capabilities in ways that lead to better management of clinical activity.

Local Implementation Groups should identify which members of staff are most appropriate – taking account of the clinical condition of individual patients - to undertake the tasks below. The following examples have been taken from the findings of the Hospital Activity Analysis. This list is for illustrative purposes and includes:

- Venepuncture
- IV Cannulation
- Urethral Catheterisation
- Naso-gastric tube insertion
- Suturing
- Drug Administration
- Drug Prescribing
- ECG Recording
- Writing a discharge letter (post decision to discharge)
- Finding and delivering X-rays and radiological results/data
- Finding and delivering pathology results/data

d) Developing a 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.

e) Handover
The Hospital Activity Analysis highlighted the extremely limited number of occasions on which formal handover takes place. Handover has 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:

- Medical and surgical handovers should be combined
- There should be clarity about who is leading the handover
- All team members should attend
- There should be a dedicated room for the handover

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.

f) Medical Education and Training and new rostering arrangements

Working with the Postgraduate Training Bodies and the Medical Council, the Medical Education and Training (MET) Group has published a series of training principles\(^\text{11}\), which, when incorporated into EWTD-compliant NCHD rosters are intended to ensure that medical education and training is not adversely affected by EWTD implementation.

\(^{11}\) Available at: http://www.dohc.ie/issues/european_working_time_directive/training_principles.pdf
In a shorter working week, one of the best means of ensuring sufficient experience is to expose trainees to sufficient workload with appropriate mentoring by senior clinicians, rather than requiring them to spend large amounts of time on the hospital site. Rosters must enable NCHDs to participate in the full spectrum of service provision and be provided with learning and training opportunities equal to their peers. This means that in busy specialties, NCHDs will need to work defined periods on a duty roster, rotating at regular intervals through early, day, and night duties. Such rosters will cover a multitude of different working patterns. These may include work at weekends, a week of early duties, a half-week, half days or work for a number of nights in succession.
3. Summary

- Taking the above into account, each Local Implementation Group can take a number of practical steps to facilitate progress by:
  a) identifying individual members of staff who will advocate and lead change,
  b) developing a communications strategy to communicate the findings of the Hospital Activity Analysis to staff and others who can contribute to change,
  c) developing a bleep policy and setting out the measures necessary to filter bleeps,
  d) setting out how handover might be developed,
  e) describing the opportunities for team working amongst staff covering the hospital during off-peak hours.
  f) Identifying areas where changes in skill-mix or practice would improve the delivery of patient care while reducing NCHD hours
  g) Setting out how cross-cover – in line with guidance from the relevant training body – could support service provision
  h) Taking account of the principles issued by the MET Group in order to ensure that that the delivery of medical education and training is not adversely affected by EWTD implementation
  i) Developing opportunities to move a proportion of the workload being completed at night into the daytime or into an extended working day,
  j) Documenting those areas where service redesign or reconfiguration is required to support reductions in NCHD hours and improvements in patient care,

- Proposals should be forwarded to the National Implementation Group by Monday 19th December 2005.

- Local Implementation Groups may not pilot or test these proposals without prior approval from the National Implementation Group.

- Queries relating to any aspect of this document or the measures set above should be sent to:

  Dr Cillian Twomey,
  Chairman, National Implementation Group-EWTD,
  c/o Cork University Hospital, Wilton, Cork and send a copy to:
  Dr Twomey c/o HSE Employers Agency, 63-64 Adelaide Road, Dublin 2

- The EWTD National Implementation Group Secretariat is:

  Elizabeth Byrne, Irish Medical Organisation; Tel: 01 6767273,
  Email: ebyrne@imo.ie

  Aoife O’Riordan, HSE Employers Agency; Tel: 01 6626966,
  Email: aoife.oriordan@mailt.hse.ie
### Membership of Local Implementation Groups

The membership of the Local Implementation Groups is as follows:

<table>
<thead>
<tr>
<th>Local Implementation Group</th>
<th>Membership</th>
</tr>
</thead>
</table>
| **Cork LIG – Cork University Hospital** | Mr. Tony Long, Deputy GM *(Chairperson)*  
Dr. John McAdoo, IMO Consultant Representative  
Dr. Mary Horgan, IMO Consultant Representative  
Dr. Pat Barry, IMO NCHD Representative  
Ms. Ber Baker, Business Manager, GMs Office  
Ms. Angela McGovern, Radiology Service Manager  
Mr. Noel Martin, Pathology Service Manager  
Ms. Mary Boyd Director of Nursing  
Mr. Mike O’Regan, IT Manager  
Ms. Lorna Sheehan, A/ Section Officer, Medical Personnel  
Ms. Mary O’Keeffe, Medical Manpower Manager |
| **Crumlin LIG – Our Lady’s Hospital for Sick Children** | Ms. Evelyn Hempenstall, *(Chairperson)*  
Dr. Martin White, Consultant Neonatologist  
Dr. Sean Walsh, Consultant in Emergency Medicine  
Mr. Feargal Quinn, Consultant Paed. Surgeon  
Mr. David Orr, Consultant Plastic Surgeon  
Dr. David Mannion, Consultant Anaesthetist  
Dr. Corrina McMahon, Consultant Haematologist  
Ms. Geraldine Regan, Director of Nursing  
Ms. Sharon Hayden, Assistant Director of Nursing  
Ms. Phil Ni Sheaghdha, INO Representative  
Ms. Suzanne Allen, Medical Manpower Manager  
and 3 NCHD representatives |
| **Galway LIG – Galway University Hospital Group** | Ms. Bridget Howley, Hospital Manager *(Chairperson)*  
Mr. Christy O’Hara, HR Manager  
Ms. Mary McHugh, Director of Nursing UCHG & MP  
Mr. James Keane, Medical Manpower Manager  
Prof. G. Loftus, Consultant Paediatrician Medical Board Representative  
Mr. Ray McLaughlin Clinical Director in Surgery /Consultant Breast Surgeon  
Dr. Kevin Clarkson, Consultant Anaesthetist GRH Intern Co-ordinator  
Mr. Joe Goulding, Medical Scientist Representative  
Ms. Noreen Muldoon, INO Representative  
Ms. Helen Murphy, SIPTU Nursing Representative  
Mr. Joe Garvin, Surgical Registrar UCHG IMO NCHD Representative  
Dr. Shaun O’Keeffe, Consultant Physician Merlin Park, IMO Consultant Representative  
Dr John Morris Medical NCHD /GP trainee IMO NCHD - Representative |
### Holles St LIG – National Maternity Hospital

- Mr. Michael Lenihan, Secretary Manager (*Chairperson*)
- Ms. Audrey Reinhardt, HR
- Ms. Cathleen Gray, Secretary
- Dr. John Murphy (Paeds), Consultant Paediatrics
- Mr. John O’Hara, EWTD Project Officer
- Ms. Karen Sherlock, Nursing INO
- Dr. Maeve Eogan, Consultant (pilot) Obs & Gynae
- Ms. Mary Brosnan, Director of Nursing and Midwifery
- Ms. Mary Hunter, Paramedical
- Dr. Mike Robson, Master
- Dr. Peter Boylan, Consultant Obs & Gynae
- Mr. Philip McAnenly, INO
- Mr. Tommy Hayden, EWTD
- Ms. Margaret Cooke, Nursing INO
- Dr. Kevin McKeating, Consultant Anaesthetics
- Dr. Cliona Murphy, SpR Obs Gynae
- Dr. Naomi McCallion, Consultant (pilot) Paeds
- Dr. Anne Doherty, SpR Anaesthetics
- Ms. Ann Delaney, Nursing Development
- Ms Penny Law, Consultant Obs & Gynae
- Ms Anya Curry – Paramedical

### Letterkenny LIG – Letterkenny General Hospital

- Mr. Patrick Murray, Medical Manpower Manager (*Chairperson*)
- Mr. Sean Murphy, General Manager
- Ms. Allison Sheppard, Assistant Director of Nursing
- Ms. Maree Blake, Radiography Services Manager
- Mr. Tony Doherty, Laboratory Services Manager
- Dr. Ken Mulpeter, Consultant Geriatrician (IMO Consultant rep)
- Mr. Gerard Lane, Emergency Dept Consultant (IHCA Consultant rep)
- Dr. Aidan Roarty, IMO NCHD representative
- Dr. Caroline McMonagle, IMO NCHD representative
- Mr. Noel Treanor, INO full-time official
- Ms. Edel Peoples, INO Nursing representative
- Mr. Austin Cribbin, SIPTU Nursing representative

### Limerick LIG – Mid-Western Regional Hospital Limerick

- Mr. Mark Sparling, A/General Manager, Mid-Western Regional Hospital (*Chairperson*)
- Ms. Majella Hogan, A/Section Officer, Medical Manpower Unit, Secretary to the Group
- Ms. Lorraine Rafter, Medical Manpower Manager
- Mr. John Hennessy, A/Network Manager
- Mr. Kevin O’Connell, Laboratory Services Manager, MWRH
- Ms. Mary O’Brien, Assistant Director of Nursing
- Ms. Mary Fogarty, INO Nursing Representative
- Ms. Pauline Ahern, Human Resource Specialist
- Dr. Mike Watts, Consultant Physician, IMO Representative
- Dr. Anne Merrigan, Consultant Surgeon
- Dr. Roy Philips Consultant Paediatrician
- And 3 NCHD Representatives
<table>
<thead>
<tr>
<th>Mullingar LIG – MRH Mullingar</th>
<th>Mullingar LIG – St Loman’s</th>
<th>St James's Hospital LIG</th>
</tr>
</thead>
</table>
| Mr. Joe Martin, General Manager *(Chairperson)*  
Dr. Sean Murphy, Consultant Physician,  
Ms. Anne Pardy, Medical Manpower Manager,  
Ms. Anne Kelly, Director of Nursing,  
Ms. Jean Corrigan, Superintendent Radiographer,  
Mr. Danny Connaughton, Medical Manpower Officer,  
Dr. Shu Hoashi, Specialist Registrar,  
Dr. Siobhán Kennelly, Specialist Registrar  
Ms. Clare Mulligan, Chief Medical Scientist,  
Mr. Trevor O’Callaghan, Hospital Manager,  
Ms. Imelda Gavin, CNM3 Theatre/SIPTU Representative  
Ms. Catherine Tormey, Night Superintendent/INO Representative  
Mr. Joe Hoolan, INO Representative. |
| Mr. Joe Martin, General Manager Acute Hospital Services *(Chairperson)*  
Dr. Lorcan Martin, Consultant Psychiatrist,  
Ms. Anne Pardy, Medical Manpower Manager,  
Mr. Larry Ward, Director of Nursing,  
Mr. William Toomes, HR Specialist,  
Dr. Tahir Galander, Registrar  
Ms. Ann Masterson, Hospital Administrator,  
Mr. Almas Naveed, Registrar  
Mr. Seamus Hoye, PNA Branch Secretary  
Mr. Pat Hughes, SIPTU Branch Secretary |
| Mr. Ken Hardy, HR Director *(Chairperson)*  
Mr. David Sweeney, Medical Manpower Manager  
Ms. Irene Moran, Deputy Medical Workforce Manager  
Mr. Paul Gallagher, Director of Nursing  
Ms. Paula Phillips, Assistant Director of Nursing  
Ms. Josephine Tully, CNM 2, Theatre  
Ms. Phil Ni Sheaghdha, Irish Nurses Organization  
Ms. Suzanne Dennan, Superintendent, Diagnostic Imaging  
Mr. John Gibbons, Laboratory Manager  
Ms. Joanne Harford, Physiotherapy (representing allied services)  
Mr. Dermot Moore, Consultant Vascular Surgeon  
Dr. Jeanne Moriarty, Consultant Anaesthetist  
Dr. Ross Murphy, Consultant Cardiologist  
Dr. Finbarr O Connell, Consultant Respiratory Physician  
Dr. Bernard Silke, Consultant Physician  
Prof. J B Walsh, Consultant Physician  
Dr. Aishling Loy  
Dr. Grainne O Kane  
Dr. Tommy Tun  
Mr. Dessie Robinson, IMPACT Representative |

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12 Mr Hoye died in August 2007 - RIP. The NIG-EWTD wants to acknowledge his contribution to the St. Loman’s Local Implementation Group and the service in general.
Appendix D

Pilot Project Proposal Application Form

APPLICATION FORM
FOR
EWTD IMPLEMENTATION PROJECTS

Please complete this form electronically, and

1. Email it to: cillian.twomey@hse.ie AND john.bulfin@hse.ie

2. Print it out and post hard copies to BOTH addresses below:

   Dr Cillian Twomey
   Chair
   National Implementation Group-EWTD
   c/o HSE Employers Agency
   63-64 Adelaide Road
   Dublin 2

   John Bulfin
   National EWTD Coordinator
   HSE Midland Area
   Central Office
   Arden Road
   Tullamore
   Co Offaly

NOTES

7. This application form is intended to standardise project proposals to the EWTD National Implementation Group. Proposals made in other formats will not be considered.

8. Those applying may wish to forward additional information. Such information should be attached to this form.

9. All relevant sections of the application form should be carefully completed. Inadequacies in this respect may lead to delays in processing the project proposal.

10. Closing date for receipt of applications is Friday 6th January 2006.

11. If assistance is required in completing the application form, please email andrew_condon@hse.ie or telephone: 045 882559
1. **Title of proposed project**

2. **Applicant details**

   - Pilot Site:

   - Local EWTD Implementation Group Chairperson:

   - Contact person:

   - Telephone:

   - Email:

   - Fax:

   - Name of Hospital:

   - Address:

3. **Approval from Local EWTD Implementation Group**

   *(Please state the date on which the Local EWTD LIG approved this proposal)*

4. **Summary of project proposal**

   *(Please summarise the proposed project in no more than 150 words)*

5. **Information details**

   - What specialty/specialties are covered by the project?
Summarise current staffing in the specialty / specialties covered by the project proposal:
(by grade, and if relevant, by specialty)

Summarise current staffing in the hospital by grade and specialty
(include the number of consultants, NCHDs, Nurses, health and social care professionals and management/administrative staff)

Summarise current NCHD hours in the specialties / areas covered by the project proposal by specialty and grade
(This should include a breakdown of on-site and off-site on-call, a description of the on-call structure and current compliance with EWTD rest/break requirements)

Summarise NCHD hours allocated to Medical Education and Training, Study or Research by specialty and grade

6. Details of the project proposal

What is the purpose of the project?

What timescale is proposed?
(Identify a date on which the project may begin, how long the project will take and a date on which the project will conclude)

Will the project involve any change in staff levels?
(describe by grade, specialty and duration of contract. Note that increases in the number of NCHDs will not be sanctioned)

Will the project involve additional resources or facilities?

How much will the project cost?
(Describe the main costs and identify expenditure on a monthly basis)

7. Outcomes and learning

Describe the changed work practices - if any – involved
(by grade and specialty)
Will the project involve the introduction of new staff roles? If yes, please describe:

Identify the reductions in NCHD hours which will result from the project:
(by grade and specialty and type of hour – rostered duty, on-site on-call, off-site on-call)

Identify any increased compliance with rest breaks which will result from the project:

Identify the ways in which the project will improve the delivery of patient care:
(e.g. reduce delays in waiting for NCHD on call; earlier access to more senior medical cover)

8. **Project Management**

Who will have operational responsibility for the project?

Describe the process whereby funds allocated to the project may be spent:

Describe the role of the Local EWTD Implementation Group in the management and oversight of the project:

9. **Project evaluation**

List three targets which the project will achieve:

Describe how these targets should be measured over the duration of the project:

Identify a date for a mid-term review of the project:

Describe how information or learning from the project will be recorded and distributed:
Appendix E

Terms of Reference of Nursing and Midwifery Expert Group

The terms of reference for the work of the Nursing and Midwifery Sub Group were agreed with the nursing unions on 24 November 2004.

They are as follows:

“The Nursing and Midwifery Sub Group will examine and report on issues as advised and requested by the National Implementation Group including:

a. Areas and issues relating to the scope of practice of nurses and midwives arising during the EWTD implementation process which will require a basis in legislation;

b. All measures/issues arising from extending the role of the staff nurse/staff midwife

c. Measures deemed necessary to facilitate the process of creating additional nursing and midwifery posts including Nurse / Midwife Specialist posts and Nurse / Midwife Advanced Practitioner posts in sufficient numbers to meet the need for altered roles and functions that may arise from EWTD implementation;

d. Skill-mix issues related to EWTD implementation where further clarification regarding scope of practice; and delegation; is required from the appropriate professional and regulatory bodies.

e. Other issues which may be referred to it by the National Implementation Group.”

Since this agreement, a number of discussions have taken place between members of the Irish Nurses Organisation, the Irish Medical Organisation, the HSE - EA and the Labour Relations Commission. Arising from these discussions the following clarifications were made to the terms of reference as agreed on 24 November 2004.

“The title of the group is changed to the Nursing and Midwifery Expert Group. The Expert Group now enjoys equal status with the National Implementation Group as regards nursing and midwifery issues. The Expert Group will continue to examine and report on issues as advised and requested by the National Implementation Group. It is agreed that communication between the NIG and the Expert Group will be through the respective chairs.

All Communication with the LIGs will be through the NIG. The National Implementation Group will coordinate the work of the Local Implementation Groups. A Conjoint Group will be established to facilitate discussion between the NIG and Expert Group on issues of a mutual interest.”
Appendix F

Guidance Paper from Nursing and Midwifery Expert Group

Who is part of this group?
This group includes the Department of Health and Children, the INO, SIPTU, PNA, Directors of Nursing and Midwifery, HSE, An Bórd Altranais and the National Council for the Professional Development of Nursing and Midwifery, a Director of Nursing and Midwifery Planning and Development.

What is the purpose of group?
This group is producing a paper as a preliminary guide to assist the National Implementation Group-EWTD (NIG-EWTD) and through it the Local Implementation Groups (LIGs) in their review of enhanced nursing and midwifery roles. Further debate and exploration will be ongoing and the NIG-EWTD and Nursing & Midwifery Expert Group will be meeting on a regular basis via the agreed Conjoint Group which is representative of both parties.

What does the Nursing and Midwifery Group recommend for nurses and midwives in the pilot sites for pilot projects?
The Nursing and Midwifery Group supports innovative nursing and midwifery practice including expanding roles which are responsive to service need. The group is agreed that nurses and midwives are ideally placed to take on increased responsibility for patient care and caseload management through new skills development and expanded and enhanced roles. The group is providing this paper to encourage and support nurses and midwives to examine their clinical areas for potential improvements in patient care through enhanced and expanded nursing and midwifery roles. The group identifies nurse/midwife managers within the pilot sites as pivotal to such examination of practice. The nurse/midwife manager is key to the enablement of this process. This paper acknowledges the key role of nurses and midwives in the health service and their very well developed knowledge, education, skills and competencies. Patients need to be looked after by the right person, in the right place at the right time with the right competencies. The nurse or midwife is often ideally placed given their availability on a 24/7 basis. A number of exemplars which outline areas as examples of clinical care provided by nurses and midwives which have developed in response to patient need are provided (see addendum).

Which nurses and midwives should be involved in expanded roles?
Expansion of practice should occur for all nurses/midwives on the clinical career pathway from staff nurse and midwife to clinical nurse/midwife specialist to advanced nurse/midwife practitioners. The expanded role of the nurse or midwife occurs from the point of registration and should be developed based on patient need. This is supported by national standards and processes i.e. the Scope of Nursing and Midwifery Practice Framework (An Bórd Altranais 2000) and the frameworks for establishment of Clinical Nurse/Midwife Specialist and Advanced Nurse/Midwife Practitioners (NCNM 2004a, b).

What clinical areas should be involved?
All nurses and midwives have the opportunity to be involved whatever the clinical setting for example general hospitals, midwifery, non-acute including elderly care, paediatrics, mental health, intellectual disability and community.
**How should expansion of practice happen?**
The decision for expansion of practice should be made where service needs indicate that such expansion of practice will enhance quality of patient care. Factors for consideration in expanding practice include anticipated patient caseload, potential patient benefits, clinical decision making required, support from multidisciplinary team and management, availability of resources and the expertise, skills and educational level of the nursing workforce and need for local protocols (see diagram next page). Expansion of practice must take place within the context of the Scope of Practice Framework (An Bórd Altranais 2000). There will be a need for further education programmes based on the competencies that will be required.

**What are the governance issues?**
Clinical governance is the system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

As partners in healthcare a multidisciplinary team approach should be taken when reviewing services. Audit systems should be in place to provide on-going evaluation for outcome measurements including evaluating the patient outcomes from nursing/midwifery contribution as part of overall clinical outcome. Expansion of practice is not just for after hours, it must be based on equity of access, high quality and efficiency of services. Therefore it must be a 24-hour response to patient need nationally.
ADDENDUM

Some examples

Example 1 Community based nurse-led wound clinic
Example 2 Cancer Care – introduction of Venepuncture and cannulation
Example 3 Enhancing Nursing Care for Haematology / Oncology/ patients
Example 4 Enhancing Nursing Care for Renal Dialysis patients
Example 5 Nurse-led Emergency Minor Injury Care for Adults and Children
Example 6 Nurse-led Anticoagulation clinic
Example 7 Midwife-led Discharge
Example 8 Midwife-led service
Example 9 Affective Disorders Nursing Service
Example 10 Mobility and Therapeutic Interventions
Service needs analysis / assessment

Skill mix
Consider the particular needs of service in the context of skill mix of staff available, i.e., nursing, medical, support staff and allied health professionals. What are the competencies needed? (i.e. by all personnel to provide the care required)

Physical Resources
Consider need for equipment, space

Expansion of nursing practice
Can service need be addressed by expanding nurses’ roles? i.e. developing competencies as necessary for service need in line with core philosophical basis for nursing care. Will quality of care improve for the patient?

Yes
No

Consider implications for service delivery i.e. service overview & activity analysis, projected level of new service to be provided. Resource implications.

Review Scope of Practice Framework (ABA 2000)

Are protocols needed?

Are new competencies needed? How will they be gained? (Consider CNEs, nursing practice development co-ordinators and 3rd level providers)

At what clinical level will care be provided? i.e. generalist, specialist or advanced nursing/midwifery practice.

Clinical & professional leadership
Who will provide the clinical leadership, peer review and clinical supervision for the expanded role? Appropriate clinical leads should be identified and could be senior staff nurses, clinical nurse/midwife managers, CNSs/CMSs, ANPs/AMPs or medical consultants depending on level of nursing practice.

Responsibilities in relation to level of care
Clarity and consistency around job titles, definition of roles, scope of practice and educational preparation ensures that the public and multi-disciplinary teams understand the level of care to expect and the knowledge and competence that the nurse possesses. This will require a communication strategy internally and publicly.

Teamworking and clinical standards
Development of nursing practice should be in the context of multi-disciplinary, multi-skilled teams. National guidelines and frameworks should provide the process and clinical standards required for best practice by all members of the multi-disciplinary team.
Appendix G

List of all submitted LIG Pilot Project Proposals

Note: The projects approved and undertaken are in bold type

Cork-LIG Cork University Hospital Group
• Anaesthesia, ITU: The introduction of a shift system to the Anaesthesia first on-call Registrar rota.
• Orthopaedic Surgery: Introduction of Trauma Coordinator
• Orthopaedic Surgery: Introduction of Clinical Specialist Physiotherapist to fracture clinic
• Plastic Surgery: Hand Therapy Led Clinics (OPD and Dressing Clinics) and Wound Care Clinical Nurse Specialist (Dressing Clinic). (Note: Although this project was approved it did not proceed.)
• Orthopaedic Surgery, Rheumatology, Neurology & General Surgery: Physiotherapy led low back pain screening clinic
• Orthopaedic Surgery: Set up Pre-assessment Clinics and Arthroplasty Clinics
• Accident & Emergency: Physiotherapy Frontline Practitioner in the Emergency Department.
• Obstetrics and Gynaecology: The introduction of a 48 hour working week for NCHD staff at Cork University Maternity Hospital together with a Consultant provided Maternity service
• Deployment of system for electronic management of and access to clinical information

Crumlin-LIG Our Lady’s Hospital for Sick Children, Dublin
• Emergency Medicine: Emergency Medicine - SHO Proposal
• All surgical specialities: Paediatric Surgery BST Proposal
• All medical specialities: Paediatric Medical SHO Proposal
• IV and Phlebotomy: Paediatric Nursing IV and Phlebotomy Proposal

Galway-LIG University College Hospital Galway
• Haematology, Oncology & Radiotherapy Project
• PICC Line Project
• Medicine and Surgery IV Cannulation Team Project
• Surgical Intern University College Hospital Galway Project (Note: Although this project was approved it did not proceed)
• Medicine & Surgery: Ward Standardisation
• Acute Surgical Admissions Unit
• Surgical Specialities: Extended Hours recovery room

Holles Street-LIG National Maternity Hospital, Dublin
• Anaesthetics: proposal to achieve full EWTD compliance for Anaesthetic Registrars
• Obstetrics & Gynaecology: proposal to achieve full EWTD compliance for NCHDs engaged in obstetrics and gynaecology
• Neonatology: Proposal to achieve EWTD Compliance below 48-hours for NCHDs
• Paediatrics: proposal to achieve full EWTD compliance for NCHDs engaged in paediatrics
**Letterkenny-LIG  Letterkenny General Hospital**
- Psychiatry: Review of the on-site on-call arrangements within psychiatric speciality at LGH with objective to convert to off-site working during out of hours periods
- All specialities within LGH: Development of a model for measurement and analysis of NCHD time dedicated to education and training activities, currently designated as working time.
- Anaesthesia: Implementation of a full shift EWTD compliant rota in Anaesthetic Department
- Medicine: Replacement of frontline Medical SHO on-call in MAU with Medical Consultant

**Limerick-LIG  Mid-Western Regional Hospitals Group, Limerick**
- Ophthalmology / A&E Pilot Project
- Paediatrics: Paediatric Phlebotomy & Reduction of working time of neonatal senior house officers
- Surgery and Medicine: Venepuncture and Cannulation Facilitator / Coordinator
- General Medicine, Surgical, Specialist Nursing: Further develop the anti-coagulation service for in-patient, out-patients and monitoring of patients on anti-coagulation therapy at home
- Orthopaedics: Theatre Care Assistant - MWROH Croom, Co. Limerick
- Rheumatology: Advanced Nurse Practitioner (ANP) in Rheumatology
- Obstetrics & Gynaecology: Midwifery-led assessment, admission and discharge of women greater than 37 weeks gestation with low risk pregnancies in the Admission Unit, Regional Maternity Hospital, Limerick
- Obstetrics & Gynaecology: Introduction of Perineal Suturing by midwives in the labour ward
- General Surgery: Reduction of interns’ working hours through the development of Preoperative Assessments Service
- Surgical & Medical Wards: Discharge Transport Administrator
- Surgery, ENT and A&E: Cross cover of BST SHOs in ENT with General Surgical SHO’s for the ‘out of hour’s’ period i.e. from 5pm to 9am

**Mullingar-LIG Midland Regional Hospital Mullingar**
- General Surgery: To achieve EWTD compliance and enhance education and training in the Department of Surgery
- Paediatrics: To develop consultant provision of service, reduce NCHD hours and protect scheduled teaching in the Department of Paediatrics
- Psychiatry: Achieving EWTD compliance at St Loman’s Mullingar
- Obstetrics & Gynaecology: Reduction of hours and enhanced teaching in Department of Obstetrics and Gynaecology at MRHM
- General Medicine: Introduction of EWTD to the Department of Medicine
- A&E: To support whole hospital EWTD compliance at MRHM

**St James’s-LIG  St. James’s Hospital, Dublin**
- Cardiology and General Medicine: Expansion of Multidisciplinary Team Roles in CCU/Robert Adams Ward
Appendix H

Executive Summaries of all approved Pilot Project Reports

Cork University Hospital Group

1. Cork University Hospital-LIG Anaesthesia Pilot Project
This project - full shift system for the first on call NCHDs - commenced on 25th September 2006 and terminated on 2nd February 2007. For the 18-week period, three locum consultants were employed at the cost of €210,000.

The roster implemented for the duration of the project is set out below. This was developed by the Department of Anaesthesia, Cork University Hospital and approved by the College of Anaesthetists in correspondence dated 15th March 2006. The College noted that there would be senior trainees on the hospital site when a consultant did not accompany the junior trainee. The roster achieved an average of 52 hours on site down from the existing 71-hour average at the time the NIG application was submitted.

<table>
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<th>No. in CUH/days</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wed.</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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</tr>
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<td>20.00 – 8.30</td>
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<td>OFF</td>
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</tr>
</tbody>
</table>

Break compliance
It was found that doctors working the shorter 9 hour shifts had on average 45 minutes break with a 60 minutes average over the longer duties. Verifiable information regarding break compliance is not available prior to the project period.

Leave taken
The roster gave satisfactory leeway to allow all forms of leave to be taken whilst leaving sufficient NCHD staff working the roster.
Completion of the project
On completion of the project, forms designed to capture requisite information for the 18-week period were analysed. NCHDs were surveyed and invited to express their views by means of telephone interview.

Completed returns were analysed under the following heading:

Hours’ variance and reasons:
The Hours worked were broadly in accordance with the roster with 42.83 excess hours recoded. The most common reasons cited for additional hours were:
- Theatre lists running over
- Transferral of patients to ITU
- Pre-operative assessments
- Hand-over to medical teams

In relation to tutorials & educational sessions, 87% of those questioned confirmed attendance. Responses to an improvement in work / life balance were evenly divided 50% indicating improvement and 50% not so. Consultant trainers and senior trainees (2\textsuperscript{nd} on call) were interviewed by Dr. Catherine Motherway as part of the project review conducted by the College of Anaesthetists, the following representing a summary of views expressed:

1\textsuperscript{st} Year Trainees’ Views

<table>
<thead>
<tr>
<th>Positives</th>
<th>Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifestyle</td>
<td>Premedication / Pre-assessment very difficult</td>
</tr>
<tr>
<td>Shifts as organised were better than A/E</td>
<td>Rigid time keeping would lead to leaving mid case</td>
</tr>
<tr>
<td>shifts</td>
<td>Not able to finish list.</td>
</tr>
<tr>
<td>Still had supervision by senior trainee</td>
<td>Decrease in consultant interaction</td>
</tr>
<tr>
<td>Less tired</td>
<td>Decreased exposure to ICU</td>
</tr>
<tr>
<td>Well organised</td>
<td>If the night is quiet then a big decrease in exposure to case load</td>
</tr>
<tr>
<td>Did not work unrostered time.</td>
<td>Attendance at CPE / education in off time</td>
</tr>
<tr>
<td></td>
<td>Extra consultants did not increase the consultant interaction as they were filling in during the day</td>
</tr>
</tbody>
</table>

Senior Trainees’ views

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worked</td>
<td>Not suitable for some modules where a lot of the work is day time</td>
</tr>
<tr>
<td>No problems with trainees</td>
<td>i.e. cardiac, neuro etc. Suitable for obstetrics, ICU, trauma, etc provided resources in place</td>
</tr>
<tr>
<td>All trainees very good</td>
<td>In his view not for senior trainees in the long term</td>
</tr>
</tbody>
</table>
**Consultants’ / Trainers’ views**

<table>
<thead>
<tr>
<th>Positives</th>
<th>Negatives</th>
</tr>
</thead>
</table>
| Worked with no difficulty  
Appeared to be no difference in confidence or ability of the trainees.  
One beginner only in the group who did very well | Anxieties re applying it to the second on call system for both resource and training issues  
Decreased contact with trainees both for interviews and references  
Confidence in allowing trainees access to difficult procedures  
Anxieties re effect on longitudinal care at senior level |

This external review also noted that for a sustainable roster, 9 to 10 NCHDs would be required allowing for annual/study/sick leave. It was postulated that training issues could be addressed in larger units, such as Cork University Hospital, provided resources were provided. Issues around consultant contact could be dealt with by an extended working day. It should be possible for CUH (and similarly sized units) to construct a roster with concentrated night work thus allowing trainees undertaking more specialised modules more day time access, the hospital having >8500 deliveries, a significant trauma workload and a busy ICU. From the training and patient point of view ICU should have 24-hour access to diagnostics, interventional radiography etc. The concept of ‘Training Time’ could be formalised whereby trainees could choose what they attended reflecting their training need at any given time. It was noted that this concept was also suggested by the UEMS Section of Surgery Group.

In conclusion, the Pilot Project established that this pattern of work was sustainable by supplementing consultant staffing in the Department of Anaesthesia. The level of service provided by the department was maintained for the period - theatre activity showing a slight increase of 1.28% from 6,248 cases in the period September 2005 to January 2006 to 6,328 cases for the same period in 2006 / 07. Consultant staff welcomed the additional numbers which facilitated greater supervision and teaching. The cost of the initiative - €210,000 - supported three additional consultant appointments for an 18-week period. Under the present NCHD contract, savings achieved if such a roster was formally adopted would only support 1.25 WTE consultants (this does not take cognisance of the pay increase due under the Consultants Contract 2008).

Before definitive conclusions are extrapolated from the Pilot project for the department as a whole, further detailed examination of the other on-call tiers would be required due to the differing levels of trainee experience and the complexity of the service currently provided. It should also be noted that there were no unexpected absences or leave by the participating NCHDs during the project. Due to the structure of the roster, such absences would have required cover.

**2 & 3. Cork University Hospital-LIG Orthopaedics Pilot Projects**

(2 linked projects)

This project ran from November 2006 to June 2007 - inclusive of training period and was composed of two separate appointments:
The Trauma service of the Orthopaedic Division in Cork University Hospital submitted an application to the NIG proposing the appointment of a Clinical Specialist Physiotherapist (CSP) for the purpose of assessing and managing under protocol simple, minimally displaced fractures at OPD review.

A second application to the NIG was for the role of Nurse Specialist Trauma Coordinator (TNC) and this was for the purpose of identifying and assessing patients with Traumatic Orthopaedic injuries to include documentation, communication and results and to put in place systems for the patient journey from admission to discharge.

The objective of the project was that the Orthopaedic Surgery service would be reorganised as Consultants, NCHDs, CSP and TNC together with the existing nursing and paramedical support and by doing so addressing the 7.00 a.m. start time, which is the norm for the service. The working day for the service prior to the project was 7.00 a.m. to 7.00 p.m. Notwithstanding unexpected difficulties regarding consultant staffing, the project ran to completion following which the working day had reduced to between 10 and 11 hours. This position has been maintained to date - it should also be noted that the TNC role has continued in post.

### Working Hours - Orthopaedic Surgery

<table>
<thead>
<tr>
<th>Grade</th>
<th>2006</th>
<th>Jan. 2007</th>
<th>Average 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>SpR</td>
<td>71</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>Registrar</td>
<td>77</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>SHO</td>
<td>77</td>
<td>77</td>
<td>74</td>
</tr>
<tr>
<td>Intern</td>
<td>74</td>
<td>75</td>
<td>70</td>
</tr>
</tbody>
</table>

Rest breaks were not captured prior to or at any stage of the project. The project gained wide acceptance amongst Consultants, NCHDs, Management & other staff grades - this was borne out in the follow up questionnaire to NCHDs, the CSP evaluation, external evaluations and fact that the TNC has been continued in post by hospital management on completion of the pilot project. During the period of the project, complaints concerning the service fell by 19% a position, which to-date has been sustained. Patient satisfaction was assessed by the CSP and is summarised as follows:

Anonymous feedback was formally sought from fracture clinic patients managed by the specialist physiotherapist, via a patient satisfaction questionnaire. The results of these completed questionnaires, using a Likert scale, are shown below. A total of 60 / 91 (66%) questionnaires were returned. The patient response to the clinical specialist role in fracture clinic was generally very positive.

For example, patient waiting-times for the specialist physiotherapist display a “good” rating of 47% (28 / 60) and a “very good” rating of 35% (21 / 60). The “poor” and “fair” ratings were minimal, at 8% (5 / 60) and 10% (6 / 60) respectively. The overall satisfaction “good” and “very good” ratings recorded by the patients of the specialist physiotherapist role in fracture clinic were 98% (59 / 60).

Additional patient comments included: “very pleasant specialist”, “the treatment was very good”, “great service, thank you”, “minor fracture, but dealt with very well…. suggestions for further exercises provided to strengthen joint & muscle & protect the joint”, “very pleased with my visit”, “very satisfied”, “very happy with service”, “very good experience”, “excellent care!”. 
Details of patient satisfaction questionnaire responses about the CSP role in the Fracture Clinic.

Returns/Total CSP Patients Question (60 / 91)

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting time</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>28</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Asked about symptoms</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>14</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>Explain Condition</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>Explain Rx / Mx</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>42</td>
<td>5</td>
</tr>
<tr>
<td>Time for questions</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>43</td>
<td>2</td>
</tr>
<tr>
<td>Understanding of the CSP</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>10</td>
<td>42</td>
<td>4</td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>47</td>
<td>0</td>
</tr>
</tbody>
</table>

CSP = Clinical Specialist Physiotherapist; N/A = Not Applicable; Rx = Treatment; Mx = Management.
Mean Age = 39.96 years Range = 6 - 80 years <16 years = 13 patients

In relation to departmental teaching, as this takes place early morning and was already well attended, the project did not have any significant affect on attendance levels. However, once the CSP had built up her own patient cohort and was practicing autonomously in clinic (last two months of project) one Registrar was then excused from OPD was then permitted time for self directed study. It was also stated by NCHDs in their commentary that the opportunity to learn and obtain direct advice from the CSP in clinic was a novel development.

In relation to work life balance, of the 13 NCHDs (6 Registrars and 7 SHO / Intern) who replied, 60% of doctors indicated that the CPS role had contributed to an improvement which, when clarification was sought, pointed to better organisation and running of fracture clinics which often see over 100 booked patients per session. However, the response concerning the TNC was only showed 29% indicating an improvement with 71% unsure. This may have been as a consequence of the ratio of Registrars to SHOs responding as the TNC role would have benefited SHO and Intern grades to a greater degree.

The evaluation conducted by the Clinical Specialist Physiotherapist suggested that the hospital should establish a CSP post as an effective alternative to a Registrar in the Orthopaedic Fracture clinic and that the role would become established member of the team in the fracture clinic, developing guidelines and providing clinic stability over a longer time period supporting the rotational medical staff.

The TNC concluded that if NCHDs are to reduce their hours then there is a need for more trauma nurse co-ordinators ideally working from 7am-7pm over a seven day week. If TNC’s were to be affiliated to particular consultants they would be able to attend clinics and cover on-call weekends with the relevant consultant thereby enhancing the continuity of care for patients, alleviating to some degree the fragmentation of care familiar to trauma services.

The external evaluation conducted by Mr. Patrick J. Kiely, Consultant Orthopaedic & Trauma Surgeon supported the above also noting the continuity brought to the service as a consequence of the initiatives but in order to maximise effectiveness, a multiplicity of appointments to each discipline would be required.
Expenditure on overtime for the Orthopaedic service was also examined, verifying that a real reduction in working hours has been achieved and maintained. This is further demonstrated by referring to the costs set out below in relation to the increases in rates of pay over the same period.

<table>
<thead>
<tr>
<th>Year</th>
<th>€</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>€1,204,403</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>€1,213,378</td>
<td>+0.75%</td>
</tr>
<tr>
<td>2008 (8 Months)</td>
<td>€733,235</td>
<td></td>
</tr>
<tr>
<td>2008 (Full projected)</td>
<td>€1,256,974</td>
<td>3.58% (est.)</td>
</tr>
</tbody>
</table>

In the period concerned, 2006 - 2008, pay scales have increase as follows: 1st June 2006: 2.5%, 1st December 2006: 3%, 1st June 2007: 2% and 1st March 2008: 2.5%. It can be confirmed that there were no other management interventions giving rise to this position.

This project demonstrated the following to the CUH LIG:
- Working hours and conditions of NCHDs were improved
- Both appointees achieved and delivered their service goals within a multidisciplinary team setting as set out in the NIG application.
- The project confirmed the potential to safely and appropriately transfer a quantum of work from NCHDs to other grades of staff. (Note: In the intervening period since the pilot phase ceased, the TNC is now trained in prescribing, applying POP and taking of bloods).
- The CUH LIG was satisfied that the appointments were consistent with the Report of the Task Force on Medical Staffing (June 2003) through identifying and addressing areas of work that need not be delivered by NCHDs
- The inability of the hospital to achieve the full reduction in working hours as anticipated was as a consequence of unforeseen difficulties in consultant staffing. However, should revised rostering of NCHDs be realized, non-medical staff will be an integral parts of a revised team structure led by consultants with NCHDs in training posts supported by a range of multidisciplinary support staff.

Galway University Hospital Group

1. Haematology, Oncology and Radiotherapy Project
2. PICC Line Project
3. IV Cannulation Team Project
(The following Executive Summary covers all three projects)

The EWTD Pilot Project
As a pilot site Galway University Hospitals Local Implementation Group (LIG) selected the Senior House Officers (SHO) in Haematology/ Oncology and Radiotherapy for a project designed to meet the EWTD requirements. The SHOs in this service worked on average 59 hours per week, including a 24 – 36 hour on call system without any mandatory break periods. This area is considered by the SHOs to be an extremely busy service during the day and particularly out of hours. As part of a multidisciplinary team the 14 SHOs provided ward cover, day ward cover and outpatient cover to all the above specialities on a 24-hour basis.
For the project the 14 SHOs were pooled together to form a shift based system. The longest shift was 13 hours in any 24 hour period, in all instances the 11 hour break period was observed. This system was piloted from October 2006 to March 2007 in agreement with the consultants in these areas. The majority of SHOs assigned to this area form part of the Western Pre-membership Rotation Scheme (WPMS), as it involved a changeover on the 1st of January 2007. 26 SHOs participated in this pilot project.

This change in working pattern was supported by an Intravenous Cannulation Team comprising an IV Cannulation Technician and three staff nurses working from 7am to 8pm Monday to Sunday. Three CNS worked Monday to Friday 9am to 5pm, one each in Haematology, Oncology and one CNS in Peripherally Inserted Central Catheters (PICC) a device used for the administration of chemotherapy. During the project the IV Cannulation Team and CNS in PICC provided a hospital wide service to 14 clinical areas.

**EWTD Compliance and Acceptability**

Over the six month period these SHOs worked on average 50 hours. In all cases the longest shift was 13 hours, the 11 hour break period was always observed. Feedback was obtained from the NCHDs, the Consultants and Nursing Staff. The majority of NCHDs were satisfied with the introduction of the EWTD rota. The majority reported a major improvement in quality of life. In addition the majority of NCHDs felt that patient care has remained unchanged. However both the Consultant and NCHD group felt that there were issues around continuity of care which could affect quality of care. Due to the shift system there was a reduced number of SHOs on the “floor”. This was seen as leading to over runs in the OPD. A comparison in activity levels between the same period in 2005 and 2006 showed that there was a marked increase in activity of both inpatient and OPD patients. SHOs felt there was a decrease in direct contact with consultants this was also supported from the feedback obtained from the consultants. The feedback from a representative view of nursing staff observed better quality of care and safer practice.

**Recommendations**

This report would support an increase in consultant’s manpower to provide a consultant led service. It highlights the importance of having NCHDs appointed by speciality rather than to a specific consultant. Improvement in the continuity of care of patients would be enhanced by the attendance of a Consultant/ Specialist Registrar at handover in the morning and evening time. In addition to improving patient care, this would also provide a valuable learning opportunity for NCHDs. The role of the IV Cannulation Team should be extended to provide 24-hour cover. This role should incorporate the taking of blood culture and the accessing of central lines.

**Letterkenny General Hospital**

1. **Psychiatry Off-Site Working Pilot Project**

**The EWTD Pilot Project**

A pilot project involving the Department of Psychiatry was undertaken between 18 Sept 2006
and 10th December 2006 inclusive. The project involved a change from on-site on-call working by NCHDs in Psychiatry, to providing on-call from home after 5pm Monday to Friday and all day at week-ends. During the project, NCHD staff on-call completed an Activity Analysis Diary form, which captured data on a number of agreed criteria.

**EWTD Compliance**
The findings suggest that NCHDs on-call were required on-site for an average of 1 hour 38 minutes per day, Monday to Friday, between the hours of 5pm and 9am the following morning. Attendance at weekends for each 48-hour period averaged only 5.5 hours in total, equating to 2.75 hours per day. This pattern of working, if continued would ensure full compliance with EWTD provisions up to, and including 2009 targets.

**Patient Care**
No additional clinical risks were noted with off-site working, though it should be noted that 5.3% (n=9) patient interactions were assessed as ‘life threatening’ by NCHDs. There was no difference in adverse incidents reported during the study, versus comparable period pre-study.

**Acceptability**
However, evaluation of NCHDs perspective of the pilot project – obtained via self-administered questionnaire - was negative in the main and ambivalent at best. All respondents (n=5) expressed negative feelings about off-site working, and favoured a return to 24-hour on call pattern. Responses were also unanimously negative about the impact of off-site working on salary, service delivery, clinical risk, continuity of patient care and wider application of off-site working, whilst feedback on education & training was mixed. However, there were no reports from either Consultants or Nursing staff of any diminution of service, or increased risk – indeed anecdotally responses indicated to discernible change in service delivery during the pilot.

2. **Anaesthetic Department Pilot Project**

**EWTD Pilot Project**
A Pilot Project involving the NCHDs in the Department of Anaesthesia was undertaken between 8th January and 15th April 2007. The project involved the introduction of full shift working amongst the NCHD cohort, replacing the standard 24 hour on-call system, where all NCHDs worked Monday – Friday 9am to 5pm each week. The project was introduced without the recruitment of additional Consultant or NCHD staff.

The project was analysed in a number of ways, but primarily via staff feedback. NCHDs were issued with Questionnaires at three stages i.e. pre-pilot, during pilot and one month after completion of pilot. Consultant Anaesthetic staff and Theatre Nurses were also surveyed once, during the project. A ‘Comments Diary’ was placed in the Anaesthetic Office, to facilitate staff record comments & feedback contemporaneously. Feedback was also obtained from the nominated representative of the College of Anaesthetists. Attendance records were reviewed to establish compliance with shift patterns, and capacity of staff to finish work at scheduled time. Clinical Incident reports for the period were also reviewed, to establish evidence of adverse incidents.
EWTD Compliance
The findings suggest that the project provided full compliance with the provisions of the European Working Time Directive, in respect of actual hours worked and rest provisions. There were also potential financial advantages to the organisation, though in the main these were relative to reduced operational man hours available. There is self reported evidence that staff felt more alert when on duty, which has potential benefits for service delivery and patient safety. No adverse clinical incidents were reported during the Pilot Project. The impact on work life balance was mixed, with equal numbers of staff at all levels identifying positive and negative elements.

Acceptability
Feedback from NCHDs, Consultants and COA representative all expressed significant concerns in relation to a number of areas. The NCHD concerns were centred on Education & Training, Clinical Supervision, Pay and the perceived rigidity of the full shift pattern. Consultants were concerned about Clinical supervision and assessment of NCHD competence, increase in Consultant workload and Continuity of care. The College of Anaesthetists representative was concerned about NCHD restricted access to pre-med assessments, the structure of the full shift roster (night duty in particular), and reduced training opportunities arising from a) reduced direct contact with Consultants and b) limited learning opportunities out of hours.

In general terms, the response to the project – as recorded via staff feedback – was negative, whilst the outcome of the project – in terms of EWTD compliance – was positive. All NCHDs indicated a preference for the 24-hour on-call work pattern, when questioned after the project.

3. Development of a model for the Measurement and Analysis of time dedicated to Education and Training activities, currently designated as working time, by NCHDs in Letterkenny General Hospital

In line with the European Working Time Directive (EWTD), from 1st August 2009, the working week of Non-Consultant hospital doctors (NCHDs) is to be reduced to 48 hours. This represents a major challenge for Letterkenny General Hospital (LGH) and indeed for all designated teaching hospitals, in enabling the NCHDs to be trained in a system that while compliant with the EWTD, retains its primary focus on service delivery. Letterkenny General Hospital currently employs 51 Consultants and 115 non-Consultant hospital doctors. This project concerns the majority but not all of the specialities within the hospital. The project began on 3rd September and finished on 12th November 2008.

The primary objectives of the project were 1) to devise a mechanism to capture and analyse the amount of NCHD time dedicated to education and training activities currently designated as working time and 2) to produce a template whereby this pilot project could be replicated nationally in a consistent and coherent manner.

Methodology
The research methodology was varied and included semi-structured interviews with hospital management and Consultants and questionnaire feedback from the NCHDs. The Researcher used non-participant observation to gain insight into the training and education potential of ‘on-the-
job’ experience of junior doctors. This involved accompanying three medical teams on their ward rounds. The quantitative aspects of the research focused on identifying and collating current data held by the Administrator in the Medical Education Office regarding the attendance by NCHD at teaching sessions.

Research Findings
It was evident from the attendance records collated for lunchtime teaching sessions in the hospital, that attendance rates for most grades and specialties are below 70%. Based on both discussions with the NCHDs and feedback from their questionnaires, the main reason presented for not attending these session, is clinical service demands.

In terms of attendance records for educational events within specialities, the research findings indicated that practices vary widely across specialities. Some specialities keep detailed on-line records for all their educational events while others keep attendees’ name for only some of their events. Based on this evidence, it was concluded that under current arrangements, it is not possible to accurately quantify the amount of time spent by NCHDs at departmental educational events.

Based on the evidence from the observational research, it was concluded that because of the complexity and inter-relatedness of service and training, it would be extremely difficult to separate out ‘service’ from ‘training’ and therefore to quantify the ‘on-the-job’ time that NCHDs spend on training and education. Feedback from the NCHD questionnaires and interviews with Consultants both conveyed a strong view that all of their daily activities have both educational and service components.

The majority of Consultants and NCHDs interviewed indicated that maintaining departmental attendance records would be a beneficial long term practice because it would provide tangible evidence of all the good practice happening in the area of education within LGH. However, more negative feedback was obtained in relation to the proposal to record NCHD attendance at these events during working hours as ‘training’. The reservations expressed by the Consultants regarding the proposal were based on their belief that these sessions are an integral part of the work being carried out in their department and that often actual patients are being discussed. However, the feedback from the NCHDs was more negative; many expressed apprehension that these proposals would have pay implications for them. NCHDs felt they should continue to be paid for this time as they have to respond to their bleep during the sessions and are therefore ‘available for work’. It is important that these concerns are acknowledged and considered when planning the implementation stage of any new recording process.

Recommendations
Based on the above findings, the proposed mechanism for capturing the amount of NCHD working time spent on training and education involves a strengthening of practices that are already in place in the hospital, namely the completion of weekly attendance forms by the NCHDs and using a sign-in attendance book at all departmental and multi-disciplinary educational events.

The aim of the proposed recording mechanism would be to capture individual attendance at training and educational events, via the completion of a weekly time attendance form. Each NCHD would indicate on the form, in addition to their usual daily working hours, any educational event
they attended that day and its duration e.g. 2-3pm. The process surrounding the attendance form remains the same; each NCHD would continue to get the timesheet signed by their Consultant and then forward the form to the HR Department.

Two options are presented here: these will be referred to as Option A and Option B. Option A involves using Excel to capture and report the attendance data. It is possible using this mechanism to produce a weekly and / or monthly excel report which quantifies the amount of NCHD time spent on training during rostered hours and otherwise. The report can also provide this information related to specific grades and specialities. An example of the proposed Excel spreadsheet and the type of report that could be produced is attached.

Option B involves using the LGH’s existing PPARs system which is used to process payments for hospital staff. PPARs records currently exist for each NCHD and it would be possible, using an additional training code, to input individual training records for each NCHD. The primary benefit of using PPARs would be the system’s reporting function; it can provide details of the hours the attendee was at the event and can transfer the information produced into an Excel format in a matter of seconds. PPARs can also provide a cost analysis of the hours spent on attending training on a weekly or monthly basis. It appears to be an attractive and effective option for those hospitals that have a PPARS system in operation.

Both options would require a facility to monitor and audit the process to ensure the accuracy and veracity of the returns being made. The mechanism proposed for this involves a strengthening of practices that currently exist in some of the specialities in the hospital, namely implementing the practice of each NCHD signing an attendance book at these sessions and indicating the time he/she arrived for the session. An attendance book is already in operation for the three core curriculum teaching sessions provided.

A model outlining the six steps involved in this new reporting process is available in the main report. Step six of this model, which involves the Consultant discussing these records with their NCHDs, may serve to balance the monitoring requirements of the recording mechanism with its professional development aspect. In agreeing any new recording mechanism, cognisance need to be taken of the concerns expressed by both NCHDs and their Consultants; in addition, clear user-friendly procedures are required, with a built-in mechanism to ensure compliance and accuracy. It is recommended that the new recording mechanism should be piloted within a designated specialty for a one month period prior to roll out to the hospital.

The main advantage of the proposed model is that it builds on existing practices within Letterkenny General Hospital, while at the same time, has the potential to achieve the desired objectives. The additional training requirement and financial commitment associated with its introduction would be minimal as it involves the application of a few additional tools within an Excel system. Another advantage is that giving each NCHD responsibility for recording and submitting their own attendance should encourage them to take ownership of their medical education and enable them to make informed choices about future proposals for EWTD compliant rotas. The reports produced by the mechanism would also play a pivotal role for hospital management in designing and negotiating EWTD compliant rotas.
In terms of the application of the learning from this pilot project nationally, the outlook is positive based on the premise that NCHDs in all hospitals are required to complete attendance forms in order to receive payment for hours worked. The information on these attendance forms is then inputted into a system, whether it is Excel or PPARS, so the practice itself is transferable. The template produced as a result of this project is based on Excel and available for immediate use by any hospital. The challenge, as with any change, lies in implementing the change in a way that ensures that all stakeholders are informed and supported at every stage of the process. This means highlighting the reason for the new work practice, giving stakeholders an opportunity to highlight their concerns or suggestions and educating them as to what is required of them as an individual and a department.

Protected education time may play an important role in maintaining team cohesiveness in the future climate of EWTD compliant rotas and the role of regular feedback will also take on additional significance. The mechanism being proposed here represents a vehicle for communicating to NCHDs that their education remains central to our hospitals; it also provides hospital Consultants with an evidence base for beginning or continuing to provide regular feedback with their team members. Finally, it provides hospital management with the information they need to ensure compliance with the EWTD.

Mid-Western Regional Hospital, Limerick

1. Ophthalmology Casualty Service Pilot Project
This report describes an evaluation of the pilot project that was undertaken in the Dept of Ophthalmology, in conjunction with the Department of Emergency Medicine in the Mid-Western Regional Hospital, Limerick. The pilot provided an opportunity for testing potential solutions for compliance with the European Working Time Directive (EWTD) and the implementation of the project was supported by robust monitoring and documentation which facilitated an objective and quantified assessment of the impact of the revised changes. It is hoped that the outcomes of the project evaluation will provide a sound basis for other sites around the country to emulate similar arrangements.

At all times during the course of the project, the evaluation team were cognisant of the view that whilst striving towards EWTD compliance, the changes implemented by the pilot should safeguard the primacy of quality patient care and should not compromise the quality of NCHD training.

The key aims of the pilot were to achieve the following:

- Reduction of on-site on-call hours
- Relief of NCHDs from inappropriate non-clinical duties through the assignation of a nurse to the Casualty clinic
- Improved training opportunities for NCHDs, thereby allowing them to spend more time on complex cases
- Key success factors of the pilot included the following:
- Reduction in the on-site hours and a consequent increase in off-site hours for each grade of NCHD.
Improvement in staff work experiences
Protection of Medical Education and Training
Primacy of patient care safeguarded

This pilot demonstrated that compliance can be achieved with the European Working Time Directive, without any detrimental effect on patient care or NCHD training.

2. Paediatric Phlebotomy Pilot Project
This report examines the potential for a reduction in Neonatal Senior House Officer working hours in the Department of Paediatrics, Mid Western Regional Hospital. The pilot undertaken in the Dept of Paediatrics provided an opportunity for testing potential solutions for compliance with the European Working Time Directive (EWTD). This pilot commenced on January 2nd 2007 for a 6 month period until June 30th 2007.

The key aims of the pilot were to achieve the following:
A. Reduction of on-site on-call hours for all Neonatal SHOs working in the Dept of Paediatrics
B. Relief of all NCHDs and in particular the Neonatal SHOs from inappropriate non-clinical duties through the assignation of a phlebotomist to the Paediatric Day Ward and the Paediatric Bay in the Emergency Dept.
C. Improved training opportunities for all NCHDs and in particular the Neonatal SHOs, thereby allowing them to concentrate on more specialised tasks which are more relevant to their training needs.

A key outcome for the pilot project was to achieve European Working Time Directive compliance and the pilot achieved the agreed reduction in working hours for Neonatal SHOs. These reductions were in line with the targets that were set out in the project proposal and approved by the National Implementation Group. Average hours decreased by 8 hours from 71 to 63 hours during the pilot, equating to an overall reduction of 38.19 hours in the working week. While the full 11 hour rest break was not achieved immediately after on-call, delayed compensatory rest was facilitated with the SHO on-call going off duty at 12 pm. This was a significant improvement on the previous working arrangements for the Neonatal SHO.

The piloted work practices were welcomed by all participants in the pilot arrangements. All of the NCHDs involved in the pilot were extremely happy with the delegation of duties to the Phlebotomist and felt that the appointment had assisted them in concentrating on tasks more relevant to their training needs. Nursing staff gave very positive feedback to the revised arrangements noting improved patient care and improved quality of service for all service users. Similarly, Consultants in the Department felt that the pilot arrangements had worked extremely well and provided a good opportunity to modernise the way SHOs work. Ultimately, they felt that the pilot project provided a stimulus for evolving the workforce around the needs of the patient, resulting in faster treatment for patients, better patient experience and a better working environment for staff.

While it was apparent and important that the project achieved acceptability by all the staff participants, more importantly its effect on patient satisfaction was extremely encouraging. The
parents/guardians using the service were all extremely complimentary of the service provided by the nursing staff and very positive feedback was received with many commenting on the positive experiences they had encountered with the staff involved.

Overall, the pilot project was a great success with a tangible value for money dimension, accruing a cost saving of €14,226.00 and without having to take on an additional NCHD in the Department. The transfer of phlebotomy tasks previously undertaken by Junior Doctors to a skilled phlebotomist has assisted in reducing NCHD working hours whilst continuing to support training opportunities and enhancing work life balance. More significantly, the pilot has culminated in a faster, more efficient service for patients and a better patient experience.

It is hoped that the outcomes as set out in this report will provide a sound basis for other sites around the country to emulate similar arrangements and will be a significant resource to all those involved in planning for skill mix changes as part of a range of EWTD compliance measures.

**Midland Regional Hospital Mullingar**

1. Department of General Surgery Pilot Project

**Department Profile**
The Department of General Surgery at Midland Regional Hospital, Mullingar has a significant challenge in meeting EWTD compliance with a staffing level of 3 Consultants, 3 Registrars, 3 SHOs, 2 Interns and 3 locums (1 Registrar, 2 SHO). Current average working hours are 73 per Registrar, 63 for SHOs and 52 hours per intern, based on the traditional 24 hour on call structure. Activity in this department in 2006 was as follows:

- Total Inpatients: 2670
- Day Cases: 2697
- Outpatients: 7862

**The EWTD Pilot Project**
The EWTD Pilot Project in General Surgery proposed to reduce working hours and facilitate partial rest break compliance through the creation of a two team structure of two Consultants, each team working as one unit with a combined team of two Registrars, two SHOs and three Interns. This two team structure required the addition of a 4th Consultant in the Department of Surgery. In practice, each of the two Registrars would be expected to be familiar with all patients for the combined team, with a handover period at the end of each 24 hour call. Two SHOs would also be attached to each team, allowing for 1 SHO to be on leave, one on nights and three on day duty. The interns would work days only, with one extended day per week from 8am to 9pm.

This project commenced on 1st July, 2006 for a six month period and proposed a reduction from 52 hours to 48 hours per intern, a reduction from 63 hours to 53 hours per SHO and a reduction from 73 hours to 60 hours per Registrar. A key feature of the team structure was the identification of a set weekday on call which could allow a synchronisation of the on call and scheduled 9-5 activity for each team. At present, there can be a simultaneous demand for Consultant management of planned elective surgical activity and acute admissions. This model separates these two activities, allowing earlier assessment of an acute presentation by the Consultants.
Skill Mix

Based on the findings of a Hospital Activity Analysis (April 2005), a number of duties were identified which could be undertaken by other grades of staff. There was significant potential recognised for the development of skill mix within nursing, commencing with IV cannulation and phlebotomy. Healthcare assistants were introduced to back fill nursing hours for night duty. An innovative change in skill mix was introduced with the creation of the role of team secretary for each of the two teams. These team secretaries differ significantly from existing medical secretaries in that they attended ward rounds and undertook administrative duties previously carried out by NCHDs.

EWTD Compliance

Registrar hours reduced by an average of 7 hours per week, 6 less than the proposed 13-hour reduction. There was full compliance with the 35 hour rest period each week for the month of August, in two cases there was 75% compliance. All four Registrars were fully compliant with the 11-hour rest period preceding 24 hours worked. However this was not the case with the 11 hours rest following 24 hours worked, with 25% compliance in one case.

The 3 interns’ hours were reduced by an average of 10 hours per week from 52 to 42 hours, 6 hours more than proposed in the project. The Pilot Project achieved full EWTD compliance for Interns for both hours and rest breaks.

The 5 SHOs hours were reduced by an actual average of 2 hours per week from 63 to 61 hours, 8 less than the proposed reduction, but achieved the project target for rest breaks. At SHO level, the project did not meet the project targets and reduced working hours by an average of 2, with full compliance with the weekly target for rest breaks. The main contributor to a limited reduction in hours for the SHOs was the lack of cover available for leave periods. The two-team structure relied heavily on intern cover during daytime periods. Unplanned intern leave was covered from within the SHO complement, maintaining their original hours for much of the project duration. The staff shortfall in manpower at SHO level in particular was highlighted in feedback from the majority of respondents and was a constant subject in reviews of project progress with all staff.

Staff and Trainer Feedback

The results of the staff questionnaires suggest there was general satisfaction with the new work practices and that there was good co-operation to support new arrangements at a multidisciplinary level. The feedback from all participants suggests this project is sustainable with certain modifications. Overall, there was a very positive response to the new arrangements in delivering a high standard of patient care.

The report of the postgraduate trainer is generally positive in terms of education and training in the context of the pilot project and reflects many of the same points presented in the questionnaires. The most consistently positive feedback received was for the team secretaries, with all respondents feeling that they contributed to both reduced NCHD hours and an improved system of care. Overall, NCHDs indicated that there was an improvement with work life balance with more free time for family and other interests, in addition to feeling fresher starting duty after a rest period.
Application of the project to other settings
The concepts within this project could easily be applied to many similar units throughout the country, with amendments in line with local need.

The Department of General Surgery and the LIG would welcome the opportunity to implement this project on a permanent basis, with certain amendments based on the lessons learned in the pilot stage. The main required change is the provision of sufficient locum cover for all NCHDs to ensure target hours are maintained on an ongoing basis.

2. Department of Paediatrics Pilot Project

The EWTD Pilot Project
The Paediatric project at Midland Regional Hospital Mullingar is unusual in its proposal to resource a long-standing 58 hour roster as an alternative to increasing hours in order to address serious service and training deficits. The roster in place in this unit was designed pre 2000 in advance of an increase in the birth rate and associated increase in OPD and emergency service demands in Mullingar.

It was proposed that the hours and roster structure could be adequate if supplemented by two consultant paediatricians who would adopt a “hot week” structure which involved taking all admissions for one week and not having OPD respiratory that week. In addition, two paediatric phlebotomists working an extended day were employed to remove the significant amount of cannulation/phlebotomy undertaken by NCHDs. Finally, a CNS in respiratory was employed to undertake patient education and non-medical follow up care of those presenting with chronic conditions in this area.

The project commenced on 1 July 2006 for a 6 month period. There were initial difficulties recruiting the required staff and dealing with organisational problems of space and facilities. The project was only fully in progress by August, 2006.

EWTD Compliance
The project was not designed to achieve a restructuring of the roster and could not address rest breaks with the existing numbers. It did facilitate hours below 2007 compliance levels at 54.1 hours for Registrars and 55 hours for SHOs.

Acceptability
There was a unanimously positive response to the CNS in respiratory and the paediatric phlebotomists. There was mixed reaction to the ‘hot week’ structure for consultants and this would require further review.

Patient Care
Indirect feedback suggests patient care was enhanced by the resources available for the project. A greater level of senior decision making is evident in the 20% reduction in admissions over the project period.
Education and Training
The postgraduate trainer concluded that teaching and supervision of the NCHDs had increased with the appointment of the additional consultants.

Value for Money
While the project required substantial resources, it was considered value for money in improved patient care.

Recommendations
The project should be implemented in full to deliver 56 hour compliance with the EWTD. Consideration needs to be given nationally to how full EWTD compliance can be achieved within current structures and departments of this size.

St. Loman’s Hospital Pilot Project

The project
A pilot project involving the Department of Psychiatry, St Loman’s Hospital was undertaken in July 2006. This project involved formalising an off-site arrangement for on call and auditing the out of hours contacts during this time.

EWTD compliance
The project found that the 48 hour weekly limit could easily be achieved with an off-site on call arrangement, with average working hours below this EWTD target. NCHDs were called in from home for an average of 1 hour 13 minutes daily over the period. Full rest compliance, unbroken for an 11 hour period, was achieved on 6 of the 31 days. For the remaining days, while the NCHD was called in for an average of 1 hour 13 minutes out of hours, this could occur at any time during the night which resulted in the 11 hour break being interrupted. On examination of the daytime service profile it was found that compensatory rest could be provided if required.

Acceptability
A focus group was held with Consultants, NCHDs, LIG Chairperson, HR Specialist and the Director of Nursing to determine the acceptability of the arrangement to all participants and raise any concerns. Issues raised regarding patient care included the management of medical emergencies out of hours and it was suggested that in fact it was best clinical practice that medical emergencies would be referred to the ambulance service (EMTs) in the first instance and transferred to the General Hospital Emergency Department if required. In addition, there were concerns regarding the reliability of mobile phones as the communication system for off-site call and a solution of using long range pagers was proposed. In order to minimise calls out of hours, introducing a bleep policy was considered beneficial. A concern raised by some members of the group was the potential impact on NCHD salaries if this arrangement was introduced formally. Finally, the response time required and acceptable distance from work was noted as an area requiring clarification. In general, the offsite arrangement was deemed the preferred approach to ensure the protection of daytime services and protect NCHD availability for teaching sessions. It was also considered best for quality of life by the NCHDs delivering the service.
Patient Care
No clinical risks were highlighted during the period of the pilot project. On further discussion in 2008, it has been suggested that the service demands have increased, partly related to the implementation of the Mental Health Act. While the activity increase would appear to impact primarily on the normal working day or late into the evening, it is proposed that prior to implementation, the hospital would need to be satisfied that the activity has not increased to the extent that an on site arrangement is now required.

Education and Training
There is a highly organised system of Education and Training in operation in this Department which was not impacted on in any manner with this arrangement. NCHDs remained fully available for all teaching sessions and therefore the impact on education and training was not considered to require specific evaluation. In contrast, had an on-site arrangement been deemed necessary, NCHDs would have lost out significantly in access to training on the days pre and post call.

Value for Money
Based on the current on-call demands, a formalisation of an off-site arrangement would represent significant value for money.

Sustainability
Having regard to the existing service demands and demographic trends, it is considered that this approach would be sustainable into the future.

Work Life Balance
There is unanimous agreement that this arrangement is preferable from a work life balance perspective.

Recommendations
The Off Site call structure is the preferred arrangement and could be implemented to achieve EWTD compliance, subject to clarification of local hospital requirements with regard to response time.

National Maternity Hospital, Holles Street

1. Anaesthesia

The EWTD Pilot Project
This report describes a pilot study initiated in an attempt to have Anaesthetic Registrars comply with the European Working Time Directive (EWTD) in the National Maternity Hospital.

At all times during the project from 1st January through to 31st December 2007 those implementing the project were cognisant of the primary objective that, whilst striving to attain compliance with the directive, the changes would not impugn the quality of patient care and would not compromise acquisition of education, training and experience by the Registrars.
The principal aim of the initiative was to bring Anaesthetic Registrars’ work practice into compliance with the EWTD i.e.
- Maximum working period
- Rest periods
- Reduction of onsite work hours to a target of 54.60 hours per week

Prior to commencement of the project, the Department of Anaesthesia and Pain Medicine had a staff complement of four (2.5 WTE) Consultants and six Registrars. One of the four Consultant Anaesthetists (2.5 WTE) is present daily and is responsible for and dictates provision of all Anaesthetic and pain medicine service demands for that day. A second consultant is available on two days each week. Two temporary Consultant Anaesthetists were appointed for the duration of the project, allowing one WTE available to NMH.

**EWTD Compliance**
From 01 January 2007 a new roster was implemented which would reduce Registrars’ on-site working hours to less than 56 per week. The changes enacted were the results of consultation with the Registrars and were limited by the very small numbers in the department. The roster in place prior to the pilot study exposed the Registrars to an average of 64.4 hour on site work with each working 24 hour shifts at least twice per week. Following introduction of the project, the Registrar on-site work-hours decreased reaching compliance with current 56-hour working maximum and only marginally exceeding the August 2009 48-hour deadline. Furthermore the incidence of 24 hour shifts was reduced by 71%. Further compliance with the EWTD was not possible due to the very small number of Registrars on the roster. This reduction in hours of on-site work was achieved by transferring some of the clinical duties carried out by Registrars to the temporary Consultant Anaesthetist appointed under the project.

However, with a complement of only six Registrars, there is no room for flexibility. In the event of any unplanned leave or concurrent leave the Registrars will have to deviate from the roster and may then no longer be fully EWTD compliant. In addition to this, each Registrar has various leave entitlements up to 12 weeks in any given year. It is clear from the roster (See page 13), which allows for one registrar to be on leave at any given time, that there are not enough weeks in the year for this roster to be implemented continuously and still accommodate the leave entitlements of all six Registrars. When two Registrars are on leave at the same time, these compliance difficulties can be overcome by Consultant cover or by the recruitment of additional Registrars.

**Education and Training**
One of the most challenging aspects of the roster implemented for the project was delivery of formal education to the Registrars. There was very little uptake of designated ring-fenced teaching especially where it involved attendance outside rostered clinical duty. Reduction in trainee numbers during office hours regularly meant that tutorial numbers were insufficient to maintain structured training in a conventional format. Numbers in this size of department are critical and any depletion seriously impugns the viability of conventional teaching methods. In an effort to maintain reduced working hours, there were fewer Registrars on site during the day than previously and the reduced numbers were also required to cover absence when required. In striving to keep the hours worked low designated ring-fenced teaching suffered as a result.
This challenge resulted in the positive development of new teaching methods, which have been universally accepted by Consultants and Registrars in the post project phase, whereby a core curriculum of PowerPoint presentations has been developed and put on disc. Trainees now receive this disc with a list of background literature for review. A series of ring-fenced sessions have been agreed. Where trainees miss a tutorial they are now obliged to seek a 1 to 1 discussion of the core curriculum subject and background literature with one of the Consultant Anaesthetists.

Acceptability
Acceptance was mixed among Consultant staff. The permanent Consultant staff needed to adjust their activities to accommodate new educational commitments. The temporary nature of the EWTD Consultant and the lack of integration of these posts within the normal career structure led to uncertainty of role, for all staff, Consultants and Registrars. Not all temporary Consultants were in a position to provide emergency cover in NMH. Consequently they could not be integrated equally to those providing services outside hours. This is discussed further in section 3.3.1.

Sustainability
Sustainability was tested by the manpower interruptions both at Registrar and Consultant level. Overall the project was not sustainable when numbers reduced unexpectedly given the critically low staffing levels for both Consultants and Registrars.

Patient Care
The continuity of care and patient experience improved as reflected by the reduction in time to specialist anaesthetic attendance. The lack of assessment tools made this difficult to quantify objectively.

Work / Life Balance
The effect on workload and work-life balance was evidenced by an increasing reluctance on the part of the Registrars in training to return to the pre-existing roster. Occasionally, need to return to the pre-existing roster was necessitated by Registrar leave requirements.

Recommendations
The only appropriate structure to provide care for patients in a third level referral centre is a 3-level structure. Specifically a Consultant led Specialist Registrar trainee with Basic Specialist Trainee under supervision. Currently this hospital has only a 2-tier system with a Consultant and either Specialist or Basic Specialist trainee available during emergency hours. This structure is being further stressed by the frequency with which Basic Specialist Trainees are being engaged at a lower level of experience. The other similar Dublin Hospitals have greater numbers compared to the 6 here and are already utilising the 3 tier system.

In order to become fully EWTD compliant without negatively impacting Registrar training or patient care, in addition to the 1 WTE Consultant, a further 2 WTE at Consultant level and an additional 3 WTE at Specialist Registrar level are required.

A cell of nine Registrars would ensure
- that no Registrars work in excess of 13 hours per day
- all daily rest breaks are included in the roster
• a more appropriate and increased presence during the day
• with two Registrars on leave at any given time, it allows greater flexibility to cover planned and unplanned leave.
• with an average of 40.71 hours per week over the seven rostered Registrars, this roster allows ample time for additional training sessions and one-to-one tuition.

The additional Consultants would be able to provide suitable one-to-one training for the Registrars and would increase the senior medical presence in Anaesthesia. The additional staff would allow for EWTD compliance, a more structured and appropriate training structure and a more flexible provision of patient care.

Overall there was a significant reduction in Registrars on site work hours with an improvement in their workload and work-life balance. However the impact on training from an educational viewpoint and the inconsistent application of the system means that it is clear that this model, with the number involved, cannot be recommended, irrespective of duty transference or roster adjustment.

2. Neonatology

The EWTD Pilot Project
This EWTD Project was undertaken in April 2007 for a period of one year at the Neonatal Intensive Care Unit, in the National Maternity Hospital (NMH), Holles Street. The remit of the Project was to make Registrars’ work EWTD compliant at 48 hours per week. The medical complement of the Unit prior to commencement of the Project was four (3 WTE) Consultants, six Registrars, and six SHOs. Three temporary Consultants were appointed at the start of the Project. The new medical complement at the time of commencing the Project was seven (6 WTE) Consultants, six Registrars, six SHOs.

Starting in April 2007 a new Registrar roster was implemented which would reduce Registrars’ hours to less than 48 hours per week. The structure of the roster was based on a combination of aspects of the six alternative models proposed by the Royal College of Physicians, London. It was appreciated that some rosters are by their very nature more stressful and tiring than others. This was borne in mind when considering the best option for the Neonatology Unit.

Compliance
Before the Project began Registrars worked 65.17 hours per week. Following the introduction of the Project the Registrar hours decreased to 48.62 hours per week while all additional Consultants were in place. This means that the Registrar roster is now EWTD compliant both for the current deadline and only slightly above the August 2009 48-hour deadline. This represents a substantial change in working conditions for the Registrars.

The reduction in the Registrar hours was predicated on the transfer of clinical duties from the Registrars to the Consultants. Work previously undertaken by Registrars was performed by Consultants. The Consultants by virtue of their increased numbers had a significantly higher profile in all aspects of patient care. This increased Consultant participation was evident for both acute and routine medical matters. Acute duties on the wards and out-patient services were transferred from
Registrars. A new order has been achieved. Consultants are now in a position to discharge a high proportion of the clinical service. Registrars are able to fulfil their aspirations and prescribed role which is to train and practice under close senior supervision at all times.

The paradigm shift that has taken place in the neonatal intensive care unit at Holles Street has resulted in a change in medical work practice. While the primary aim had been a reduction in Registrar hours, many other benefits have ensued. Patient care and Consultant clinical involvement has risen. Clinical decision-making has transferred from junior to more senior shoulders.

**Education and Training**

The increased Consultant presence has had a significant positive impact on Registrar teaching, training and research. The Consultants are present at teaching sessions each day. The Consultants are available to support Registrars at all the emergencies and complex cases occurring in the hospital. Consultants now have the time and space to initiate and supervise research projects for each Registrar. In addition over the last year the Unit has been able to admit and supervise two research Registrars enrolled for MD theses. At a recent inspection of the Faculty of Paediatrics the Unit was further upgraded as a specialist registrar training centre. In addition to the three specialist registrar posts, the Unit has been recommended for an additional post of a year 3 or a year 4 registrar who wishes to train as a Consultant Neonatologist. This represents a significant advance in the ability of the Unit to train doctors in their speciality.

It can be difficult to define the relative input of NCHDs and Consultants in some of the research projects. As this is a particularly large unit, the output of research in relation SHOs and Registrars is best reflected in the Abstract Publications section (page 94) because their work has been presented at meetings and the abstracts produced. The work undertaken will not have been published yet due to the fact that this process takes longer. Among the 62 published abstracts, 36 were produced by the NCHD complement not including the Research Registrars.

**Value for Money**

For all of the reasons stated above the addition of three Consultants to the service of the Neonatology unit of NMH has proved to be real value for money. The quality of patient care has risen; training and education of Non-Consultant Hospital Doctors (NCHDs) has improved; quality of life issues, not only for NCHDs, but also for Consultants and other staff, have been enhanced and the work environment has generally become more positive for all stakeholders.

This EWTD project successfully reduced Registrars’ working hours and improved compliance with the rest break provisions. It has been a major boost to the Unit and the services that it provides. The Registrars’ working hours were made EWTD compliant. However, due to the small cell of Registrars, it was not possible to provide all the rest breaks immediately when the complement was reduced due to sick leave or annual leave. To make it work completely, in addition to the three extra Consultants, three additional Registrars would also be necessary. In other words, a cell of nine Registrars is required.

The project was the first detailed study of the medical staffing and clinical workload undertaken in the Neonatology department at Holles Street. The data generated demonstrated the large quantum
of day-to-day and emergency duties being undertaken by the NCHDs. Particularly evident was the onerous nature of the out-of-hours work. The findings indicate that there is a deficit in the medical staff numbers in the Unit. For a sustained, acceptable reduction hours, the appointment of more NCHDs is required. Consultants alone cannot cover all the duties of the NCHDs. As stated, a cell of nine Registrars would be required for the optimal delivery of NCHD work. Similarly it is felt that the Consultant numbers need to be increased and that seven are required.

**Acceptability**

As might have been anticipated, there were a number of concerns and negative comments expressed by the Registrar group. The 48-hour system of working was new to the Registrars and they had not experienced this pattern previously. In the beginning they found that it increased the complexity of the roster in that they were coming to work at different times and that each day represented a different duration of work. The organisation of the roster was difficult and, in retrospect, more administrative input was required. The other concern expressed by our Registrars, which has been highlighted by NCHDs in the UK, is that there will be periods where the work is mainly at night. The fact that there were just six Registrars in the system created many of these problems and to make rosters more user friendly and effective a cell of nine Registrars would have been required.

Undoubtedly, more could have been achieved if the project had been left in place for a longer period of time. More time was required to determine how best to deploy Registrars in relation to their working day. Other modifications of the roster needed to be tried. Unfortunately, the project is now over and the Unit has had to revert back to the previous ways of working. More clinical care has had to be handed back to the Registrars. It is disappointing that the gains achieved have now been lost.

In summary, this EWTD project successfully reduced Registrars’ working hours and improved compliance with the rest break provisions. There were many positive achievements. The details in this report provide an insight into how EWTD compliance can be achieved in a large Unit.

3. Obstetrics and Gynaecology

**Background**

The pilot project was introduced at a time of increased activity for the hospital with an additional 600 deliveries during 2007. Pre-pilot, the hospital had nine registrars (8 whole time equivalents (WTE), one WTE less than the other similar sized maternity hospitals. There are 6 SHOs which is the same number as Galway with approximately 3000 deliveries compared to around 8600 at NMH. 2007 was one of the busiest years recorded at the National Maternity Hospital with over 700 deliveries in eight months of the year. There was a total of 1,611 Caesarean sections, a rate of 18.9%.

There are 24 antenatal inpatient beds which cope with both private and public patients and a busy day ward. The National Maternity Hospital has one labour ward with nine rooms and ten beds. There are two theatres to cope with elective and emergency surgery including emergency caesarean sections. One of the theatres is significantly smaller than the other. Elective operating lists are continually interrupted by emergency caesarean sections. The recovery area also acts as a High Dependency Unit.
Obstetrics is recognised as a high intensity specialty with seasonal highs and lows. The increased intensity of work over the summer months is a particular challenge. The infrastructure is far below what might be expected for the number of deliveries. The clinical areas to be covered daily are shown below and skill mix is crucial.

- Labour ward
- Fetal assessment unit
- Unit Three Antenatal Ward
- Theatre
- Gynaecology Clinics
- Colposcopy Clinics
- Semi-private Clinics
- Miscarriage Clinic
- Perineal Clinic
- Bereavement Clinic
- Antenatal Clinics

Compliance
Although the project did not reduce the Registrars’ hours to the target of 50.5, it was successful in reducing the weekly hours worked from 62.0 to 54.5, which is within the current EWTD limit of 56 hours per week. Further compliance (such as the 2009 48-hour deadline and the granting of consistently adequate compensatory rest) will not be possible with the current complement of Registrars and Consultants.

Acceptability to staff involved
Overall, the project was acceptable to Consultants, Registrars and Midwifery and Nursing staff. Generally the reduced hours were found to be beneficial. The reduction in on call hours, from up to 36 hours, to a more acceptable 16 to 24 hours, was the main benefit identified by the participants. There were some issues with regard to training and exposure. The main disadvantages identified were the loss of the trainer-trainee pairing and the reduction in specialist clinic attendances on a consistent basis. These are discussed further in the report. Midwifery and nursing colleagues had more positive than negative feedback and were supportive in the aims of the project.

Sustainability
At the current staff levels, this project is not sustainable in the long term. It is estimated that to allow for a 48-hour maximum EWTD compliant, rolling registrar roster, incorporating holiday cover, an additional three registrars and four consultants would be required. This would still however not allow us to have two registrars on call simultaneously as is the case in most other major hospitals such as the Coombe, Rotunda and Cork University Hospital.

The external evaluator recommended for all NCHDs to be EWTD compliant that a cell of 10 whole time equivalent (WTE) Registrars, an additional 4 WTE SHOs and a further six or seven consultants would be required.
Currently, midwives have a much broader role at NMH than most midwives and they made an important contribution to the success of the project.

The National Maternity Hospital midwifery staff have already taken on tasks that in general hospitals are done by interns or phlebotomists. Midwives routinely suture all uncomplicated tears and episiotomies. Midwives site intravenous infusions, take blood, analyse fetal and cord blood samples. There is an early discharge scheme and uncomplicated patients are discharged by the midwives. The first independent drug prescribers course has been completed by midwives in the NMH. There are also a number of nurse led smear clinics.

One possible solution to the problem of trying to cover low risk clinics by doctors would be to enhance the role of midwives in the community through Primary, Community and Continuing Care (PCCC). This will provide an integrated multidisciplinary approach providing appropriate care, by the appropriate professional in the appropriate location.

**Patient Experience**

Although it is difficult to quantify improvements in the patient experience, partly because the obstetric population pre-pilot was a different group of patients to those during the pilot, improvement was evidenced by the fact that a consultant delivered service was available in antenatal and Gynaecology clinics. The additional consultants at the bereavement and miscarriage clinics were found to greatly reduce complaints and were seen by all as a huge improvement. It is not possible to verify this objectively. Some increased waiting times were noted for patients attending the early pregnancy unit due to deployment of SHOs to the antenatal clinics.

**Continuity of Care**

The continuity of care was largely unaffected by the new work patterns.

**Training and Education**

Some issues arose with regard to training and education and it was felt that due to reduced exposure, the Registrars’ training suffered. Structured morning meetings at 0730 continued to be maintained and this allowed for detailed discussion. SHOs and Registrars discuss the previous 24-hours’ events with the Master every morning at 0730. Practice points are discussed and plans made for the day’s responsibilities.

The majority of the Registrars remained satisfied that their post would help them acquire the competencies required at this stage of their training. Many Registrars, particularly Specialist Registrars, were worried that consistent exposure in particular areas (e.g. Gynaecology, Colposcopy and special clinics) was reduced by the EWTD and that training objectives and competencies could be compromised.

It should be noted that for many different reasons there has been a reduction in number of surgical procedures performed in recent years, particularly hysterectomies performed. This issue existed even before the EWTD (Jacobsen et al. Obstetrics and Gynaecology 2006; 107: 1278 – 1283) and does mean less training for registrars. However, it has also been accompanied by an increase in
laparoscopic surgery. Training for undergraduate students will inevitably suffer because of the new time constraints unless it is prioritised not only in the consultant timetables but also the registrar timetables.

**National Application**
Due to the fact that the Registrars’ hours are over the EWTD maximum of 48 hours, and the issues surrounding training and education, this project as described is not nationally applicable. The progress attained during the pilot which reduced hours could be implemented elsewhere at local level using a similar template and, subject to more adequate staffing levels, could prove successful in achieving full EWTD compliance.

**Effect on Workloads**
The workload in Obstetrics and Gynaecology is recognised as being of a high intensity and, in spite of the positive impact of the new ways of working, this remained during the project. The night workload was noted to be persistently heavy. There was unanimous agreement that an end to 36-hour shifts enabled registrars to deal more easily with the work at night.

**Work Life Balance**
The Registrars noted a positive impact on their work life balance and particularly welcomed time off post call.
Appendix I

Profile of Acute Hospitals in Ireland

General Adult / Paediatric Emergency Departments (open 24/7)

North East
• OLOL Hospital, Drogheda
• Cavan General Hospital
• Navan Hospital
• Louth County Hospital
• Monaghan General Hospital

Dublin North
• Beaumont Hospital
• Mater Misericordiae Hospital
• Connolly Hospital

Dublin South
• St James’s Hospital
• St Vincent’s University Hospital
• St Colmcille’s Hospital, Loughlinstown

Dublin Midlands
• Tallaght Hospital
• Naas General Hospital
• Longford Westmeath Hospital, Mullingar
• Portlaoise General Hospital
• Tullamore General Hospital

South-East
• St Luke’s Hospital, Kilkenny
• Waterford Regional Hospital
• Wexford General Hospital
• South Tipperary General Hospital Clonmel

South
• Cork University Hospital (including CUMH)
• St. Finbarr’s Hospital
• Mercy University Hospital
• South Infirmary-Victoria University Hospital
• Kerry General Hospital
• Bantry General Hospital
Mid-West
• Mid-Western Regional, Limerick
• Mid-Western Regional Maternity, Limerick
• Mid-Western Regional Ennis
• Mid-Western Regional Nenagh

West / North-West
• University College Hospital Galway + Merlin Park University Hospital
• Mayo General Hospital
• Portiuncula Hospital
• Roscommon Hospital
• Sligo General Hospital
• Letterkenny General Hospital

General Adult Emergency Departments (open a non-24/7 basis):

Dublin South:
• St Michael’s Hospital, Dún Laoghaire (part of the St Vincent’s University Hospital Group)

Mid-West:
• St John’s Hospital, Limerick

South-East:
• South Tipperary General Hospital, Cashel (Minor Injuries Unit under the governance of PCCC)

South:
• Mallow General Hospital (part of the CUH Group)

Paediatric Emergency Departments (open 24/7)

Dublin North:
• Children’s University Hospital, Temple Street

Dublin Midlands:
• Tallaght
• OLHSC, Crumlin
Adult / Paediatric specialty-specific Emergency Departments:

Dublin South:
• Royal Victoria Eye & Ear Hospital

Dublin Maternity Hospitals receiving Emergency attendees

Dublin North:
• Rotunda Hospital

Dublin South:
• National Maternity Hospital, Holles Street

Dublin Midlands:
• Coombe Lying In Hospital

Other Acute / Elective Orthopaedic Hospitals

Dublin North
• Cappagh Hospital

South-East
• Kilcreene Hospital

Mid-West
• Mid-Western Regional Orthopaedic Hospital, Croom

South
• St. Mary’s Orthopaedic Hospital, Cork