This guidance paper sets out principles for assessing work during on-call periods.

Non-resident on-call (NROC) working patterns are required when employers do not need on-site cover, but require the doctor to be available to provide advice over the phone and/or to return to the site if needed. The terms and conditions of service (TCS) define on-call as:

A doctor is on-call when (s)he is required by the employer to be available to return to work or give advice by telephone but is not normally expected to be working on site for the whole period. A doctor carrying an 'on-call bleep' while already present in the workplace as part of their scheduled duties does not meet the definition on-call working.

Five key areas have been identified in developing appropriate NROC rotas. This will also help facilitate and address any ongoing issues arising with the rotas.

- **How to prospectively calculate hours for work done**
- **Determining predictable and unpredictable work**
- **NROC rota design process**
- **Exception reporting for on-call periods**
- **Effective management of the rota after the design and implementation process**

**How to prospectively calculate hours for work done**

To ensure the hours of work set out in the work schedule are correct, on-call working patterns require employers to make a prospective estimate of average work carried out while on-call. They will then need to use the exception reporting and work schedule review processes to address variation from this estimate. Relevant available data should also be used, including feedback from staff rostered for on-call duties.

To begin, the number of hours for on-call work across an actual (and typical) week should be totalled. From this, an average amount of work for each weekday (Monday to Friday) and weekend (Saturday and Sunday) can be calculated. For example, a rota where each week of on-call generates on average 7.5 hours of work spread across the five weekday nights (in addition to the normal working day) and each weekend generates 7.5 hours of work across the two days of the weekend.

- To determine how many prospective hours of actual work done Monday to Friday, employers will need to divide 7.5 hours by 5 (no of nights): 7.5 hours / 5 nights = 1.5 hours (average) per night (plus 8 hours for the normal working day).
- To determine how many hours of actual work done on weekends, employers will need to divide 7.5 hours / 2 days = 3.75 hours (average) per duty period.

Employers will need to identify, from each of the five nights, what the busy (maximum hours) and quiet (minimum hours) times are for each of these periods in the working pattern. Assessing how frequent the rota is deviating from the maximum or minimum hours. For example, it might be that the quietest night required 15 minutes of work and the busiest required five hours.
Speaking to colleagues in the departments, obtaining feedback from doctors working on the rota and using historic (but recent) monitoring data will help to determine how many of the above average hours are likely to be worked between 2100 and 0700 and therefore to attract the 37 per cent enhancement.

Prospective hours should be communicated to doctors in advance of starting work so they are aware when they may be risking a breach of rest requirements. Employers should provide clarity on the working pattern, for example, Wednesdays on-call may typically include working until a certain time before midnight, etc.

**Note:**
For the sake of clarity, in calculating whether a working pattern meets the limit of 72 hours across seven days, it is recommended that employers and doctors seek to work within both the spirit and the letter of this provision and consider the limit to be 72 hours in any consecutive 168 (7 x 24) hour period.

The 72 hours should be the maximum limit of hours and not a benchmark. Employers should try wherever possible to roster below this limit to provide a safety margin for doctors working close to these limits.

**Determining predictable and unpredictable work**
It is important for the rota managers to be clear in specifying the average number of hours of actual work expected to be carried out during each of the duty periods, and the time(s) of day when the work would be expected to be done.

- For example, over three on-call duty periods, a doctor may be expected to work nine hours, an average of three hours per night.

- The work schedule should include an indication of the amount of predictable and unpredictable work before and after 9:00pm. Examples of predictable work may include activities such as a ward round or handover time. An example of unpredictable work may include calls from the emergency department.

- Giving as much information as possible, as set out above, allows the doctor to know what is reasonable to expect and there may be variations in shifts, and thus allows for sensible judgements about when an exception report might be appropriate (ie where an individual night falls outside of the normal range), or a work schedule review (where the total of hours looks likely to cause the average to be higher, or lower than the work schedule hours than expected).

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NROC rota design process

When designing NROC rotas attention to the following points should be considered.

- Clearly identify the start and end times of all duty periods. All travel time when the doctor is required to return to work, or travel between sites, is part of the duty.

- Consider whether the doctors on-call will normally be able to get sufficient rest at night. Can this be audited? Has there been a bleep/telephone call audit to check how intense the duty is at night? How might the failure to get sufficient rest be compensated to keep the doctor safe?

- Using historical (but recent) monitoring, diary cards, bleep and telephone audits data may be helpful to use when setting up the initial working patterns, particularly in identifying the predicted range, timing and average number of hours worked during on-call duty periods.

- Consideration should be given to variations in work occurring after a telephone call. For example, is the doctor regularly required to return to the hospital after a call or is there a routine amount of after call work that can be accounted for in the design of the rota?

- Include sufficient handover, this is critical for safe transfer of patient information to deliver continuity of care and good quality patient management. Rotas must contain sufficient time for handover. Most services will require a minimum handover of 15 to 30 minutes, some services may need to allow for 60 minutes or (in rare cases) longer. Coming in specifically to attend handover and telephone handover is classed as the duty period.

- Once the rota is designed and implemented, problems with the rota can and should be raised via exception reporting and if necessary resolved through a work schedule review.

Exemptions

- If safe and acceptable, the employer and trainee may agree to roster longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days as per Schedule 3 para 27.

- If the trainee works a low on-call intensity weekend as defined in Schedule 3 para 35, a maximum of 12 days (rather than eight) can be rostered or worked consecutively.

- As on-call duty periods should comply with safe working rules around overnight rest, the expectation on almost all on-call working patterns is that the trainee can (and should normally) be rostered to work the next day (unless other safety provisions of the contract make it impractical). Where on-call duty periods can be busy this should be for no longer than five hours, timetabled to follow the on-call duty both to allow for effective handover and to ensure meaningful rest at the end of the following shift.

- On occasion however, work at night may be such that the doctor is unable to come in the next day. Where this is happening on a regular basis, then the working pattern will need to be reviewed – it may be that an on-call roster is no longer appropriate for that service/grade.

- Employers may want to put a day off after an NROC shift, to give the trainee the opportunity to rest if the NROC has been unusually busy – however, due consideration should be given to the potential impact on the continuity of patient care, including the need for handover and/or the doctor’s training opportunities before making any such decision.
Exception reporting for on-call period

Given the nature of NROC work, the average hours are likely to fluctuate to some extent and the hours worked may well differ from the average hours, simply because some nights will be busier than others (which is why an average is used for the purposes of pay, as it is for consultant and SAS work patterns). Busier nights, which fall within the expected range and pattern, would not necessarily require an exception report, nor would they necessarily trigger additional time off or extra payments (although they might, in some circumstances).

However, if the doctor perceives that the on-call activity does vary significantly, or regularly, from what has been predicted, then an exception report should be completed.

If the rota hours are breached, this should be highlighted at the first available opportunity by an exception report. This gives employers real-time information and helps identify key issues over safe working and/or missed educational opportunities.

There is also a need to assess the usual timing of work episodes. This is to ensure that the work is paid at the correct rate and mandatory rest can be achieved.

Exception reporting for an on-call period would be expected when:

• the doctor considers his/her actual hours worked create an immediate safety risk, eg if the doctor has worked throughout much of the night

• the actual hours worked create the risk of a breach of the contractual safety rules, eg the limit of 72 hours worked in a seven-day period

• the actual hours do not create an immediate risk, but vary ‘significantly and/or regularly from the agreed work schedule’ (TCS Schedule 5, para 2)

• a trainee stays later than expected during the predictable, ‘shift work’ element of a period of on-call duty (eg the twilight handover period)

• a trainee does more than the expected average hours during the unpredictable element of a period of on-call duty.

Immediate safety risk/potential breach of contractual limits

• Where an exception report indicates a concern and there is an immediate and substantial safety risk, the procedure in Schedule 5, paragraph 17 should be followed and time off given as necessary. This is required on safety grounds, even when the average hours worked while on-call have not been exceeded over the rota cycle.

• Where an exception report indicates the hours worked are likely to breach the contractual limits (72 hours over 7 days/168 hours as above), the supervisor must ensure time off in lieu (TOIL) is granted so the doctor does not exceed those limits and the breach does not occur. This is required even when the average hours assigned to work done while on-call have not been (or are unlikely to be) exceeded over the rota cycle. Contractual penalties will apply if the relevant limits are breached and the guardian may need to intervene to ensure there are no further breaches of this nature.
Significant or regular variation from the work schedule

- Where a doctor is working beyond the agreed hours and/or missing breaks, this must be highlighted by an exception report at the first available opportunity. This gives employers real-time information and helps identify key issues over safe working and/or missed educational opportunities.

- An exception report may indicate a concern that there is a significant or regular variation from the work schedule. This should be explored in discussion between the doctor and the supervisor.

- Exception reports requesting consideration for additional payment should be submitted by the doctor within seven working days of the event and should be responded to by the supervisor within seven working days of the report being submitted.

Managing the roster after the design and implementation process

Effective rostering means rosters are reviewed on a regular basis to ensure they meet service and training requirements. The rotas should be reviewed on a regular basis, using the contractual provisions for managing exceptions and the work schedule review process as set out in the TCS where these are appropriate.

In circumstances where the trainee is regularly exceeding the maximum hours or never hitting the minimum number of hours per shift, a work schedule review is required. In the former case, consideration might need to be given to changing the working pattern to a full shift, having an additional doctor on-call or reducing the workload covered by the on-call doctor.