INTRODUCTION

This guidance is the result of detailed negotiations and discussions with junior doctors' representatives, NHS regional New Deal task force officers, representatives from postgraduate deaneries, NHS managers, NHS Estates staff and other interested parties. It sets out standards for accommodation and catering (Annex A). It also sets out the steps to be taken where these standards are not met (Annex B), and includes case studies and examples of good practice (Annexes C and F).

The guidance contributes to achieving one of the three strategic aims of *Working Together*, the NHS human resources framework: *"Be able to demonstrate we are improving the quality of working life for staff". Working Together* highlights acceptable catering and accommodation for on-call staff as a minimum target for all NHS employers to achieve. Meeting this target is, in turn, an element in achieving the *Improving Working Lives* standard against which Trusts' performance will be managed.

Doctors in training who work busy hours, often round the clock, have a right to expect decent living and working conditions whilst on duty. Patients too have a right to be treated by doctors whose morale and motivation is not undermined by the conditions in which they live and work. Staff morale can often be given a big boost from relatively small outlays on improved facilities, and trusts which provide good facilities can expect to attract and retain able applicants.

Staff involvement and consultation on facilities provision and standards

All NHS staff groups should be consulted on plans that affect them, in line with the *Working Together* principles on staff involvement. Junior doctors' interests should be taken fully into account when new building work or major refurbishments are carried out, whether juniors are affected uniquely (by changes to, for example, on-call accommodation) or jointly (for example, on site security).

We intend to include some appropriate specific references to consultation with juniors, as key end users, in any future edition of the *NHS Capital Investment Manual* or similar guidance.

Local New Deal implementation groups

As well as improving standards, it is also important that any improvements are sustained. Local New Deal Implementation Groups (LIGs) have been set up in many trusts to provide a forum in which hours, accommodation, catering and related issues can be discussed and any suggestions or complaints followed up. They also provide the necessary continuity between the ever-changing intakes of juniors. LIGs should be set up in *all* trusts employing doctors in training, with agreed terms of reference and core composition. To be truly effective, these groups must be properly supported at Board level within trusts. Where no such group yet exists, the local BMA junior representative(s) should be consulted.

ANNEX A

STANDARDS FOR LIVING AND WORKING CONDITIONS FOR HOSPITAL DOCTORS IN TRAINING

General

- Doctors in training have a responsibility to ensure that they keep hospital accommodation clean and do not cause damage to facilities (fabric, furnishings or equipment).

- Where current or future legislation for houses of multiple occupancy cover hospital accommodation, all regulations and powers of enforcement by local authorities will apply. All hospital accommodation must meet relevant legal requirements and NHS Estates guidelines.

- **The following minimum agreed standards will apply to all hospital accommodation**.

A. Minimum HIMOR standard (Housing in Multiple Occupancy): see annex D

A dwelling is unfit if it fails to meet **one** of the requirements set out below and, by reason of that failure, is not suitable for occupation. The requirements constitute the minimum deemed necessary for any dwelling to be fit for human habitation. All hospital accommodation must:

- Be free from serious disrepair
- Be structurally stable
- Be free from dampness prejudicial to the health of the occupants
- Have adequate provision for lighting, heating and ventilation
- Have an adequate piped supply of wholesome water
- Have an effective system for the drainage of foul, waste and surface water
- Have a suitably located WC for exclusive use of the occupants
- Have a bath or shower and wash-hand basin, with hot and cold water
- Have satisfactory facilities for the preparation and cooking of food including a sink with hot and cold water.

B. Minimum building requirements

Residential accommodation

B.1. The configuration of accommodation is at the discretion of the employing authority subject to proper consultation with the end-users or their representatives as stipulated in the NHS Estates' Capital Investment Manual. However, the following minimum ratios must apply:

- each bedroom should be for one occupant (except in married accommodation);

- each WC, bath and shower should be for no more than three, and by August 2003 no more than two, occupants;

- each kitchen, dining area and living room should be for no more than four occupants, taking into account the size of the room.

B.2. Each bedroom should have proper light and sound proofing to ensure the occupant is not disturbed, night or daytime, and should be lockable. In addition, there should be a minimum of two power points; a telephone connected using a standard BT or cable socket to the internal hospital telephone system; access to the facility for making external calls at no higher than relevant BT rates; and a wash basin with hot and cold running water.

B.3. The temperature in each room should be able to be individually adjusted by the occupant.

B.4. Each kitchen should contain at least four power points.

B.5. Each living room should contain at least four power points, telephone connection and TV aerial connection.

B.6. The washing and sanitary facilities should be arranged to ensure adequate privacy for the user.

B.7. Water closets should be connected to a suitable drainage system, and be provided with an effective means for flushing with water.

B.8. Any room containing a sanitary convenience should be sufficiently ventilated, so that offensive odours do not linger. Measures should also be taken to prevent odours entering other rooms.

B.9. The rooms containing sanitary conveniences should be adequately lit.

B.10. Toilet paper in a holder or dispenser and a coat hook should be provided in each room containing a sanitary convenience. Suitable means should be provided for the disposal of sanitary dressings.

B.11. Showers which are fed by both hot and cold water should be fitted with a device such as a thermostatic mixer valve to prevent users being scalded.

B.12. All appropriate fire and smoke precautions should be installed, according to fire regulations.

On call rooms

B.13. The New Deal states that on call rooms should be of the same standard as residential accommodation. The above standards must therefore apply to on call accommodation.

B.14. Hospitals must provide a sufficient number of on call rooms for their junior doctors, including all juniors who are compulsorily or voluntary resident, as demand prescribes. This should be agreed by local consultation with junior doctors and their representatives. Nevertheless, at a minimum there should be a sufficient number of on call rooms provided for all junior doctors who are on call or working a partial shift during all or part of any one particular night on duty (defined in HSC 1998/240 as 10pm to 8am).

B.15. The on call rooms should be a separate unit away from clinical areas, though at a maximum of between 5 and 10 minutes walking distance from the relevant wards. The rooms must not be built next to power plants or goods delivery areas, or other areas that could disturb occupants' rest.

Doctors' Mess and other common areas

B.16. There should be a doctors' mess easily accessible from wards and departments. In large hospitals this may require more than one mess. In small trusts a joint mess for all clinical staff may be acceptable.

B.17. All standards stipulated in this document for residential accommodation and on call rooms, including standards for sanitary, washing and kitchen facilities, apply equally to the doctors' mess, except that:

- there should be access to an adequate number of water closets and wash basins, not shared with patients or the public.
- There need be only one kitchen and dining area.

B.18. The following areas should also be provided for staff on site, wherever is most appropriate, and not necessarily exclusively for junior doctors:

(i) lounge (with power points, telephone connection and TV aerial);

(ii) study/reading room (with power points);

(iii) office area (with power points, telephone connection and the facility for IT/Internet access);

(iv) laundry with an adequate number of washing machines and dryers (reasonably priced and well-maintained).

(v) changing facilities and showers;

(vi) bar/games room/fitness room or alternative recreational arrangements, catering for the preferences of a wide range of staff.

Miscellaneous

B.19. Access to and from the on call rooms, doctors' mess and clinical areas should be safe and without risk to health or welfare, for example, well lit.

B.20. On-site security and safety policies and procedures must be agreed with staff, including junior doctors, and implemented.

B.21. Secure, communal cycle store.

B.22. Resident or on-call junior doctors should have access to a parking space near their accommodation where on-site car parking is available. Where this is not available, employers should attempt to ensure that alternative secure parking arrangements are in place.

C. Minimum Living and Working Conditions

The standards below assume the following minimum conditions:

- all decoration should be free from damp/leaks and clean
- all furniture must be in working order and fire retardant.

Accommodation

C.1 Separate standards do not exist for married accommodation as the standard must be the same as for single accommodation with changes to be made only as appropriate for married accommodation.

C.2 *Bedroom* (NB - one per occupant)

Suitable floor covering;
Lined curtains;
Bed (3ft) [double (4ft6 minimum) for married accommodation];
Weekly linen change and twice weekly towel change;
For on-call rooms, change of bedlinen and towels between occupants
Desk and chair;
Wardrobe, drawers and bookcase/shelves;
Easy chair;
Reading light by bed and desk;
Room cleaned three times a week;
Smoke alarm in the room

C.3 *Bathroom* (NB –one between three, working towards one between two occupants)

Shower; bath; toilet – all must be provided

C.4 *Kitchen* (NB – one between four occupants)

Cooker (4 rings and oven);
Microwave;
Fridge-freezer;
Utensils for cooking and eating;
Kettle;
Toaster;
Steam iron and ironing board;
Smoke alarm in the kitchen

C.5 *Dining area* (NB –one between four occupants)

Table;
At least one chair per occupant.

C.6 *Living room* (NB – one between four occupants)

Sufficient seating for all occupants using sofas and comfortable chairs;
Coffee table.

C.7 *Miscellaneous:*
Exercise/sporting facilities for all staff - where this is not possible, employers should make arrangements with local sports centres and swimming pools and should inform juniors of these facilities.

Catering

C.8 Junior doctors on duty must be able to get good quality hot and cold food at any time. If the canteen is closed, this should be through a supply of microwave meals, cold cabinet or a similar arrangement. Supplies should be sufficient for all staff on duty, and readily accessible to doctors in training. Supplies should be regularly restocked, with swipe cards or change machines provided where necessary. The inability to obtain hot food for any reason will result in failure to meet these minimum standards.

C.9 Where the canteen is shut or there is no canteen, alternative facilities must be available - for example microwave meals (where possible, in the doctors' mess); local agreements with delivery fast food retail outlets for takeaway food; and/or a trolley service. Bread, cereals and drinks should be available at all times.

C.10 In small trusts (where there are less than 10 junior doctors on-call at any one time) canteen opening hours can be reduced from the minimum standard set out below. However, the minimum standard (availability of good quality hot and cold food round the clock) must be observed.

C.11 *Canteen*

Where catering facilities exist, they must be open 365 days a year.
Meals provided must be adequate, varied, attractively and efficiently served and freshly prepared.
Canteen must be open and serving hot food for extended meal times for breakfast, lunch and dinner, wherever possible with a minimum late opening until 11.00pm and a further two hour period after 11.00pm and before 7 am.
Canteen must always provide healthy eating options and a vegetarian option, and should provide for a range of cultural and dietary requirements.
Serving and dining area must be situated away from facilities provided for patients, relatives and other non-employees.

D. Star rating system

Once all the above minimum living and working conditions have been achieved, employing authorities may improve the facilities offered to junior doctors by including the following details:

Incorporating five of the following items = one star
Incorporating ten of the following items = two star
Incorporating fifteen of the following items = three star

This will encourage trusts, for just a small extra investment, to attract junior doctors to their hospital by providing accommodation and other facilities of a high standard.

D.1 *Bedroom*

Double bed;
En suite shower;
Daily towel and linen change;
Duvet (minimum 12 togs);
Radio/alarm clock;
Tea/coffee making facilities;
Facilities for IT/Internet access;
TV aerial connection.

D.2 *Kitchen*

Filter coffee machine;
Automatic washing machine;
Tumble dryer
Dishwasher.

D.3 *Living room*

TV and video recorder;
IT/Internet access.

D.4 *Miscellaneous*

Indoor and locked communal cycle store;
Car parking on site
Double glazing;
Security - internal voice communication with front door and camera link with main door.

ANNEX B

INSPECTION, MONITORING AND ENFORCEMENT OF STANDARDS

1. Trust facilities must be monitored regularly to ensure that standards are maintained and/or improved. This guidance aims to ensure consistency across Regions and deaneries in interpreting standards and taking enforcement action. There is scope for eliminating duplication in inspecting accommodation and catering facilities, whilst recognising the need for deaneries and Royal College training advisors to visit to address education and training issues.

Facilities monitoring

Function

2. Regional offices are required to designate the duties of facilities monitoring to cover each trust within their region. The facilities monitoring function will be to provide an independent third party inspection of trust facilities, visiting sites on a regular basis and working consistently with trusts to draw up plans for any necessary improvements. This system is already being used successfully in at least one English region. This function fits well alongside the key role of regions in providing trusts with independent advice and managing their performance on wider juniors' issues, eg improving hours, monitoring and tackling problem posts – which will, of course, assume much greater importance as we step up the impetus to secure 100% hours compliance with current targets and to start to implement the Working Time Directive for doctors in training.

3. Regions may wish to take a multiprofessional approach and make arrangements which cover inspection of living and working conditions for non-medical as well as medical staff , especially in view of the trend towards 24-hour services which implies an increase in on-call, weekend and/or night work for staff groups who may not traditionally have adopted such working patterns. This will be consistent with the approach of *Improving Working Lives* and the HR Performance Framework, which set targets to improve and accredit the living and working conditions of all staff including doctors.

Remit

4. The officers performing the facilities inspection function will be responsible for inspecting the living and working conditions of junior doctors and recommending enforcement action to ensure that the standards specified in Annex A are met. This includes accommodation, catering arrangements, doctors' mess and rest areas , and safety and security issues, but not educational facilities, which are the remit of the Postgraduate Deans and Royal Colleges. Accommodation includes both on-call and compulsory residential accommodation, and voluntary residential accommodation which may be used for on-call purposes. The standards against which facilities will be assessed are set out in annex A.

5. Facilities Inspection officers will be responsible for ensuring that breaches of standards or failure to improve within the specified timescales are brought to the attention of the regional office performance management function, the Regional taskforce or equivalent, the relevant postgraduate dean, and the Royal Colleges. Responsibility for applying sanctions where minimum standards are not met rests with the appropriate body as set out in the guidance on enforcement below.

Frequency and mechanism of visits

6. Initially each Trust should be **visited** in the first year after this guidance is issued. Before each visit, the officer performing the facilities inspection function should make contact with the trust facilities officer, medical director, postgraduate tutor and, most importantly, with junior doctors themselves both through their representatives and through organised mess meetings and/or informal meetings. Standard questionnaires are a useful way of obtaining input in advance of the visit.

7. Within one month after the initial visit, the officer will produce a report on each trust and submit it to the regional office performance manager, regional taskforce or its equivalent at RO, the dean, the Royal Colleges, the junior doctor representative and the trust itself. The Regional Office will ensure the trust submits an action plan within 6 weeks of the report for

improvements where these are required, and will inform the Trust of the consequences of failing to meet these targets.

8. Subsequent visits will take place at intervals of between 6 months and 18 months thereafter depending upon the standards achieved and action plan or other enforcement action still to be carried out. Trusts will be required by Regional Office to demonstrate progress six-monthly until they can be accredited as meeting the minimum standards in annex A; trusts meeting these standards can be visited less frequently. All visits will result in a progress report to the Regional Office copied to interested parties. Where minimum standards have been achieved, the Trust LNC can alert the facilities inspection officer at any time and request a visit if ad hoc problems have not been resolved locally.

Enforcement

9. The accommodation and catering standards outlined in Annex A must be implemented, adhered to and enforced, and will contribute to accreditation for the *Improving Working Lives* (IWL)standard. It is the responsibility of Trusts to take action to improve standards, and of Regional Offices to performance manage them and to help them work towards accreditation at IWL Pledge, Practice and Practice Plus levels.

10. It is the responsibility of Regions, where appropriate through postgraduate deans, to take action to enforce compliance with the agreed minimum standards.

11. A staged approach should be taken to the enforcement of minimum standards and the encouragement of "best practice" improved standards. Enforcement will require the following action when minimum accommodation and catering standards [Annex A] are not met.

12. For failure to meet the standards set out in Annex A - where the work is relatively minor and achievable without major outlay:

An action plan should be drawn up **within six weeks** of the inspection report to specify the remedial work or organisational change which needs to be done to meet the accommodation or catering standards. The improvements should be completed within 6 months or less. The Trust will be visited at the end of this time to check on progress.

13. For failure to meet the standards set out in Annex A - where remedial work would require major investment:

Trusts will be required by the regional performance manager to draw up an action plan **within six weeks** of the visit showing how they intend to address these problems and within what timescale. Realistically this will need to take into account factors such as the Trust's financial position, structural/organisational changes (eg impending merger), future medical staffing levels, split site working, PFI arrangements etc. The expertise of Regional Estates officers will be invaluable in this context. Action plans with a realistic timescale to resolve the problem will need to be agreed with all interested parties (ie the Trust, the dean, the Taskforce or equivalent, regional performance management and the Local Negotiating Committee).

14. Where minimum standards are not met for accommodation, the provisions of ***revised paragraph 175a*** of the Hospital Medical Terms and Conditions of service will apply ***(see annex E).*** This will oblige employers to provide accommodation free of charge until such time as improvements have been completed. This change to terms and Conditions of service will be promulgated in a separate Advance Letter.

15. Where the minimum agreed standards are not met, training posts should be advertised accordingly.

16. Where, despite an action plan agreed by all parties, improvements have not been completed within the agreed timescale, no training posts can be advertised until the Trust has reached minimum standards. Trusts would also be required to find alternative accommodation for any trainees in post, and to provide transport to and from hospital if necessary.

17. In accordance with standard performance management approaches, Regional Offices (through the RTF or equivalent) will expect postgraduate deans to apply their powers under HSC 1998/229 to withdraw approval for posts. Incumbents would still have approval until they completed their contract.

18. Where living and working conditions fail Annex A minimum standards, New Deal accreditation, if previously awarded to the trust, must be withdrawn.

HIMOR failure- steps to take

19. Where inspection suggests that junior doctors' living and working conditions are so poor that they may not meet minimum *legal* requirements, the inspection officer should inform the local authority environmental health department. Local authorities are responsible for inspecting accommodation for fitness for human habitation, and taking appropriate action (eg

improvement notices or closure) where legal minima are not met. Annex D sets out the provisions of the relevant legislation (*Houses in Multiple Occupation Regulations - HIMOR).*

20. Where the local authority confirms that accommodation has failed HIMOR standards and has issued a closure notice, all *on-call and compulsory accommodation and voluntary accommodation used for on-call purposes* must be withdrawn from service until the HIMOR notice has been lifted. The Trust must provide alternative accommodation, with transport to and from the hospital if necessary. Trusts must take steps as a matter of urgency to provide accommodation which meets local authority requirements and minimum Annex A standards *within twelve months* from the date of the HIMOR notice.

21. During this 12 month period, or until the Annex A minimum standards are met, if sooner, the trust would be unable to advertise training posts as having postgraduate dean approval. Incumbents would still have approval until they completed their contract if this had less than 12 months to run. Should the trust fail to provide accommodation which meets these standards by 12 months after the date of the notice, postgraduate deans should withdraw deanery funding and approval for posts in accordance with the provisions of HSC/1998/229 and would be required to find alternative posts for any trainees in post when approval is withdrawn.

22. Where *voluntary* accommodation fails HIMOR standards and has been issued with a closure notice, it must be withdrawn from service until the HIMOR notice has been lifted. The Trust must provide alternative accommodation until the HIMOR notice has been lifted or until the junior's contract comes to an end. The Trust will meet the cost difference on juniors' behalf if the new accommodation is more expensive. The Trust, as a result, when advertising the new post will have to make it clear to applicants (both UK and overseas) that they will have to find their own accommodation.

23. Where accommodation (on-call, compulsory residential or voluntary) fails HIMOR standards and is issued with an improvement notice, Trust must offer alternative accommodation to those in post and take steps to meet standards as outlined in the two preceding paragraphs. Residents may choose to remain in the premises whilst improvements are carried out if this is feasible, in which case the abatement provisions of paragraph 175a of the Hospital Medical Terms and Conditions of service will apply. This will oblige employers to provide accommodation free of charge until such time as improvements have been completed.

24. Where accommodation (on-call, compulsory residential or voluntary) fails HIMOR standards, New Deal accreditation, if previously awarded to the trust, must be withdrawn.

ANNEX C

GOOD PRACTICE: EXAMPLE OF SERVICE LEVEL AGREEMENT

NB. This is an example only and, as such, can be improved or expanded upon. It does not cover all eventualities in detail: local circumstances must be taken into account and each case judged on its merits.

Fault	*Working days*
Buildings/building fabric	
Major	1
Routine	depending on nature of fault, up to10
Heating faults	
British Summer Time (approx end March - end October)	5
All other times	1
Hot water	
Failure of whole system (with no alternative)	1
Failure of part system	5
Electrical appliances	3
TV aerials	5
Telephones	Report to switchboard
Sanitary blockages	
Blocked toilet	1
Blocked sink	2
Damages	
Make safe	1
Replacement	2
Internal fixtures/fittings Cupboards/shelves etc	5
Floor finishes - Damage	10

Note:

1 Any structural problems with accommodation or with the equipment provided within it should be reported to the nominated Accommodation Officer and/or nominated contact in the Estates Department, according to local protocol.

2 Where serious faults should be rectified within one working day according to the list above (eg blocked toilet, no hot water or heating) it would be unreasonable for occupants to have to wait from Friday evening until Monday morning for these to receive attention. Apart from these, only in circumstances where there is danger or damage to the fabric of the building such as flooding or gas leaks will repair/maintenance staff or contractors be called to the site out of working hours.

3 Whilst every effort will be made to carry out repairs or maintenance as speedily as possible, on-call staff or resident staff are not entitled to expect a higher level of service than could reasonably be expected if they lived in their own property. The above table outlines the agreed breakdown response times and common sense should obviously be applied. For example, a response time of 10 days will be inadequate for some "routine" buildings faults, but acceptable for others, depending upon the nature of the fault..

4 Where there are competing priorities, patient areas will normally receive priority over staff accommodation.

ANNEX D

HOUSES IN MULTIPLE OCCUPATION REGULATIONS (HIMOR); OTHER RELEVANT REGULATIONS; AND NHS ESTATES GUIDANCE/GOOD PRACTICE

Introduction

1. Under Section 352 of the Housing Act 1985, a local housing authority may serve a notice requiring the execution of works to make houses in multiple occupation (HMO) fit for the number of occupants. In addition, under the Housing Act 1996, HMO landlords have a duty to prevent the property from being in such a condition that a notice needs to be served to install fire precautions or additional facilities. If they fail in this duty, a tenant may sue for damages. The 1996 Act also lays down requirements relating to contracts and tenancy agreements.

HIMOR fitness standards

2. There are two fitness standards which apply to HMO: fitness for human habitation and fitness for the number of occupants.

3.1 *The fitness for human habitation* standards require that:

a property is structurally sound;

a property is in a reasonable state of repair;

there is no dampness severe enough to affect the health of occupants;

there is adequate lighting, heating and ventilation;

there is an adequate supply of wholesome water;

there are satisfactory facilities for preparing and cooking food, including a sink with hot and cold water;

there is a bath or shower and a wash hand basin (both with hot and cold water) and a WC, all in a suitable place and for the use only of the occupants;

there is an effective drainage system.

3.2 The factors to be taken into account when considering whether an HMO *is fit for the number of occupants* are as follows:

the facilities for the storage, preparation and cooking of food, which should include an adequate number of sinks with a satisfactory supply of hot and cold water;

the number of WCs, for the exclusive use of the occupants, and whether they are suitably located;

the number of fixed baths or showers and wash hand basins, each provided with a satisfactory supply of hot and cold water for the exclusive use of the occupants, and whether they are suitably located;

means of escape from fire;

the other fire precautions.

4. The guidance relating to fitness standards is advisory. Local Authorities are asked to have regard to it when considering the exercise of their powers; they may consider higher or lower standards to be appropriate in particular circumstances. The guidance is not prescriptive. Authorities are reminded that excessively high standards of accommodation may deter some landlords from making accommodation available at all; they are encouraged to adopt standards which are *achievable* in the light of the housing characteristics of their area and the resources

available to the providers of housing. Authorities may wish to make known the standards they adopt by publishing leaflets.

5. The above requirements are expanded upon in the regulations and accompanying guidance as follows:

5.1 *where houses are occupied on a shared basis by five or fewer individuals, one sink and one full size cooker may be regarded as sufficient. The sink should also have an adequate and wholesome supply of cold drinking water which conforms to the Water Bylaws.*

5.2 where amenities are shared, each occupant should be able to reach a WC, washbasin and bath or shower without having to pass through accommodation which is occupied exclusively by another household. Where amenities are shared, they should be provided in the ratio of not less than one of each amenity per 5 individuals sharing such amenities. Each amenity should be connected to an effective drainage system. Each WC should have a flushing apparatus and each washbasin, fixed bath and shower should be provided with a piped supply of hot and cold water adequate for their purpose. All WCs, washbasins and baths or showers should have at least artificial lighting and be either naturally or mechanically ventilated.

Enforcement

6. Hospital residential accommodation can be inspected by the Local Authority Environmental Health Department, who advise on HMO standards and regulations. If standards are not met, the trust may be subject to an improvement notice or closure. It is normal practice for problems to be discussed with trust representatives prior to any action being taken.

Other relevant regulations

7. In addition to the HIMOR regulations, there are a number of other relevant regulations with which landlords need to comply.

The Electrical Equipment (Safety) Regulations 1994 - landlords must ensure that equipment supplied is safe. Wiring should be checked and certified by a qualified electrician and any defects identified must be attended to without delay.

The Gas Safety (Installation and Use) Regulations 1994 - all gas appliances must be checked at least once a year by a CORGI registered installer. A copy of the records of the safety checks to be given to tenants within 28 days of the check and to all new tenants when they move in.

The Furniture and Furnishing (Fire)(Safety) Regulations 1988 and The Furniture and Furnishing (Fire)(Safety)(Amendment) Regulations 1993 - applies to furniture let to tenants.

Housing (Management of Houses in Multiple Occupation) Regulations 1990 - duty placed on every manager of an HMO to ensure that the premises are properly managed.

Housing Act 1996 – Tenancies must comply with this Act in respect of contracts/tenancy agreements etc. The owner or manager of an HMO has a duty of care to prevent the property from being in such a condition that a notice can be served to install fire precautions or additional facilities. Failure can lead to tenant being able to sue for damages.

NHS Estates guidance

Policy responsibility for managing NHS premises rests with to NHS Estates, an Executive Agency of the Department of Health. They publish guidance and technical instructions when required, and these are available through their Library & Information Service, based in Leeds, tel 0113 254 7091/2/3. Nominated trust officers should be responsible for making sure that the trust had ready access to the latest information and guidance. Some key publications are listed below:

Hospital Building Note: Residential Accommodation for Staff: DHSS November 1974, reprinted 1972)

Firecode: policy and principles: DHSS March 1994

Capital Investment Strategy for the Department of Health: HSC/1999/113, May 1999

Fire Safety and Health and Safety Targets: HSC/1999/191, August 1999

Health Technical Memoranda (HTMs); Fire Practice notes - various

Firecode focuses on important issues:

- the provisions within existing legislation for imposing severe penalties for failure to comply with statutory requirements
- the obligation of the NHS Executive to monitor health service compliance with the provisions of Firecode
- the nomination of an executive director within each trust or health authority who will be directly responsible to the Chief Executive for fire safety
- the submission of an annual Certificate of Firecode Compliance to the Director of Policy and Performance Management at NHS Estates
- new procedures for reporting outbreaks of fire.

ANNEX E

HOSPITAL MEDICAL AND DENTAL TERMS AND CONDITIONS OF SERVICE: DOCTORS AND DENTISTS IN TRAINING
Note: Paragraph 175a amends the current TCS and will be promulgated separately by way of an Advance Letter.

CHARGES FOR RESIDENCE

Para 173: Compulsorily resident practitioners

a. A practitioner who is required, whether as a condition of his/her appointment, or statutorily, to reside in a hospital shall be provided with accommodation without charge. Should the practitioner elect to occupy alternative accommodation for which a rent is payable, the employing authority shall abate the rental charge up to the cost of the accommodation which would otherwise have been provided.

b. Where any other practitioner, other than one to whom paragraphs 174 and 175 apply, is required to stay overnight in the hospital while as part of an on-call rota or partial shift system, no charge shall be made for his/her necessary accommodation.

Para 174: Voluntary resident practitioners

Where a practitioner resides in hospital voluntarily a charge for the accommodation should be made and, provided consent is given, deducted from his/her remuneration. Lodging charges for existing accommodation will be increased at the same time, and by the same percentage, as increases in junior doctors pay. Lodging charges may, where appropriate, be further increased by reasonable amounts to be determined by local negotiation and agreement, in order to phase a move towards charges which reflect the standard of accommodation provided and notional local market value. Lodging charges for new accommodation will be determined by local negotiation and agreement to reflect the standard of accommodation provided and notional market value.

Para 175: Abatement of voluntary lodging charges

a. Charges made for accommodation should reflect the standard and amenities provided. ***Should those standards fall below the minimum stipulated in Annex B of HSC 2000/XX employers must provide the accommodation free of charge until such time as improvements have been completed.***

b. Practitioners who are required to stay overnight in hospital as part of an on-call rota or partial shift system one night in seven or more often, but who are not eligible for free accommodation under paragraph 173, shall pay the following proportion of the lodging charge :

Required to stay overnight	Proportion
One night in three	0%
One night in four	35%
One night in five	55%
One night in six or seven	75%

ANNEX F

TRUST CATERING - CASE STUDIES

Case Study 1

- The trust has over 100 juniors. It runs a 24-hour canteen which delivers a range of hot meals to eat in or take away at all times of the day. The range of food and the prices are the same as during the day. Juniors can ring through their orders to collect - there is no delivery service.

- Although the canteen makes a loss at night this cost is reduced to a minimum by using the night catering staff to prepare food for general consumption during the next day. The only difference between the day and night service is the loss of a trolley service.

- There are no vending machines on any of the wards because of contractual difficulties, the only place to get any food is in the canteen. The juniors have a mess nearby which has a cold drinks vending machine (the only one in the trust). A separate dining area for staff is not an issue as at night there are few patients or visitors in that part of the hospital. Dining areas, including the mess, are kept clean at all times.

- The catering manager is the person nominated for juniors to contact. Juniors can also go to their mess president, fill in a form in the canteen or go to the catering manager to change the menus or service. Menus are decided by questionnaires filled in by staff who use the canteen. There is also an internal E mail link between the mess president and the catering manager.

- The junior doctors are happy with the service.

Case Study 2

- There are approximately 150 juniors. There is a canteen service open for extended hours up to 4.45am, apart from a short period when the canteen closes for cleaning. The meals are varied with some prepared on-site and others heated up. A kitchen area is provided in the doctors' mess where food can be stored and heated up. There is no bar on ordering or deliving outside take-aways if that is wanted. The canteen will also deliver within reason. There are two members of staff on duty in the canteen and one will deliver while the other cooks. There is a small pizza chain franchise within the canteen while the main contract is run by a private firm who can deliver prepared food from off-site.

- The prices are the same day or night. The pricing strategy looks at the cost of meals based on the longer opening hours rather than on getting the most money out of the service from the peak demand periods. It is also kept low by extending the service to non-medical users such as ambulance staff or night time visitors to patients.

- Food is also available through vending machines on the wards. There is a doctors' mess near the canteen where doctors can prepare or take their food.

- There are named personnel responsible for catering: either the medical staffing manager or the catering manager. There is also comprehensive induction for juniors where the mechanisms are explained.

- The trust has an open door policy for complaints. There are meetings with junior doctors on a quarterly basis with no consultants present. The menus are decided by suggestions from all staff. The canteen is also discussed at other weekly meetings with juniors.

Case Study 3

- Here there are 85 juniors. The canteen closes at 7.30 pm and then re-opens between 11.30pm and 1.30am. The late opening is partly subsidised by a levy on non-trust employees, ie higher prices for patients and visitors. There are no vending machines on the wards for snacks but the trust provides free of charge snacks in the doctors' mess. The mess has a well-fitted kitchen area which is cleaned by hotel services on a regular basis. The mess has been refitted and is spacious so this tends to act as the focus of juniors' activity. There are freshly prepared hot meals, including healthy options, which the juniors can take out of the canteen to their mess if they want.

- The trust is putting in vending machines and juniors have been consulted over what they should stock. Snacks are provided free in the mess (toast, hot drinks). The canteen does not deliver but orders can be phoned through.

- The trust has qualified for *ISO 9002* which denotes they have a working complaints system including named individuals.

- There is a quarterly junior doctors meeting where catering can be discussed if necessary. The BMA star system is well known in the trust and they would easily get the maximum number of stars. There is a shoulder-level partition between staff and patients.

Case Study 4

- The postgraduate deanery sent out a survey on catering for juniors to all the trusts in its area. As part of the local preparation towards accreditation for the New Deal, the replies from the local juniors within this trust were compiled. These highlighted three main areas where the juniors would like improvements made to their out of hours catering:

  - ♦ a sandwich ordering service to provide fresh sandwiches at night.
  - ♦ provision of frozen, ready-made meals suitable for the microwave.
  - ♦ having the canteen open for a further two hours at night.

- A liaison meeting was set up with representatives from the local New Deal monitoring group, the junior doctors' representative and the catering management to discuss what improvements could be made to out of hours catering. A sandwich ordering service was then set up where doctors could order during the day and have their named sandwich pack delivered to the mess fridge during the evening.

- The proposal to provide frozen, ready-made and microwaveable meals await renovations and decorations in the doctors' mess. It is then planned that the junior doctors will be invited to a "taste test" to decide on which meals they prefer. A new freezer has already been ordered in preparation for this service.

- The positive outcome is better liaison between the catering department, the juniors and the local New Deal monitoring group. The trust realises the benefits of having a focus group for junior doctors where they can air their views and concerns over such areas as accommodation, security, cleaning, rotas, hours, etc - and not just for the New Deal. It is planned that the forum will meet regularly, chaired by a named trust manager.

Case Study 5

- Employs about 70 junior doctors. This trust has a well-run restaurant which opens at peak periods and also offers a late-night shift. It has recently been refurbished and provides a varied menu.

- Between 10.45 pm and 2.30 am a night chef is employed to provide freshly cooked food from the "grill bar" on request. There is also the facility to order internal "take-away" by phone, for later collection, with a menu provided to the A & E department showing availability. The late night canteen service attracts up to 50 people per night and is utilised not only by doctors but non-trust night service providers, such as ambulance crews and the police.

- As an extra facility, there are vending machines throughout the hospital which provide snacks. These are re-stocked regularly as they are also used frequently by outside visitors. The mess is supplied daily with fresh bread and milk. Theatres have their own fridges and microwaves and the vending machines in theatre are stocked with suitable food. The extra cost to the trust is containable within overall running costs.

Case Study 6

- Employs about 80 junior doctors. It provides an outstanding example of how a good system can be well maintained, long-term. The trust has a staff restaurant which is open from 7.30 am and 8.30 pm and again from 10.30 pm to 2.00 am. It has received a "Heartbeat" award for healthy eating from the local Environmental Health Department for the third successive year. The trust employs two short-order night chefs who work a late night shift until 2.30 am. They provide a consistent service of cooked meals on request for all the staff within the hospital and also ambulance crews and police. These two chefs are used to prepare the kitchens for the day staff and restock supplies and therefore are fully employed at a time when there may otherwise be a low demand for the catering. In this way the service is cost effective to the trust.

- Vending machines with hot and cold drinks and snack foods are provided throughout the hospital, and particularly in A&E. There are microwave, toast and tea-making facilities in the doctors' mess.

- Within the restaurant there is a screened area that is solely for staff and no members of the public are allowed in the restaurant during the lunch interval from 12.00 midday until 1.30 pm. There is a separate dining room in the Education Centre, which is situated a hundred yards from the main hospital.

- The system has been running efficiently for over five years and the junior doctors within the trust are highly satisfied with the services provided. The trust has said publicly that they view appropriate catering arrangements as a high priority for junior medical staff as a way of increasing morale, reducing stress and gaining co-operation at times when they are hard pressed.

Case Study 7

- Agreed link-up between a small community trust site and a larger neighbouring acute site to provide an out of hours service. Juniors can choose whether to order their hot evening meal in advance from the same menu as the in-patients, to be delivered to the doctors' mess. Alternatively they can order a take-away meal from outside local firms (pizza, curry etc) and be reimbursed by the trust up to a maximum of £6.00 a meal.