THE SCOTTISH OFFICE
Department of Health

NHS
MEL(1997)71

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

15th October 1997

Dear Colleague

THE NEW DEAL ON JUNIOR DOCTORS' HOURS: THE NEXT STAGE

1. This letter reports the good progress made in implementing the New Deal on Junior Doctors' Hours in Scotland since its launch in 1991. Ministers have recently confirmed their commitment to ensuring that the New Deal is fully implemented. This letter details our strategy for addressing the remaining problems preventing implementation in Trusts where the targets have yet to be achieved, as well as proposals for maintaining and monitoring the New Deal in Trusts where it is in place.

2. Annex 1 documents the progress made in achieving the New Deal between 1992 and 31 March 1997. There have been major reductions in junior doctors' contracted and actual hours of work along with significant improvements in their living and working conditions. The majority of junior doctors are now working within the limits set 6 years ago. Many Trusts have shown dedication to achieving the targets and I am grateful to all those staff - managers, consultants, junior doctors, nurses and others - who have worked hard and successfully to bring hours down. This has been a remarkable achievement, particularly when set against a background of significant change in the NHS in Scotland and the many competing demands on scarce resources.

3. There remains, however, a hard core of problem posts which are contracted for over 72 hours a week, together with more widespread problems in reaching the target for actual hours worked. Some difficulties in the intensity of work during out-of-hours duty and the quality and adequacy of rest periods also remain to be addressed. The absence of effective systems to monitor actual hours worked in some Trusts may be masking the extent of these problems and the need to develop suitable mechanisms to ensure adequate monitoring is discussed in paragraphs 7-8 of Annex 2. It is important too that the non-hours standards are both achieved and maintained by all Trusts.

Addresses

For action
Chief Executives, NHS Trusts

General Managers, Health Boards

General Manager, Common Services Agency

General Manager, State Hospital's Board for Scotland

For information
Executive Director, Scottish Council for Postgraduate Medical and Dental Education

Postgraduate Deans and Directors

Chief Executive, Health Education Board for Scotland

Enquiries to:

Mr K McMillan
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2476
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MONITORING COMPLIANCE WITH THE NEW DEAL, JUNIOR DOCTORS' HOURS: A GUIDE FOR TRUST (BY BMA) IS AVAILABLE TO LOOK AT IN ISD LIBRARY.

There is, therefore, still further ground to cover to ensure that the principles of the New Deal apply fully for all junior doctors.

4. The key elements of our strategy for taking forward the New Deal are outlined below and detailed at Annex 2. In order to ensure that the New Deal is put in place, Trusts should:

- take steps immediately to ensure that the non-hours standards for accommodation, catering and security are achieved and maintained;

- work towards eliminating posts contracted for over 72 hours a week;

- develop simple and effective monitoring systems to collect accurate data on actual hours of work and out of hours intensity and take steps to bring down the actual hours worked by junior doctors;

- continue to report progress towards the New Deal targets by the 6 monthly statistical returns.

5. The Management Executive will continue to take the lead in co-ordinating the New Deal. To ensure that Trusts have in place a strategy for full implementation, we will commission detailed action plans from Trusts to be returned by the end of November and will monitor progress towards achieving set goals.

6. The principles of the New Deal are as pertinent now as they were when the initiative began in 1991. We all must demonstrate a commitment to providing a quality health service to patients while ensuring that junior doctors' working hours and conditions are sensitive to the needs of family life and the requirements of training. Achieving the appropriate balance within existing resources will not be easy and will take the full, personal and continued commitment of Trust Chief Executives, junior doctors and their senior colleagues.

Yours sincerely

Ingrid Clayden

pp. GERRY MARR
Director of Human Resources

HOURS OF WORK OF JUNIOR DOCTORS AND DENTISTS IN SCOTLAND: MARCH 1992-MARCH 1997

Date	Number of posts	Number on Full shift		Number on Partial Shift		Number on Rota		Over 83 Hours		82-73 Hours		72 Hours or Less		Number of Posts where hours actually worked exceeded 56*	
31.03.92	3,287	135	(4.1%)	64	(1.9%)	3,088	(93.9%)	1304	(42.2%)	1,982	(64.2%)	-	-	-	-
30.09.92	3,407	178	(5.2%)	221	(6.5%)	2,998	(87.9%)	962	(32%)	2,434	(82.2%)	-	-	-	-
31.03.93	3,320	189	(5.7%)	358	(10.8%)	2,753	(82.9%)	693	(25.2%)	2,609	(94.8%)	-	-	-	-
30.09.93	3,466	197	(5.7%)	551	(15.9%)	2,708	(78.1%)	498	(18.4%)	1,131	(41.8%)	1,076	(39.7%)	-	-
31.03.94	3,514	205	(5.8%)	531	(15.4%)	2,746	(78.1%)	338	(12.3%)	1,159	(42.2%)	1,255	(45.7%)	-	-
30.09.94	3,643	199	(5.5%)	599	(16.4%)	2,799	(76.8%)	178	(6.4%)	648	(23.2%)	1,973	(70.5%)	-	-
31.12.94	3,670	206	(5.6%)	626	(17.1%)	2,788	(75.9%)	13	(0.5%)	660	(23.6%)	2,115	(75.8%)	595	(18%)
30.09.95	3,805	267	(7%)	733	(19.2%)	2,769	(72.7%)	1	(0.03%)	288	(10.4%)	2,480	(89.5%)	607	(26%)
31.03.96	3805	263	(6.9%)	718	(18.8%)	2,798	(73.5%)	1	(0.03%)	264	(9.4%)	2,533	(90.5%)	729	(27%)
31.09.96	3,860	270	(6.9%)	827	(21.4%)	2,714.4	(70.3%)	-	-	116	(4.3%)	2,598.4	(95.7%)	458	(17%)

		Number of Posts Meeting Targets				Number of Posts Not Meeting Targets							
		Contracted		Actual*		Contracted				Actual			
						FS	PS	ROTA		FS	PS	ROTA	
31.3.97	3,959	3,873	(97.8%)	2,967	(93.3%)	NIL	18	68	(2.2%)	NIL	25	189	(6.7%)

* The percentages are calculated using the number of posts for which information has been received, rather than the total number of posts on rotas.

ANNEX 1

KMA10705

FORM 1

DOCTORS AND DENTISTS IN TRAINING
STATISTICAL RETURNS FOR HOURS OF WORK
AS AT 31 MARCH 1997

SCOTLAND

SUMMARY

Grade	Total Number of Posts	Number of Posts meeting		Number of Posts *Not*Meeting Contracted and Actual Hours Targets					
		Contracted Hours Targets	Actual Hours Targets	Contracted Hours			Actual Hours		
				Full Shifts	Partial Shifts	Rotas	Full Shifts	Partial Shifts	Rotas
Senior Registrar	338.5	324.5	233.5			14			15
Registrar	110	108	90			2			3
Specialist Registrar	762.4	727.4	549.5		6	29			31
SHO	2085.5	2063.5	1638			22		4	84
PHRO	663	650	456		12	1		21	56
TOTAL	3959.4	3873.4	296.7*		18	68		25	189

* Information not supplied by the following Trusts:- Aberdeen Royal Hospitals, Highland Communities, Lanarkshire Healthcare, Southern General, West Glasgow Hospitals (5 Trusts in Total)

Trust figures have been validated by the Trust Chief Executive and a representative of the Junior Doctors. Those Trusts supplying incompletely validated figures were Argyll and Bute, Central Scotland Healthcare, Glasgow Royal Infirmary, Hairmyres, Law, Raigmore, Royal Infirmary of Edinburgh, South Ayrshire Hospitals, West Glasgow Hospital and Yorkhill (10 Trusts in total).

ANNEX 1

KMA05103

THE NEW DEAL: THE WAY FORWARD

Introduction

1. Despite the progress in implementing the New Deal, there remains a residue of posts which do not yet comply with the targets for contracted or actual hours worked. Trusts will need to revisit these posts when preparing their action plans to ensure that appropriate measures are taken to address long-standing problems. In the short term, there is a lot that can and should be done to take the New Deal forward. There are, for example, 14 further Trusts which could fully meet the requirements of the New Deal by resolving their failure to comply with one of the 3 non-hours standards for accommodation, catering and security. Similarly, Trusts should take steps now to ensure that monitoring systems for actual hours of work are in place and operating effectively so that their progress towards achieving the actual hours targets can be measured.

2. In order to monitor and co-ordinate progress towards full implementation of the New Deal, the Management Executive will require Trusts to continue to submit 6-monthly statistical returns on their performance against targets. In addition, Trusts should prepare action plans for full implementation of the New Deal for submission to the Management Executive **by 21 November** as detailed in paragraph 15. The Management Executive will focus on those Trusts which require to make substantial progress in order to achieve the actual hours target, particularly in cases where an effective monitoring system has yet to be put in place. Close attention will also be given to Trust plans for ensuring the non-hours standards are met and maintained. For those Trusts claiming to have the New Deal in place, we will seek verification that there is full compliance with all targets and standards. We will also require these Trusts to supply details of their monitoring systems for actual hours worked. The Management Executive will ensure that such examples of successful implementation strategies are included in the Good Practice Guide for the benefit of all Trusts. The following paragraphs provide detail on what Trusts are now expected to do to take forward the New Deal.

Non-hours Standards

3. The importance of the living and working conditions of doctors on training was emphasised by the Heads of Agreement on Junior Doctors' Hours in December 1990 and the requirements on non-hours standards were circulated to Trusts in 1991 as part of the booklet *Junior Doctors - the New Deal.* This guidance set out the minimum recommended standards for residential accommodation and provided advice on other ways of improving living and working conditions. A copy of the guidance is enclosed.

4. These New Deal non-hours standards have been a requirement for 6 years and Trusts are expected to give achievement of this aspect of the New Deal a high priority during the coming months. Those Trusts which have not met the standards should include full and timetabled proposals for meeting these requirements in their action plans and those Trusts which have met the standards should include their proposals for maintaining and monitoring them in future.

Contracted Hours

5. While we expect immediate Trust action to achieve the non-hours standards, the hours targets should not be neglected. We acknowledge the success Trusts have had in meeting the contracted hours target but several problems remain for which solutions need to be found. Trust action plans should identify all posts still contracted for more than 72 hours per week and should propose timed solutions for these problems. In exceptional cases, where no effective resolution seems possible, Trusts must include justification for the long hours of each of the posts concerned.

Actual Hours of Work

6. We recognise the difficulties that exist in meeting the target for actual hours worked. However, a substantial part of the problem faced by many Trusts appears not to be that actual hours targets cannot be met but rather that there is no simple and effective monitoring system in place which would allow accurate determination of the actual hours position. We note, for example, that 5 Trusts submitted an 'unknown' return on actual hours for the period up to 31 March 1997 while others expressed considerable doubt over the accuracy of their figures despite the requirement for validation by the Chief Executive and a junior doctors' representative. It is essential that Trusts have available clear and unambiguous information on actual hours worked before solutions can be devised for actual hours problems. Every Trust must therefore have an effective monitoring system in place which collects accurate information and is easy to use. Ideally, a junior doctor should be invited to take responsibility for a Trust's monitoring procedures and for ensuring that compliance with the actual hours target is co-ordinated with other priorities. We also recognise the importance of identifying inappropriate duties carried out by junior doctors which increase their actual hours of work. Trusts should devise imaginative working patterns to reduce these inappropriate duties. When drawing up their action plans, Trusts should identify specific solutions for those posts that still fall outwith the actual hours targets.

Hours Monitoring Systems

7. Trusts which have in place effective monitoring systems for actual hours worked are asked to submit information about them to the Management Executive for inclusion in the Good Practice Guide for the benefit of other Trusts. There is already a considerable volume of information on hours monitoring systems, both in the Guide and in the BMA Junior Doctors Committee's booklet *Monitoring Compliance with the New Deal.* A copy of this booklet is attached. Trusts seeking to install or improve their systems are encouraged to make use of this information.

8. Work has been done in England on the development of purpose-built computer software for the monitoring of junior doctors' hours and we are currently considering whether this would be of help to Trusts in Scotland. The programme - *'New Deal 3' - Software to Monitor Working Hours of Doctors in Training* was piloted in 6 acute hospitals and subsequently launched in the South of England in July 1996. An independent evaluation was completed in December 1996 which highlighted the relative ease of entering and modifying data and there are now plans to extend its application throughout England. To allow Trusts to find out more about the software, we propose to arrange a presentation by the author of the New Deal 3

software and to invite Trust management, the profession and members of SACMW-ND to attend. Trusts are asked to complete and return the expression of interest form at Annex 3 by **24 October at the latest** to allow us to gauge the level of interest and to make final preparations for the presentation.

Role of the Management Executive

9. The Management Executive will continue in its role of co-ordinating the New Deal and will seek advice from the Scottish Advisory Committee on the Medical Workforce - New Deal Sub-committee (SACMW-ND) as necessary. We will promote delivery of the strategies contained in Trusts' action plans by:

- assisting Trusts where necessary in the preparation and implementation of their action plans;

- facilitating the development of effective hours monitoring systems;

- liaising closely with those Trusts experiencing particular difficulties and meeting with Trust management and doctors to assist in the development of solutions;

- maintaining regular contact with Trusts as they work towards full achievement of the New Deal.

- continuing to monitor the overall position on the New Deal via the 6-monthly statistical returns from Trusts on junior doctors' hours.

10. The Management Executive's task will be helped by the reports produced by the Support Project Team as they undertook their visits to Trusts in 1995-96. We will ensure that the advice and good practice guidance compiled by the Team is disseminated to further the full implementation of the New Deal.

11. We would expect that actions flowing from the implementation of Trust plans will generate many further examples of good practice. The Management Executive will encourage Trusts to submit these examples as they arise for inclusion in the Good Practice Guide for the benefit of all Trusts.

Work Intensity

12. A subsidiary New Deal target is that on-call work intensity must be within acceptable limits. This is not always possible and the payment of partial shift additional duty hours rates (Class 2 ADHs) is a device aimed at remunerating junior doctors for their additional work while at the same time encouraging Trusts to work towards reducing work intensity to within acceptable limits. The uptake of intensity payments at 31 March 1997 was:

- 377 junior doctors' posts in 27 Trusts were receiving the enhanced payment for a total of 10,132 hours.

In statistical returns, only 10 Trusts reported a reduction in work intensity following the payment of Class 2 ADHs. A number of Trusts have made intensity payments over a significant period of time without evidence of any impact on intensity. Once the 6-monthly returns for 30 September 1997 are collected and analysed, we hope to improve our understanding of the position in relation to intensity payments.

13. A further concern which has arisen in relation to intensity payments is the apparent lack of a suitable mechanism for juniors to appeal against non-payment of Class 2 ADHs. We are particularly concerned that some Trusts are apparently refusing to hear juniors' appeals. All Trusts must ensure that juniors are able to appeal against non-payment of Class 2 ADHs. Trusts are therefore asked to establish an appeals panel at Trust Board level chaired by a non-executive director. This panel should also have a junior doctor who is conversant with the working patterns involved and an external independent member drawn from a pool of experts approved by the Management Executive and the BMA Junior Doctors' Committee. An appeals panel of this sort would ensure that those involved in the original decision to refuse payment could appear before the panel but would not be involved in decisions taken by it. Trusts are expected to hear appeals during juniors' appointments rather than after they have left their posts. The panel would be charged with considering all the relevant evidence, making a balanced decision and informing Trust management and the junior(s) involved of its conclusions. Trusts should describe in their action plans the mechanisms they have in place or intend to put in place to hear juniors' appeals.

14. The English Advisory Group on Manpower, Education, Training and Staffing (AGMETS) New Deal Sub-Group will meet in October to examine junior doctors' ADH structures and working patterns. The Territorial Departments are represented on this Group and will, therefore, participate fully in the discussions about the future of ADH payments.

Trust Action Plans

15. The Trust action plan is an essential component of our strategy. All Trusts are asked to prepare an action plan for consideration by the Management Executive. Plans should be available by **21 November 1997**. We expect Chief Executives to take personal responsibility for finalising the plan and, subsequently, for ensuring its implementation, thereby signalling the Trust's commitment to ensuring that the New Deal targets are met. The plans should contain full and timetabled proposals to meet the New Deal requirements as follows:

Non-hours standards

Trust action plans should include detailed proposals for the achievement of the New Deal standards for accommodation, catering and security where these are not in place. Trusts which consider the standards have been met should report that fact and indicate how these standards will be monitored and maintained in future.

Contracted Hours

Trusts are asked to review the position on contracted hours and to make timed proposals to bring down the contracted hours of each post which currently fails to meet the 72 hour target.

If, in exceptional circumstances, it is felt that the problem cannot be resolved, the action plan should include justification for the long contracted hours.

Actual Hours of Work

It is clear that the absence of effective hours monitoring systems is a barrier to determining whether the actual hours target is being met. Trusts are asked to include in their action plans their proposals for the installation of effective monitoring systems and specific proposals to improve the position for all posts currently known to fall outwith the targets.

Intensity Payments

Trusts are asked to ensure that there is a mechanism in place to hear appeals from juniors against non-payment of Class 2 ADHs and should include details in their action plans.

Good practice Guidance

All Trusts are asked to share their successes with the rest of the service and to contribute further examples for the Good Practice Guide as and when these arise.

European Working Time Directive

16. Finally, Trusts are asked to note the possible impact on the process of reducing junior doctors' hours of the European Commission proposal to extend the Working Time Directive to include doctors in training. The Government has made a commitment to support the Working Time Directive, which provides for minimum daily and weekly rest periods, annual paid holidays, a 48-hour limit on the working week and restrictions on night work. The Commission's proposed extension is at an early stage and we remain unclear as to the likely outcome. Nevertheless, the timescale needed to implement change in the area of medical training is potentially very long. Trusts are therefore asked to bear in mind in their planning the possibility that the full implementation of the New Deal for junior doctors may be an interim, rather than a final measure.

LIVING *and* WORKING CONDITIONS *of* DOCTORS *in* TRAINING

1. The Heads of Agreement on Junior Doctors' Hours (December 1990):-

a) asked local managers to review urgently the work environment of doctors in training;

b) called for guidance on good practice in the provision of job descriptions, residential accommodation, catering and other facilities for doctors in training.

This guidance sets out recommended minimum standards for residential accommodation and provides advice on other ways of improving the living and working conditions of doctors in training.

2. Responsibility for achieving and maintaining high quality living and working conditions for doctors in training, as for other staff, rests with Unit General Managers. As part of their function of monitoring the implementation of the Heads of Agreement, Regional Task Forces and their visiting teams will wish to satisfy themselves that acceptable accommodation and other facilities are available for doctors in training.

3. It will be for managers locally, in consultation with doctors in training or their representatives, to:-

- review current living and working conditions, including accommodation;
- consider what changes and improvements to current arrangements or procedures are desirable;
- determine priorities for action; and
- implement change.

4. Managers should bear in mind that:-

a) hospital accommodation is home for many doctors in training and they are entitled to expect such accommodation to be of a decent standard, properly serviced and maintained;

b) the changing balance of the medical career structure means that doctors in training have a greater opportunity to choose where they work. Their decisions are likely increasingly to be influenced by the living and working conditions as well as the clinical duties of the post;

c) the Royal Colleges (and universities in the case of pre-registration house officer posts) can withdraw educational approval from posts where accommodation does not meet acceptable standards.

Many hospitals already offer accommodation and other facilities which meet, or improve upon, the recommended standards. Nevertheless current arrangements should be kept under review and improvements made where possible.

5. Some of this advice can be implemented at nil or minimal cost. In other cases investment may be required, for instance to improve poor quality accommodation, and managers should look imaginatively at ways of funding such improvements.

6. Any enquiries on this guidance should be addressed to

Ms L Wilkinson, Room 427 Portland Court, 158-176 Great Portland Street, London W1N 5TB
Tel: 071 972 8264

Accommodation

These accommodation standards replace and update those issued with Victor Paige's letter of 19 May 1986.

1. Adequate accommodation should be provided for resident staff including accommodation for married staff. The accommodation should be within the hospital grounds where possible. Where this is not possible the residents' place of work should be readily accessible. All connecting corridors, paths and roads in hospital grounds should be well-lit and measures should be taken to ensure the safety of residents called to the hospital during hours of darkness. All accommodation should recognise that residents have a right to privacy and quiet. Accommodation should be sound and free from leaks or damp, and should be properly maintained.

2. Although there is a distinction between on-call rooms and general residential accommodation, many of the same standards apply to both. **On-call rooms should not be regarded as second rate accommodation**.

3. Where accommodation is home for a number of residents there should be a properly furnished common room separate from any dining room.

4. Security locks should be fitted to residents' rooms, for which residents should hold the key. Local arrangements should be made to resolve security problems which can arise where hospitals have limited accommodation and rooms are occupied by other doctors during periods of leave.

5. A resident should be able to relax and study in comfort in his or her room. To ensure this the room should be large enough to allow for, and should contain, a three foot bed or divan, necessary cupboards and drawers, a writing table and chair, bookcase or bookshelves, and an armchair. If the room is not large enough to provide sufficient bed-sitting space a separate sitting room should be made available. The room should be in good decorative condition and the floor should be carpeted and windows curtained. There should be a reading/bedside light and the room should contain several electric sockets to take square three pin plugs. All fixtures and fittings should be of reasonable quality and maintained in a good state of repair. The safety of the occupant should be given priority, particularly in the provision of fire protection devices.

6. Heating arrangements should allow rooms to be heated quickly and efficiently. Where possible, heating should be under the resident's control.

7. Each room should contain a washbasin with hot and cold running water. A bathroom and WC should be provided. Ideally these should not be shared by more than two residents.

8. There should be a telephone by each bed connected to the internal hospital telephone system. External telephones should be readily accessible from residents' rooms and there should be one in the common room. Telephone charges should be reasonable.

9. Domestic services should include regular room cleaning and laundering of bed linen and towels. **Doctors using on-call rooms must have made beds with a change of linen between changes of occupant**. Shared facilities - common rooms, dining rooms, kitchens, bathrooms and toilets - should be cleaned regularly.

10. Residents should have access to personal laundry facilities. These could be provided by an on site launderette, the provision of hand washing and ironing facilities in residences or arrangements with a laundry delivery service. Equipment provided should be maintained in a good state of repair.

11. Kitchen facilities should be provided for residents who wish to cater for themselves and for the preparation of beverages and snacks. Equipment provided should be maintained in a good state of repair.

12. There should be clearly understood arrangements for the recovery of costs for damage caused by residents, fair wear and tear excepted, provided that no deductions may be made from a practitioner's salary without his or her prior written consent.

Catering

13. In view of the length and irregularity of the hours of duty of doctors in training it is important that meals should be adequate, varied, attractively and efficiently served and, where possible, freshly prepared. Catering facilities should be separate from those provided for patients, relatives and other non-employees. Proper provision should be made for out of hours catering. Main catering facilities can be supplemented in a variety of ways to enable doctors in training to eat during periods of duty. These include:-

- vending machines, provided the quality of food can be maintained;
- microwave facilities in the doctors' mess or dining area, together with a supply of food;

Complaints

14. Residents should be encouraged to take an active interest in the services provided for them and there should be informal arrangements for discussing their views. Responsibility for resolving complaints about accommodation or other aspects of living and working conditions should rest at local level. Doctors in training should be able to put complaints to their employing Authority, Board or Trust if they wish.

Induction Courses

15. Most hospitals already run induction courses for doctors in training, and all should. Senior doctors should allow enough time, if necessary by providing direct cover, to enable doctors in training to attend such courses. Induction courses should be appropriate to the grade and experience of the doctors concerned and should normally last for at least one day.

Job Description

16. The job description forms part of the doctor's contract of employment. It should contain sufficient information to provide an adequate and accurate picture of the living and working conditions, as well as of the duties of the post itself and the training available. It should make clear whether the post is compulsorily resident. An outline of the areas which should be covered in a job description is annexed.

Libraries

17. The new working patterns which are being introduced may require doctors in training to be on duty outside normal working hours more frequently than hitherto. Managers should ensure where possible that access to the hospital library or postgraduate centre does not cease at the end of the normal working day.

Personnel

18. A medical staffing officer should provide the main link with doctors in training. Consideration should be given to basing this post in the doctors' mess to help develop relations with doctors in training.

Recreational and Other Facilities

19. Each hospital should provide a doctors' mess facility which should be of reasonable size, well equipped, and easily accessible from wards and departments.

20. Where possible adequate car parking should be provided on the hospital site for doctors in training.

21. Where recreational facilities are not provided on site managers should look into the possibility of establishing concessionary deals with local sports clubs or swimming pools. Information should in any case be provided on local amenities when staff take up their posts.

ANNEX # GUIDELINES FOR TRAINING GRADE JOB DESCRIPTIONS

Job descriptions for training grade posts should include information in the following areas:-

The Post

1. The job description should include:-

a) a brief statement of the reason why the vacancy has arisen;

b) a description of the duties of the post, including a provisional list of daily commitments and the arrangements for emergency duty;

c) a person specification. This should be a statement of the key attributes the appointee should possess, covering both previous clinical experience and any personal qualities which are felt desirable. Any criteria should be capable of use at the appointment committee.

Job descriptions and person specifications should be couched in non-sexist language. Requirements about age, qualifications and length or nature of experience should not be included unless specifically required for the post. Employee/person specifications should not include requirements on marital status nor include references to marriage plans or domestic arrangements.

The Training Scheme

2. There should be a description of the training opportunities offered by the post, including, where applicable, a description of the training scheme and rotation of which the post forms part. This section can take the form of a uniform brochure or prospectus produced for all posts in a particular training scheme.

People

3. This section should set out the names of those with whom the post holder will have most contact. The list should include the consultant(s) to whom the doctor will be clinically accountable, the person in charge of training, both in the district or unit and in the overall training scheme, and the person in the medical personnel department who will be the postholder's main contact point.

Terms and Conditions

4. This section should detail the terms and conditions of service of the post, including remuneration, and state if the post is compulsorily resident. This could be a separate, standard leaflet.

The District, Unit and Service

5. This section, which could be presented in a format for use in many different posts, should describe the service, including an overall description of the district and unit.

Facilities

6. Information should be provided on accommodation and other facilities available - eg doctors' mess, catering facilities, car parking.

ANNEX 3

PRESENTATION OF THE NEW DEAL 3 SOFTWARE TO MONITOR WORKING HOURS OF DOCTORS IN TRAINING

This form should be used to register an interest in attending a presentation on the New Deal 3 Software to Monitor Working Hours of Doctors in Training to be arranged by the Management Executive. It places no obligation on Trusts or Health Boards but will give us a measure of the level of interest in a presentation and will allow us to make the necessary arrangements. The presentation is likely to take place in St Andrew's House in November or December this year.

Trust/Health Board ..... would be interested in sending a representative(s) to a presentation on the New Deal 3 Software.

Position of representative(s) in Trust/Health Board:

We may have to limit numbers depending on the level of interest shown.

Please send the completed form to:

Ken McMillan
Directorate of Human Resources
Room 61A
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

by **24 October 1997 at the latest.**