Introduction

Contract negotiations and proposed changes to the shape of training have remained high priorities this year. The changes proposed in these areas will have a huge impact on the careers, training, and patient care provided by doctors in training.

In all our conversations, we have made it clear that the safety of patients and doctors is simply non-negotiable, and that we’re not prepared to agree to anything that would lower the quality of doctors training. As it is so important that junior doctors have a real and tangible voice in any discussions about the future of their training, we have fought hard for and secured a seat on the Shape of Training board. As a bad contract will hurt not just your working life and your training, but also patient care, we took the difficult decision to stall negotiations with NHS Employers last October, rather than agree a bad deal.

However, the past year has not just been about contract negotiations and the shape of training. The regular work of JDC has continued apace and, in reading this report, you will be able to see that we have acted on every single resolution passed by the junior doctors conference last year. Alongside this, we have also carried on with ‘business as usual’ – attending banding appeals, lobbying for fair training, advising members on matters relating to their training and employment, and more.

All of JDC’s achievements are the result of the hard work and dedication of the members of our committee and its secretariat. We would like to thank them all for their continued efforts on behalf of doctors in training in the UK this year.

Contract negotiations

Over the last two years, our priority has been to negotiate with NHS Employers to deliver a new contract for doctors in training that put safety and training at its heart. Ultimately, we had to take the difficult decision to stall those negotiations because it gradually became clear that the welfare of doctors and patients was not being effectively considered by NHS Employers. In particular, we were being asked to remove key safeguards without adequate protections in place for doctors and patients. You can read more about why the negotiations stalled here: https://bma.org.uk/news-views-analysis/the-bma-blog/2014/october/ten-reasons-why-the-juniors-contract-talks-stalled

In October last year, the Doctors and Dentists Review Body were asked by the Government to make recommendations about new contractual arrangements for doctors in training. We have submitted detailed written and oral evidence to the Review Body. We explained clearly what we would want to see in a new contract, the data that is needed to allow us to develop a contract that is fit for purpose, and the safeguards that must be included in any new contract. You can read more about our evidence here: http://bma.org.uk/ddrbevidence.

We expect the DDRB to publish its report in July, after a new government has formed. Although we cannot know in advance exactly what they can say, we are developing plans that will enable us to respond to a range of potential scenarios.

Shape of Training

The 2013 Shape of Training Review, led by Professor Sir David Greenaway, outlined 19 recommendations for changing the structure of postgraduate medical education and training to meet changing patient needs and the future demands of the health service. JDC has voiced its serious concerns about some of the core recommendations and the lack of adequate consultation over the past year.
In various stakeholder engagement events and within Health Education England’s Shape of Training Stakeholder Engagement Group, JDC representatives raised our strong opposition to these policy proposals, specifically one to shorten the length of medical training. However, we did not feel that the concerns of doctors in training were being properly considered.

To ensure our voice was heard loud and clear, the BMA brought together 14 organisations representing doctors in training and signed a consensus statement detailing our collective opposition to the Greenaway report. We sent the statement to Dan Poulter, MP then Parliamentary Under Secretary of State for Health and the UK Shape of Training Steering Group ahead of an expected announcement about next steps.

After months of speculation, the UK Shape of Training Steering Group (STSG) announced its plans to move forward in a statement issued in February 2015. Specifically, next steps include:

– A mapping exercise to look at how doctors’ training can be more generic to better meet the current and future needs of patients;
– measures to further develop the careers of doctors who are outside formal postgraduate training and who are not consultants, such as SAS grade doctors;
– measures to better prepare doctors to work across the interface between primary care, secondary care and the community with more flexibility in training between the sectors; and
– STSG support for the GMC as they develop and pilot credentialing.

Importantly, the STSG makes clear that “those aspects of the current training system that have been shown to work well and are fit for purpose should remain.”

We are also pleased that the STSG heeded our calls for further consultation, but we will not rest on our laurels. Notably, the BMA has secured a seat on the STSG and we will continue to closely engage in this work at the current time.

For more on the Shape of Training Review, visit: http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/shape-of-training-review

Get involved, and tell us what you think
We are always keen to hear from you, and the more you tell us the more we can address the issues that matter to you and to our members. Please do take the opportunity to let us know what you think. Whether it’s telling us what you think of our performance over the past year, asking us for more detail about what we’ve done or we are going to do, or simply telling us what you’re concerned about – we’d love to hear from you.

If you want to get involved in supporting and representing junior doctors, please consider attending a local junior doctor committee meeting or visiting one of our national meetings. To find out more, simply email us at info.jdc@bma.org.uk.

Andrew Collier
Kitty Mohan
Key areas of work

The future of pre and postgraduate medical training and development
The BMA is seeking members’ views on the Shape of Training and more broadly on the future on pre and postgraduate training and development. Deliberative events were held in London and Edinburgh in March 2015 that brought together members from all grades and specialties to discuss key issues and gather feedback. In addition, a member consultation that sets out principles that will form the basis for a vision document will help to guide the BMA’s future policies and action in this area. The consultation is live on BMA Communities and can be accessed at https://communities.bma.org.uk/policy_debate/f/70/t/1083.

Clarification of leave entitlements
There has been uncertainty and variability among employers about the accrual of public holidays for doctors on maternity and paternity leave. At JNC(J) the NHS Employers agreed with our understanding of the terms and conditions and that such doctors should accrue public holidays and so should be able to take the time back in lieu on their return to work. We have informed all LNCs of this clarification and asked them to ensure all affected doctors seek remuneration or time off in lieu.

Less than full time training
Over the last few years a number of surveys have shown an increase in the number of doctors training less than full time, moving from 8.0% of the junior doctor workforce in 2012, to 11.3% in 2014. With this in mind, the JDC are reviewing the BMA guidance in this area and ensuring members are provided with comprehensive and meaningful information when considering training less than full time.

Tax guidance
The BMA has received an increasing number of queries related to tax and reimbursements for various activities that are required of junior doctors (for example examinations, courses etc). Over the last year the BMA has been working with tax law experts to combine all tax information for junior doctors into one comprehensive guide, which will be published later this year.

Proposal to bring forward the point of full registration
Originally included in Professor Greenaway’s Shape of Training report, this proposal is now being considered independent of the Shape of Training agenda. The JDC, Medical Academic Staff Committee and the Medical Students Committee have worked closely together to develop the BMA’s position and have met with the Medical Schools Council, the GMC and HEE on several occasions throughout the year to express our opposition. The GMC conducted an engagement exercise in early 2015 where the BMA raised its concerns.

Specialty Recruitment Assessment (SRA)
In January 2015, the SRA (formerly known as the Specialty Selection Test) was piloted for a second time in Core Psychiatry and Ophthalmology following recommendations from the evaluation of the initial pilot in 2014. We have, from the outset, been concerned about the suitability of a single, generic SRA as a tool for specialty recruitment and selection and based
on the data from the first pilot, we remain unconvinced of its validity, reliability and cost-effectiveness. We believe that the use of new, properly validated tools to improve selection methodology can offer benefits for patients and doctors. We know that a fair and effective recruitment system is a big priority for trainees and we continue to liaise with HEE to ensure recruitment systems are proportionate and fit for purpose.

**Funding for postgraduate education and training**
In April 2014, the Department of Health (DH) introduced a new tariff system to allocate funding for education and training in England. This replaces the Multi-Professional Education and Training (MPET) levy. A salary contribution and a fixed stipend are paid directly from Local Education and Training Board (LETB) budgets to employers. This means that the budget for study leave, access to learning services, and out-of-programme activities will now be administered by employers, not by LETBs as it was in the past. Health Education England (HEE) is responsible for implementation and intends to design a set of ‘levers’ that will require employers to achieve quality targets with the budget allocated to them. JDC has produced a [video animation](#) explaining the new tariff and is working with DH and HEE to ensure that its education and quality incentives are properly aligned with good training.

**Training system improvements**
We are in the process of finalising guidance on taking time Out of Programme (OOP) and the ARCP process. As part of these work streams, we will press LETBs/deaneries and Health Education England (HEE) to ensure consistency in the application of national standards. We have also lobbied the Conference of Postgraduate Medical Deans (COPMeD) and other stakeholders to protect the period of grace and to break down system barriers faced by trainees who receive unsatisfactory ARCP outcomes.

**Communications activity**
The spectre of a general election in 2015 has been felt throughout the past year. The uncertainty of the outcome placed even greater question marks over the future of the NHS, in particular workforce and funding. Against this backdrop, we have continued to set out the challenges faced by junior doctors to policy makers, politicians and the media.

Issues facing junior doctors specifically continue to be the subject of discussion and debate, from the outcomes of the General Medical Council’s annual national training survey to recruitment and leave. The decision to call time on contract negotiations in October 2014 drew media and political attention, with coverage from the Daily Telegraph, the BBC and HSJ. When questions were raised around the Shape of Training review, JDC members were called upon to give their views on a range of media, including BBC radio and television.

There has also been great success in the regional media. Will Seligman and Melody Redman have had a number of opinion pieces published in their local newspapers looking at junior doctor issues, including nine to date with the Yorkshire Post.

In the run-up to any general election, health is always a touchstone issue. With so much uncertainty around this election, however, the parties were vocal about their headline health bids, if slightly quieter on the detail. The BMA continued to press the parties and their spokespeople for greater clarity and, importantly, called for No More Games with the NHS as part of its pre-election work.

Around 20 regional hustings took place across England and Wales, with BMA members coming together to hear from the candidates vying for their votes. In addition, the BMA co-hosted a health and care debate with the health spokespeople from the Conservatives, Labour, the Liberal Democrats and UKIP, chaired by the BBC's Sarah Montague.

Of course it is easy to focus on the high profile events and activity. From monthly newsletters to web content to junior-focused Communities pages, the BMA communications team is working to ensure members get the right information at the right time, supporting the JDC and its members all year round.
Junior doctor contract

Following the stall in negotiations in October 2014, when the Department of Health asked the DDRB to consider all evidence relating to the junior doctor contracts and make recommendations for doctors in England by next July, the administrations in Wales and NI also indicated that they wanted the DDRB’s work to cover trainees in their nations. In mid-December, the Scottish Government also gave the DDRB a remit to review the contract for trainees in Scotland.

The final DDRB supplementary evidence was submitted to the DDRB on 20 February.

HSC E-Locum system

Until recently, BMA(NI) was involved in negotiations with Trusts in NI and their intention to establish a HSC E-Locum Agency. The purpose of the single HSC e-locum agency was to try and reduce locum costs through an internal solution, whereby HSC staff could be engaged to cover rotas/shifts, rather than the 100% reliance upon medical agencies.

Discussions regarding the HSC e-locum system have been ongoing now for some time and the Trusts were very keen to progress this. However, NIJDC has now written to the Steering Group advising that their proposed rates and conditions are unacceptable and our original request still stands and BMA is disengaging from any further involvement and withdrawing support for the establishment of the system. Junior doctors in Northern Ireland are also being advised that they do not have to register on the HSC e-locum system.

Shape of Training

JDC wrote to the four devolved nation health departments with a consensus statement amongst the representatives of a wide range of doctors in training around the Shape of Training in January 2015.

The Shape of Training Steering Group (STSG) also produced a statement outlining a number of proposals, one of which is to develop groups in each country with appropriate stakeholders to develop proposals as agreed by Ministers. BMA NI has requested and been granted an additional three seats (NIJDC already has representation) on the Medical Education Policy Group which is the departmental oversight group tasked with taking forward all Shape of Training recommendations in NI.

Medical workforce planning

The Chair of NI Council has written to the Minister on the lack of progress with the medical workforce planning review in NI.

Miriam Simpson, the new BMA health policy and economic research unit staff member working specifically with the devolved nations, will be producing a focused piece of work to gather evidence to support future discussions with the Minister as to why trainees are leaving NI to work elsewhere, what skills and experiences they acquire when they are away and what benefits they can bring back to the health service in NI when they return. This piece of work conveniently dovetails with her work programme for the nations, one of which is an overview of the medical workforce, including a specific focus on doctors’ career intentions.

Governance in the HSC

Sir Liam Donaldson’s report had been released on 27 January and a BMA NI response to the report was compiled and finalised by the Northern Ireland Council Executive Subcommittee on 25 March 2015. The overall aim of the Review was to examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland, to assess their strengths and weaknesses and to make proposals to strengthen them.
BMA/DHSSPS HR Engagement Forum
The NIJDC chair continues to attend meetings of the BMA/DHSSPS HR Engagement Forum where issues discussed include updates on workforce planning, the consultant and junior doctor contract negotiations, for example.

This Forum was established as BMA NI is not a member of the formal Staff Side Group of trades unions and is therefore not represented on the joint Negotiating Forum for Management and Staff side groups, therefore, it was important that BMA had some form of engagement to facilitate dialogue between DHSSPS and BMA as it is the trade union for doctors.

Northern Ireland Deanery
The Chairmen of NIJDC and NIMSC continue to meet with representatives from NI Medical & Dental Training Agency (NIMDTA) to discuss issues such as foundation/specialty training, HSC E-Locum system and revalidation.

Communications
This session NIJDC has looked at different ways to better communicate with its members and a new Facebook group has been set up on a trial basis to see if it is a more useful tool for communicating with junior doctors in the province.

If you would like to know more about the work of NIJDC or are interested in joining the Committee please contact the secretariat on hnesbitt@bma.org.uk
New junior doctor contract
Following over a year of contract talks with juniors over a new contract, contract negotiations were stalled over concerns about patient safety and doctors not being effectively considered by NHS Employers (NHSE). The Doctors and Dentists Review Body (DDRB) was directed to consider all evidence relating to contract negotiation talks for junior doctors and consultants and recommendations for doctors in England by July. The administrations in Wales and NI also indicated that they wanted the DDRB’s work to cover trainees in their nations. In December 2014, the Scottish Government also gave the DDRB a remit to review the contract for trainees in Scotland. BMA have submitted evidence to the DDRB, and await its final report.

Shape of Training Review
SJDC continues to be concerned over the implications of the recommendations outlined in the Shape of Training Review report. In meetings and in correspondence with the former Cabinet Secretary for Health and Wellbeing, SJDC representatives have conveyed BMA Scotland wide concerns over key review recommendations, and pressed for BMA Scotland to be fully involved in determining consensus on the way forward for Scotland. The Scottish Government assured BMA Scotland that they will not commit to any of the detailed recommendations without full exploration of the relevant issues and stakeholder consultation. BMA Scotland is represented by David Reid, Chair of SJDC, on the Scottish Shape of Training Transition Group (SSTTG) and has representation on the newly formed Scottish Shape of Training Implementation Group, which had its first meeting on 13 March 2015.

A BMA deliberative event, aimed at grass roots members, on Shape of Training and the future of postgraduate training more widely, took place in March 2015, in Edinburgh.

Junior doctor working patterns and hours
SJDC has continued to raise concerns with MSG and the Scottish Government about the effect of shift-working on the health and performance of junior doctors and lobbied for the removal of rotas that contain seven nights in a row. SJDC welcomes the Scottish Government commitment to end the practice of rostering junior doctors working seven full night shifts in a row by February 2015. The proposed additional limit of seven days in a row by 2016 will present a significant challenge to NHS Boards and SJDC will work with them and the Scottish Government to implement safe and sensible rotas in Scotland.

Monitoring
At meetings with MSG and the Scottish Government, SJDC have raised concerns about barriers to accurate monitoring of junior doctor working hours and how improvements could be made to the monitoring process. The Scottish Government announced it would work with NHS Boards in Scotland to ensure a more simplified and cohesive monitoring process of junior doctor working hours, and the removal of barriers to ensure accurate recording and monitoring of junior doctor working hours. This includes some Boards’ requirement of a consultant signature sign-off that is solely used during monitoring periods. NHS Boards have also been instructed to ensure that all staff have access to appropriate rest facilities, where they can rest during or after their shifts. SJDC is represented on the New Deal Plus Group that has been set up to explore the development of a standardised monitoring process in Scotland, identifying best practice, and ensuring that actions agreed upon with SJDC and MSG are progressed to improve the working lives of junior doctors.
HR Shared Services – Medical and Other Trainees
The Medical and Other Trainees is one of three workstreams being taken forward by NHS Scotland as part of the HR Shared Services (HRSS) Programme. The HRSS consultation – Compelling Case for Change (CCfC), led by NHS Services Scotland, put forward a proposal for single lead employer arrangements to be introduced for trainees in Scotland. In response, SJDC affirmed its support in principle – the BMA for some time has pressed for host or lead employer arrangements that enable trainees to be issued with a contract of employment that reflects the length of their training programme. SJDC did highlight some reservations over the main proposal for a single employer model operated by NES for all trainees, whilst acknowledging that NES already is the host employer for GP trainees in Scotland for the GP component of their training and that this arrangement has worked well. BMA Scotland have asked for a full appraisal of all available options, followed by a further period of consultation in advance of any final decision reached.

Attracting and retaining junior doctors in Scotland
The NES Strategy for Attracting and Retaining Trainees (StART) is a joint stakeholder approach to addressing shared challenges of attracting trainees to and retaining trainees in Scotland. StART aims to improve recruitment and retention of medical trainees to specialty training programmes in Scotland, by developing understanding of poor fill rates, gaps and attrition by specialty; and understanding factors affecting trainees’ choices.

SJDC is represented on the StART Alliance – the stakeholder partnership leading the initiative. The StART Alliance have been developing their marketing strategy and have focused on raising the profile of Scotland as a training destination through development of the Scottish Medical Training website, use of social media and advertising and profile within the student BMJ and attendance at BMJ Careers Fairs. The Alliance have also developed a network of Trainee Ambassadors to promote medical education and training in Scotland. SJDC have expressed some concerns regarding the slow progress and focus of the initiative thus far. SJDC will continue to engage with the stakeholder group to progress efforts to attract and retain trainees within Scotland.

For more information on this report or if you are interested in joining SJDC, please contact SJDC secretariat Geraldine Donnelly at gdonnelly@bma.org.uk.
The BMA’s Welsh Junior Doctors Committee (WJDC) is committed to representing and acting upon issues that affect junior doctors in training in Wales. The Committee works with and regularly makes representations to the Welsh Government, the Postgraduate Deanery and Local Health Boards on behalf of junior doctors. The WJDC also works in co-operation with the BMA Welsh Council and other Committees that represent various branches of practice of the medical profession in Wales.

We also have an important role in actively contributing to the work of the UK Junior Doctors Committee, ensuring that the views of junior doctors in Wales are represented. This was particularly important during the junior doctor contract negotiations in which Elliott King participated as the Wales representative. Although those negotiations have now stalled, WJDC is committed to maintaining a single UK contract and we will play an active part in any future negotiations should they resume.

WJDC has been lobbying for the continuation of the Junior Doctor Review Group (JDRG). Currently this is the only forum in Wales at which junior doctor issues (other than training) can be discussed, and it also provides the reporting structure for the Monitoring Scrutiny Group and the Accommodation Review Group. We feel that the JDRG should play a role in reviewing junior terms and conditions of service in Wales and ensure that agreements reached at the Joint Negotiating Committee (Juniors) are effectively communicated to the service and implemented in Wales.

We have been reviewing a re-drafted All-Wales Rota Monitoring Process which contains a number of provisions that are not acceptable to WJDC, particularly in respect of natural breaks. We will ensure that our views are heard through our membership of the Monitoring Scrutiny Group.

During the past twelve months, for the first, a number of banding appeals have taken place in Wales. Members of WJDC have taken part in these appeals to ensure that the provisions of the TCs are represented and that decisions are made in accordance with these.

WJDC has been negotiating a new trainee relocation policy. Once this has been introduced (anticipated August 2015) WJDC will be publicising the policy to ensure that juniors in Wales are aware of, and benefiting from, its provisions.

Our aim is to ensure good communication between the Committee and the junior doctors that it represents. This is a two-way process that allows junior doctors’ opinion to reach the WJDC and ensures that junior doctors from the grassroots are involved in its lobbying, surveys and activities. To help us achieve this we are always happy to welcome new members to the Committee who are committed to working on behalf of and representing the views of their colleagues.

If you would like further information about any of the issues mentioned above, or are interested in joining WJDC, please contact Mrs Lynn Steer – lsteer@bma.org.uk.
Actions on resolutions from the 2014 junior doctors conference

1  **Resolved:** That this conference believes that service and training are inextricably linked and that JDC should actively resist any moves to separate them.

   The BMA has made this clear through its participation in an HEE working group set up to consider the recommendations of the Working Time Regulations, which was chaired by Norman Williams, Chair of the Royal College of Surgeons. The BMA also expressed this view in its response to a recent GMC consultation on new education and training standards which are designed to make sure that fairness and patients’ safety, experience and quality of care are at the heart of the teaching and training received by medical students and doctors.

2  **Resolved:** That this conference is concerned by suggestions from Health Education England that increasing restrictions are going to be placed on out-of-programme (OOP) opportunities for specialty trainees. This conference believes that OOP opportunities are highly valuable training experiences which create well-trained, adaptable doctors who are able to meet future challenges in health care delivery. This conference calls on the JDC to:
   i) press for a thorough review of the eligibility criteria for all types of OOP opportunities with the aim of widening access and ensuring consistency in a structured way;
   ii) work to ensure that trainees who wish to go OOP for research have equal opportunity to do so whatever their stage of training or identity of their research funder;
   iii) press for the retention of OOP for Training, which can add significant value to an individual training programme.

   JDC worked closely with the Joint Academic Trainees Subcommittee to lobby against suggestions from Health Education England to increase restrictions to out-of-programme opportunities. A BMA position paper encouraging wider access to OOP was shared with HEE and we presented COPMeD with recommendations for improving the application process. We are currently finalising guidance for trainees who are considering taking time out of programme and will keep a watching brief for any new developments in this policy area.

3  **Resolved:** That this conference notes the Shape of Training Report. It recognises the need for more generally trained doctors, but is concerned:

   i) with the proposed shortening of training;
   ii) the replacement of CCT with CST as the end-point of training;
   and calls upon JDC to:
   iii) raise awareness that training good generalists takes longer than training specialists;
   iv) reject CST as the end-point of training, as it will create a sub-consultant grade compared to the current CCT;
   v) lobby against moving the attainment of full GMC registration to the point of graduation from university.
In January 2015, the BMA brought together 14 organisations representing doctors in training, and signed a consensus statement strongly opposing certain recommendations of the Greenaway report including the shortening of training and the proposed replacement of the certificate of completion of training with a certificate of specialty training (CST). We sent the statement to Dan Poulter, MP then Parliamentary Under Secretary of State for Health and the UK Shape of Training Steering Group.

The Steering Group’s announcement in February 2015 outlining immediate next steps for taking forward the recommendations of the Greenaway Review did not include a further recommendation to shorten training. The announcement also noted that “any proposed changes to training will be properly considered, modelled and costed and consulted upon before any changes are made.”

However, HEE has commissioned a “mapping exercise” of College curricula to a hypothetical Shape of Training-compliant world. This will be a very complex exercise, without complete clarity of purpose behind it.

The BMA has voiced these concerns and opposed the relevant Greenaway recommendations consistently and will continue to do so through our recently secured seat on the UK Shape of Training Steering Group.

A proposal to move the point of registration forward to the end of medical school is being taken forward outside of the Shape of Training agenda. JDC, Medical Academic Staff Committee and the Medical Students Committee have worked closely together in the development of the policy regarding the point of registration. To help inform this work and to further lobby, representatives from all three committees met with representatives from the Medical Schools Council and with HEE on several occasions throughout the year.

Resolved: That this conference believes junior doctors should be involved in discussions that affect their future careers from the outset. We therefore mandate the JDC to lobby relevant stakeholders:

i) for a meaningful seat on groups discussing implementation of the Shape of Training Review;

ii) to ensure there is no implementation of any elements of the Shape of Training Review without full and open consultation;

iii) to ensure explicit and robust transition arrangements for current trainees are specified should any part of the Shape of Training Review be implemented.

The BMA participated in stakeholder engagement workshops held in September 2014 and subsequently secured a seat on Health Education England’s Shape of Training Stakeholder Engagement Group. Following months of lobbying, the BMA secured a seat on the UK Shape of Training Steering Group, which is tasked with development activities to take forward the recommendations in the Shape of Training report. In February 2015, the group announced that any proposed changes to training would be “properly considered, modelled and costed and consulted upon before any changes are made”.

The BMA is currently developing a consultation to gather members’ views on the future of education and training which will feed into the work of the steering group.
5 Resolved: That this conference sees continuing sacrifice of structured training to provide tariff generating activity for employers. We call for the JDC to:

i) lobby deaneries/LETBs to formalise arrangements with employers for minimum levels of training activity;
ii) ensure a mechanism to report under-provision of training to deaneries/LETBs should service needs override educational responsibilities of the employer;
iii) mandate deaneries/LETBs to take swift and decisive action to rectify where this is breached, potentially removing trainees where training is not being appropriately delivered.

The BMA submitted a robust response to the GMC’s recent consultation on new education and training standards. We expressed strong support for new standards that require organisations to have effective systems of educational governance to manage and control the quality of medical education and training. We continue to keep a watching brief and respond to individual problems as they arise.

6 Resolved: This conference:

i) recognises the pressure medical registrars are under in the NHS as described in the Royal College of Physicians’ report ‘The Medical Registrar’;
ii) believes that such pressure on a relatively small number of individuals is detrimental to their health, training and potentially to patients;
iii) believes that a greater number of medical specialties should be participating in the acute medical take where curricula permit, with more medical trainees dual accrediting in both their chosen sub-specialty and general medicine;
iv) acknowledges that such a move would need to be done in a managed, prospective way to guarantee patient safety;
v) believes that acute medicine must be better supported and resourced as a standalone medical specialty and measures to boost recruitment should be brought forward by HEE.

The sentiments in this resolution are reflected in a 2014 paper titled “Non-GIM Trainee Participation in the Acute Medical Take.” The JDC lobbied HEE, the GMC and royal colleges on this issue and advised members who had concerns about changes in local policies.

7 Resolved: That this conference:

i) believes no trainee should be disadvantaged in specialty training applications owing to their visa status;

ii) welcomes NHS Education for Scotland’s move to become the central sponsor for all doctors in training in Scotland on tier 2 visas from August 2014 which will help solve this problem;

iii) calls on BMA JDC to act in concert with the BMA International Committee to urgently and more effectively lobby Health Education England, the UK Border Agency and UK Government Ministers, to ensure parity and fairness for tier 2 visa holders;

iv) calls on BMA JDC to raise the profile of this issue.

As a direct result of BMA lobbying, Health Education England agreed to be the single central sponsor for all doctors in training in England on Tier 2 visas from March 2015. We continue to work with HEE to ensure a smooth transition for these trainees.

8 Resolved: That this conference believes that the meeting of competencies and thus a favourable ARCP outcome is not always in the control of trainees. If the training environment is unsupportive, planned training opportunities are not available or academic training time slows progression, good trainees may fail and receive an outcome 3 through no fault of their own.

We call on JDC to develop proposals for a new ARCP outcome that permits an extension to training but is clearly “no fault”.

JDC developed a proposal for an ARCP outcome that allows for an extension of training but recognises “no fault” on the part of trainee. COPMeD reviewed the proposal and decided not to take it forward at this time. JDC is currently working to mitigate the negative impacts of an Outcome 3, for example, as a disqualifier from obtaining an inter-deanery transfer, alongside further work to see its proposal for a new outcome implemented.

9 Resolved: That this conference believes that the design and frequency of Work-Based Assessments (WBAs) must be determined by their educational use to trainees rather than the desire of training programmes to defensively “prove” trainee competence. It believes that:

i) WBA types should only be used where they have proven educational value;

ii) the number of WBAs required should be consistent by specialty training programme throughout the UK and calls on the JDC to:

iii) collect information from all individual specialty training programmes on the types and numbers of WBAs required and expected for trainee progression (CARRIED AS A REFERENCE);

iv) survey specialty trainees on their views and experiences of WBAs (CARRIED AS A REFERENCE);

v) lobby the Conference of Postgraduate Medical Deans to work on ensuring greater consistency, proportionality and fairness in WBAs.

JDC is developing a position on WBAs and we plan to discuss this issue with COPMeD in the near future.
10 **Resolved:** That this conference notes that support for doctors undergoing ARCP is lacking and information provided to doctors prior to the panel meeting is inadequate, and calls for:

i) a structured guide doctors can use as an aide for their ARCP, outlining the requirements and the standards of assessment they should expect;

ii) support for doctors experiencing difficulties in their ARCP including detailed advice on procedures for appealing decisions where applicable.

JDC is developing a comprehensive guide to the ARCP process which we plan to publish later this year.

11 **Resolved:** That this conference notes with regret the substantial financial burden on junior doctors, with the ever increasing cost of examination fees and essential courses. This conference calls on the BMA to:

i) continue to lobby faculties, colleges and providers to reduce costs of examination, assessment and essential training;

ii) lobby employers to make recognition of the cost of essential training in allocation of study budgets;

iii) ensure that BMA membership subscription tax receipt is available for download online;

iv) lobby the Royal Colleges, the HMRC and other appropriate bodies to ensure tax relief on college exam fees and professional courses.

Through trainee links at the AoMRC we have continued to lobby for lower training-related fees and greater transparency of course costs. JDC also met with the Royal College of Physicians to discuss ways in which exam fees might be lowered.

12 **Resolved:** That this conference calls on the BMA, in the run-up to the 2015 General Election:

i) to robustly challenge all the major parties on their respective records on the NHS;

ii) to challenge each party on its plans for the NHS with clear rebuttal of untruths, inconsistencies or misleading statements, and support for truthful, honest or pragmatic statements;

iii) to not stand on the sidelines for fear of being thought partisan, and to defend the NHS strongly and fearlessly.

**No More Games**
In mid-February the BMA launched the No More Games campaign: [https://nomoregames.org.uk](https://nomoregames.org.uk). This was a major public facing campaign calling on politicians to stop using the NHS as a political football in the run up to the general election. As well as a launch event at BMA House, more than 3,000 posters were displayed across England, Wales and Northern Ireland and print adverts were published in the majority of national newspapers. As well as this the campaign has had its own social media channels (Twitter & Facebook) and an ongoing digital advert campaign. In terms of media we have generated more 630 ‘hits’ across print, broadcast and online media.
Westminster health lectures
The BMA invited the health spokespeople from 6 political parties (Conservatives, Liberal Democrats, Labour, Greens, UKIP and NHAP) to talk with members and be held to account on their policies. Unfortunately the Conservatives did not provide a spokesperson. These events were open to all members to attend and can be watched here: http://bma.org.uk/working-for-change/policy-and-lobbying/general-election-2015/westminster-health-lectures

Health and care debate
The BMA co-hosted the health and care debate, a health hustings event with Jeremy Hunt, Andy Burnham, Norman Lamb and Dr Julia Reid (on behalf of UKIP). The event, chaired by the BBC’s Sarah Montague, ensured that each party was interrogated on their policies and records. The BMA asked a question on workforce issues and BMA attendees were also given the opportunity to ask questions. The event can be watched here: http://bma.org.uk/working-for-change/policy-and-lobbying/general-election-2015/health-and-care-debate

Local Hustings
We organised regional hustings, generally in marginal seats, to give members the opportunity to challenge local politicians on their policies related to health. Details of these events can be found here: http://bma.org.uk/working-for-change/policy-and-lobbying/general-election-2015/regional-hustings

13 Resolved: That this conference:

i) recognises the challenge that obesity poses for the NHS, described by the Foresight group and the Royal College of Physicians, with one in two adults likely to be obese in 2050;

ii) also recognises that obese patients often have complex medical, psychological and social needs.

The BMA board of science is developing a report on ways to promote healthy diets among children and young people (due to be published in July 2015) which considers overweight/obesity from a prevention perspective.

14 Resolved: That this conference notes the increasing prevalence of novel psychoactive substance (“legal high”) usage amongst the population. Given the dangerous nature of these substances and significant negative impact it is having upon users, we call upon the BMA to:

i) provide further education and press statements noting the dangers of "legal high" use;

ii) lobby the government to provide funding for further research into the effects of "legal high" use;

iii) lobby the government to provide funding to reduce the use of "legal highs";

iv) lobby the government to launch a campaign on the impacts and dangers of "legal highs".

A 2013 BMA board of science report, Drugs of dependence, acknowledges the emerging problems around novel psychoactive substances and the need to keep this under review. We have passed this resolution to the BMA’s professional policy department for any further action.
15 Resolved: That this conference notes the events that occurred in the run up to the removal of doctors-in-training from Bedford Hospital. This conference:

i) lauds the actions undertaken by the East of England LETB senior team;
ii) fully supports the removal of trainees from learning environments where there is inadequate support;
iii) asks for JDC to lobby HEE, NES, NIMDTA, Wales Deanery and COPMeD to put in place a formal pathway for efficient trainee removal when the placement is inappropriately supported.

The BMA submitted a robust response to the GMC’s recent consultation on new education and training standards. We expressed strong support for new standards that promote high quality placements and require employers, medical schools, postgraduate deaneries, and LETBs to have systems and processes to monitor the quality of teaching and facilities on placements, and to respond when standards are not being met.

16 Resolved: That this conference deplores the proposed plans, by this Government, to compel NHS organisations to track the immigration status of new migrants to the UK and to charge fees for access to GP and Emergency Department services. We affirm that the principle of universal access to healthcare on the basis of need is a cornerstone of the British healthcare system. We urge the BMA to:

i) produce clear communications and policy briefs; aimed at both public and medical professionals, unequivocally opposing any attempts to implement such discriminatory measures and providing clear empirical evidence against Government claims and obfuscations;
ii) support and give clear legal and pastoral guidance to doctors in dealing with NHS Trusts (or equivalent) and finance departments in the process of implementing such discriminatory measures.

The BMA has voiced strong concerns about the Government proposals to extend charging to primary care and emergency services. This was a key point in our response to the government consultation on the issue and has since been raised in BMA briefings for the Immigration Bill as it progressed through Parliament. We will continue to lobby the incoming Government on this issue.

17 Resolved: That this conference recognises the findings of the Nuffield Trust report ‘The Francis Report: One Year On’ and the concerns amongst NHS management around the challenges of ensuring correct staffing levels in the context of financial constraints. Recognising that despite media narrative this is not a challenge uniquely confined to nurse staffing levels, we call upon the BMA to lobby for:

i) a further increase in doctor numbers with the aim of meeting the OECD average of 3.2 per 1000 population;
ii) that this be paid for with additional funding not from the current pay bill.

The 2013 annual HPERU Medical Workforce Briefing highlights that the distribution of doctors in each of the UK nations is below the OECD average. The 2014 Medical Workforce Briefing (pending publication) continues to accentuate this point.
Resolved: That this conference is concerned with the current oversubscription to the Foundation Programme with risk of unemployment for newly qualified doctors. This conference demands that medical schools control their intake numbers to reduce oversupply of medical students.

The BMA Medical Students Committee is leading on this issue. The Foundation programme (FP) for 2015 is oversubscribed by 399 applications. JDC and the Medical Students Committee have had several meetings with key stakeholders including: HEE, tMSC, UKFPO, GMC and the CMO on the subject. The BMA has been lobbying for both short term and long term solutions to address the oversubscription to the FP problem.

In several letters to stakeholders and in news articles, the BMA has stressed that it would be a waste of personal and public investment if graduates could not secure a FP post. Lobbying will continue on this important issue.

Resolved: This conference notes the recently published research commissioned by the GMC in response to the disparity in pass rates between UK trained doctors and the IMGs in the CSA Exam, concluded the possibility that all BME doctors have a lower pass rate than their counterparts and could not rule out discrimination. We call on the GMC to further investigate this issue.

The issue of differential attainment is a key focal point for the GMC. A workshop was held at this year’s GMC annual conference to which JDC representatives. JDC and the wider BMA continue to keep a close watching brief on this issue.

Resolved: That this conference:

i) believes that in refusing to accept the pay recommendations of an independent pay review body, the Westminster Government and other devolved administrations have failed to acknowledge the hard work and dedication of doctors;

ii) notes the Scottish Government’s acceptance of the Doctors and Dentists Review Body recommendation of a 1% pay uplift for all NHS staff in Scotland;

iii) believes that incremental pay progression rewards commitment to the NHS as well as professional experience and development;

iv) believes that incremental pay progression does not remove the need for pay to keep pace with the cost-of-living;

v) believes that this real terms pay cut for the fifth year in a row will reduce morale, and is evidence of the Government’s continued failure to value NHS staff.

The BMA has clearly explained that the Government’s refusal to accept the DDRB’s pay recommendations damages trust in this process. We continue to push the Government to implement these proposals and, recognising that a new government is possible in 2015, have made our views clear to all political parties.
21 **Resolved:** That this conference is appalled by the UK Government’s recent announcement about an annual pay increase for NHS staff.

The BMA clearly explained that the Government’s refusal to accept the DDRB’s pay recommendations damages trust in this process. We pushed the Government to implement these proposals and made our views clear to all political parties.

22 **Resolved:** That this conference:

i) believes that, unless NHS funding is to expand, any move to 7-day services should focus on improvements to unplanned out-of-hours care before weekend elective working is considered;

ii) notes and supports calls from consultants for access to the full range of in-hours facilities (such as radiographic, laboratory and other specialist services) if they are expected to provide an extended consultant presence in the interests of a safe and high quality service;

iii) demands that juniors be provided with the same resources if they are expected to continue to provide 24-7 services;

iv) notes that important barriers to discharging patients out-of-hours (and consequent hospital capacity issues) relate to the current working patterns of other health and social care staff;

v) calls on the BMA to lobby governments to engage with all health unions to come to a sensible solution to the benefit of patients.

As well as making our views clear on this through lobbying, the BMA also addressed these points in the 2014 contract negotiations and in our recent evidence to the DDRB.

23 **Resolved:** That this conference notes the current system of hours monitoring whereby hours are averaged over 26 weeks to ensure compliance with Working Time Regulations still allows for the number of hours worked in one week (7 days) to exceed 90, putting both junior doctors and patients at risk as a result of excessive tiredness. Therefore, we call upon the BMA to lobby for:

i) a shortened reference period of 13 weeks rather than 26 weeks (CARRIED AS A REFERENCE);

ii) the maximum number of hours worked in one week to be limited to 72 (CARRIED AS A REFERENCE).

The BMA discussed the WTR and safe working hours in some depth with NHS Employers during the contract negotiations of 2013/14. We stressed the need to reduce the maximum number of working hours per week and for a shortened reference period for WTR compliance. Following the end of negotiations, we have reiterated these in our evidence to the DDRB. The DDRB is expected to report in July 2015.
24 **Resolved:** That this conference, saddened by recent high profile fatal traffic collisions involving junior doctors, and noting the evidence that suggests that junior doctors have a higher risk of being involved in a road traffic collision:

i) believes that a junior doctor being involved in a traffic accident where tiredness caused by their work was a contributing factor, means that they would have been too fatigued to work safely;

ii) calls on the relevant body to add this to their list of ‘never events.’

During the contract negotiations of 2013/14, the BMA discussed safe working hours limits. We stressed the need for provision of facilities for doctors who are too fatigued to work/drive. Following the end of negotiations, we have reiterated this in our evidence to the DDRB. The DDRB is expected to report in July 2015.

25 **Resolved:** That this conference notes the wide disparity in unsuccessful ARCP outcomes between regions and:

i) demands that the BMA negotiators ensure that any proposed use of ARCP outcomes to determine pay is fair and equitable;

ii) requests that the GMC analyse their data set to determine whether disparities exist for groups of doctors with protected characteristics;

iii) demands that COPMeD address this situation urgently to reduce geographical variation of ARCP outcomes across the UK;

iv) calls on the JDC to publish annual “league tables” for Deaneries and LETBs showing these disparities (CARRIED AS A REFERENCE).

During the contract negotiations of 2013/14, the BMA made clear that any use of ARCP outcomes to determine pay should be fair and equitable. We also made a number of proposals which we believe could deliver this. Following the end of negotiations, we have reiterated this in our evidence to the DDRB. The DDRB is expected to report in July 2015.

A major piece of related work about ARCPs is currently underway and discussions with the GMC and COPMeD will take place in due course.

26 **Resolved:** That this conference recognises the high cost to trainees of rotational training posts in terms of relocation and travel expenses, with many employers making up their own rules. We ask the contract negotiators to ameliorate this situation in any new contract.

The BMA discussed relocation and travel expenses extensively during the contract negotiations of 2013/14. We stressed that the rotational nature of training posts puts doctors in a unique position and that the terms and conditions related to expenses must reflect this. Following the end of negotiations, we have reiterated this in our evidence to the DDRB. The DDRB is expected to report in July 2015.
27  **Resolved:** That this conference understands that any future contract for juniors will not be approved by the treasury unless automatic annual pay progression is removed. If this provision were to be lost, we demand:

i) that any cost savings be ploughed back into the basic salary scale of doctors in training (CARRIED AS A REFERENCE);

ii) JDC negotiators to absolutely minimise the number of doctors who do not get increments at appropriate gateways;

iii) dispensation for those who undertake Deanery/LETB approved out-of-programme to ensure an academic career in medicine does not become even less attractive than it is currently (CARRIED AS A REFERENCE);

iv) a work-around to ensure that doctors who take maternity/paternity/caring leave or have to work less than full-time are not disproportionately affected compared to their peers.

The BMA discussed pay progression in some depth with NHS Employers during the contract negotiations of 2013/14. We stressed the need to ensure no doctor or group of doctors is disadvantaged due to a new pay progression system. Following the end of negotiations, we have reiterated these in our evidence to the DDRB. The DDRB is expected to report in July 2015.

28  **Resolved:** That this conference notes the move from final salary to CARE pensions and therefore feels that one of the basic principles underpinning junior contract negotiations should be to increase pensionable pay.

The BMA discussed pensionable pay in some depth with NHS Employers during the contract negotiations of 2013/14. Before commencing the negotiations the government committed to providing extra funding for increased pension contributions. Following the end of negotiations, we have reiterated these points in our evidence to the DDRB. The DDRB is expected to report in July 2015.

29  **Resolved:** That this conference believes that exam fees paid by the junior doctors should be tax deductible. The negotiation team should consider if this could be implemented via the new junior doctors contract of employment.

The BMA discussed tax deductions in some depth with NHS Employers during the contract negotiations of 2013/14. We stressed the need to ensure all financial requirements for doctors in training (for example exam fees) are tax deductible. Following the end of negotiations, we have reiterated these in our evidence to the DDRB. The DDRB is expected to report in July 2015.

We are also working on a separate project which we believe will help junior doctors to claim tax back on exam fees and other employment related costs.

30  **Resolved:** That this conference calls upon the JDC’s Contract Negotiating Team to ensure that sensible and safe hours limits for junior doctors are enshrined in any new contract in order to prevent excessive working hours being imposed on junior doctors if the NHS is subsequently granted an exemption from the Working Time Directive.

The BMA discussed safe working hours in some depth with NHS Employers during the contract negotiations of 2013/14. We stressed the need to reduce the maximum number of working hours per shift and per week, ensure regular breaks, and limits on the number of consecutive shift worked. Following the end of negotiations, we have reiterated these in our evidence to the DDRB. The DDRB is expected to report in July 2015.
31 **Resolved:** That this conference believes that the “Code of Practice on the Provision of Information for Postgraduate Medical Training” is poorly implemented and requires JDC to ensure compliance is restored and act to maintain this at 100%.

JDC raised this issue throughout contract negotiations and reiterated its position in evidence submitted to the DDRB.

32 **Resolved:** That this conference notes the untapped potential as junior doctors as agents for change, to innovate and improve quality and services. We ask the contract negotiators to seek protected time within the work pattern to pursue this activity.

The BMA discussed this with NHS Employers during the contract negotiations of 2013/14, with a view to incorporating it into plans for work scheduling. Following the end of negotiations, we have reiterated these points in our evidence to the DDRB. The DDRB is expected to report in July 2015.

We made similar points in meetings with key stakeholders, and supported the 2014 Agents for Change Conference, which was held at BMA House.

33 **Resolved:** This conference notes that patients are not always empowered to choose the most appropriate NHS service. This can lead to inappropriate attendances to A&E. We ask the BMA to support patient education in this area by:

i) publishing examples of good local practice;
ii) working with the GMC and educators to empower junior doctors to help patients make the right choice next time;
iii) working with employers to highlight the value of junior doctors in the work.

The BMA’s Patient Liaison Group (PLG) has supported the Board of Science call for young people to be equipped with the knowledge and skills required to make safe and effective use of NHS services, and to take responsibility for self-management of their health when it is appropriate to do so.

The PLG are currently updating their 2006 resource on Medical Titles – a who’s who in the NHS. This resource provides patients with information on the different types of doctors that they will come into contact with in the various NHS settings. It also encourages patients to ask doctors to introduce themselves and explain who they are and what they do, thereby ensuring patients are better educated on the NHS.

The PLG are also exploring the subject of quality care – what it means for patients and what it means for doctors. While also examining the role of patients in improving quality care and encouraging patients to educate themselves about their condition and treatment options.
34 Resolved: That this conference recognises the value of clinical guidelines and standards in supporting best practice and guiding treatment and is concerned that such evidence based practice, namely the Liverpool Care Pathway, has been withdrawn from the practice of palliative medicine. In order to facilitate best practice and minimise unwarranted variation in standards of care, we call upon the BMA to lobby for:

i) the prompt introduction of patient focused, multidisciplinary clinical guidelines for the palliative management of the dying patient;

ii) universal and comprehensive training to junior medical staff in the communication skills that are so vital to this field, and in the clinical implementation of this new guideline.


The BMA is currently working on a new project on end of life care and physician-assisted dying, which will carry out research into a number of issues relating to perceptions and attitudes towards end of life care and physician-assisted dying. This research will take the form of a literature review and deliberative events conducted with BMA members and the general public. The aim of the project is to develop a comprehensive understanding of doctors’ and the public’s views of some of the practical and ethical issues around end of life care and physician assisted dying. In order to deliver the best possible care for patients, it is important that doctors understand their needs and the choices about the care they would like. This project will give the BMA a better understanding of current concerns about end of life and palliative care, which will help doctors and other healthcare professionals design and deliver the best possible care. Full details of the project can be found at http://bma.org.uk/working-for-change/improving-and-protecting-health/end-of-life-care.

35 Resolved: That this conference strongly believes in the principles of patient autonomy and patient confidentiality as the foundation of all clinical work and therefore:

i) supports each patient’s choice to object to the storage of their data in a central database, through an opt-out system;

ii) demands the right of each patient to view all of their stored data, to be informed with whom their data is shared, and to have any objections to its accuracy recorded;

iii) calls for access to pseudonymised data to be limited to situations in which there is a public interest (for example, a specific research hypothesis);

iv) requires data cannot be traced back to the individual patients if data is shared outside the NHS, without the consent of its use for this purpose by patients (CARRIED AS A REFERENCE);

v) opposes the use of patient data by NHS and government to generate profit (CARRIED AS A REFERENCE).
Patients have the right to object to confidential data leaving their GP practice for purposes other than their care. For care.data, this right has been placed on a statutory basis through Directions to the Health and Social Care Information Centre. The BMA has consistently stressed that patients must be informed about who will be using their data and for what purpose. The BMA was pleased to note that the Independent Information Governance Oversight Panel’s report into the care.data programme has made it a condition that the pathfinder CCGs must be able to demonstrate that patients understand what data will flow and for what purpose if the programme is to proceed further.

The BMA continues to work with the HSCIC and NHS England on the development of a secure data facility which would allow access to pseudonymous data without the data leaving the HSCIC. Initially this facility will be in place to support the care.data programme. The HSCIC has also committed to increased transparency and now publishes details of all data releases on its website. The provisions of the Care Act 2014 prevent the release of data from the HSCIC for purposes other than the provision of healthcare or promotion of health and data cannot be sold for commercial profit. The Care Act also requires the independent Confidentiality Advisory Group (CAG) to advise the HSCIC on its data releases. New regulations will further clarify the CAG’s role in this area.

Patients have existing rights under the Data Protection Act 1998 to see their personal data and to have accuracies corrected.

Resolved: That this conference notes its affirmation in 2013 of the statement “Mental and Physical Health are Equal”, and applauds the NHS England statement of Parity of Esteem that suggests a similar commitment. This conference further notes that all NHS Trusts, whether providing care in the acute, community, mental health or a combination of these sectors, have a moral duty to address the changes suggested in the Francis Report to safeguard patient care. We therefore:

i) condemn the decision of Monitor and NHS England to persist in implementing a ‘differential tariff deflator’, amounting to enforcing cuts to mental health and community services 20% greater than those imposed in the acute sector;
ii) call upon the BMA to join other groups in lobbying for cuts in the former sectors to be no greater than the latter.

The BMA has undertaken a range of lobbying activities in light of the 2014 Board of Science report, Recognising the importance of physical health in mental health and intellectual disability. This includes various parliamentary briefings and media work, and meetings with the Chief Executive of Public Health England (September 2014) and with the then Minister of State for Care and Support, Norman Lamb MP (in October 2014). The BMA fed into the development of the revisions to the mental health aspects of the NHS Mandate, as well as the new Department of Health five year plan, Achieving Better Access to Mental Health Services by 2020. The lack of parity between physical and mental health is also being considered as a part of the work of the ‘Public health and healthcare delivery’ Task and Finish Group. Aspects of the Groups work relevant to parity between physical and mental health include the way services are commissioned, delivered and funded.

Resolved: This conference abhors the portrayal of patients with mental health difficulties by the national media, specifically noting headline by the Sun newspaper, and costume displays of Asda and Tesco. We call on the BMA to:

i) recognise the poor representation of a vulnerable patient group;
ii) support patients’ rights to accurate and fair portrayal.
The BMA’s report, *Recognising the importance of physical health in mental health and intellectual disability – Achieving parity of outcomes*, recognises the discrimination mental health patients pace in accessing services. See resolution 36 for additional information on BMA lobbying activities in this area.

38 Resolved: That this conference expresses its concern that there are more slaves in Britain than ever before and human trafficking into the UK is becoming increasingly common. We therefore call upon the BMA to:

i) highlight the concern amongst the medical profession of the health consequences of human trafficking, and raise awareness of this issue amongst doctors;

ii) publish guidance on the recognition and management of trafficked individuals when they come into contact with health services.

The BMA supported the introduction of the UK Modern Slavery Act, which was granted royal assent on 26 March 2015. The act will see the creation of an independent anti-slavery commissioner, as well as strengthening existing laws by:

– Introducing life sentences for those guilty of the most serious trafficking and slavery offenders

– Tougher asset confiscation for those convicted of slavery or trafficking

– The creation of trafficking and slavery risk and prevention orders aimed at restricting the actions of individuals likely to cause them

– Ensuring the protection of victims of slavery from criminalisation through a statutory defence

39 Resolved: That this conference believes that to enable more effective identification, treatment and prevention of female genital mutilation, it should be on undergraduate curricula and the appropriate postgraduate curricula, in particular obstetrics and gynaecology, surgery and general practice.

In the last few years there has been an unprecedented amount of resources, initiatives, parliamentary and media coverage, policy developments and legislative changes aimed at eradicating female genital mutilation (FGM). FGM already forms part of the postgraduate curriculum in some specialties, including the RCOGs in core modules 4 (Ethics and legal issues), 8 (Antenatal care) and 11 (The management of delivery). The National Institute for Health and Clinical Excellence (NICE) also notes that healthcare professionals routinely involved in the care of pregnant women should be given training on “the specific health needs of women who are recent migrants, asylum seekers or refugees, such as needs arising from female genital mutilation...” Statutory guidance (England and Wales) on FGM is also anticipated in the near future.

One recent new development has been the launch of a free FGM e-Learning programme by Health Education England (HEE) (available in all four nations, including medical students) - available at www.e-lfh.org.uk/programmes/female-genital-mutilation. The e-learning modules contain practical advice on how best to ask ‘difficult’ questions about FGM in a sensitive manner, to give healthcare professionals the confidence to fulfil their role to protect girls, prevent FGM, and care for women and girls who have had FGM. The BMA has promoted the modules through the BMA’s membership network.
40 Resolved: That this conference calls upon JDC to liaise with LETBs to ensure the selection of junior doctor representatives to LETBs is democratic.

National/regional JDCs have strongly advocated for BMA and wider trainee representation on LETB boards and to ensure that the selection of representatives is fair and transparent.

41 Resolved: That this conference notes with dismay the continued assault on junior doctors’ study budgets and the continued erosion and reduction of funding available. We feel this is a short term solution that will lead to worse training in the present and a less educated workforce in the future. We call upon the JDC to:

i) demand a cessation in any further reduction of the study budgets;
ii) lobby LETBs on the importance of study budgets for all doctors;
iii) campaign for a reinstatement of study budgets in areas where they have been reduced.

JDC has lobbied to protect study budgets on a local/regional basis, as required. We are keeping a close watching brief on the management of study budgets and will respond accordingly to oppose any moves to reduce or otherwise restrict access to funds.

42 Resolved: That this conference believes that in light of the devastating burden of disease associated with smoking, and the proven effects of passive smoking, a greater emphasis should be placed on interventions supporting smoking cessation, and in safeguarding the ‘smoke free’ environment. This conference calls upon the BMA to lobby for:

i) greater support to healthcare workers who wish to work in smoke-free environments whilst delivering community-based healthcare;
ii) stronger implementation of ‘smoke free’ hospital premises;
iii) tougher penalties for those who smoke on hospital property.

Following the adoption of similar ARM policy in 2013, the BMA board of science chair wrote to NHS Employers, NHS England and the NHS Trust Development Authority to highlight the need for better enforcement of smoke-free hospital policies, coupled with the wider provision of smoking cessation services to patients and staff. The board is also currently developing some work on the future for tobacco control, which incorporates a call for the full implementation of NICE public health guidance on tobacco control (which includes smoke-free NHS policies).

43 Resolved: That this conference:

i) applauds the actions taken by successive Governments to tackle the dangers of passive smoking;
ii) is appalled by the numbers of patients, visitors and staff who regularly smoke outside hospital entrances;
iii) believes this is damaging the health of health care workers and their patients;
iv) therefore calls on the BMA Board of Science to work with the four Health Departments to come up with potential solutions to this problem.

See resolution 42.
44 Resolved: That this conference recognises the potential value to trainees and the service of inviting trainees nearing the end of core training who have completed membership exams to ‘act up’ taking on the higher trainee role. We are concerned that these trainees are at risk of exploitation, educationally or financially, when they are asked to fill gaps in the face of a growing recruitment crisis in acute care. We ask JDC’s subcommittees to:

i) undertake joint work leading to well-publicised best practice guidelines for trainees who wish to ‘act up’; to cover (but not be limited to) educational, contractual and indemnity aspects;
ii) seek endorsement of these guidelines by employers and trainers across all four nations;
iii) use the guidelines to highlight the value and responsiveness of the junior doctor workforce to patient need.

JDC is developing guidelines for `acting up` and will seek endorsement from the appropriate bodies.

45 Resolved: That this conference notes the displacement of trainee doctors in many situations with paraprofessionals and other healthcare workers. We call on HEE to recognise the importance of having trained doctors for the future and to assess funding for trainees in this context, where paraprofessionals may in the short term be cheaper for employers and therefore training opportunities could be lost.

The JDC has raised concerns about the loss of training opportunities to paraprofessionals to various external stakeholders including Health Education England and the GMC. We are keeping a close watching brief on this issue.

46 Resolved: That this conference:

i) notes the importance of retaining and promoting medical leadership within the profession and supporting organisational structures;
ii) acknowledges the forthcoming review planned for the Northern Ireland Medical and Dental Training Agency and mandates NIJDC to lobby to protect autonomous medical leadership within the deanery.

The planned review of NIMDTA stalled last year. It is likely that the current review of HSC Administration Structures will include a review of NIMDTA and BMA Northern Ireland will be making representation via the BMA/DHSSPS HR Engagement Forum in accordance with the sentiment of this resolution.

47 Resolved: That this conference believes there should be a minimum expected period of six weeks’ notice of any new rota, particularly when rotating to a new post, and calls on the current BMA recommendation on this to be formalised.

The BMA discussed provision of rota information in some depth with NHS Employers during the contract negotiations of 2013/14. We stressed the need to provide information in a timely manner, particularly when rotating to a new post. Following the end of negotiations, we have reiterated these in our evidence to the DDRB. The DDRB is expected to report in July 2015.

48 Resolved: That this conference notes that some Trusts are “double counting” when a rostered zero day falls on a bank holiday and therefore some trainees are only receiving one day off rather than the two to which they are entitled. We call upon employers to cease this practice immediately and, when a zero day falls on a bank holiday, for that trainee to either receive a day in lieu for the bank holiday or for their zero day to be re-allocated.

Following agreement at the Joint Negotiating Committee (Juniors), the BMA has published joint BMA/NHSE Employers guidance outlining that if a bank holiday falls on a zero-hour day doctors should receive a day off in lieu.
Resolved: That this conference regrets that provision of rest facilities for junior doctors remains frequently inadequate. This conference recognises that the provision of sufficient amenities improves morale and productivity. This conference further notes that rest areas need to be accessible. Therefore, we call on:

i) the BMA to lobby NHS Trusts to provide specific rest areas for junior doctors in accordance with HSC1998/240;
ii) the BMA to provide specific guidance regarding the proximity of rest facilities to work areas;
iii) the BMA to provide guidance regarding the catering facilities, basic drink and food which should be available free of charge, particularly in areas where staff may be working long shifts or out of hours;
iv) employers to provide access to IT facilities in rest areas, as access to emails, calendars and medical resources are needed by junior doctors both for work and to organise life around work.

The BMA discussed provision of rest facilities in some depth with NHS Employers during the contract negotiations of 2013/14. We stressed the need to provide appropriate facilities within proximity of work areas, as well as catering and IT facilities. Following the end of negotiations, we have reiterated these in our evidence to the DDRB. The DDRB is expected to report in July 2015.

Resolved: That this conference believes that minimum standards of catering and access to sustenance for NHS workers in hospitals are often not adhered to. Therefore we wish:

i) to see a better range and quality of food for healthcare staff;
ii) for better and consistent provision of food for staff working out-of-hours (including evenings).

The BMA discussed minimum standards of catering during the contract negotiations of 2013/14 and reiterated its position in evidence submitted to the DDRB.
Contact

Want to find out more about what we’re doing on an issue you care about? Interested in joining your local committee? Contact your national JDC for more information:

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