Introduction

Contract negotiations, training reforms and a major review of working hours have meant that it’s been a challenging six months representing the interests of junior doctors in the UK.

We’ve achieved successes in areas as diverse as revalidation and bank holiday working, and have produced good practice guidance on category two fees and rota design.

All of the JDC’s achievements are the result of the hard work of our committee, the JDC Officers and the national JDC Chairs. In particular, we must extend our huge thanks to our Secretariat: Sam Wakeford, Rob Kidney, Rosie Bate, Sarah Walker, Colin Hindson, Andy Young and Sheridan Hammond.

Contract negotiations
The current contract for junior doctors was introduced more than ten years ago, and it is beginning to show its age. There is a chasm between the rights and protections that junior doctors should expect, and the reality of working in the NHS.

Hours have come down from the unsafe levels that existed ten years ago but the system that has evolved is far from perfect. Pay can fluctuate wildly from post to post and rota information is rarely provided in advance. Often, juniors don’t know where they’ll be working – or even what hours they’ll be working – the following week. On top of this, training opportunities are constantly being squeezed by the need to deliver service.

Although the timing isn’t ideal, we have the opportunity to negotiate significant improvements to the junior doctors contract that will enhance your training and quality of life. Since last September we’ve been negotiating with NHS Employers to deliver these changes. And as you might expect, the negotiations have been tough.

We’ve been working to develop a contract with training at its heart. The first step towards this is to design a system of work scheduling that will clearly explain both the learning opportunities that you will receive and the duties that you will be asked to undertake.

As a prerequisite to entering contract negotiations we’ve received an assurance that the overall pay envelope for junior doctors won’t go down. However, the way pay will be distributed is likely to change. The Government has made it very clear that it intends to remove automatic, time based pay progression from NHS employment contracts. We have made it clear that we won’t agree anything unless it is fair to all juniors.

We are committed to holding a ballot, asking junior doctors (and final and penultimate year medical students) to tell us what they think of the draft contract.
Working Time Regulations (WTR)
The Government’s commitment to reforming the European Union has been felt in the increased scrutiny of the Working Time Regulations. Earlier this year, we took part in a taskforce led by the Royal College of Surgeons to look at how the WTR have been implemented in the NHS.

We have always believed that the problems stemming from the WTR are in large part due to its poor implementation. We are pleased that the first recommendation from the taskforce is to ask NHS employers to identify and share best practice. However, other recommendations may be more challenging. For example, is it really possible to separate the time we spend working and training?

Shape of Training
The Shape of Training Review recommended reforms to the structure of postgraduate medical education and training across the UK. In March the BMA published its full response to the report, rejecting two of its core recommendations: moving the point of full GMC registration and redefining postgraduate training. Whether or how the report’s recommendations are implemented will become clearer following a ministerial response. We will work hard to make sure that the voice of junior doctors is heard loud and clear.

Alongside all of this, the regular work of JDC has continued apace. We’ve been attending banding appeals, advising members, improving arrangements for F1 shadowing and supporting the inter-deanery transfer process.

We are always keen to hear from you, and the more you tell us the more we can address the issues that matter to our members. Please take the time to visit our website and contribute to the debates within our new BMA Communities forum. You can attend a local junior doctor committee meeting or visit one of our national meetings, which are held on a quarterly basis. Or, if you’d prefer, simply email us at jdcchair@bma.org.uk.

Kitty Mohan  
Andrew Collier
Key issues

Shadowing
The introduction of 4 days paid shadowing for all new FY1s, an initiative we negotiated with NHS Employers, enables incoming FY1s to become familiar with working practices and hospital systems but also helps them to gain confidence and professional skills.

There are no nationally agreed contractual arrangements in England for FY1s undertaking paid shadowing placements and Trusts make payments for shadowing in 3 main ways:

- Extension of the current FY1 contract (early start date)
- Stand alone contract
- Contract for training (advised by NHS Employers)

Our preferred approach continues to be that the FY1 contract should be extended as this allows new FY1s to engage fully in clinical activity whilst shadowing. However, we have been engaged in discussions around the wording of the contract for training with NHS Employers as we felt it was important that any FY1s on this contract were not disadvantaged in terms of the activities they could undertake in this period. As a result, this year NHS Employers has published a revised contract, and updated guidance. This revised contract and guidance means that the activities and responsibilities of FY1s on this contract are more aligned to those FY1s on contracts of employment.

JDC will continue to work to ensure that the best possible arrangements for shadowing are in place for incoming FY1s.
Clarification on leave entitlements

There has been uncertainty among employers about how zero-hour days interact with bank holidays in rotas. At JNC(J) employers agreed with our position that it is unacceptable to double-count a zero-hour day as a bank holiday.

We have published joint BMA/NHSE Employers guidance outlining that if a bank holiday falls on a zero-hour day doctors are entitled to a day off in lieu.

Shape of Training Review report

In October 2013, the independently commissioned Shape of Training Review recommended radical changes to the UK’s postgraduate medical training structure. The author of the Review, Professor David Greenaway, believes this will create a more flexible workforce that can meet the changing needs of patients in the future. Changes include:

- Moving the point of GMC registration to the end of medical school;
- Shortening the length of training to between four and six years after the Foundation Programme;
- Grouping specialties or areas of practice together in broad-based specialty ‘themes’. Certified doctors would be expected to manage acutely ill patients within their broad specialty area;
- Changing the CCT to the Certificate of Specialty Competency (CST) to demonstrate that a doctor’s development does not finish at the end of training;
- Allowing a minority of doctors to specialise in the ‘narrower’ areas of specialty practice as credentials post-CST, available according to the needs of local populations as defined by employers.

We don’t believe this model will produce doctors that are trained to the same level of competency as today’s doctors, so we cannot support moves to shorten training or redefine its end point. But there are some elements of the report we do support: more flexible academic training, developing the out of programme year and involving patients in the education of doctors. We think these could (and should) all be incorporated in the current system. Our core views were set out in our response, available online at bma.org.uk.

We know that societal change in the UK could affect how the NHS is used by patients in the future, but we don’t think a radical overhaul of the training system is necessary. What do you think? Tell us by emailing info.jdc@bma.org.uk.

Banding and monitoring

We continue to support the banding and monitoring process, including providing representatives for banding appeals and updating existing guidance. We have also published new guidance for junior doctors which explains the process up to, and after, a banding appeal and is intended to prepare juniors for each stage of the process.

NHS reforms

Under the Government’s NHS reforms in England, Health Education England (HEE) is now responsible for managing education and training for the whole healthcare workforce. Its education and training boards (LETBs) make local decisions about education funding and workforce across 13 areas of England. One year after they were introduced, it is clear that some LETBs are more mature than others. For example, there is huge variation in the development of representative structures. In the coming year we are committed to identifying and driving forward best practice through our network of regional JDCs.
Specialty Selection Test
On a national level, we know that a fair and effective recruitment system is a big priority for trainees. In January 2014 HEE piloted a machine-markable test for entry to specialty training. We flagged inconsistencies in the methodology for this pilot when it was first proposed in 2013 and published our concerns in BMA News when the pilot began. We support attempts to improve recruitment structures, but only if they are evidence-based and properly piloted. Now in its evaluation phase, we still don’t think the pilot is robust enough to support the introduction of a machine-markable test as part of recruitment. We continue to liaise with HEE to ensure recruitment systems are proportionate and fit for purpose.

Foundation programme oversubscription
Applications to the 2014 Foundation Programme (FP) have exceeded the number of places available for the fourth year in a row. HEE is mandated to ensure competent graduates secure full GMC registration and is driving a proposal to move the point of registration to the end of medical school. This could open eligibility for the FP to graduates from all over the world, which would worsen oversubscription. We don’t think it is right that highly competent UK-educated graduates could be prevented from completing their training in the UK. We are working with other BMA committees, including the Medical Students Committee, to lobby HEE for clear evidence to support its proposal.

Inter-Deanery Transfers (IDTs)
IDTs allow trainees whose circumstances have changed to move to a different location without forfeiting their place on a national programme. We made this process possible by successfully lobbying for its introduction in 2009. Following a recent review of the transfer process, a new system was implemented in April 2013. We are pleased that the option to transfer is still available to trainees facing difficult circumstances, and support the new system. We are satisfied that it is fair, transparent and robust. We monitor progress by observing the allocation process, and suggest improvements based on member feedback at evaluation sessions. Transfer windows are open twice a year, around April and October. Full guidance is on our website at bma.org.uk.

Guidance
Guidance on category 2 fees, agreed with NHS Employers, and good practice examples of rota design have been published. We are in the process of producing a number of guidance documents including on tax and employment tribunals.

Revalidation
JDC were strongly against the GMC’s proposal to de-couple revalidation from the CCT date. Following consultation, including with JDC, the GMC confirmed that it will not be taking forward this proposal.

Raising concerns
JDC is in the process of considering what advice it can produce for junior doctors who wish to raise concerns about patient safety. If you have any suggestions for this work, email info.jdc@bma.org.uk.

Media activity
In the past year the media office has begun to steadily increase its overall levels of media coverage, in particular within regional media. In terms of JDC related coverage the media office has commented on the junior doctor listening exercise ahead of the beginning of contract negotiations, which received national newspaper coverage, and the August changeover.

Junior doctors have also been visible on broadcast media including the Today Programme, BBC Radio 5Live, Channel 5 news, Sky News and BBC News with Ben Molyneux, Andrew Collier and Latifa Patel all carrying out interviews. We have also had extensive coverage of the issues around seven day working, including the publication of the BMA's position paper ahead of the start of both junior doctor and consultant contract negotiations, with ongoing media coverage of the issues.

Public affairs activity
Throughout 2013, the BMA continued to be the most quoted health organisation in Parliament with 150 mentions. Some of the top issues where the BMA was mentioned frequently included changes to the immigration rules, the 'Section 75' procurement regulations, and various public health issues (in particular alcohol and tobacco).

In terms of lobbying on legislation, the BMA was active on the Care Bill’s proposals on education and training for health professionals. JDC contributed to a number of briefings throughout the passage of the Bill through parliament, especially on requirements for Health Education England for long term workforce planning and matching medical practitioners, in number and by specialty, to the national need. The Government gave firm oral commitments to ensuring long term workforce planning for the medical workforce and matching trainee numbers. At the time of writing the Bill is in the final ping pong stage, with the House of Lords considering amendments made by the House of Commons. We expect the Bill to become law in April 2014.

The BMA also lobbied extensively on the Transparency of Lobbying, Non Party Campaigning and Trade Union Administration Bill (now the Transparency of Lobbying, Non-party Campaigning and Trade Union Administration Act 2014). The Act contains proposals to change rules on election spending by groups such as the BMA which are not standing for election or registered as political parties. We helped secured changes to the legislation to help provide greater clarity on what organisations can and can’t do in the run-up to a general election. We are currently considering the full implications the Act will have for the BMA ahead of the 2015 UK General Election.

In March 2014, Dr Andrew Collier, JDC Co-Chair, attended the BMA dinner with the labour health team where there were opportunities to raise issues around education and training and issues affecting junior doctors. Key topics for discussion included Whole Person Care and the Labour Party policy review, the Health and Social Care Act and wider NHS reform agenda, and workforce issues – including contract negotiations.
Key issues

Junior doctors contract
In December, the BMA launched a major member engagement programme to support junior doctors and consultants throughout the contract negotiations period. As part of this member engagement process, a series of Deliberative events will be held across the UK. In Northern Ireland, this event took place on 30 April in Dunadry with juniors and consultants in attendance.

HSC E-Locum system (Formerly Regionally Managed Medical Locum System (RMMLS))
BMA(NI) is currently involved in ongoing negotiations with Trusts in NI and their intention to establish a HSC E-Locum Agency.

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, a single HSC E-Locum database was proposed. The work on this has been taken forward and developed by a Project Team comprising Trust medical HR experts, a representative from NIJD C and a member of the BMA(NI) Industrial Relations Team.

The main BMA concerns continue to be ensuring junior doctors receive adequate rates of pay, no split rates, clarification on travel expenses and the assurance that junior doctors are not “tied in” to this system exclusively.

Shape of Training
Further to the BMA decision to continue to cautiously engage with the review, BMA(NI) have contacted stakeholders in Northern Ireland to set out the BMA position and to invite further discussion on the proposals contained within Professor Greenaway’s Review.

Board liaison group
Accommodation and catering inspections are being carried out across the 5 Trusts in Northern Ireland and NIJD C representatives continue to provide assistance to the Medical Project Officer of the Board Liaison Group during these inspections.

Local engagement
There continue to be challenges for doctors engaging with LNCs particularly for junior doctors. The BMA is keen to develop support for LNCs and get junior doctors engaged. NIJD C will be working with colleagues to ensure the profile of LNCs is raised and encouraging juniors to get involved.

Northern Ireland Deanery
The Chairmen NIJD C and NIMSC continue to meet with representatives from NIMDTA to discuss issues such as specialty training, HSC E-Locum system and revalidation.

Communications
This session NIJD C has continued to produce the quarterly newsletter and distribution alternates between hard copy and electronic format. This has proved a useful tool in communicating with our members.

If you would like to know more about the work of NIJD C or are interested in joining the Committee please contact the secretariat on Bryson-nesbitt@bma.org.uk
Scottish Junior Doctors Committee 2013-14

Key issues

SJDC continues to be involved in the junior doctor contract negotiations with Tom Berry, deputy SJDC Chair, representing SJDC in formal UK negotiations.

Shape of Training Review

SJDC has liaised closely with JDC on inputting into the UK BMA Shape of Training Review Response. The Chair of SJDC, David Reid met with Alex Neil, the Cabinet Secretary for Health and Wellbeing in January and conveyed BMA Scotland wide concerns regarding two key Shape of Training recommendations:

- the proposed move from the Certificate of Completion of Training (CCT) to a Certificate of Specialty Training (CST), including wholesale curricula change and
- the proposal to move full GMC registration to the point of graduation from medical school.

SJDC has been informed by the Cabinet Secretary that there will be BMA representation on any Scottish Shape of Training implementation group.

Junior doctor working hours/patterns

David Reid, SJDC Chair met with Alex Neil, Cabinet Secretary for Health and Wellbeing to discuss junior doctor working hours and monitoring in January. Following this meeting, a letter from SJDC to the Cabinet Secretary was sent providing current concerns on junior doctor working hours and patterns, outlining a number of actions SJDC would like to see taken, including: the removal of seven consecutive night shifts,long shifts and the need to implement safe and sensible rotas with involvement of junior doctors. SJDC will continue to meet with the Scottish Government to discuss these issues and the next meeting with the Cabinet Secretary will focus on how improvements could be made to the monitoring process.

Monitoring

At the last meeting of the Scottish LNC Forum in November, there was discussion on rota monitoring and it was agreed that it would be useful to provide guidance to LNCs on the importance of monitoring, and highlighting LNC involvement in engaging with NHS Boards in Scotland to ensure there are robust local monitoring arrangements supported by national guidance in place to allow for accurate recording of hours, rest and breaks and to deliver a high return rate of monitoring forms. SJDC have produced this guidance which will be sent to all LNCs in Scotland.

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 from 2014 onwards.

SJDC Chair David Reid is the nominated BMA representative on the START Alliance – the stakeholder partnership leading the initiative. Since September, 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 been looking to create a network of Trainee Ambassadors to promote medical education and training in Scotland.
Tier 2 visas
Over the past year, the SJDC worked with the BMA International Department and NHS Education for Scotland (NES) in order to try to ensure that NES would become the Tier 2 sponsor for all Medical Trainees in Scotland. In December 2013 NES successfully reached agreement with the Home Office to enable them to become the sponsor for all doctors in training in Scotland from August 2014. The lead sponsor arrangements mean that medical trainees who are currently under Tier 2 immigration status will no longer have to reapply for sponsorship at the beginning of each of their rotations. From August 2014, the Tier 2 sponsorship certificate will cover all rotations, up to a maximum of three years.

SJDC had been lobbying for this change for some time. The current system is costly and can be disruptive to training and patient care. Lead sponsor arrangements will make Scotland a more attractive option for medical trainees from overseas as it will minimise costs and administration.

Scottish medical training
SJDC continues to be represented on the Scottish Medical Training Board (SMTB), the Selection and Recruitment Delivery Board (SRDB), the seven Specialty Training Boards and the Foundation Programme Board.

Medical undergraduate numbers
The recommendations from the Medical Undergraduate Group, which includes BMA representation, to the Cabinet Secretaries for Health and Wellbeing and Education and Lifelong Learning were accepted, with medical undergraduate intake numbers at 2013 levels retained for 2014-15. The Scottish Government is also involved in UK discussions on medical undergraduate intakes and international students.

For more information about the work of SJDC, please contact gdonnelly@bma.org.uk
Key issues

The BMAs 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.

Contract negotiations

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 has been particularly important during the last few months. We have been participating in the ongoing junior doctor contract negotiations as the Wales representative. WJDC is committed to maintaining a single UK contract and we will continue to play an active part in the negotiations which are expected to continue for some months to come.

NHS Wales reconfiguration

One of the major challenges facing junior doctors is the ongoing reconfiguration of the NHS services in Wales. Against a background of stringent budgets and continuing vacancies on some rotas, we remain concerned about the adverse impact that the restructuring of services will have on junior doctors’ training. We are of the view that to “make ends meet” health boards in Wales will continue to rely on trainees to prop up the service instead of focusing on individual training needs. We will be working with Welsh Council to lobby both the Wales Deanery and Welsh Government to ensure that trainees are not simply used to fill gaps in rotas.

Terms and conditions of service / education and training

During the coming months our other priorities will include continuing to scrutinise monitoring data and ensuring that issues are addressed by health boards; checking that study budgets are being made available in a fair and equitable manner to trainees in accordance with the Wales Deanery’s policy; reviewing the provision of hospital accommodation to ascertain whether the new standards introduced in 2012 are being implemented by health boards and fighting the threat from Welsh Government to remove the benefit of free F1 accommodation still currently available in Wales.

Outreach to junior doctors

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.
Action on resolutions from the 2013 Junior Doctors Conference

Resolutions allocated to the Executive subcommittee

1. This conference notes the findings of the Francis Report and the unique perspective that junior doctors have when it comes to comparing quality between healthcare providers, but is concerned about the inherent conflict of interest in raising concerns about a department upon which career progression is dependent. We call on JDC to work with NHSE and the GMC to establish specific guidance for junior doctors who raise concerns, their trainers and their employers.

JDC members are currently working with the BMA NHS Culture Project on what further advice can be provided to junior doctors who wish to raise concerns about patient safety.

2. That this conference:
   i) believes there is an accepted culture of bullying and harassment of doctors in training (CARRIED)
   ii) believes that more support is required for doctors who are subject to bullying or harassment (CARRIED)
   iii) calls on the BMA to encourage a more open culture to report bullying and harassment (CARRIED)
   iv) believes that tougher punishments are needed to deter people from engaging in bullying and harassment (LOST)
   v) believes that cases of bullying and harassment should be overseen by a national body (LOST).

This is being taken forward as part of the BMA’s NHS culture project: http://bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture.

3. That this conference welcomes the Francis report describing trainees as “valuable eyes and ears” in a hospital setting, and mandates JDC to ensure there are named persons within each employer responsible for responding to doctors who report Significant Untoward Events (SUE) and updating them on the action taken. This is essential for ensuring junior doctors know what happened following their report, in order to allow them to make a judgement on whether or not they need to escalate the matter further.

As part of revalidation, all doctors have to record and reflect on Significant Events. GMC advice on revalidation sets out that hospitals should have formal processes in place for logging and responding to all events. JDC continues to raise, and emphasise the importance of, these points, particularly that processes should be in place so that junior doctors know what happens after their report.

4. That this conference views with great concern the conclusion of the Francis report on Staffordshire scandal and mandates JDC to:
   i) lobby for the implementation of recommendation no 23 regarding the need to develop measures on minimum staffing levels, involving the national institute of health and clinical excellence;
   ii) work with other relevant bodies to develop evidence based tools to establish the minimum staff numbers;
iii) ensure these measures and tools should be used to establish minimum staffing needs for each service and should be readily implemented by healthcare organisations.

The Government also accepted recommendation 23 and NICE has commenced a comprehensive review of the evidence relating staffing levels, and will produce definitive guidance on safe and efficient staffing levels in a range of NHS settings. The guidance will initially focus on adult wards in acute in-patient settings. Following this, guidance on safer staffing levels across the NHS will be published from August 2014. The information will be made available on a new “patient safety” website, with monthly reports on how often wards fall short of the new standard.

Work is being taken forward in this area as part of the BMAs NHS culture project: http://bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture

5 That this conference is aware that junior doctor contract discussions are proceeding, during what are difficult financial times. We call on BMA Council to support industrial action in the event of imposition of a contract deemed unsatisfactory by members. No action required to date. Negotiations on a new contract for doctors in training continue.

6 That this conference:

i) believes the true aim of the Health and Social Care Act is the privatisation of the NHS;
ii) believes that greater pressure should be placed on the UK Government to repeal the Health and Social Care Act;
iii) believes that any future profits made by private firms running parts of the health service should be invested back into the health service;
iv) believes that training jobs should not be affected if private firms invest in an NHS service;
v) believes that passing into law Bills which have little or no support within the medical profession is unacceptable.

The BMA held a parliamentary seminar in Portcullis House on 1 April 2014 to assess change in the NHS since the implementation of the Health and Social Care Act and to call for the repeal of the Act. We are applying pressure on parliamentarians to raise further debate on the Act, to highlight the need to prioritise integration over competition and to ensure NHS services provide seamless care rather than fragmented care. In the run up to the general election in 2015 we are encouraging members to hold their own events to spread the message, and we are designing resources for you to use. Keep an eye on the BMAs Health and Social Care Act webpage online for more detail.
That this conference is appalled by the evolving practice of denying payment for completion of category 2 work. Conference:

i) feels that the response by the wider BMA has been woefully inadequate in stark contrast to the excellent support provided by the local office (LOST);
ii) calls on the BMA to consider every possible course of action to support doctors involved (CARRIED);
iii) calls on the BMA to publically name and shame Trusts involved (CARRIED AS A REFERENCE);
iv) calls on the Chair of Council to write a letter to the Trusts involved demanding a resolution to this issue (CARRIED).

This motion was taken in parts.

JDC has provided support in the form of guidance on category 2 fees. This was agreed at JNC(J) and has been published on both the BMA and NHS Employers websites respectively. We are also continuing to support doctors locally when issues arise. The Terms and conditions of service and negotiating subcommittee will continue to work on this issue.

This conference notes the recommendations made in the recently published Francis report, and in particular we highlight the current lack of a national regulator for healthcare directors and managers. We call upon the BMA to lobby government to establish a national regulator for health care directors and managers at all levels and that this body should:

i) have powers comparable with the General Medical Council and the Nursing and Midwifery Council (CARRIED AS A REFERENCE);
ii) serve the functions of keeping up to date registers of directors and managers, foster good managerial practice, promote high standards of managerial education and training and deal with directors and managers whose fitness to work is in doubt (CARRIED); and
iii) be formed by collaboration with those bodies already experienced in providing regulation of health care provision (CARRIED).

This motion was taken in parts.

On 2 April 2014 the Law Commission published a final report, explaining and setting out recommendations, and draft Bill on the Regulation of Health and Social Care Professionals. The final report and draft Bill sets out a new single legal framework for the regulation of all health and social care professionals. This will be a BMA-wide project and work has started reviewing the report and draft Bill.
9 That this conference:

i) is dismayed at the recent announcement by the NHS Confederation which suggested patients could be charged to see an out of hours GP (CARRIED);

ii) reaffirms its belief that the NHS should be free at the point of entry for all patients (CARRIED)

iii) believes that charging patients to see a GP could have drastic consequences for the individual patient but also for the NHS (CARRIED);

iv) calls on the BMA to vociferously and publicly oppose these proposals for the good of our patients (CARRIED AS A REFERENCE).

This motion was taken in parts.

The BMA continues to lobby relevant bodies to ensure the NHS is free at the point of entry for all patients.

10 That this conference:

i) notes there has been much media interest in the Liverpool Care Pathway (LCP), with a great deal of negative press;

ii) notes many articles included personal stories from relatives of patients on the LCP, who were unhappy with the care provided;

iii) believes in many cases dissatisfaction with the LCP is not due to the LCP itself but poor implementation of it;

iv) believes junior doctors are often not effectively trained in the use of the LCP and implementation of it;

vi) believes public trust in the LCP has decreased as a result of this negative press coverage;

vii) believes some hospitals are looking into alternatives to the LCP as they do not believe this trust will be regained;

viii) believes that the LCP is an excellent care pathway providing humane care and support for people at the end of life and their families;

ix) resolves that the BMA remain supportive of the LCP as the gold standard in providing end of life care, and make this support public;

x) resolves that the BMA works with the GMC and Deaneries to ensure that adequate training on the LCP is provided to all junior doctors.

It was announced in July 2013 that the Liverpool Care Pathway would be phased out over 6 to 12 months. A steering group was convened to develop a set of principles surrounding end of life care, to which the BMA’s Ethics Department submitted evidence. At the time of writing we expect the principles to be published in May 2014.
11 That this conference notes the alarming outbreak of Measles affecting South West Wales since January 2013. It also notes the link to bad publicity given to the MMR vaccine by a local paper almost a decade ago. It therefore calls on the BMA Public Health Committee to reaffirm publically the safety record of the MMR vaccine and to increase its efforts to ensure community protection across the UK.

This motion was carried as amended.

The BMA worked with Public Health England to increase efforts in community protection across the UK. As a result of working in partnership with public health stakeholders, the number of reported measles cases reduced from 676 in the first quarter of 2013 to just 24 in the final quarter of 2013.

12 This conference:

i) believes that JDC needs to redouble its efforts to engage the grassroots junior doctor BMA membership (CARRIED);

ii) laments the fact that some junior doctor representatives on trust LNCs are inactive (CARRIED);

iii) supports the development of a clear role profile for junior doctors representing their peers on LNCs detailing a minimum set of standards (CARRIED);

iv) believes that a mechanism should exist for grassroots junior doctors to dismiss and replace their LNC representative where evidence exists to suggest underperformance (CARRIED);

v) believes that contact details of junior doctor LNC members should be made available to their regional JDC Chair, and that measures compliant with data protection law should be developed by the BMA to facilitate exchange of this information wherever possible (CARRIED).

This motion was taken in parts.

A key activity for JDC is to support collective bargaining on a local level. JDC has:

• Updated the LNC role profile and guidance and this has been communicated widely
• Since 1 September 2012, successfully recruited 84 new junior doctor LNC reps and will continue to build on this success
• Continued to work closely with regional services to ensure that local representatives receive support. We liaise with regional services staff individually, via the Regional Services Liaison Group and national JDC staff attend LNC meetings.
• JDC will continue to build and maintain relationships in this area.
13 That this conference

i) acknowledges the excellent work carried out by members of regional junior doctors’ committees (CARRIED);

ii) notes the important role the regional junior doctors’ committees will play in any contract negotiations in terms of communicating with grass roots members (CARRIED);

iii) calls for additional funding and support to be allocated to develop and further train these individuals for their important local and regional roles; (CARRIED AS A REFERENCE)

iv) calls for regular updates to regional junior doctors’ committee chairs on the progress of any contract negotiations so that this information may be disseminated to junior doctors in their regions in a timely manner (CARRIED).

This motion was taken in parts.

Regular meetings with the Chairs of regional junior doctors’ committees take place throughout the year, in order for updates and information to be shared. We have also provided presentations and toolkits for RJDC chairmen to feedback to their committees. JDC will continue with this work.

14 This conference believes that the GMC’s guidance on the use of social media is not fit for purpose, and:

i) believes that it doesn’t protect the public from those outside of the jurisdiction of the GMC;

ii) believes that it is currently outside of the GMC’s remit;

iii) believes that it infringes freedom of expression;

iv) calls on the BMA to demand its immediate retraction.

We continue to raise this in discussions with the GMC to ensure their guidance is reasonable and fair.
This conference applauds the decision by the BMA to sign up to the ‘alltrials’ campaign, fully supporting the principles of transparency and openness in clinical trials and research, and welcomes the opportunity to further bolster the evidence base to the medicine we practice. We call upon the BMA to:

i) reiterate our support for the practice of evidence based medicine in all areas of practice (CARRIED);

ii) to raise concern regarding the provision of non-evidence based services such as those Complementary and Alternative Medicines that lack evidence base, within the NHS during difficult economic times (CARRIED);

iii) further campaign to withdraw the provision of non-evidence based medicine on the NHS (LOST).

This motion was taken in parts.

The resolution has informed the BMA's work to promote greater transparency in clinical trials. The BMA's latest activities in this area can be found on this page of the Association’s website: http://bma.org.uk/working-for-change/improving-and-protecting-health/clinical-trials.

The BMA has raised its concerns about practices and procedures without a sufficient evidence base in its discussions with the Department of Health on the draft Medical Innovation Bill and in response to the Department's consultation document on the subject.

That this conference:

i) notes with concern the continued increase in the rates of sexually transmitted infections and unplanned pregnancies in the UK;

ii) notes that the planned reforms to the provision of sexual health services is predicted to cost the NHS and welfare state £136 billion by 2020;

iii) calls upon the BMA Board of Science to update its 2002 report ‘Sexually transmitted infections’ as a matter of urgency.

We passed this on to the BMAs Board of Science to consider.
17 That this conference:

i) notes with dismay that the NHS in England, in contrast to the NHS in Wales and Scotland, continues to restrict access to free secondary care for refused asylum seekers and undocumented migrants;

ii) believes that due to inadequate undergraduate education regarding refused asylum seekers and undocumented migrants, many doctors are unaware of the health issues affecting this group and their rights to health care within the UK;

iii) calls upon the BMA to:
   • raise awareness of the rights of different groups of migrants to health care and the disparities that exist between England and the rest of Great Britain;
   • raise awareness among doctors of their role in providing the same standard of care to different groups of migrants as they would to any other patient group;

lobby the relevant bodies for the NHS in England to provide equitable care to all people within its borders.

The BMA is lobbying against the clause in the Immigration Bill currently going through Parliament which proposes restricting access to free healthcare only to those who have indefinite leave to remain. The BMA has also made available guidance for doctors on access to healthcare for refused asylum seekers.

Resolutions allocated to the Education and Training subcommittee

18 This conference notes with interest the decision of the UK government to sell UK training to foreign nations. Concerns have been raised that there has not been adequate due process and planning for this to occur safely and efficiently. No reliable data on training capacity and any potential excess, in the UK, currently exists. We therefore call for:

i) a reliable quantification of excess training capacity within the UK;

ii) the Departments of Health and other involved parties to undertake a full and thorough pilot, with limited numbers, evaluated by external review;

iii) the needs of patients, and UK-based doctors in training, to be prioritised above political and monetary aspirations;

iv) the BMA to critically engage in the design of this process to uphold the needs of the UK public;

v) the BMA to publically oppose this programme until such time as they are satisfied that appropriate safeguards have been introduced and adequate planning has been undertaken.

Health Education England (HEE) has overall responsibility for this project. Working alongside the BMA’s International Committee, we have met regularly with HEE officials to make our objections clear. We continue to liaise closely on progress.
19 This conference calls on the UK government to have nothing to do with any organized scheme to train large numbers of doctors from countries with a repressive government unless it can be demonstrated convincingly that the scheme will improve the human rights situation in the country in question.

As motion 18.

20 That this Conference notes with concern a trend towards further fragmentation of our career progression. This conference rejects any move to further increase the number of tiers to an already elongated career path, and calls upon:

i) the BMA reject any attempt to introduce a sub-consultant grade (CARRIED);
ii) the Royal Colleges to resist and reverse the growth in post-CCT fellowships (CARRIED);
iii) the BMA ensure any future consultant contract negotiations reject a two-tier consultant model (CARRIED).

This motion was taken in parts.

We outlined in our response to the Shape of Training that we could not accept the introduction of credentialing as proposed by the Review because it would, in effect, create a sub-consultant grade. We have also raised the issue of post-CCT fellowships with Colleges and continue to keep a watching brief on any development. Negotiations on the consultants contract are currently in progress and are considering a range of issues.

21 That this conference

i) believes that credentialing, as discussed by the GMC, has the potential to be damaging to existing training programmes and devalue the Certificate of Completion of Training (CARRIED);
ii) believes that credentialing will detrimentally affect national terms and conditions of service and increase professional costs (CARRIED);
iii) calls on the BMA to oppose the introduction of credentialing (CARRIED AS A REFERENCE);
iv) calls on the BMA to oppose the introduction of credentialing for doctors before they gain a CCT (CARRIED);
v) calls on the BMA to oppose the introduction of credentialing altogether (CARRIED AS A REFERENCE).

This motion was taken in parts.

The CCT is a valuable marker for a fully competent specialty doctor and the JDC has fought against any attempt this year to undermine it. For example, we have contributed to the GMC’s work on introducing credentialing to ensure no model will devalue the current CCT. We also outlined our position in our response to the Shape of Training Review, which includes a proposal to shorten and remove parts of the current training programme so that doctors can be trained more quickly.
That this conference notes the proposed pilot and implementation of a national machine markable test (MMT) for selection into specialty training, involving situational judgment and clinical knowledge components, and:

i) does not believe that this is necessarily an appropriate method of selection for all specialty-training posts;

ii) does not believe that it is appropriate for this test to be used to label trainees “unappointable” for specialty training;

iii) mandates the JDC to oppose any pilot until there is an agreed plan for this test’s use in the selection process;

iv) mandates the JDC to oppose the imposition of a national MMT (involving situational judgment and clinical knowledge components) for selection into specialty training.

This motion was carried UNANIMOUSLY

At the December 2013 meeting, JDC agreed to publicise its concerns about the specialty selection test (SST) pilot. We published an article in BMA news online condemning the methodology surrounding the pilot, and the story was tweeted. A post was also uploaded onto the BMA Communities website for grassroots member views. The pilot took place over January 2014 and saw a low turnout, with only 529 trainees out of the approximately 800 who registered attending. We are now contributing to the evaluation phase of the pilot and ensuring any future attempts to change recruitment methods are reasonable and useful.

This conference notes that NHS Employers have unilaterally published a model contract for new doctors undertaking shadowing for FY1 posts and regrets that this deviates from the WAPPIG and HEE guidance for shadowing and has not been negotiated with the BMA. This sets an unacceptable precedent and therefore this conference calls for;

i) an urgent meeting between the BMA and NHS Employers to address this problem;

ii) the immediate withdrawal of this model contract;

iii) any negotiated solution to meet the WAPPIG and HEE requirements as a minimum.

JDC has been engaged in discussions with NHS Employers around the wording of the model contract for training. As a result, NHS Employers has published a revised contract and updated guidance. This is much more in line with WAPPIG and HEE requirements and means that the activities and responsibilities of F1s on the model contract for training are more aligned to those F1s on contracts of employment.
We have also informed NHS Employers that their advice on how payments should be calculated for the shadowing period is incorrect as it constitutes a rate of pay that is below the actual rate received by F1 doctors. We have fully briefed briefing Regional Services on how pay should be calculated for the shadowing period so that this can be negotiated at a local level.

JDC will continue to work to ensure that the best possible arrangements for shadowing are in place for incoming F1s.

24 That this conference believes it should be a requirement of every Local Education and Training Board (LETB) to have junior doctor representation at membership council or board level. We therefore call on Health Education England to take responsibility for ensuring junior representation for every LETB; to publish guidance for employers stating the importance of junior representation; and to ensure juniors are facilitated by their employers to attend LETB meetings.

LETBs came into existence on 1 April 2013. Since then, we have requested both HEE and its regional LETBs establish proper representative structures for junior doctors. At the time of writing, we are in the process of producing a review of LETB maturity since they were inaugurated, which will highlight the importance of junior representation. We have not heard of any instance where juniors have been prevented by their employer from attending, but will help to secure them time off if we do.

25 That this Conference believes generalist & specialist knowledge and skills can & should co-exist in the same doctor, and we:

i) believe the solution to the problems of the acute take is not to create a new cadre of generalist-only doctors, but to better equip doctors in speciality training with more generalist training (CARRIED);

ii) call on the Shape of Training review to avoid recommending a separation of generalist & specialist training (LOST);

iii) call on the Royal Colleges to consider extending training programmes to allow more generalist experience to be gained in the setting of a regulated, funded training programme rather than outside training (LOST)

This motion was taken in parts.

We contributed to the BMA response to the Shape of Training. We highlighted that a broader-based beginning to training that covers generalist skills is preferable to a cohort of under-trained specialists with some general competences.
That conference is concerned that the MRCPG examination pass rates for IMGs are consistently lower than UK graduates and the discrepancy is getting worse, and:

i) is worried that this raises concerns about the validity of the MRCPG exam (CARRIED);
ii) calls for a GMC, RCPGP and BMA investigation into the reasons for the disparity, which is robust and establishes definitively at which part(s) of the training or examination process any problem lies (LOST);
iii) calls on the RCGP to set up a career guidance service for trainees who had to leave GP training as a result of being unsuccessful in obtaining the MRCPG (CARRIED);
iv) demands the feedback from the MRC GP exams to be improved immediately (CARRIED).

This motion was taken in parts.

The Equality and Diversity Committee undertook a review of the equality and diversity monitoring of specialty exams. As a part of the BMA’s commitment to working collaboratively to ensure that medical students and doctors are treated fairly and do not face discrimination in their education and career progression, in January 2014 the BMA published Examining Equality - A survey of Royal College Examinations: progress Review. This progress review updates our 2005 report in this area. Both the 2005 and 2014 reports can be accessed via the BMA website here. The BMA also supported a judicial review into the disparity between GP exam pass rates.

That this conference wishes to note the ever-increasing costs of training for junior doctors. It also notes the “mandatory” portfolios which come at a significant cost to trainees. It therefore calls on:

i) the GMC to have a tiered cost of registration to compensate for these costs, and student debts on graduation (CARRIED UNANIMOUSLY);
ii) the JRCPTB to explain the need to charge up to £800 for a portfolio which is mandatory part of training (CARRIED);
iii) Royal colleges to publically explain the breakdown of the cost of their internal courses; (CARRIED)
iv) specialist courses to be heavily subsidized, if not free of charge to allow the future consultants of the UK to train worry free of debt (LOST).

This motion was taken in parts.

Through trainee links at the AoMRC we have continued to lobby for lower training-related fees and greater transparency of course costs.
28 That this conference notes the changes to the structures of postgraduate education and training and moves towards contract negotiations, and mandates JDC to:

i) lobby appropriate bodies to ring-fence and protect study leave budget;
ii) work with LETBs and other relevant bodies to ensure each trainee is aware of their budget and that this is equitable across different areas of the country.

We have continued to lobby on both national and local levels for the medical education and training budget to be protected. The Department of Health introduced a tariff system from April 2014 that will be adjusted based on real-time training costs, which that they are collecting over the course of this summer. We continue to liaise with officials nationally to ensure budgets are representative and fair.

29 This conference demands that every Trainee be given:

i) a personal study budget per year with a clearly specified sum, that cannot be used for mandatory training (CARRIED AS A REFERENCE);
ii) a specified number of personal study days which the trainee can use to better their training experience, that should not be part of mandatory training (CARRIED);
iii) private study days to prepare for the mandatory examinations of the training program (CARRIED).

This motion was taken in parts.

Study leave and access to study budgets will be discussed as part of the negotiations for a new contract for doctors in training.

30 That this conference is concerned about the direction of travel of proposed solutions to Foundation Programme oversubscription. We welcome the assertion that, although 295 final year medical students were not allocated posts in the first round, that all will have a Foundation Programme job to achieve full registration. We remain worried about potential solutions of coupling FY1 year training to current medical school education. We believe:

i) that long term solutions need to be fair and reasonable (CARRIED UNANIMOUSLY);
ii) that new doctors should not see deterioration in their terms and conditions of service and lose a year of pensionable benefits (CARRIED UNANIMOUSLY);
iii) the TCS for doctors in training should always apply to all doctors in training with primary medical qualifications, including those in FY1 posts (CARRIED UNANIMOUSLY);
iv) that coupling has no place as a solution to the oversubscription problem (CARRIED).
This motion was taken in parts.

We have worked alongside other BMA branches of practice to lobby Health Education England (HEE) to find a solution that ends oversubscription. As HEE is mandated to secure GMC registration for every UK medical graduate, it has proposed to move the point of registration to the end of medical school. We do not believe this is fair and reasonable, and we continue to make our views known both to HEE and the national health departments.

**Resolutions allocated to the TCS&N subcommittee**

31 That this conference condemns any form of local or regional pay structures which will lead to further geographical inequalities of patient care and cause inequalities to junior doctor training, and calls upon the government to take steps to ensure that any pay and conditions consortia are prevented.

JDC has continued to resist moves to regional pay, and the new contract negotiations for doctors in training is designed to deliver a four-nations contract.

32 That this conference wishes to note its disappointment and anger at the removal of Wales from the Junior Doctors Terms of Conditions of Service and the potentially catastrophic impact on other Welsh BOP TC&S. It therefore calls on:

i) JDC to publicly condemn NHS Employers and the Welsh Government for their unilateral action (CARRIED AS A REFERENCE);

ii) JDC to lobby for a reversal of this decision until such a time where appropriate, sufficient and effective negotiation mechanisms are in place in Wales to allow for Welsh contract amendments to take place;

iii) BMA to provide all the resources necessary for BMA Wales and WJDC to be in a position to take part in devolved nations talks for a Welsh TC&S.

The Terms and Conditions of Service and Negotiations subcommittee has raised this issue on several occasions and has gained agreement that JNC(J) is the forum for discussions about terms and conditions for junior doctors employed in Wales, and that agreements reached at JNC(J) will continue to apply to doctors in training in Wales.
This conference believes that any new contract for junior doctors should:

i) include a mechanism for verifying compliance with controls on hours worked; (CARRIED UNANIMOUSLY)

ii) include a distinction between social and unsocial hours; (CARRIED UNANIMOUSLY)

iii) include a mechanism for incentivising humane working patterns which take into account factors known to affect worker’s cognitive performance and health; (CARRIED)

iv) includes a recognition that time spent carrying out professional activities (including work for e.g. Royal Colleges, the BMA, and deaneries/LETBs) is of benefit to the NHS and should be supported by employers; (CARRIED UNANIMOUSLY)

v) should incorporate less-than-full-time training as part of the mainstream experience and not an exception. (CARRIED)

This motion was taken in parts.

Negotiations on a new contract for doctors in training have included discussion on safe working hours for junior doctors, with a focus on improving work-life balance and investigating limits on the number of actual working hours in a defined period.

That this conference notes the current talks on negotiating a new junior doctors contract at a time of financial restraint, and:

i) is concerned about the statement from NHS Employers that a new contract must be “affordable for employers”;

ii) is concerned that negotiations may bring about the removal of banding to be replaced with a system that does not provide the same level of remuneration;

iii) would find any further reduction in total pay unacceptable when junior doctors have already been adversely affected by recent wholesale pensions reform and multiple pay freezes;

iv) calls on the UK JDC to

v) ensure that maintaining the current level of pay and remuneration is a key priority in any future negotiations;

vi) reject any contract proposal in which the current pay envelope is decreased.

The agreed Heads of Terms for the contract negotiations requires proposals for new pay arrangements to not change the overall pay bill in comparison the current contract. The negotiators have maintained this position in contract negotiations.
35 That this conference:

i) considers the proposal that “the hospitals should be able to provide the same services 7 days a week” as a further attempt from the government to dismantle and privatise the NHS (LOST);

ii) believes that the financial pressures placed on NHS providers following a trend to 24/7 working may lead to closure of NHS services and will be detrimental to both patients and doctors (LOST);

iii) mandates the BMA to maintain the differentiation between weekend and weekday working in the current any proposed new contracts for junior doctors or consultants (CARRIED).

This motion was taken in parts.

The agreed Heads of Terms for the contract negotiations is clear that there should be a higher basic rate for work out of hours and under the current contract this is generally defined as taking place between 7pm and 7am and at weekends.

36 That this conference recognises the move towards negotiating a new contract for junior doctors, and:

i) recognises the vital importance of education and training for junior doctors (CARRIED);

ii) believes that this should be enshrined in the junior doctors contract (CARRIED);

iii) mandates the negotiating team to push for a minimum, non-discretionary study leave allowance of 20 days for all doctors in training (CARRIED AS A REFERENCE);

iv) recognising that some trainees may need more than 20 days, mandates the negotiating team to maintain total study leave at 30 days, with 10 additional discretionary days available if required (CARRIED AS A REFERENCE);

v) believes that this same study leave allowance should apply to all doctors including FY1 doctors (CARRIED).

This motion was taken in parts.

Facilitating training in the new contract is a focus of contract negotiations, including the access to, and amount of study leave available for all doctors in training.
37 This conference:

i) recognises that many trusts across the country impose annual leave embargoes on junior doctors;

ii) notes that such embargoes are often imposed at certain times of year e.g. August and Christmas;

iii) believes that an annual leave embargo should be regarded as an emergency measure, and should only be used when there is clear demonstrable evidence that the needs of the service require it;

iv) does not support the routine use of annual leave embargoes;

v) believes that junior doctors must be consulted before the imposition of an annual leave embargo;

vi) mandates JDC to lobby for the inclusion of regulations on the use of annual leave embargoes in any future junior doctor contract and associated changes in the national terms and conditions of service.

There have not been any changes to the current TCS but the Terms and Conditions of Service and Negotiations subcommittee has argued for, and gained agreement on, new guidance on leave entitlements relating to zero-hour days. Joint BMA/NHSE Employers guidance has been published outlining that if a bank holiday falls on a zero-hour day doctors are entitled to a day off in lieu.

38 That this conference:

i) notes there are wide variations in a junior doctors’ day to day work load (CARRIED);

ii) believes that in the UK, remuneration of and quantification of effort in the workplace by junior doctors is poor (CARRIED);

iii) believes that overworked doctors are unable to provide high quality safe patient care (CARRIED);

iv) calls on JDC to pursue negotiations with NHS employers for any new contract to include a cap on the ratio of inpatients cared for to post-registration junior doctors, with a maximum of 12:1, and less in higher dependency areas as judged locally by medical staff (LOST).

This motion was taken in parts.

See motion 33 on working hours.
That this Meeting notes that the number of junior doctors providing out-of-hours ward cover is variable across different hospitals and departments. Junior doctors often cover large numbers of patients and wards, leading to unsafe situations when multiple problems arise at once, and are unable to take any breaks during long shifts. These conditions impact on both mental and physical health of juniors, and the quality of service provision and patient safety. This Meeting calls on the BMA to lobby NHS organisations:

i) to ask NHS Employers to publish their out-of-hours ward cover doctor-to-patient ratios (CARRIED);
ii) to analyse and compare the workload, safety and practicality of these ratios, including appropriate break provisions in line with the European Working Time Directive and the New Deal (CARRIED);
iii) to commit to providing a safe and consistent doctor-to-patient ratio appropriate for clinical needs and that is more consistent between hospitals (CARRIED).

This motion was taken in parts. (Transferred from the Junior Members Forum)

See motion 4 on Patient Safety.

Conference notes that increasing numbers of Trusts/hospitals are seeking PFI new builds. As a result many new builds have been designed in short sightedness without the adequate provision of mess facilities and on-call/rest rooms.

i) conference urges all Trusts/hospital to reconsider their short sighted behaviour and ensure that adequate facilities are put in place to promote safe working conditions;
ii) calls on the BMA JDC to include the provision of mess facilities in any future amendments to the junior doctors contract;
iii) calls upon the BMA to update and promotes its guidance on minimum requirements in accordance with HSC 1998/240.

The Terms and Conditions of Service & Negotiating subcommittee is undertaking work in this area, with a view to raising awareness of issues around fatigue and the importance of facilities and updating our existing guidance.

This is being considered as part of the new contract negotiations for doctors in training.
This conference:

i)  acknowledges that there is less time available in each year for training than there was prior to WTR implementation (CARRIED);
ii)  believes that extending working hours again is not the correct response to concerns about experience (CARRIED);
iii)  calls for training programmes to be extended where concerns about experience are shown to be justified, to allow more experience to be gained while competencies are achieved (CARRIED).

This motion was taken in parts.

The BMA has participated in the WTR taskforce and we have made our position clear by submitting evidence and contributing to taskforce meetings.

That this conference recognises the vital importance of clinical teaching and education during postgraduate training, and:

i)  recognises that high quality education and training is essential for patient safety;
ii)  believes that clinical teaching and education is often provided in a haphazard and opportunistic way, and not sufficiently protected through the junior doctors contract;
iii)  mandates the JDC to ensure that in any new contract training should continue to be considered as work;
iv)  requests that JDC considers options of how to best have protected teaching time written into any new contract, with sanctions for employers for not meeting their teaching commitment.

This motion was carried UNANIMOUSLY.

See motion 36 on training in the new junior doctors contract.
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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