Media attention was recently drawn to the RVH ED following the declaration of a major incident on 9th January ’14. However doctors in NI are aware that this did not occur in isolation. Not only are the issues surrounding this incident affecting all EDs in NI but they are inseparable from the challenges affecting the health service throughout primary and secondary care.

While official figures may state that attendances at our EDs have decreased, the workload certainly has not. Those who attend our EDs tend to be older, often with a significant background of co-morbidity such as dementia cardiac or renal failure, poor mobility or chronic respiratory disease. These patients therefore require a high level of medical and social support even when not acutely ill. Delivering appropriate care for these patients in an ED can be difficult at the best of times and this is certainly not helped when resources including staff are stretched.

Senior doctors in primary and secondary care are doing their best to alleviate pressure on our EDs. Doctors are seeking to reduce referrals whether that be GPs struggling to manage and treat patients in the community, or by medical participation in patient education schemes to reduce inappropriate self referral.

Medical staff have not been slow in devising and participating in innovative solutions to increase efficiency such as the introduction of acute assessment units, GP federations etc. However increased efficiency can go only so far. When a service is working at full capacity, when there is no give, no slack, no redundancy in the system, then that system is forever balanced on the edge of an inability to cope, an inability to deliver.

To discharge a patient from an ED, one needs to be able to have a place to discharge them to, whether that be an available bed within the hospital setting or the availability of a community based package of care.

Another significant issue to add to the mix is the lack of ED Consultants, a problem not just in one Trust but right across Northern Ireland and indeed throughout the UK. This is an issue that has to be recognised. We need to be able to recruit and, just as crucial, retain our ED Consultants. In the short term, targeted local recruitment can only go so far. The problem of striking a positive work life balance must be addressed and in the long term we need more effective workforce planning.

This latest issue highlights a problem that cannot be ignored and that is that the problems surrounding our EDs affect all aspects of healthcare, both primary and secondary.

There is increasing demand on the health service due to demographic changes, an ageing population, new technologies and increased patient expectation. This is
occurring against a backdrop of increased financial constraint. We are told that funding for the Health Service is ring fenced. However in order to meet demand, funding must not just match inflation but increase at 4% above inflation year on year.

This poses a question for wider society particularly our elected representatives and should form the basis for a wider mature debate which encompasses all stakeholders including doctors. Just how can we meet and manage that increased demand? What sort of health service do we want and how are we prepared to finance that service?

In England we have seen political expediency where Conservative Ministers have used the problems affecting EDs as a club to beat GPs when trying to impose a harsh GMS contract. This political opportunism worthy of Machiavelli, manipulating public concern to further a political goal can only be deplored as unworthy of high office holders.

BMA(NI) will continue to provide a mature realistic analysis engaging with all decision makers to ensure that the voice of doctors is heard, that medical leadership in innovation is recognised and promoted and that the people of NI get the healthcare they need, require and deserve.

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Calling all Consultants and Junior Doctors

**Make Change Better**

**YOUR employment contract could be changing**

Contract negotiations are taking place now that could affect you and your job.*

You can have an impact on the negotiations and help shape your working life.

Tell us how to make change better by coming along to a free event in your area and join the discussion in our online community.

To find out more go to bma.org.uk/makechangebetter

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*The contract negotiations would directly affect all junior doctors working in the UK, but only consultants working in England and Northern Ireland. Some aspects of these negotiations could also affect public health doctors and clinical academics.

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Dunadry Hotel, Templepatrick

Wednesday 30 April

To book your place, visit bma.org.uk/doctorsworth

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‘This is the future for all of us. We’ve all got very different practices, and we’re all at different stages of our careers, so we’re all going to have different views and the solution we find needs to be fair for everyone.’

Consultant (Event attendee)

‘I think it’s really important that doctors at all levels and in different specialties are involved with the BMA in these discussions. It’s all too easy to talk on the ward about how difficult things are, this is an opportunity to do something about it.’

Junior doctor (Event attendee)
NIGPC has committed itself to developing a network of federations of GP practices throughout Northern Ireland this year with the majority of these being in place in the next 3-6 months.

We expect that there will be up to five federations in each of the four Local Medical Committee (LMC) areas.

The need for GP practice federations became evident with the uncontrolled shift of work out of hospitals into primary care as part of “Transforming Your Care” (TYC). This transfer should have been planned, agreed and resourced but the Trusts are taking the opportunity to dump any work they can onto practices without any funding. This cannot be controlled at Board or LMC level and needs to be dealt with locally.

Local federations will co-ordinate the push back against Trusts and will look for funding for the appropriate transfer of work, especially if staff need to move with the work. GP practices already have a saturated workload without being asked to do secondary care work as well.

Coordinating and Empowering
However federations aren’t just a way of protecting practices from external threats. They will also co-ordinate and empower the work of practices, enabling them to work in a more effective and integrated manner. We need local advocates from practices to highlight local issues, develop local solutions and be empowered with the funding, flexibility and autonomy to implement change where needed.

The destruction of the district nursing service by the Trusts is a stark reminder of how a centralised secondary care focus can result in a key service being undermined. How can TYC work in its shift left if community services have been decimated? GP practice federations will make increased funding of community nursing a priority as TYC can only work if there are fully staffed primary care teams.

Another significant area for development is prescribing. The present centralised command and control policy of HSCB for engaging with GPs in prescribing initiatives is seriously flawed. GPs don’t respond to central diktat and NIGPC has entered into talks with HSCB to develop indicative prescribing budgets for GP federations with savings ploughed back into primary care. The effective management of prescriptions coming out of secondary care is not core GMS work.

GP federations will also co-ordinate the management of workload in primary care, rationalising patient access, integrating with OOH and EDs to ensure appropriate care for patients.

Federations Spread the Workload
If GP practices are dealing with an increased share of the work, then funding needs to follow the patients. There is a profound organisational prejudice against GPs at virtually every level of management within the health service. If managers can’t stomach funding GP practices then they will need to hold their noses and fund federations of practices.

Federations can also be used to develop innovative GMS plus type services in the community for the frail elderly, nursing home patients and those with complex co-morbidities. This type of service can be difficult to develop in a single practice but could be developed in a federation. A significant part of what is traditionally viewed as hospital outpatient and diagnostic services could be managed or provided in the community by federations.

NIGPC has worked with the 4 LMCs to set up 3 pilot federations in Derry, Belfast and North Down and we expect to roll out a single organisational model throughout Northern Ireland in the next few months. Expect Federations to be not-for-profit GP membership organisations acting as primary care providers which focus on workload management and advocate for increased primary care resource.

Federations will bring local practices together to empower and enable GPs to provide a better service for their patients.
**GPs Finding The Way Forward**

**Finding the Way Forward – GP Conference 27 November 2013**

Dr Tom Black chaired a successful GP Conference at the Hilton Templepatrick that was well attended by GPs and Practice Managers.

Delegates were keen to learn more about details of the GMS Contract negotiations for 2014-2015, developments concerning the Out-of-Hours services in Northern Ireland, the concept of GP Federations, as well as important news on tax and annual allowance changes to pensions.

Dr Black presented the facts and figures of a reasonable deal for Northern Ireland GPs on the GMC contract negotiations that were ongoing with the Department. Good news was that a large number of QOF points were to be reduced and the funding put back into the Global Sum equivalent with some lower indicator thresholds and no new NICE recommendations. NIGPC has some work to do through a sub-group with the Department on other areas of funding such as seniority, locum superannuation, MPIG, EPS and CPI.

The main thrust of the conference debate was a challenge to GPs in Northern Ireland to take control of Out-of-Hours services as the current arrangements are unsustainable and potentially unsafe. Dr Black presented the history of the Out-of Hours model and explained how it has experienced savage funding cuts against an increase in demand, mostly due to an ageing demographic. He stated that the current GP Out-of-Hours service in Northern Ireland has been centralised, bureaucratised and cost-cut to the point where it is much cheaper in itself but inevitably is costing more to the whole system of care.

“The only way forward as we see it is the adoption of a local, GP-led Out of Hours service which can significantly contribute to the priorities under Transforming Your Care. We need a local, flexible, adaptable and responsive service for Out-of-Hours which will integrate with local EDs and ambulance services and better manage priority areas such as enhanced visiting and surveillance for vulnerable elderly patients. This in turn will help keeping patients out of EDs and hospital admissions”.

Since the conference, NIGPC has worked with HSCB and DHSSPSNI to find a solution for Out-of-Hours services and has had significant input on the Strategic Framework for Out-of-Hours which was approved by the Minister on 7 February 2014.

“Together we are stronger, better and can make things happen”.

There were many questions from the floor and support from delegates. In particular, the RCGP were supportive in having a “common vehicle to take it forward”.

Mr Andy Blake gave an update on the Life Time Allowance (LTA), Annual Allowance and changes from 2015 given that the existing April 2006 rules have been abolished with new rules coming in. The LTA will reduce from £1.5m to £1.25m from April 2014. The total amount of benefits that can accrue from all pension provisions without becoming subject to additional taxation reduces to £40,000 from 6 April 2014. He explained how to apply for protections.
Consultant Contract Update

Update on Consultant Contract Negotiations
Below I have included the most recent correspondence sent jointly from myself and Chair of BMA UK Consultants Committee to communicate progress to members on consultant contract negotiations.

Key milestone in Consultant Contract Negotiations: we want your views
Since October 2013, the BMA has been in negotiations with NHS Employers on possible changes to the contract for Consultants working in England and Northern Ireland. We have just reached a key milestone, reporting on initial progress to both Government and the wider BMA. Though we are clear that nothing is agreed until everything is agreed, we want to update you on progress and get your feedback on the issues that matter most to you. The main focus of the six negotiation sessions we have had to date has been the facilitation of more 7-day services and, to a lesser extent, pay progression. Other issues, such as Clinical Excellence Awards (CEAs), which are currently non-contractual, and SPA (supporting professional activity) time, are also within the remit of the talks but we have not yet had time to discuss them in detail.

7-day services
The BMA is committed to ensuring patients receive the same high quality of care – though not necessarily the same range of services – across the entire week. As Consultants, we have always taken a lead on quality improvements. Achieving common quality standards for all acutely ill patients is now likely to require changes over time to more traditional working patterns, including the increased presence of senior clinical staff in the evenings and at weekends, as well as the supporting resources we need to deliver that care.

We are clear that this should not mean a greater workload for individual Consultants. Many of us are already working beyond our contracted hours, and we have to ensure a healthy work/life balance, for the sake of our patients as well as ourselves. An essential aspect of any future deal would also be the agreement of fair rates of pay for Consultants who work unsocial hours. We are working with NHS Employers to model the impact of increased Consultant presence on the Consultant pay bill to feed into the wider contract negotiations. NHS Employers accept the vital importance of any changes being supported by appropriate safeguards to protect and promote the health and well-being of consultants and safe practice for patients.

Pay progression and SPA time
The Government is seeking an end to automatic pay progression across the whole of the public sector. We are currently considering a number of alternatives to the current NHS pay structure where almost all Consultants progress through the salary levels at the same pace. We are clear that there would have to be fair ways of linking pay to responsibilities and performance in any revised system. On SPA time, NHS Employers are in agreement with us on the significance of educational, training, research and innovation activities as key components of medical professionalism. We are seeking to end pressure from individual employers to reduce SPAs.

Be informed and get involved
In these contract negotiations, we are sharing as much as we can about the issues and progress. As we made clear last summer when we were considering whether or not to enter talks, we want to be as open as possible throughout the entire process.

These were never going to be easy discussions – the NHS is experiencing significant financial pressure and growing demand. Increasing numbers of individual NHS employers are seeking to chip away at staff terms and conditions. In Northern Ireland, there has been an underinvestment in Clinical Excellence Awards in recent years. Consultants in both nations have experienced difficulty in agreeing adequate SPA time in their job plans. At the same time, the Francis Inquiry has shown we need to focus more than ever on safety and quality. It is essential that your views help guide us. Already over 4,000 of you told us the issues that are most important. Two themes emerged – the need to fairly reward and protect those who work unsocial hours and the need to maintain a national contract. We think both are essential if the NHS is to have any chance of delivering universal, high quality care sustainably.

Dr John D. Woods, Chairman of NICC, is currently involved in the Consultant Contract negotiations and reports on how these are progressing against the backdrop of the emergency care situation and its implications for members.

We are all aware of the current difficulties in emergency care either through personal experience, or the media. Members agree that fully staffed, fully resourced emergency care needs to be available to patients in emergency departments and indeed right throughout hospitals. In order to achieve this, we understand that difficult decisions will have to be made. I have been impressed that so long as all change is properly planned, managed and resourced, members are fully in support of reorganisation. However, although the media spotlight is focused on EDs, solutions will need to be provided along the entirety of the patient path through to discharge. Innovative solutions need to be developed which either avoid hospital admission or maximise patient flow through to discharge and community care.

These solutions may already exist. Members report that they advocate for innovative ideas, or even proven concepts, but still have difficulty being heard. Trusts need to listen and actively engage with our members so that these ideas can be discussed, tested, and where successful, implemented. What we are seeing being played out in our EDs is real experience, or the media. Members agree that fully staffed, fully resourced emergency care needs to be available to patients in emergency departments and indeed right throughout hospitals. In order to achieve this, we understand that difficult decisions will have to be made. I have been impressed that so long as all change is properly planned, managed and resourced, members are fully in support of reorganisation. However, although the media spotlight is focused on EDs, solutions will need to be provided along the entirety of the patient path through to discharge. Innovative solutions need to be developed which either avoid hospital admission or maximise patient flow through to discharge and community care.

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Junior Doctors

Work continues on the national negotiations for the agreement of a new Junior Doctor Contract. On 6 December, the BMA launched a major member engagement programme to support Junior Doctors and Consultants throughout the contract negotiations period.

The programme entitled Make Change Better: Junior and Consultant Working Lives aims to keep doctors informed and involved in the negotiations and wider issues affecting their working lives. Key activities launched as part of the programme are:

Online BMA communities: the My Working Life Group where doctors can find the latest on the contract negotiations and debate in real-time with colleagues about key issues.

What’s a doctor worth? A series of innovative and entertaining events held across six cities in England and Northern Ireland from January to April 2014. The event in Northern Ireland is due to take place on 30 April 2014 in The Dunadry Hotel, Templepatrick. This is your chance to make your views known. More details can be found on page 2.

An online resource area and toolkit: Materials for BMA activists and members to support them with local discussions and meetings (launched in January 2014)

Find out more at bma.org.uk/makechangebetter

NIJDC is currently involved in negotiations with Trusts with regards to establishing a HSC E-Locum Agency. The purpose of this Agency is to enable Trusts to more effectively provide cover for short-term vacancies, reduce their reliance upon medical agencies and reduce locum costs.

In order for BMA (NI) to ensure that adequate and proper rates of pay are determined and agreed, we sought trainee views via a short email survey in November 2013. Our thanks to those of you who took the time to complete the survey. The findings have been very useful in informing our discussions and helping us to protect your interests. We will keep you posted regarding any future developments in this matter.

The Shape of Training review published in the autumn, and sponsored by the GMC and the four Departments of Health across the UK, included a key proposal for the introduction of more broad-based specialty training ‘themes’ in postgraduate curricula.

We are all aware that the population is ageing and the patients have increasingly complex conditions, often with multiple morbidities. We also recognise that the medical profession needs to respond to changing trends and requirements for patient care. We do not disagree with the principles behind the suggestion of obtaining more generic competencies, which is to allow trainees greater flexibility to move between specialties and respond to the changing needs of the population. In fact, for years we have been arguing for increased flexibility in the training system. However, we do not think a complete overhaul of the training structure is necessary to achieve the desired aims.

We also have reservations about moving GMC registration to the point of graduation, as advocated by the Greenaway report. This would seem to be beyond the remit of the review. We do not believe that removing a whole year of education and experiential training best serves patients. BMA prepared an initial response to the Shape of Training Report that can be viewed on http://bit.ly/1m707SF. A final response to the report has now been submitted and will shortly be available to read online.
F1 Shadowing-induction
An important step forward for NIMSC and NIJDC over the summer of 2013 was the publication of DHSSPS’s circular about F1 shadowing-induction.

Historically, arrangements for pre-F1 induction-shadowing during the end of July/beginning of August period varied across the five Trusts. This was a source of confusion and dissatisfaction for our recent graduates commencing the foundation programme and was a significant issue for us.

The main purpose of induction is to ensure new doctors can provide safe and high quality of care from their first day as a F1 doctor. Indeed, there is evidence to suggest that shadowing can reduce the number of serious adverse events committed by inexperienced trainees.

Health Education England and equivalent bodies in Wales and Scotland had accepted that this period should consist of a minimum of 4 days and occur as close to starting F1 proper as possible (typically immediately before) with an equal mix of Ward Based Shadowing and Employer Based Induction.

Disappointingly, the five Trusts in Northern Ireland had no standardised process for induction-shadowing for F1s and lagged behind the rest of the UK on this matter.

The publication of the circular signalled an acknowledgement by the DHSSPS of the significance of shadowing-induction period and recognition that it should be given due importance in terms of a standardised, formalised process.

The arrangements will be implemented in August 2014 and we look forward to that.

Looking after your mental health
Looking after your mental health is one of the most important things you can do whilst at university. In Northern Ireland we should know this better than most with this region having one of the highest rates of mental illness in the developed world.

Medical students would not seem to be an especially vulnerable group. They are far removed from those who are termed NEETS (Not in Education, Employment or Training). However the reality is that undertaking a medical degree does at times bring considerable stresses. It is important that students learn to manage and cope with these demands.

Like our counterparts in the rest of the UK, we therefore welcome the national guidance published at the end of July by the GMC. Supporting medical students with mental health conditions (http://bit.ly/1cCo6UJ) was developed in partnership with the Medical Schools Council and overseen by an operational group.

Locally, NIMSC has also been trying to raise the profile of the BMA’s Doctors for Doctors counselling service that is available to all BMA members including students. Whilst we acknowledge that Queens University Belfast (QUB) does have good in-house support mechanisms for students in difficulty, often it can be reassuring to know that Doctors for Doctors is completely confidential and independent and is not linked to any internal or external agencies.

We have been advertising the service in and around QUB and have been discussing it in depth in our recent edition of NI StudentBytes. To find out more visit http://bit.ly/1fp8RBO

Medical student finance guide for NI domiciled students
Finally, just to let you know that NIMSC has also produced an updated finance guide for NI domiciled students. This follows the publication of the Browne Review on tuition fees and locally the updated report from Joanne Stuart commissioned by the Department of Employment and Learning.

Our revised guide contains up-to-date facts and figures for the 2013-14 academic year. To view, visit http://bit.ly/1c3wqjL
What You Need To Know About The Appraisal Process

Industrial Relations Update
During September and October 2013, we ran a number of training sessions designed to offer Consultants and SAS Doctors practical advice and guidance on preparing for the enhanced appraisal process. Feedback was positive and further training sessions are scheduled for spring 2014.

The training sessions highlighted a number of key learning points:

1. Take ownership of your Appraisal
   While most Trusts are diarising a timetable for Doctors to undertake appraisal, it is your personal responsibility to ensure you are appraised. It is therefore important that you take ownership of your appraisal and are proactive in ensuring you complete the appraisal process each year in a timely manner. If arrangements are not in place, contact your clinical manager by phone initially and then follow up with an email to schedule an appraisal meeting.

2. Ensure you prepare
   The ‘enhanced’ appraisal process is much more robust than the one currently in place. Preparation is vital and we cannot emphasise enough the need to plan throughout the year and use your SPA time. You should familiarise yourself with the GMC – Good Medical Practice Framework for Appraisal and Revalidation document.

   There is also some excellent Trust intranet guidance on appraisal. You should plan to have your supporting documentation prepared six weeks before your appraisal date. Two weeks before your appraisal you should submit your portfolio to your appraiser.

3. Cross referencing your supporting evidence
   Form 3 of the documentation captures the appraisal discussion, summarises the actions going forward, and documents the evidence around which the discussion is based.

   This form is perhaps the most challenging to complete. It requires supporting evidence to be referenced against all four domains.

   It is acceptable to cross reference supporting documentation against a number of domains, helping you to effectively manage your preparation time.

4. Include evidence of Reflection
   Evidence of reflective practice forms an essential part of the enhanced appraisal process. In any scenario it involves:

   • being aware of what happened
   • evaluating your own practice
   • outlining how that ties into existing theory/policies/guidelines
   • lessons for the future – changes in approach/perspective/understanding

   Reflective templates are available to download from the respective colleges and can be used in a wide range of scenarios, i.e. from CPD to dealing with complaints. Ensure that within a template you document the following:

   • A description of the event
   • What worked well and why/what could have been done better/ issues that arose
   • How your performance linked into existing policies/guidelines
   • Upon reflection any changes you will make to your future practice

5. Undertake your Appraisal with a view to it supporting your revalidation
   The table below outlines the type of information that will be required for revalidation. Ensure that you use the appraisal process to capture the type of information required and at the appropriate frequency to satisfy the five-year revalidation cycle.

<table>
<thead>
<tr>
<th>Type of information</th>
<th>Min required in 5 year period</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant event or case review</td>
<td>10: min 2 per year</td>
<td></td>
</tr>
<tr>
<td>Complaints and compliments review</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>Formal and informal clinical audits</td>
<td>5: min 1 per year</td>
<td></td>
</tr>
<tr>
<td>Patient feedback survey and review</td>
<td>1: presented by year 5</td>
<td></td>
</tr>
<tr>
<td>Colleague feedback survey/review</td>
<td>1: presented by year 5</td>
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<tr>
<td>New PDP and previous PDPs review</td>
<td>5: annually</td>
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<tr>
<td>Completion of CPD</td>
<td>5: annually</td>
<td></td>
</tr>
<tr>
<td>Health self-declaration and review</td>
<td>5: annually</td>
<td></td>
</tr>
<tr>
<td>Probity self-declaration and review</td>
<td>5: annually</td>
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</tbody>
</table>

If you would like to register an interest in our further appraisal training sessions scheduled for early 2014 please contact Claire Whitford cwhitford@bma.org.uk
SAS Doctors Meet The Challenge

At the moment, one of the most important issues specifically affecting the SAS profession and the most urgent for debate, is the continuing lack of infrastructure for SAS Development and Training.

To gain relevant information, to help our negotiations and to inform any business case that will be expected, we developed and circulated a survey on the demographics, levels of expertise and specific training needs of SAS doctors in Northern Ireland. We also wished to understand what areas of professional and personal development would be of benefit to SAS doctors and the HSC in the current environment of Transforming your Care (TYC).

SAS doctors make up a significant and increasing proportion of the trained medical workforce. Collectively we need to promote the relevance of our contribution in the provision of high quality healthcare and in leadership roles and education.

NISASC needs the support and engagement of the SAS profession to enable us to take these issues forward in a productive way. I am very aware that individuals in each Trust are working locally to promote the craft and are taking on leadership roles. However with a more cohesive approach, our voices are more likely to be heard.

One of the issues taking centre stage in SASCUK debates is the question of autonomy of SAS doctors and the paucity of coding evidence to reflect our level of autonomy. This is such an important concern for us particularly with regards to providing robust evidence for revalidation.

Where a SAS doctor is of the view that he or she has demonstrated the ability to take decisions and carry responsibility without direct supervision, this should be raised as part of job planning discussions. Employers have a responsibility to support SAS doctors in developing their skills and experience to allow them to require less supervision and take on more responsibility as they progress through their careers as Specialty Doctors or Associate Specialists.

I was recently invited to speak about my autonomous work as an Associate Specialist in dermatology in a podcast on the BMA website, which also includes updated autonomy advice. This can be accessed at: http://bma.org.uk/news-views-analysis/news/2014/january/survey-reveals-level-of-sas-doctors-autonomy.

With the proposed changes within TYC that will come into force over the next few years, there will be a significant increase in the number of Specialty Doctor posts in Northern Ireland. An ability to fill these posts with enthusiastic and optimistic candidates who are making a positive life choice will undoubtedly go a long way in helping to maintain morale within the grade.

As Chair of NISASC I feel it is my responsibility to actively promote this “Non-Consultant Career Grade” as a positive choice to trainees and to undergraduates. It may not be everyone’s “cup of tea” but many of my colleagues and I are living proof that it can be a very rewarding career option with many benefits that improve the important work/life balance. This is one of my goals for the rest of my time as Chair of NISASC.

Taking a much needed proactive approach, in November 2013 NISASC hosted a one-day Development Conference SAS – Meeting the Challenge. The purpose was to present an opportunity to SAS professionals to hear about some of the inevitable changes to the Health Service under the auspices of Transforming Your Care and to provide an opportunity to reflect on those changes and their effect on the education, development and training of SAS Doctors in particular.

The conference was primarily aimed at Staff, Associate Specialists and Specialty Doctors in Northern Ireland. However, latterly, NISASC agreed to extend an invitation to Junior Doctors who were considering entering the SAS grade, or those who were similarly interested in exploring what SAS was all about.

Speakers included Mr John Compton CBE, Chief Executive of the Health and Social Care Board; Dr Brian Patterson OBE, Regional ICP Lead; Mrs Elaine Way, CBE, Chief Executive, Western Trust; Dr John Simpson, Medical Director, Southern Trust; Dr Michael Mannion, Deputy Medical Director, Northern Trust; Mr Alan Walker, GMC; and Ms Mary MacFarlane, BMA Careers. During the ensuing question and answer session, John Compton acknowledged the need for organised training and career development of this group of doctors.

The conference heralded strong support and interest from doctors from across the province and from many specialities, amounting to one fifth of the SAS profession in Northern Ireland. It also proved to be a great way to meet and engage with other SAS colleagues from around the province, to hear what is going on in other Trusts and in the wider remit of Health and Social care changes that are soon to be in place in the form of TYC.
Men’s Health – How Much Do You Know?

Dr Paul Darragh
Chairman NIC

What is men’s health? Well I can tell you what it isn’t. It isn’t the eponymous magazine with the cover picture of a young Adonis sporting a six pack to which those of us with a four pack, a two pack or even a keg could never aspire. Even with the benefit of Photoshop.

On the other hand, there is increasing recognition that men’s health extends beyond the narrow confines of conditions of the reproductive organs. The usual suspects are prostate problems, testicular pathology and erectile dysfunction.

For some, these concerns remain a prominent feature of the general discussion about men’s health. However this narrows the definition with the unfortunate result that the wider problem is not recognised and therefore not tackled.

What is Men’s Health?
To deal with an issue we must first define it. The Men’s Health Forum (MHF) provides an excellent starting point:

“Good male health is a state of physical, mental and social well-being that enables individual boys and men, and the male population as a whole, to meet the demands of everyday life and to realise their aspirations and biological potential.”

The complementary definition of a male health issue is as follows:

“A male health issue is one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or necessitates male specific actions to achieve improvements in health or well-being at either individual or population level”.

This definition acknowledges that there are more factors involved than the biological.

And it recognises that the health of men and boys cannot be divorced either from prevailing notions of masculinity or from the influences of the wider world, of work or relationships.

These notions of masculinity – self-reliance, and a reluctance to seek help or communicate concerns – contribute to the fact that men in the UK generally ignore important health issues. They typically only seek help when lasting long-term damage has occurred. By then the time for effective intervention or therapy has passed. Or the outcome is terminal with tragic consequences for the individuals concerned, their families and their dependents.

Addressing The Issues
Where there has been sufficient progress resulting in government activity, the activity tends to fall into one of two categories. The first is politically-led, directly intended to improve male health by the development of dedicated policy and/or investment in health programmes targeted at men. Examples of such can be found in Australia or the Republic of Ireland. The latter is an example we would encourage the NI Assembly to emulate.

The second category of progress has been in those countries where an emphasis on gender equality in overall social policy has strengthened arguments that men’s poorer health outcomes must be addressed. The difficulty lies in shifting the obstructive public and political view that “gender inequality” is a problem that affects only women.

The argument runs the risk of alienating politicians whose views are that men can never be seen as disadvantaged. It may also
be perceived as diminishing the importance of those aspects of life where women do suffer discrimination. In fact, an emphasis on gender-sensitivity in health and healthcare provision has the potential greatly to benefit both sexes.

**Social Lottery of Life Expectancy**

Take the example of the famous Belfast bus journey and life expectancy. In the city centre electoral ward where Donegall Square is situated, the life expectancy for males is 71 and females is 77. Stay on the bus and head for the leafy suburbs and life expectancy magically rises as the gender gap in expectancy simultaneously diminishes.

By the time you get to Malone Road the corresponding figures are 79 and 82. If you alight on Finaghy Road South, the figures are 80 and 83.

The lesson here is clear. If we can tackle social determinants, we are improving life expectancy for everyone and in diminishing the gender gap we are addressing this aspect of male health inequality.

The figures for Northern Ireland are stark. Male life expectancy is on average almost five years lower than the female life expectancy. Men in Ireland have higher death rates for most of the leading causes of death. Men from lower socio-economic groups are up to six times more likely to die from the leading causes of death. Young men (aged 18-35 years) are a high-risk group being almost four times more likely to die earlier than female counterparts and they currently have the second highest rate of suicide among the 30 OECD Member States.

It was figures such as these that led to BMA (NI) developing a policy paper after consultation with BMA representatives, stakeholders and most importantly, the BMA Patient Liaison Group as well as representatives from as wide a spectrum as possible of voluntary groups.

"A male health issue is one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or necessitates male specific actions to achieve improvements in health or well-being at either individual or population level."

**Men’s Health Policy**

**Men’s Health BMA (NI) Policy Document** published in 2011 considers initiatives to improve men’s health, the need to engage men about their health and makes recommendations as to how access to supportive health care services can be improved.

The key recommendations were:

1. The need for increased research to develop a men’s health policy
2. The need for improved services in a supportive environment
3. Promoting responsibility in men to take ownership of their personal health

BMA (NI) will drive to influence policy so that all men shall be enabled to enjoy full healthy lives, empowered to fully engage in their central roles in the family, wider society and contribute to the social and economic life of Northern Ireland.
Working With GPs And Practice Managers

The BMA (NI) Industrial Relations Team working with GPs and Practice Managers

A big thank you to all those Practices that responded to our Training and Support Needs Analysis Questionnaire carried out early last year. Your feedback has enabled us to prioritise how the IR Team can best meet the needs of GPs and Practice Managers in recruiting and managing staff.

Training sessions were delivered during November and December for partnership agreements, performance management and recruitment and selection. These events were well attended and we are now ready to progress to the next stage of this work.

We are keen to offer further help and advice by providing short taster modules at Practice Manager Association events over the course of the next few months.

These modules are free of charge and they provide an introduction to topics such as disciplinary and grievance, contracts of employment, managing sickness absence and recruitment and selection.

Other areas can be considered as identified by Practice Managers via their Associations. Should any Practice Manager Association be interested in this opportunity please contact BMA (NI) by email bmanorthernireland@bma.org.uk

A number of Practices have benefitted from a personal visit by an Employment Adviser from the IR Team to address specific queries relating to policies and procedures, and/or current staffing issues. This service continues to be available to any Practice with GP membership of the BMA. Should you require an Employment Adviser to meet with you please E-mail bmanorthernireland@bma.org.uk

Non-members can join online at http://bma.org.uk/join4092

Developing New Guidance Notes
We are also in the process of updating the BMA (NI) staff handbook and related policies and procedures. This will be made available to members in the coming weeks and will be accessible via our website https://bma.org.uk/practical-support-at-work/gp-practices/practice-staff-handbook-northern-ireland.

Information for Junior Doctors re HSC e locum system
BMA (NI) is currently involved in on-going negotiations with Trusts in relation to their intention to establish a HSC E-Locum Agency. According to the Trusts, the purpose of this E-Locum Agency is to provide a system that helps them to provide cover for short-term vacancies, in a more effective manner. Also to reduce their reliance upon medical agencies; and to reduce costs associated with locum cover.

Trusts appear to be very keen to establish this Agency as quickly as possible by building a large pool of registered doctors, and BMA (NI) understands that they have already made contact with junior doctors inviting them to register onto the system.

We further understand that some Trust communications are indicating that this E-Locum Agency is currently the only system that facilitates junior doctors to carry out locum work across Trusts in NI.

Please be advised that this is not in fact the current situation and junior doctors continue to be able to register with an external agency, if they so wish.

Whilst BMA (NI) continues to be involved in current negotiations with Trusts, we would urge all junior doctors in NI to be patient, to provide BMA (NI) with sufficient time to ensure the system is fit for purpose with reasonable and acceptable rates agreed.

To this end please do not feel pressurised to register onto the system.

Should you require further information please contact Lucinda Wright in the BMA NI office lwright@bma.org.uk or 028 90 269 666
As psychiatrists in Northern Ireland, we are committed to the drive for parity of physical and mental health in our community. The prevalence of mental illness in Northern Ireland is higher compared to elsewhere in the NHS yet the funding of services here is not comparable.

The strong relationship between mental and physical health is widely accepted. We know that those with a mental illness can have a reduced life expectancy of up to 20 years due to the increased likelihood of physical illnesses, some of which are potentially preventable, while patients with medical illness are three to four times more likely to develop a psychiatric disorder than a member of the average population.¹

Evidence consistently shows how over 25% of all people admitted to acute hospitals have a comorbid mental health and physical problem which can negatively influence both their length of stay as well as their clinical outcome. 80% of all hospital beds in UK are occupied by people with comorbid physical and mental health problems.²

The model for future health and social care services in Northern Ireland is described in Transforming Your Care (TYC),³ and reasonably promotes values of integration, personalization of care and safeguarding those most vulnerable, while developing sustainable and evidence based cost effective services.

Resources in Northern Ireland have traditionally been targeted at episodes of care for acute conditions at the expense of integrated, proactive, and preventive care for chronic conditions and recommends a shift to community and primary care with an emphasis on prevention. We are aware that our acute hospitals are under stress with the recent reviews of the Accident and Emergency service in Belfast highlighting these significant pressures. Hospital services here need to change in order to facilitate the flow of patients. The development of a comprehensive liaison psychiatric service or, as it is also called ‘Psychological Medical’ service must be a priority if our acute hospitals are to be effective and safe. The liaison psychiatric service enables other professionals to do their job by connecting and moving the patient’s care to the right pathway so acting as a conduit for patient flow.⁴

Liaison services are poorly developed here in Northern Ireland in spite of the indisputable evidence of their effectiveness. Benefits seen include improved experience of care, better outcomes, reduced ED waiting times as well as reduction in the rates of admissions, readmissions and lengths of stay. There is also robust evidence that for every £1 invested in a liaison psychiatry service that up to £4 of value is returned to the local health and social care economy. Liaison services must be integrated with all other hospital services from the Emergency Department to discharge planning and into the primary care setting. Specific key patient groups attending for emergency at our acute hospitals stand to benefit from an effective liaison service including those who self harm, those with psychological and physical consequences of alcohol and drug misuse, frail elderly, those with unexplained physical symptoms, vulnerable groups including young people at risk, people with personality disorders as well as those with a known psychiatric illness referred to in the Liaison Psychiatry Services Guidance.

The development of liaison psychiatric services most definitely supports the shift from acute hospital care to community care with services at out-patient and primary care levels reducing the need for admission. This is particularly the case in relation to long term conditions. In the UK it has been recommended that all clinical commissioning groups should consider the development of community collaborative care services with an integrated liaison psychiatry component as high priority (parsonage et al 2012:5).

While some work is taking place into developing the case for better liaison services, as a College we believe that there is a real urgency to expedite this if the goals of Transforming Your Care are to be realised.

¹ National Confederation (2009) Briefing Issue 179 Healthy Mind Healthy Body  
² Royal College of Psychiatrists (2013) Whole person care; from rhetoric to reality. Achieving parity between mental and physical health London: Royal College of Psychiatrists  
³ www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-rep  
Are You Paying Too Much For Childcare?

Employers For Childcare Charitable Group’s 2013 Childcare Cost Survey revealed that the average cost of a full-time childcare place in Northern Ireland is now a staggering £158 per week.

You should be saving up to £933 annually with Childcare Vouchers. This is done by swapping part of your salary, tax and National Insurance, to pay for your childcare costs. The scheme is not means-tested and is operated through your employer’s payroll.

Childcare Vouchers work in a similar way to online banking so paying for your childcare with them is easy. The vouchers are available to both parents, meaning potential family savings of up to £1,866 each year.

Childcare Vouchers can be used to pay for any type of registered childcare for children up to the age of 15. This includes childminders, day nurseries, holiday schemes, breakfast and afterschool clubs.

If you are a parent, you should be making the most of the financial assistance that is available and you should spread the word to other parents too.

Call 0800 028 3008 or visit www.employersforchildcare.org to find out how much you could be saving on your registered childcare costs.

GMC News: GMC Revalidation Update

GMC Revalidation has been in operation for slightly more than a year, with over 700 doctors in Northern Ireland already seen under the new system of checks introduced for doctors practising in the UK. To date a total of nearly 25,000 doctors in the UK have had their licence revalidated.

Since its introduction in December 2012, every doctor registered with a licence to practise in the UK is now legally required to show the General Medical Council (GMC) that they are competent and fit to practise, usually once every five years, to be able to continue treating patients.

More than 10,000 doctors on the GP Register, including nearly 300 in Northern Ireland, and 12,000 on the Specialist Register have successfully revalidated in the first 12 months.

Medical leaders including Professor Sir Peter Rubin, Chair of the GMC, were among the first to be revalidated following introduction of the checks in 2012.

Niall Dickson, the GMC’s Chief Executive and Registrar, said:

“These are very early days but we are pleased with the progress made in the first year. This new system of checks is a world first and over time we believe it will make a significant contribution towards making sure patients in the UK receive safe, effective care.

“There is more to do but this is about supporting doctors to provide the best possible care and making sure patients can have confidence in the care their doctors provide. We will develop the model, and we will listen and learn from the experience of those who use it as we do so. But this is a good start.”

Staff from the GMC Northern Ireland office continue to support doctors, speaking to over 1,200 doctors throughout 2013 on a range of topics including revalidation, GMC guidance on protecting children and young people, Doctors’ use of social media and raising and acting on concerns about patient safety.

GMC staff attended a number of conferences including BMA Northern Ireland Staff, Associate Specialists and Specialty Doctors Committee (NISASC) annual conference, liaising with BMA representatives in Northern Ireland.

They also attended the British Orthopaedic Foot and Ankle Society annual conference in November and attended an Ophthalmology Training Event in March. Staff updated members on revalidation, explained the revalidation process and answered numerous queries.

The GMC expects to revalidate the majority of licensed doctors by the end of March 2016 and all remaining licensed doctors by the end of March 2018.

5 Figures included in the release are correct as of midnight 26 November 2013. They cover the period 3 December 2012 to 26 November 2013 – one week before the end of the first full year of revalidation.
Assembly Round Up
BMA(NI) have been actively engaging with the Northern Ireland Assembly, the Health, Social Services and Public Safety Committee, the Finance and Personnel Committee and MLAs across all of the main political parties. This ongoing work is done to promote the profile of the organisation as a whole, contribute to the legislative process and discuss issues of concern and relevance to members across all branches of practice.

Public Service Pensions Bill
During the passage of the Public Service Pensions Bill, BMA(NI) staff and members lobbied MLAs across all the main political parties sitting on the Finance and Personnel Committee. We provided briefs to the politicians, discussing the main issues and causes of concern to our members. In addition to informal one-to-one meetings with MLAs, Dr Paul Darragh NI Council Chair and Andy Blake, Head of Pensions, gave evidence to the Finance and Personnel Committee. As a result of these activities, both the SDLP and Sinn Fein tabled amendments in the Consideration Stage of the Bill specifically in regards to clause 10 of the Bill dealing with retirement age. Unfortunately these amendments fell and the Bill continued its passage through to Final Stage on 4 February 2014 and from there will receive Royal Assent and become an Act.

Organ Donation
BMA(NI) acts as secretariat to the Assembly All Party Group on organ donation which meets quarterly in Parliament Buildings. It is chaired by UUP MLA for Upper Bann Jo-Anne Dobson and co-chaired by SDLP MLA for Foyle, Pat Ramsey. BMA(NI) has responded to both organ donation consultations put forward by Jo-Anne Dobson on the introduction of a soft opt-out system and Alastair Ross DUP MLA for East Antrim proposing the introduction of a mandatory question on organ donation on driving licence proforma.

Alcohol
BMA(NI) continues to call for the introduction of minimum unit pricing of alcohol and recently wrote again to the DHSSPS Minister asking for action to be taken in Northern Ireland following an announcement by the Health Minister in the Republic of Ireland that they intend to introduce minimum unit pricing as part of a Public Health Bill. BMA(NI) has also met with the Institute of Public Health and have formally requested that we be given the opportunity to make representation to the North South Alcohol Policy Advisory Forum.

European Union Cross Border Directive
BMA(NI) submitted a response to the consultation from DHSSPS on EU Cross Border Healthcare Directive. As a result of this, Dr Tom Black and Dr Alan Stout gave evidence and expressed the views of BMA(NI) during the Committee Stage of the Bill.

Consultations
Other consultations that BMA(NI) have made responses to include:

- Enhancing Healthcare Services for Children and Young People in Northern Ireland (From Birth to 18 Years)
- Amendments to the Health and Social Care (HSC) Pension Scheme Regulations
- Community Resuscitation Strategy Consultation for Northern Ireland
- Review of Children’s Palliative and End-of-Life Care Phase 3.

Other Political Engagement
Members from various branches of practice have been meeting with MLAs to develop relationships, discuss issues of relevance to members and promote the profile of BMA(NI) informing elected representatives of the work being done.

Political Party Conferences
BMA(NI) attended and exhibited at the Political Party Conferences for UUP, SDLP, DUP and Sinn Fein, engaging with MLAs and promoting our members’ interests and BMA(NI) policies.
Make the BMA part of your DNA!

There’s never been a tougher time to be a doctor.

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Join today – bma.org.uk/join

*Our advice and support is only available to members, and we are unable to help with any issues that arise before your membership commences.
Welcome to Belfast

BMA(NI) were very proud to host the September 2013 meeting of UK Council in Belfast. This meeting was chaired by Dr Mark Porter in the iconic Titanic Building.

To mark this important occasion, a dinner was hosted the evening prior to the meeting by the Chairman of NI Council, Dr Paul Darragh in the Members’ Dining Room at Parliament Buildings in the Stormont Estate.

Minister for Health, Social Services and Public Safety, Edwin Poots MLA, was the main sponsor and guest speaker. A representative MLA from each of the five major political parties in Northern Ireland were also in attendance, Roy Beggs UUP MLA for East Antrim, Mickey Brady Sinn Fein MLA for Newry and Armagh, Kieran McCarthy Alliance MLA for Strangford, Alasdair McDonnell SDLP MLA for South Belfast and Jim Wells DUP MLA for South Down.

Joining these and many prominent BMA members and staff from across England, Scotland and Wales were the most senior figures from the Department of Health, Social Services and Public Safety, the Health and Social Care Board and the Trusts. The occasion proved to be an excellent networking and influencing opportunity for all members in attendance.
Dr Heather Wood: Lessons From Mid-Staffordshire

Dr Heather Wood who led the Healthcare Commission investigation that uncovered the failings at the Mid-Staffordshire Foundation Trust was the keynote speaker at the BMA NI Joint Divisional Meeting in October 2013. Dr Wood, who originally comes from Northern Ireland, provided a compelling presentation highlighting key events during the investigation and outlined why the medical profession must be integral in the future “management” of our health service. Dr. Wood’s presentation was extremely well received by all doctors across all branches of practice in attendance. Hosting the event, BMA(NI) Chair Dr Paul Darragh thanked Dr Wood for sharing her work with members.

“What we have learned from Mid-Staffordshire and what has been reinforced by Dr Wood is the need for senior clinical staff to be given greater managerial and leadership responsibilities in running the health service, with doctors not only at the forefront of care and treatment, but also an integral part of NHS decision making”.

Dr Wood graduated from Trinity College Dublin and was a University lecturer in pathology before becoming a Senior NHS manager in a health authority in England. She has chaired two Community Health Councils and has spent the last 10 years as Investigation Manager examining serious failings in a number of NHS facilities including Stoke Mandeville, Maidstone & Tunbridge Wells, as well as Mid Staffordshire.
New book from Ulster Historical Foundation

A Directory of Ulster Doctors (who qualified before 1901)

By R.S.J. Clarke

The north of Ireland has always produced a large number of doctors, not only for Ireland generally, but for the armed forces and for the wider world. This volume is a directory of all those doctors who qualified before 1901.

There are nearly six thousand names with biographical notes on all, including details of parentage and dates of birth, marriage and death, and medical education and career.

This directory is therefore of special value to anyone studying medical or local history and also for many genealogists tracing Ulster families. The information is derived from a wide variety of sources, published and unpublished, set in the context of the development of the medical profession over several centuries.

In its final stages the directory has received generous support from the Ulster Medical Society and an enthusiastic introduction from Sir Peter Froggatt, former Vice-Chancellor, Queen's University Belfast.

ABOUT THE AUTHOR: Richard Clarke is emeritus professor of anaesthetics at Queen's University and on retirement took on the role of honorary archivist of the Royal Victoria Hospital, Belfast. He has been able to use his experience in writing A History of the Royal Victoria Hospital as a basis for further research on doctors throughout the province. This is in addition to forty years of work on gravestones in Down, Antrim and Belfast, published by the Ulster Historical Foundation, and a lifetime of work on family history.

P&P COSTS: This is a substantial publication running to some 1,344 pages in 2 hardback volumes, the combined weight is approx. 2.9 KGs. P&P costs have been kept as economical as possible.

FORMAT: Hardback in 2 volumes (with illustrations) ISBN: 978-1-909556-02-7 (for 2 volume set)
EXTENT: 1,344pp (approx.) SIZE: 242mm x 156mm DUE: OCTOBER 2013 PRICE: £50 (per set) PLUS P&P

P&P Costs: £7.75 (UK) £16.50/€19.45 (Europe) £20.60/$31.85 Rest of the World

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Order books direct at www.booksireland.org.uk
Dates for your Diary

Joint Divisional Meeting
The next joint divisional meeting will be held on Tuesday 1 April at 7:15pm in The Dunsilly Hotel, Antrim (a fork buffet will be available from 6:30pm).

The guest speaker will be Dr Mark Porter, Chair of UK Council.

Please confirm your attendance by email to amclay@bma.org.uk indicating whether or not you wish to avail of the buffet beforehand and specifying any dietary requirements you may have.

http://bma.org.uk/events/2014/april/bma-northern-ireland-joint-divisional-meeting

Need Help with your Job Plan?
BMA(NI) is providing workshops for Staff/Associate Specialist/Specialty Doctors.

Staff/Associate Specialists
Monday 24 March 2014

Specialty Doctors
The workshop will commence at 6.00pm, concluding at 8.30pm and will be held in BMA(NI) premises. The workshops are provided free of charge to BMA members and £100 (+VAT) for non-members.

2 category 1 CPD credits have been granted

Register to attend by email to: hcassell@bma.org.uk

‘What’s A Doctor Worth? – Deliberative Event
BMA(NI) is hosting this innovative event on Wednesday, 30 April 2014, in The Dunadry Hotel, Templepatrick. Commencing with lunch at 1.00pm, this is your opportunity to get your views heard on the possible changes to employment contracts for consultants and junior doctors.

Register to attend at http://bma.org.uk/events/2014/april/whats-a-doctor-worth-belfast

2nd Year Revision Day – Preparation for ‘Exit’ Exam
BMA(NI) is hosting a ‘revision day’ on Saturday 10 May, 9.00am – 5.30pm in LT1, Medical Biology Centre.

Brought to you by QUB medicine final year students and covering core topics relevant for exam preparation – integrating pre-clinical medicine in a single day! The event is for BMA members only. If you’re not currently a BMA member, please email acampbell@bma.org.uk to request an application form (please ensure you include your mailing address) or join online at http://bma.org.uk/membership/join-us

Members – register to attend by email to hcassell@bma.org.uk – further details will be emailed directly to those registered to attend.

http://bma.org.uk/events/2014/may/2nd-year-medical-students-revision-day-belfast

Make Change Better

BMA Briefing

http://bma.org.uk/events/2014/april/whats-a-doctor-worth-belfast

http://bma.org.uk/membership/join-us

http://bma.org.uk/events/2014/may/2nd-year-medical-students-revision-day-belfast