BRITISH MEDICAL ASSOCIATION 2012

ARM

AGENDA

ANNUAL REPRESENTATIVE MEETING
MONDAY 25 – THURSDAY 28 JUNE 2012
BOURNEMOUTH INTERNATIONAL CENTRE

BMA 2012 BOURNEMOUTH
Annual Representative Meeting

BMA

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2012

British Medical Association

AGENDA
of
ANNUAL REPRESENTATIVE MEETING

TO BE HELD AT

Bournemouth International Centre

FROM

MONDAY, 25 JUNE 2012

UNTIL

THURSDAY, 28 June 2012

Chairman: Dr Steve Hajioff

INDUCTION SESSION

A teach-in session for all members will be held before the commencement of the official part of the meeting in the main auditorium from 8.45am until 9.15am.

INTRODUCTIONS **Monday 09.30 – 10.00**

1 **Receive**: Introductions and welcome to the meeting from the Chairman of The Representative Body.

STANDING ORDERS

2 **Motion** by THE CHAIRMAN: That the Standing Orders (Appendix 1), be adopted as the Standing Orders of the Meeting.

PRECINCTS OF THE MEETING

3 **Motion** by THE CHAIRMAN: That for the purpose of Standing Order 76 the precincts of the Meeting be regarded as the whole Bournemouth International Centre.

RETURN OF REPRESENTATIVES

4 **Motion** by THE CHAIRMAN: That the return of election of Representatives for 2011-12 and members of Council (ARM 3 and 4) is received.

APOLOGIES FOR ABSENCE

5 **Motion** by THE CHAIRMAN: That apologies for absence from (a) Representatives and (b) Members of Council be received, taken as read, and entered on the Minutes.

ELECTIONS

6 **Motion** by THE CHAIRMAN: That the timetable for elections to be carried out during the meeting, as set out in ARM 5, be approved.

REPORTS OF BRANCH OF PRACTICE COMMITTEES

7 **Receive**: The following reports are available on the web:-Reports of the General Practitioners Committee, the Consultants Committee, the Junior Doctors Committee, the Medical Academic Staff Committee, the Medical Students Committee, the Public Health Medicine Committee and the Staff, Associate Specialists and Specialty Doctors Committee for the session 2011-12.

MINUTES

8 **Confirm**: Minutes of the Annual Representative Meeting held on 27 June to 30 June 2011 (ARM 12, 2011).

REPORT OF THE AGENDA COMMITTEE

9 **Receive**: Report that the Committee has arranged in groups certain motions and amendments which cover substantially the same ground and has selected in each group one motion or amendment (marked with a star) on which it is proposed that discussion should take place. Items prefixed "P" and "C" will be dealt with in accordance with Standing Orders 36 and 40. Motions or amendments prefixed "A" or "AR" will be dealt with in accordance with Standing Orders 38 and 39.

10 **Receive**: Report that in accordance with Standing Order 37, a ballot of Representatives will be held on the first morning of the ARM to enable them to choose motions, amendments or riders which should be given priority ("C" motions). A ballot paper has been circulated with the documents for the Meeting which should be returned to the enquiry desk in the arena by 12 noon on Monday 25 June 2012.

11 **Motion** by THE AGENDA COMMITTEE: That the business be taken in the order and at the times indicated below:-

Monday AM
09:30 Introductions and preliminary business (items 1- 15)
10:00 Report by Chairman of Council (item 16)
10:20 National Health Service (items 17 - 66)
10:50 NHS Organisation and Commissioning (items 67 - 101)
11:30 Health and Social Care Act (items 102 - 119)
12:30 Contingency time
12:35 Wales (items 120 - 128)
12:50 The NHS in Wales (items 129 - 133)
13:00 Session closes

Monday PM
14:00 Training and Education (items 134 - 160)
14:40 Staff, Associate Specialists and Specialty Doctors (items 161 - 168)
15:05 Medical Students (items 169 - 184)
15:40 General Practice (items 185 - 213)
16:15 Consultants (items 214 - 229)
17:00 Junior Doctors (items 230 - 233)
17:25 Contingency time
17:30 Q&A Chairman of Council
17:45 Session closes

Tuesday AM
09:15 Medical Academic Staff (items 234 - 239)
09:40 Public Health Medicine (items 240 -246)
10:00 Science, Health and Society (items 247 - 277)
11:05 Alcohol, tobacco and other dangerous drugs (items 278 - 284)
11:25 Workforce (items 285 - 319)
12:15 Contingency time
12:20 Annual General Meeting
12:25 Charities (item 320)
12:30 Q&A Branch of practice
12:45 Session closes

Wednesday AM
09:30 Scotland (items 321 - 322)
09:45 Northern Ireland (items 323 - 325)
10:00 Medical Ethics (items 326 - 348)
11:35 Contingency time
11:40 International Affairs (items 349 - 355)
12:05 British Medical Journal (items 356 - 359)
12:20 Medico-Legal Affairs (items 360 - 364)
12:35 Session closes
12:35 Ethical Procurement Video

Wednesday PM
14:00 Finances of the Association (items 365 - 369)
14:25 BMA Structure and Function (items 370 - 424)
15:25 Professional Regulation and the GMC (items 425 - 445)
16:05 Contingency time
16:10 Doctors' Pay and Contracts (items 446 - 452)
16:30 Health Information Management and IT (items 453 - 462)
16:40 Forensic Medicine (items 463 - 467)
16:45 Armed Forces (items 468 - 472)
17:00 Professional Fees (items 473 - 475)
17:05 Private Practice (items 476 - 478)
17:30 Q&A Treasurer
17:45 Session closes

Thursday AM
09:30 Occupational Medicine (items 479 - 482)
09:45 Civil and Public Service Committee (item 483)

09:50 Community Care and Mental Health (items 484 - 499)
10:25 Pensions (items 500 - 526)
11:00 Chosen Motions
11:35 Contingency time
11:40 Motions Arising from ARM
12:40 Approval of the Annual Report of Council and provisional approval of the Minutes (items 527 - 528)
13:00 ARM Closes

PRESIDENT 2013-14

12 **Motion** by THE CHAIRMAN OF COUNCIL: That Professor Sir Sabaratnam Arulkumaran be elected President of the Association for 2013-14.

BYE-LAWS

13 **Motion** by THE CHAIRMAN OF THE ORGANISATION COMMITTEE: That, subject to any amendments arising out of the decisions of the meeting, the bye-laws of the Association be amended in the manner shown in Appendix II to this agenda.

BMA POLICY

14 **Motion** by THE CHAIRMAN OF COUNCIL: That this Meeting approves the recommendations for policy passed in 2006-2007 to be lapsed as indicated on document ARM 10.

'A' MOTIONS

15 **Confirm**: That the 'A' motions be approved and pass into the policy book.

REPORT BY THE CHAIRMAN OF COUNCIL **Monday 10.00 – 10.20**

16 **Receive**: Report by the Chairman of Council, Hamish Meldrum.

NATIONAL HEALTH SERVICE **Monday 10.20 – 10.50**

* 17 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE BRISTOL DIVISION): That this Meeting is opposed to the £20 billion "savings" being cut from NHS resources and:-
i) deplores the fact that the government have reneged on a commitment to increase the NHS budget in real terms;
ii) believes that these "savings" will only be achieved by cutting and rationing services;
iii) believes that Clinical Commissioning Groups will be forced to become the primary agents for this programme;
iv) insists that the Department of Health show transparency in how such "savings" are being re-invested in the NHS.

17a **Motion** by BRISTOL DIVISION: That this Meeting accuses this government of reneging on its commitment to increase the NHS budget in real terms by forcing through £20 billion of efficiency savings without any mechanism to reinvest them. Efficiency savings which are not reinvested are cuts.

17b **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting is opposed to the £20bn Quality, Innovation, Productivity and Prevention (QIPP) cuts which are designed to recycle funding into the new market structures and private sector contracts. This Meeting calls on BMA Council to change its press statements such that the £20bn QIPP savings are officially opposed by the BMA.

17c **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting regrets that the £20 billion Nicholson 'savings' throughout the English NHS are crude instruments of change, allowing reallocation by political whim which creates two funding streams, actual financial chaos and calls on the DH to account for these monies publically.

17d **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting demands that the government spells out how it is going to increase the budget of the NHS in real terms as they promised given that it is presently cutting it by 20 billion pounds in actual terms.

17e **Motion** by CONSULTANTS CONFERENCE: That this Meeting regrets that the £20 billion Nicholson savings

reallocation into healthcare through the NHS are not declared, searchable, or open to informed debate, and calls on the Department of Health to account for these monies publically.

17f **Motion** by BRISTOL DIVISION: That this Meeting demands that the Secretary of State for Health publishes plans to explain how the £20 billion presently being extracted from NHS budgets will be reinvested so as not to break the coalition's promise to increase the NHS budget in real terms.

17g **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting with reference to draconian NHS savings plans:-
i) views with caution the drive to save £20Bn of NHS resources;
ii) believes that such drastic savings can only be achieved by cutting and rationing services;
iii) believes that Clinical Commissioning Groups (CCGs) will be forced to become the primary agents of this policy;
iv) cautions that CCGs are therefore being set up to fail.

17h **Motion** by NORTH & MID STAFFORDSHIRE DIVISION: That this Meeting deplores the semantic dishonesty that underlies the Department of Health's instruction that the term CIP should be replaced by the term QIPP. Both terms describe funding cuts and at least CIP – with C standing for Cost – hints at this. This Meeting directs Council to advocate the use of plain English.

* 18 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE EALING DIVISION): That this Meeting believes that with the current programme of cuts, redundancies and enforced reconfiguration of clinical services:-
i) there will be adverse effects on the delivery of high quality care to patients;
ii) there are risks to the provision of essential services in some geographic areas;
iii) there are threats to the future of some departments;
iv) there is the risk of hospital closures;
v) the BMA must oppose these changes when they are imposed purely for financial reasons;
vi) all alternative options must be reviewed before considering staff cuts.

18a **Motion** by EALING DIVISION: That this Meeting is extremely disturbed by the consequences of the reconfiguration of the clinical services presently taking place in West London, particularly in Ealing Hospital, where numerous long term cancer patients have received letters telling them to be referred to other hospitals against their express wishes, thus limiting their choice, destroying the continuity and hence reducing the quality of their care. These actions are taken without the agreement of their consultants who are completely sidelined and are not given the option to relocate with their patients. We call on the BMA to take any action deemed necessary to oppose these measures and to defend the basic principle of consultant clinical responsibility.

18b **Motion** by REDBRIDGE & STRATFORD DIVISION: That this Meeting believes that closure of A&E and maternity units in Hospitals will result in:-
i) loss of essential services in some areas;
ii) puts enormous stress on neighbouring hospitals an eventually their failure to provide efficient service;
iii) leads to escalation of demand in primary care services.

18c **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting considers that the continual reduction in hospital beds is detrimental to patient care. It does not recognise the clinical complexity of patients presenting acutely at hospitals and asks the BMA to ensure the recognition of the importance of services for emergencies and unscheduled care.

18d **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that a standard ploy to close down District General Hospitals is to remove their A&E and maternity departments first.
Such was the five year intention at Chase Farm Hospital, which has been resisted by a community campaign, culminating in a daily picket and the plan to occupy these departments upon closure. This Meeting supports the Chase Farm struggle and proposals to occupy hospitals or departments threatened with closure, to keep them running.

18e **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that because of the £20bn QIPP cuts to funding, 12 to 16 of London's acute DGHs have been projected as "financially unviable" (NHS London's McKinsey Safe report).

18f **Motion** by BRISTOL DIVISION: That this Meeting believes that, given the chaos induced by radical top down reorganisation imposed on the NHS at the same time as extracting £20 billion of efficiency savings whilst pressing on with market competitive tendering of services, that the NHS is not safe in this government's hands.

18g **Motion** by KENT LMC: That this Meeting demands that the government and CCGs be open and transparent and acknowledge that the only way to balance the budget is to close hospitals.

18h **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting cannot agree to the proposed destruction of hospital care in the capital and nationwide and calls on BMA Council to ballot members for strike action to save jobs and keep hospitals open as fully functioning district general hospitals.

18i **Motion** by SASC CONFERENCE AGENDA COMMITTEE: That this Meeting believes that NHS employers could be compromising the delivery of quality healthcare by reconfiguration of services in the short-sighted attempt to achieve significant savings. We believe that NHS employers must explore the full range of alternative options to achieve these savings before considering redundancies and where redundancies are unavoidable, employers must have robust corporate governance arrangements to transparently demonstrate the probity, consistency, efficiencies and value for money of any proposed redundancies in the interests of the service. These must take account of equality legislation and be in line with the required standards in the public sector, to avoid involvement of the Audit Commission, Counter Fraud Service or the judicial system. This Meeting exhorts the BMA to ensure that these are the minimum acceptable standards for progressing any redundancy proposals.

18j **Motion** by WELSH JDC: That this Meeting wishes to note its disgust at the recent report showing that over 3000 nurses have lost their jobs over the past year in the NHS and calls on the government to take immediate action to halt any further reduction in nursing numbers or admit it is willing to jeopardise patient care in order to balance budgets.

18k **Motion** by ROCHDALE DIVISION: That this Meeting deplores the decision to make doctors redundant as a result of reconfiguration and or decommissioning of services.

18l **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that 50,000 NHS jobs are lost or threatened by the £20bn McKinsey QIPP cuts. This Meeting calls on the BMA:-
i) to explode the myth that these cuts are essential and to inform that they were drawn up by McKinseys to transfer funds out of frontline NHS and into the market;
ii) to organise a publicity campaign against these cuts and the loss of staff and closures which ensue;
iii) to ballot for industrial action where members' jobs are threatened by closures due to these cuts;
iv) to join forces with other NHS staff in other unions to take industrial action to protect jobs and services.

* 19 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting believes that if "low priority treatments" and "referral thresholds" are truly evidenced based as claimed by PCOs then:-
i) all should be implemented nationally;
ii) local "low priority treatments" should then be correctly described as rationing;
iii) the BMA should campaign to ensure that there is a national list of treatments that the National Health Service should provide.

19a **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting believes that so called 'Low Priority Procedures' are an unethical form of rationing of healthcare except where there is a clear evidence base for such a classification, and insists that any such rationing decisions must be made on strict clinical grounds and not motivated by cost savings.

19b **Motion** by EAST DORSET DIVISION: That this Meeting urges the government to be honest with the electorate and take responsibility for NHS budget cuts and not pass the blame to trusts and doctors.

The motion(s) below, in the shaded area, are unlikely to be reached

* 20 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE NORTH EAST REGIONAL COUNCIL): That this Meeting believes:-
i) that the experiment of the internal market has not only engendered great expenditure but has also been at the cost of maintaining meaningful clinical engagement in the management and development of the NHS;
ii) that in most cases the necessary expertise for clinical and financial efficiency is already in the NHS;
iii) that Council must now adopt a policy of promoting collaborative models of NHS service development in all parts of the UK, where service improvement is led by health care professionals;
iv) that all tenders for, and implementation of, contracts with advisors or management consultants from outwith the NHS family be transparent and open to public scrutiny.

20a **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting believes:-
i) that the 20 years experiment in England of an NHS internal market has failed to demonstrate any

significant benefit;
ii) that the experiment of the internal market has not only engendered great expenditure but has also been at the cost of maintaining meaningful clinical engagement in the management and development of the NHS;
iii) Council must now adopt a policy of promoting collaborative models of NHS service development in all parts of the UK, where service improvement is led by health care professionals.

20b **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting:-
i) believes that the Nicholson challenge is best addressed by managers and clinicians working together;
ii) believes that in most cases the necessary expertise for clinical and financial efficiency is already in the NHS;
iii) demands that all tenders for, and contracts with, advisors or management consultants from outwith the NHS family be transparent and open to public scrutiny.

20c **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting:-
i) believes that the Nicholson challenge is best addressed by managers and clinicians working together;
ii) believes that in most cases the necessary expertise for clinical and financial efficiency is already in the NHS;
iii) demands that all tenders for, and contracts with, advisors or management consultants from outwith the NHS family be transparent and open to public scrutiny.

20d **Motion** by EASTERN REGIONAL COUNCIL: That this Meeting strongly supports the policy that NHS departments should be managed by NHS organisations, not private companies, and if private companies are allowed to take over NHS departments, the take-over should be audited by the NHS and every aspect of the success or failure of the hand-over should be made public to avoid repetition of problems e.g. failure of transfer of patients' computer records, which are dangerous to patients.

20e **Motion** by CORNWALL AND ISLES OF SCILLY LMC: That this Meeting believes that the NHS legal duty of candour requirement is routinely being ignored when the matter of any qualified provider is under discussion.

20f **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting supports the consensus behind integrated social and health care and:-
i) is alarmed by examples where tendering of services are reversing integrated health and social care;
ii) fears that the expected escalation of tendering will rapidly damage existing examples of such integration;
iii) calls on UK governments to protect integration in any marketisation of health care.

21 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting believes that rigidly splitting the NHS into primary and secondary care is:-
i) incongruent with the government's ostensible wish for "integration" in the NHS;
ii) illogical and outdated;
iii) fragments and duplicates care for patients, and increases transaction costs;
iv) divides doctors across the primary-secondary care interface;
v) results in perverse incentives and behaviour to the detriment of patients;
and this Meeting calls for a meaningful integrated approach to health care planning and delivery in the NHS.

22 **Motion** by CITY & HACKNEY DIVISION: That this Meeting has no confidence in Andrew Lansley, the Secretary of State for Health, and calls for him to resign.

23 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting does not believe that the NHS is safe in the hands of this government.

24 **Motion** by LAMBETH & SOUTHWARK DIVISION: That this Meeting calls upon the National Audit Office to present an annual report to Parliament containing a list of all the private companies which have received public funding for providing clinical care during the previous financial year, and the amounts paid.

25 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that private company Circle has been given £1bn contract to run Hinchingbrooke DGH, for 10 years, make a profit and cut the deficit. This Meeting believes that the lifting of the private patient bed cap to 49% has facilitated this aim, and will encourage a spate of private company take-overs of NHS hospitals. We call on BMA Council to:-
i) publicly campaign to stop private companies taking over NHS hospitals;
ii) to campaign against the 49% pp bed cap.

26 **Motion** by CONSULTANTS CONFERENCE: That this Meeting has no confidence in the Secretary of State for Health.

27 **Motion** by CONFERENCE OF LMCS AGENDA COMMITTEE: That this Meeting deplores the political arrogance towards the medical profession illustrated by, and calls for the resignation of:-
i) the Prime Minister;
ii) the Secretary of State for Health.

28 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting has no confidence in the Secretary of State for Health to prevent the progressive break up, fragmentation and privatisation of the NHS.

29 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting recognises that regular review of serious adverse incidents, patient morbidity and mortality is central to quality improvement, is dismayed at reports that such activities are being cancelled to meet short term capacity targets, and demands that Trust Medical Directors be held accountable for such failings in Clinical Governance.

30 **Motion** by LOTHIAN DIVISION: That this Meeting calls on the health departments to make the Royal College of Radiologists referral guidelines, iRefer, available free of charge throughout the NHS.

31 **Motion** by HULL AND EAST YORKSHIRE: That this Meeting , with regard to the British National Formulary:-
i) believes it is an invaluable tool for health professionals and congratulates the Joint Formulary Committee on its relevance, ease of use, accuracy, and impartiality;
ii) calls for its rapid integration into clinical IT systems;
iii) believes that it must remain a comprehensive formulary and continue to list those drugs which are less suitable for prescribing but which are nevertheless prescribable.

32 **Motion** by RETIRED MEMBERS FORUM: That this Meeting views with dismay evidence that staff in hospitals are required to deceive patients about the length of operating waiting lists to satisfy management targets and demands that the BMA asks the DH take action to prevent its occurrence.

33 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the leaders of the medical profession have failed the NHS.

34 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting deplores the dismantling of integrated patient care with supporting governance structures which may be well provided in District General Hospitals, backed up by Regional Specialist Facilities, and insists that any shift of care to the community must be based on clear evidence and not dogma.

35 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting believes that government is failing in its constitutional duty to patients given the increase in patients waiting more than 18 weeks from referral to treatment, and calls upon it to ensure that the NHS is focussed on providing safe timely care to patients rather than being diverted in politically driven structural reform.

36 **Motion** by WORCESTERSHIRE LMC: That this Meeting demands that the NHS choices website be shut down as it is unfit for purpose and is currently a waste of scarce NHS resources.

37 **Motion** by BRISTOL DIVISION: That this Meeting is concerned about the waste of prescribed medication and requests the Department of Health to take steps to ensure that pharmacies automatically add the cost of medicines to patient medicine labels and receipts.

38 **Motion** by WEST GLAMORGAN DIVISION: That this Meeting, whilst supporting the principle of patients being treated nearer to home, believes that this should not compromise the quality of patient care.

39 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting recognises the blunt instrument of disordered change is being applied as a top down revolution in the English NHS as an experiment without regard for expressed opinion and advice that this is a high risk for the NHS and each voter's health care.

40 **Motion** by CLWYD NORTH DIVISION: That this Meeting calls upon the government not to break up the NHS.

41 **Motion** by GLOUCESTERSHIRE DIVISION: That this Meeting calls upon the BMA to oppose any government policy or contract change as a matter of principle, unless or until there is proper evidence of clinical benefits for patients and improved cost effectiveness.

42 **Motion** by WELSH COUNCIL: That this Meeting considers that continuation of methylphenidate and similar treatments in some individuals into adulthood is appropriate even when they are beyond the "licenced" age, and urges Health Boards and PCT's to ensure that there is a robust mechanism for shared care of treatment between Primary and Secondary care.

43 **Motion** by OXFORD DIVISION: That this Meeting notes that the current NHS Funding Formula creates differences of more than 40% in the per capita funding available for different SHAs in England, but that the costs of commissioning secondary care in England are now largely fixed by national PBR tariffs.
This Meeting calls on the BMA to:-
i) publicise the fact that the existing NHS Funding Formula is now outdated, unfair, and no longer fit for purpose;
ii) insist that the government replaces the current NHS Funding Formula with a fairer system;
iii) proposes a system with a minimum basic level of healthcare funding per capita, which is set at a level close to that of the current average level of funding in England, and is "topped up" with tailored funding support for populations that demonstrate a need for additional healthcare resources.

44 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting notes that the current NHS Funding Formula creates differences of more than 40% in the per capita funding available for different SHAs in England, but that the costs of commissioning secondary care in England are now largely fixed by national PBR tariffs. We therefore call on the BMA to:-
i) publicise the fact that the existing NHS Funding Formula is now outdated, unfair, and no longer fit for purpose;
ii) insist that the government replaces the current NHS Funding Formula with a fairer system;
iii) proposes a system with a Minimum Basic Level of Healthcare Funding per capita, which is set at a level close to that of the current average level of funding in England, and is "topped up" with tailored funding support for populations that demonstrate a need for additional healthcare resources.

45 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting notes that the current NHS Funding Formula creates differences of more than 40% in per capita funding available for different SHA's in England, but that the costs of commissioning secondary care in England are now largely fixed by national PBR tariffs.
This Meeting therefore calls on the BMA to:-
i) publicise the fact that the existing NHS Funding Formula is now outdated, unfair, and no longer fit for purpose;
ii) insist that the government replaces the current NHS Funding Formula with a fairer system;
iii) proposes a system with a Minimum Basic Level of Healthcare Funding per capita, which is set at a level close to that of the current average level of funding in England, which may be 'topped-up' with special funding support for a defined period of time for specific populations that demonstrate a need for additional healthcare resources.

46 **Motion** by OXFORD DIVISION: That this Meeting demands that the Department of Health urgently increases the payment by results tariffs for treating patients with complex problems including complex trauma patients so that the costs of care are adequately reimbursed.

47 **Motion** by CONSULTANTS CONFERENCE: That this Meeting believes that the NHS should set an example on transparency in 'boardroom pay' by requiring NHS organisations to annually publish the salary of each Trust Board executive as a single comprehensible figure.

48 **Motion** by GLOUCESTERSHIRE DIVISION: That this Meeting deplores the neglect of successive governments in failing to direct public funding towards core aspects of the NHS in the form of new hospital buildings and services.

49 **Motion** by WEST MIDLANDS RCSC: That this Meeting supports decisions to close Emergency Departments out of hours when that is in the best interests of patient safety, as has occurred in Mid-Staffordshire NHS Foundation Trust and in other trusts in similar circumstances.

50 **Motion** by CITY & HACKNEY DIVISION: That this Meeting deplores the costs-led rationalisation of NHS pathology services following the publication of Lord Carter's reports on Pathology Modernisation (2006, 2008). In recent years, several NHS laboratories have closed or been downgraded. These reforms have led to increased private-sector involvement in NHS pathology services. This Meeting calls on the BMA to lobby the government to immediately halt any further NHS pathology rationalisations, Public Private Partnerships or joint ventures with the private sector in

pathology so that the benefits and/or harms of these changes can be assessed by an independent body.

A 51 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting calls on the BMA to publicly campaign against the constant incentives of government to reduce GP referrals to hospital, in order to save money. GPs must have the freedom to refer patients to a consultant, in the patients' best clinical interest.

A 52 **Motion** by OXFORD DIVISION: That this Meeting reaffirms its view that in the re-organised NHS, GP to consultant referrals should reinstate the right to refer patients to named consultants.

A 53 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting believes that it is vital for general practitioners to be able to freely and without interference refer patients directly to a named consultant for a specialist opinion in order to achieve a high standard of medical care and to maintain the trust of patients.

A 54 **Motion** by WALTHAM FOREST DIVISION: That this Meeting notes the increased number of drugs unavailable in the UK as companies seek better prices elsewhere, and demands that government address this issue instantly.

A 55 **Motion** by LOTHIAN DIVISION: That this Meeting believes the term "bed blocker" should no longer be used as:-
i) it implies that patients are to blame for any shortage of hospital beds;
ii) it implies that patients are less important than hospital beds.

A 56 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting does not accept that doctors should be held responsible for rationing healthcare, and insists that rationing must always be the ultimate responsibility of the government, who are directly answerable to the public who elected them.

A 57 **Motion** by GLOUCESTERSHIRE DIVISION: That this Meeting deplores the heavy expenditure by successive governments on repeated reorganisation of the NHS.

A 58 **Motion** by CORNWALL AND ISLES OF SCILLY LMC: That this Meeting notes the plethora of ex ministers in the pay of private health organisations, pharmaceutical companies and dispensing chemists and insists the government ensures that 'insider' knowledge and contacts do not influence Department of Health decisions.

A 59 **Motion** by SALFORD AND TRAFFORD LMC: That this Meeting believes that increasing competition in a market that cannot expand can be short sighted and potentially more expensive in the long run.

A 60 **Motion** by ROCHDALE AND BURY LMC: That this Meeting recognises that the private sector cherry picking local services will compromise the future viability of local hospital trusts.

A 61 **Motion** by CLWYD NORTH DIVISION: That this Meeting reminds Health Boards and trusts that withdrawal of trainees by Deaneries does not mean automatic closure of services and that there are many opportunities for providing enhanced services run by consultants and experienced SAS doctors.

A 62 **Motion** by WALTHAM FOREST DIVISION: That this Meeting demands that future local health delivery is not so entangled with preference for provision by private companies that there is a risk of high administrative costs, shareholder supremacy and as a result reduced resources for local care.

A 63 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting insists that the provision of private care in Foundation Trusts must not be at the expense of NHS care to patients and requires that trusts explicitly and publically demonstrate that the running of private services will be resourced from additionality in terms of staffing and infrastructure.

A 64 **Motion** by SALFORD AND TRAFFORD LMC: That this Meeting believes that new arrangements that allow NHS hospitals to increase their private patient ratio to as much as 49% will compromise NHS patient care, and is to be deplored.

A 65 **Motion** by ROCHDALE AND BURY LMC: That this Meeting believes that removing the activity cap on foundation trust performing private work will compromise access to local NHS services.

A 66 **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting is concerned that up to 49% of Foundation Trust income will be allowed to come from private work and demands:-
i) increasing private work does not interfere with the primary duty of providing NHS care;

ii) robust safeguards put in place must be adhered to and audited with results made public;
iii) a two-tier health service is not created with those with the ability to pay enabled to go to the front of the queue.

NHS Organisation and Commissioning **Monday 10.50 – 11.30**

* 67 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE EDGWARE AND HENDON DIVISION): That this Meeting believes that in respect of commissioning and tendering for services, the following principles must apply:-
i) quality should be at the heart of all NHS contracts;
ii) contracts should include meaningful financial penalties for failure to achieve sustained quality improvement;
iii) providers must have long term and binding insurance / indemnity cover for the full costs of all potential complications, deficiencies or mishaps arising from services they provide;
iv) before transfer of services to primary care, commissioners should ensure that the necessary infrastructure, governance, capacity and resources are in place;
v) imposed conditions of commercial confidentiality are unacceptable;
vi) local NHS organisations should be regarded as preferred providers and alternative providers should only be sought if local organisations are unable or unwilling to improve services to the required standard;
vii) an impact assessment on local NHS services must be considered as part of any decision to tender for alternative providers;
viii) "cherry picking" must be prohibited.

67a **Motion** by EDGWARE & HENDON DIVISION: That this Meeting believes that in the light of the government's support for "integration" in the NHS, and the right of clinical commissioning groups (CCGs) to choose to use competition only if it benefits patients:-
i) CCGs should support local NHS services as preferred providers;
ii) CCGs should only consider alternative providers after establishing that local NHS services are unwilling or unable to improve services to requisite standards;
iii) the decision to tender for alternative provides must consider an impact analysis on local NHS services, and prohibit cherry picking;
iv) CCGs should choose to replace Payment by Results with funding arrangements that support integration.

67b **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting believes that quality should be at the heart of all NHS contracts and calls on commissioners to:-
i) ensure that the quality contract is fit for purpose;
ii) is constructed in such a way to encourage meaningful and sustainable quality improvement;
iii) has meaningful financial penalties for failure to achieve sustained quality improvement.

67c **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting believes it is unacceptable for medical services to be commissioned for NHS patients from any provider that does not have long-term and binding insurance/indemnity cover for the full costs of all potential medical complications, deficiencies in care or medical mishaps which may arise from diagnostics or treatments provided by them. It is not acceptable for such providers to cease trading or go into liquidation leaving the NHS to cover the costs of any deficiencies in care given by these organisations.

67d **Motion** by OXFORD DIVISION: That this Meeting believes it is unacceptable for medical services to be commissioned for NHS patients from any provider that does not have long-term and binding insurance/indemnity cover for the full costs of all potential medical complications, deficiencies in care or medical mishaps which may arise from diagnostics or treatments provided by them. It is also not acceptable for such providers to cease trading or go into liquidation leaving the NHS to cover the costs of any deficiencies in care given by these organisations.

67e **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting believes that it is unacceptable for medical services to be commissioned for NHS patients from any provider that does not have long-term and binding insurance/indemnity cover for the full costs of all potential medical complications, deficiencies in care or medical mishaps which may arise from diagnostics or treatments provided by them.

67f **Motion** by CONSULTANTS CONFERENCE: That this Meeting believes it is unacceptable for medical services to be commissioned for NHS patients from any provider that does not have long-term and binding insurance/indemnity cover for the full costs of all potential medical complications, deficiencies in care or medical mishaps which may arise from diagnostics or treatments provided by them.

67g **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting is concerned that shift of patient care into the community may put excessive burdens on GP practices resulting in fragmented and sub-standard care if it is not carefully managed. This Meeting therefore advises commissioners to:-
i) fully evaluate the evidence base for decisions to move care to the community and base their decisions on quality and not cost;

ii) ensure that appropriate audit and governance structures are in place;
iii) ensure facilities, and appropriately trained staff are available;
iv) ensure proper liaison with secondary care to facilitate easy transfer of patients if hospital care becomes necessary;
v) ensure proper resourcing of primary care prior to any transfer of secondary care work.

67h **Motion** by RETIRED MEMBERS FORUM: That this Meeting remembers that, despite the passing of the Health and Social Care Bill, that BMA policy is still opposition to the Bill and retired members will need NHS services for the rest of their lives and therefore calls for the BMA:-
i) to support GPs in Clinical Commissioning Groups;
ii) to take no action or adopt any policy which would undermine patients continued access to the existing health services which they now need;
iii) to ensure that GPs when commissioning must reserve the right to decide whom they commission to provide services for their patients and refuse any imposition of 'Any Qualified Provider' (AQP);
iv) not to agree to any contract which impose 'commercial confidentiality' and will present such contracts to regular public meetings for review and consultation.

67i **Motion** by LIVERPOOL LMC: That this Meeting believes that despite the changes to the Health and Social Care Act, there will be unforeseen consequences to provision of care by allowing any qualified provider to cherry pick services, taking resources from NHS services which provide the whole spectrum of care.

* 68 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE ISLINGTON DIVISION): That this Meeting, in respect of clinical commissioning support services (CSS), believes:-
i) that the outsourcing of CSS should be halted until there is transparency about how the CSS will prioritise patient services and promote collaboration;
ii) that safeguards are needed to protect patients from vested interests;
iii) that CSS should be selected by commissioners without external pressure;
iv) that CSS should not be forced to become non-NHS organisations;
v) that commissioners should not be forced to outsource commissioning support to private companies.

68a **Motion** by ISLINGTON DIVISION: That this Meeting urges the BMA to campaign for the government to halt any outsourcing for commissioning support from private companies until there is complete transparency in how patient services will be prioritised, and how collaboration across services will be promoted in order to protect CCGs and patients from inappropriate advice and vested interests.

68b **Motion** by CONFERENCE OF LMCS AGENDA COMMITTEE: That this Meeting believes that commissioning support services should:-
i) be NHS led;
ii) not be sold to the private sector;
iii) be managed directly by CCGs working in cooperation with other CCGs;
iv) be retained in house by CCGs where possible;
v) always be chosen by CCGs and not influenced from above.

68c **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes that Clinical Commissioning Groups should:-
i) employ their own commissioning support or share it with other CCGs;
ii) not become dependent on commissioning support services external to the NHS.

68d **Motion** by BRISTOL DIVISION: That this Meeting is concerned that clinical commissioning groups are being pressured to prepare their commissioning support services for privatisation and ask the Secretary of State for Health to ensure that this pressure stops in line with his promise that it would not happen.

68e **Motion** by EDGWARE & HENDON DIVISION: That this Meeting vigorously opposes the government's proposals to force all NHS commissioning support services to become "free standing enterprises" by 2016, and believes that this will de facto lead to privatisation of commissioning in the NHS.

68f **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting is clear that commissioning in England is being privatised. "Commercial support organisations" such as corporations McKinseys, KPMG, and United Health, accountable to shareholders, would in effect control up to £80bn of NHS funds. The BMA is completely opposed to the privatisation of commissioning and favours the Scottish model with no commissioner provider split.

* 69 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE NORTH EAST REGIONAL COUNCIL) : That this Meeting believes that in respect of the proposals for performance management of Clinical Commissioning Groups (CCGs):-
i) the proposed financial rewards are potentially unethical and undermine the trust between patients, doctors and society;
ii) CCGs will be pressured to ration care;
iii) CCGs should adopt an ethical code of conduct which ensures transparency and the prioritisation of patient interests over performance targets;
iv) the proposals increase bureaucracy and limit effective commissioning;
v) the proposals should be opposed.

69a **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting in respect of the Health and Social Care Bill believes:-
i) it is a fundamental threat to the overriding duty of doctors to make the care of their patient their first concern;
ii) that GPs will be forced to ration care and deny the sick some aspects of the treatment they may need;
iii) that it risks losing the trust that the public and patients have in GPs.

69b **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting welcomes and supports the increased role for GPs in the NHS in England in service design but is concerned that:-
i) GPs' initial impressions of clinical commissioning have been changed by the reality the Health and Social Care Bill imposes on GPs;
ii) new layers of bureaucracy will limit freedom for clinical commissioners;
iii) the potential future increased role for private companies will control commissioning in many areas;
iv) elements of the Health and Social Care Bill have the potential to damage the doctor patient relationship.

69c **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting is extremely concerned about proposals to reward Clinical Commissioning Groups (CCGs) and their membership practices for achieving performance targets, some of which will be budgetary and believes that such payments:-
i) are potentially unethical;
ii) risk destroying the trust inherent in the doctor-patient relationship;
iii) will create an intolerable conflict of interest for all practices;
iv) and calls upon the government to abandon these proposals.

69d **Motion** by EDGWARE & HENDON DIVISION: That this Meeting supports all CCGs to adopt an ethical code of conduct, based upon:-
i) ensuring that commissioning policies are made in the best interests of patients and local communities;
ii) ensuring that the professionalism of doctors is supported, and that the trust between doctor and patient is not undermined;
iii) transparency and not engaging in any contracts or negotiations which impose conditions of commercial confidentiality;
iv) consulting local communities before implementing any significant changes that affect them, and the (CCG) Board making all major decisions relating to services in public session;
v) the ability to reject, challenge and speak out against any external pressure or polices that thwart or undermine its ability to procure safe, effective and equitable care to patients.

69e **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting believes:-
i) that the Health and Social Care Bill will result in Clinical Commissioning Groups providing fewer services for fewer people;
ii) that Clinical Commissioning Groups must inform GP practices and publicise to local patients when a service is removed or decommissioned from that area's NHS provision and where that service was previously free.

69f **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes the proposed quality reward payment to Clinical Commissioning Groups:-
i) could undermine the doctor patient/relationship;
ii) could widen health inequalities;
iii) should be opposed.

69g **Motion** by EDGWARE & HENDON DIVISION: That this Meeting rejects the government's proposal for a Quality Reward for CCGs on the basis that:-
i) it is not a reward but a withholding of resources to CCGs which needs to be earned back on achieving central performance indictors;
ii) will result in reduction of care and services to patients due to upfront withholding of resources;
iii) will impair the ability of CCGs to commission effectively due to inadequate management resources;
iv) will exacerbate inequalities in care geographically;
v) will result in CCGs being distracted in fulfilling a Quality Reward agenda due to the financial penalty of non achievement, rather than meeting the local needs of patients.

69h **Motion** by EDGWARE & HENDON DIVISION: That this Meeting rejects and vigorously opposes any financial rewards or incentives to GPs or Clinical Commissioning Groups for any crude reductions in costs or number of referrals to hospitals, and believes this to be unethical and with inevitable damage to patients' trust in the NHS.

69i **Motion** by EDGWARE & HENDON DIVISION: That this Meeting believes that the proposed Clinical Outcomes Framework (COF) to performance manage Clinical Commissioning Groups is a flawed and misguided approach that fails to recognise the inter-related roles of commissioners, providers, social care and government fiscal policy all impacting on the health outcomes of patients.

* 70 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting believes that the development of Clinical Commissioning Groups are not fit for purpose and is at odds with the governments intention for clinical led commissioning due to:-
i) inadequate and reduced management resources to effectively commission;
ii) excessive outsourcing of commissioning functions that will undermine local determination and equitable planning of healthcare;
iii) excessive central control via the NHS Commissioning Board;
iv) excessive bureaucracy of liaising with multiple bodes in commissioning decisions;
v) excessive and inappropriate central performance management such as via the commissioning outcomes framework;
vi) perverse incentives arising from the proposed Quality Reward.

70a **Motion** by MID-SURREY KINGSTON & ESHER DIVISION: That this Meeting is concerned that emerging Clinical Commissioning Groups endeavouring to reconfigure services optimally for patients may not yet have the organisational maturity to implement and to foresee the consequences of such changes.

The motion(s) below, in the shaded area, are unlikely to be reached

71 **Motion** by ISLINGTON DIVISION: That this Meeting calls on the BMA to support GPs in their role in CCGs by promoting the development of clear professional guidance with the Royal College of General Practitioners on how to manage conflicts of interests in CCGs when budgetary pressures such as cutting referrals risks putting cash savings above patients needs.

72 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting:- notes with concern the growing trend for commissioning organisations to insist on referrals being routed via referral management centres, and believes that:-
i) this threatens clinical and professional freedom;
ii) this erodes the professional relationship between primary and secondary care clinicians;
iii) the development of Clinical Commissioning Groups (CCGs) is likely to produce an increase in the scope and geographical coverage of such centres and;
iv) demands Commissioners including CCGs ensure that referral management centres protect clinical freedom by always allowing referral to a named consultant.

73 **Motion** by GREENWICH, BEXLEY & BROMLEY DIVISION: That this Meeting believes that diabetes should be excluded from GP Commissioning, so that NHS diabetes care can be directly funded, similar to UK transplant services, thereby protecting integrated specialist diabetes care and as such avoiding the risk of outsourcing diabetes care to private providers on the basis of lowest cost provider, resulting in complete fragmentation of care.

74 **Motion** by WALTHAM FOREST DIVISION: That this Meeting demands that, in the light of proposed local commissioning activities, the role of NICE in assessment of new drugs and technologies must no longer be downgraded but must be restored to its previous level.

75 **Motion** by WALTHAM FOREST LMC: That this Meeting demands that the role of NICE in assessment of new drugs and technologies must no longer be downgraded but must be restored to its previous level.

76 **Motion** by ISLINGTON DIVISION: That this Meeting:-
i) urges the BMA to call on the government to insist that all organisations who tender for provider services or CSO (Commissioning Support Organisation) contracts must list all previous work and reports commissioned and paid for by the NHS in England in the prior 10 years to ensure transparency and prevent commercial confidentiality muddying conflicts of interest.
ii) calls on the BMA to urge the government to insist that all GPs who wish to take up CCG roles and have any interests in the aforesaid companies to declare these interests as part of any appointment

to a CCG as well as in any tendering process.

77 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting urges general practitioners who have become involved in the new evolving commissioning consortia to ballot 'grass roots' GP's within their localities:-
i) to assess their support for the commissioning arrangements which are being put in place;
ii) publish the results of such ballots to demonstrate that their colleagues, who remain exclusively in clinical practice believe they are being properly represented.

78 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting calls on the BMA to strongly advise commissioning groups to take a vote of its individual GP membership on whether or not to proceed with the application for authorisation and for the result to be made public.

79 **Motion** by NORTH WEST RCSC: That this Meeting is concerned that commissioning as intended will seriously disadvantage specialties such as mental health which has no defined tariff and urges the BMA to ensure that HPERU analyses emerging evidence across specialties to determine equitability.

80 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting resolves to urge the BMA to take responsibility for taking forward "clinical care led by clinicians not managers" and:-
i) empower clinicians for commissioning and management decisions through appropriate training;
ii) compel government to support such training through financial and non-financial means;
iii) take steps to integrate primary and secondary care clinicians.

81 **Motion** by RETIRED MEMBERS FORUM: That this Meeting insists that the DH trains doctors who are members of Clinical Commissioning Groups.

82 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes the commissioning outcome framework:-
i) could, if reduced in size, form the basis of a method of assessing the achievements of CCGs;
ii) could be limited to areas directly related to the CCG;
iii) could lead to adverse unintended consequences;
iv) could be used for patient and peer information and not for the allocation of the "quality reward".

83 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting observes the tension that exists in the potential for locally responsive services to generate unequal access geographically and notes that:-
i) these inequalities are likely to increase when Clinical Commissioning Groups begin operating in full form as of April 2013;
ii) such local responsiveness is to be welcomed and should not be described as a "postcode lottery".

84 **Motion** by LINCOLN DIVISION: That this Meeting notes the government's vacillation over the optimum size for Clinical Commissioning Groups, which makes it impossible for CCGs to plan the commissioning of local services because of unknown budgets and costs, and suggests that, in the absence of a strategy, the Department of Health might as well configure CCGs to be coterminous with local BMA Structures in England.

85 **Motion** by SUNDERLAND DIVISION: That this Meeting believes commissioning is a first step to privatisation because of selective funding, it may be forced to be selective in care of the patients. We support commissioning as clinicians are leading to provide care. Commissioning brings clinical leadership in management and will address clinical needs in relevant manner.

86 **Motion** by REDBRIDGE & STRATFORD DIVISION: That this Meeting believes that CCGs' commissioning strategy of reducing referrals to secondary care will:-
i) result in destabilising some of the services in the local hospitals and might result in closure of some departments;
ii) the infrastructure in community care must be improved before reducing the services in secondary care.

87 **Motion** by REDBRIDGE & STRATFORD DIVISION: This Meeting believes that the CCGs' controversial recommendations like reducing referrals to secondary care and reducing prescribing costs will eventually lead to complaints from patients hence the whole complaints system must be overhauled to prevent the escalation of complaints against doctors.

88 **Motion** by BRISTOL DIVISION: That this Meeting notes that centralised dictat on the provision of services caused by unwillingness to allow post code differences in service provision is diametrically opposed to the policy to ensure local decision making on commissioning of services. This is now leading to loss of freedom of clinical decision making and friction between colleagues. We call on the government to address how the discrepancy between these two opposing policies can be managed.

89 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting feels that it is ethically wrong that CCGs are directly linked to financial rewards in commissioning healthcare as it may affect its probity.

90 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting proposes that LMCs should get formally involved in supporting all General Practitioners who are the stakeholders in the CCGs; are fully participating in decision making of the commissioning so that their and their patients' needs and interests are protected.

91 **Motion** by ROCHDALE AND BURY LMC: That this Meeting urges PCOs not to commit future CCGs to any new contracts that go beyond 2013 without extensive local primary care consultation.

92 **Motion** by LAMBETH & SOUTHWARK DIVISION: That this Meeting believes that conflicts of interest in commissioning are so detrimental to the provision of high quality patient care that any CCG Board member who has a financial interest in a company bidding for a contract tendered by their own CCG Board (other than GMS/PMS contracts) should immediately resign their commissioning role.

93 **Motion** by ISLINGTON DIVISION: That this Meeting calls upon the BMA to advise its members to resign from any provider organisations in which they have a financial interest if they are part of a CCG, in order to protect the standing of doctors.

94 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting deplores local commissioning policies that seek to control budgets through restricting access to healthcare through discrimination disguised as evidence based public health, for example blanket bans of certain elective surgical procedures for patients who are obese or smokers.

95 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting demands that the NHS and its patients are better served when consultants and general practitioners work in partnership and therefore demands that all commissioning bodies in the NHS have direct input from both consultants and general practitioners.

96 **Motion** by CONSULTANTS CONFERENCE: That this Meeting recognises that the NHS and its patients are better served when consultants and general practitioners work in partnership and therefore demands that all commissioning bodies in the NHS have direct input from both consultants and general practitioners, including during the setting of quality indicators.

97 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting believes that whatever the DH mismanages in past, present and future, that it is the localities that deliver health care through the NHS, and that both a lawful medical professional representation, and medical advice should be included to help oversee NHS commissioning for the good of the public health.

98 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting believes that doctors in primary care should all be kept informed without discrimination about the process of NHS Commissioning, and their participation should be enabled fairly if they wish to be involved.

99 **Motion** by LEWISHAM DIVISION: That this Meeting calls on BMA to urge clinical commissioning groups to agree that when services are put out to tender, the clinical commissioning groups should include a requirement for a level playing field of terms and conditions of service for the employees of NHS and non-NHS applicants, such that applicants should not be able to cite commercial confidentiality as a reason not to publish staff terms and conditions.

A 100 **Motion** by LEWISHAM DIVISION: That this Meeting calls on BMA to urge CCGs to agree that when services are put out to tender, the clinical commissioning groups should include a requirement for the provision of in-service training for the employees of NHS and non-NHS applicants, and applicants should identify what element of their costs is allocated to training.

A 101 **Motion** by MAIDSTONE DIVISION: That this Meeting urges that clinical commissioning should be enacted as a collaborative venture between primary and secondary care clinicians.

Health and Social Care Act **Monday 11.30 – 12.30**

* 102 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE BRISTOL DIVISION): That this Meeting condemns the passing of the Health and Social Care Act and resolves that the BMA must:-
i) highlight how the Act will lead to increasing NHS privatisation;
ii) continue to call for full publication of the NHS risk register;
iii) monitor and collate information about the effects of the Act on the NHS and the profession;
iv) co-ordinate the presentation to the public of the view of the medical profession on the Act;
v) provide guidance and support to doctors on mitigating damage to the NHS;
vi) continue to strive to find mechanisms to protect an NHS which is both sustainable and free at the point of delivery for all UK patients;
vii) make proposals to mitigate and reverse its damaging effects.

102a **Motion** by BRISTOL DIVISION: That this Meeting condemns the Health and Social Care Act and mandates the BMA to continue to strive to find mechanisms to protect an NHS which is both sustainable and free at the point of delivery for all UK patients.

102b **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting wonders whether the government considers itself above the law in refusing to publish the risk register and calls on the government to demonstrate its commitment to transparency and patient safety by publishing the full risk register associated with the Health and Social Care Bill.

102c **Motion** by CITY & HACKNEY DIVISION: That this Meeting instructs the BMA to call for full publication of the NHS Risk Register, as instructed by the Information Commissioner. This Meeting calls on the BMA to undertake a public information campaign about the risks to the NHS detailed in the Risk Register.

102d **Motion** by KENT LMC: That this Meeting deplores the government's attempts to cover up the true consequences of the Health and Social Care Act by refusing to publish the 'risk analysis.

102e **Motion** by SOUTH WESTERN RJDC: That this Meeting calls on the government to publish the risk register associated with the Health and Social Care Bill to demonstrate to the public and medical profession that the Bill is not anticipated to have a detrimental effect on patient safety.

102f **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes that the BMA should exert pressure on the government to publish the confidential risk register on the Health and Social Care Bill in order to help Clinical Commissioning Groups.

102g **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting strongly condemns the non publication of the Risk Register before the Health Bill legislation was passed and is seriously concerned:-
i) lessons of past serious untoward events are not learned and failures are repeated;
ii) safety is compromised by lack of clarity on accountability, poor staff morale and loss of knowledge due to organisational and structural change;
iii) that this does not set a good precedent for the NHS in not openly publishing the register and evidencing what mitigating steps are being undertaken to reduce risk.

102h **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting:-
i) notes the significant conflicts of interests of many parliamentarians voting in favour of the Health and Social Care Bill;
ii) regrets that these conflicts of interests are not more widely publicised;
iii) believes that no government should attempt to railroad legislation by refusing to comply with a decision of the information commissioners office;
iv) believes that the risk registers for proposed legislation should be made available to all parliamentarians as a matter of good governance.

102i **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting is concerned that the passage of Health and Social Care Act ultimately paves the way to privatised healthcare system.

102j **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting believes a privatised healthcare system is the only logical consequence to the Health Bill.

102k **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting is opposed to patient charges for NHS clinical care, rendered possible by the Health Act and calls on the BMA to organise its members to prevent their introduction.

102l **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting mandates Council to launch a public campaign:-
i) to call for the restoration of the legal basis of the NHS in England;

ii) to call for the purchaser-provider split in health care to be abandoned;
iii) to effectively explain how the Health and Social Care Act (2012) will lead to increasing NHS privatisation;
iv) to effectively explain how a single payer, publicly funded, publicly provided and publicly accountable NHS is the most equitable and cost effective way to deliver health care;
v) to highlight the private health care business interests of MPs and Peers.

102m **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting believes that the need of each government to make the NHS its own by radically reorganising it:-
i) creates escalating inefficiency;
ii) increasingly threatens the future of the National Health Service;
iii) harms patients and staff;
iv) does not allow time for changes imposed to ever have a chance of providing positive outcomes before the next government radically reorganises the NHS;
v) and that political parties should together find a way of avoiding this continuous cycle of reorganisation.

102n **Motion** by SUNDERLAND DIVISION: That this Meeting believes:-
i) changes every time government changes are taking its toll on the profession and on care of the patients;
ii) it is time for any changes to be assessed its efficacy before any new changes are implemented.

102o **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting believes that the purchaser provider split:-
i) is not good value for money;
ii) is damaging to integrated health care;
iii) produces post code lottery in health care;
iv) is undermining the pursuit of integrated health and social care;
v) threatens the future of a National Health Service.

102p **Motion** by SOMERSET LMC: That this Meeting notes the Commonwealth Fund review in November 2011 rates the NHS as one of the best healthcare systems in the world and believes that this is substantially attributable to the high and improving quality of evidence based care provided by general practices across the country.

102q **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting acknowledges that the Health and Social Care Act will provide "profit streams for investors, insurers and hospital chains" to the detriment of patients' needs and demands that the BMA continues to pursue the interests of patients in defiance of the manipulations of government.

102r **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting is concerned at the passing of the Health and Social Care Bill which marks a significant change in the ethos of the health service in England and demands that:-
i) Council continues to strive in the attempt to mitigate the potentially serious consequences of the legislation;
ii) the principle of putting patients first must always remain paramount;
iii) the best aspects and values of the present NHS must prevail.

102s **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting in respect of the Health and Social Care Bill believes:-
i) the passing of the Bill poses great risks for the health service;
ii) the pressure placed on doctors to reduce health budgets while delivering more services will cause serious difficulties;
iii) the profession will potentially be blamed and lose trust for cutting services;
iv) Council must devise and pursue policy during the implementation of the Bill which will limit the damage to patient care and the profession.

102t **Motion** by SHEFFIELD DIVISION: That this Meeting believes that the general public has been given the impression that the medical profession cares more about its pensions than the future of the NHS. This needs to be redressed. Although it may not possible to take industrial action against the Health and Social Care Act, there may be other ways to make clear the feelings of the majority of doctors such as wearing black or a black arm band as a visible display of feeling to the general public. This could be done in conjunction with nurses and other health care professionals .

102u **Motion** by EDGWARE & HENDON DIVISION: That this Meeting calls upon the BMA to develop guidance for doctors across the branches of practices of ways to mitigate the damaging effects of the Health and Social Care Act, with local systems of collaboration and integration, and which supports the NHS as a commissioner and provider of care.

102v **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting calls on the BMA to help Clinical Commissioning Groups to:-

i) uphold the values of the NHS;
ii) promote integration rather than unnecessary competition;
iii) work with clinicians in secondary and tertiary care.

102w **Motion** by REDBRIDGE & STRATFORD DIVISION: This Meeting believes that the beleaguered NHS Bill is going through only because of division in profession. The BMA which represents all crafts must take initiative in producing a document amending the Bill which would be acceptable to profession

102x **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting believes that the Health and Social Care Bill should be significantly amended before implementation.

102y **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting would:-
i) support a further major reorganisation of the English NHS in order to reverse the most damaging policies contained within the Health and Social Care Act (2012);
ii) call on the BMA to work with organisations committed to reversing the most damaging aspects of the Act.

102z **Motion** by ISLINGTON DIVISION: That this Meeting calls on the BMA to monitor and collate information about the effects of the Health and Social Care Act on the NHS and the profession.

102aa **Motion** by ISLINGTON DIVISION: That this Meeting believes that Health and Social Care Act will damage the English NHS and calls on the BMA to campaign for it to be repealed.

102bb **Motion** by ISLINGTON DIVISION: That this Meeting urges the BMA to campaign for any party, who may form part of a future government, to cultivate a policy and winning platform of repealing the Health and Social Care Act.

102cc **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting is opposed to the Health Act which aims to privatise the commissioning and delivery of NHS care in England and abolishes the legal basis and essential structures of our publicly provided NHS. This Meeting calls on BMA Council to organise a public campaign against its measures, including:- campaign pamphlets for members and the public explaining the implications of the Bill, road shows, publicity and a large central demonstration and rally inviting other unions to take part.

102dd **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting is opposed to the Health and Social Care Act which aims to privatise the commissioning and delivery of NHS care in England and abolishes the legal basis and essential structures of our publicly provided NHS. We call on BMA Council to:-
i) mount a large public campaign against the measures in the Act;
ii) to ballot for strike action to stop its implementation, to include the option of such actions as non-co-operation with CCGs plans and strike actions of hospital doctors.

102ee **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting notes that the role of the DGH/Trust model in delivery of NHS services is being changed by experiment across England's NHS. A responsible institution should monitor and promote best practice to help better models to succeed and mitigate the damage of current disordered change. The BMA should actively contribute to this national process to give both a professional oversight, and offer local advice through its professional resources.

102ff **Motion** by SHEFFIELD DIVISION: That this Meeting believes that the BMA should produce guidance to assist doctors in:-
i) ensuring that Clinical Commissioning Groups commission services in the best interests of patients;
ii) reducing the risk of services being commissioned by profit making organisations;
iii) monitoring, documenting and resisting changes to services which would be damaging to patients;

102gg **Motion** by CITY & HACKNEY DIVISION: That this Meeting notes that three CCGs (Tower Hamlets, City & Hackney and Oxford) have written to the Prime Minister asking for the withdrawal of the Health and Social Care Bill, and challenging the Secretary of State's assertion that GPs have joined CCGs because they support the Bill.
This Meeting calls on the BMA to support the actions of CCGs which oppose the introduction of private providers into NHS provision, particularly where this has been imposed on CCGs, and when they have not been free to determine whether this provision is beneficial to patients and to the wider NHS.

102hh **Motion** by EALING DIVISION: That this Meeting believes that:-
i) it is increasingly unlikely that Andrew Lansley's assertion of doctors leading commissioning in the reformed NHS will come to fruition, since emerging information shows managers outnumbering general practitioners in the Clinical Commissioning Groups;
ii) the chaos resulting from the organisational changes taking place will last years rather than months and will drain scarce resources. Now that the Health and Social Care Act is part of English law, the BMA must ensure medical engagement at every possible level in the system to mitigate the likely damage to the NHS.

102ii **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting is opposed to Clinical Commissioning Groups (CCGs) in England, because they:-
i) force GPs to join them whether they like to or not and without negotiation with the BMA;
ii) have no mandate to provide comprehensive care for geographically defined populations;
iii) can select which services they provide free on the NHS and which they charge for;
iv) can force GPs to prioritise budget reduction over clinical need;
v) have a "choice mandate" which demands CCGs contract care to private companies on the market, under competition law;
vi) will not be controlled by GPs, but by commercial commissioning support companies such as McKinsey and KPMG, which will do the main commissioning functions;
vii) can be run by FTs or private companies including health insurance companies and large primary commercial care providers.
This Meeting proposes that the BMA Council and GPC ballot for a policy of national non-co-operation with CCG's plans forthwith and the defence of the current functioning of independent GP surgeries.

102jj **Motion** by LEWISHAM DIVISION: That this Meeting believes the BMA has a duty to work to limit the damaging effects of the Health and Social Care Act, in particular the creation of a market for healthcare in England, and to protect NHS services. Therefore this Meeting calls on the BMA to lobby all CCGs to sign the following pledge:-
"This CCG will uphold the principle of "first do no harm": we will take no action and adopt no policy that might undermine our patients' continued access to existing local health services that they need, trust and rely upon. In the spirit of clinically-led commissioning, we reserve entirely the right to decide who we contract with to provide services for our patients. We will take those decisions on the basis of the best interests of our patients and wider local communities. Among other priorities, and in the interests of offering the best care for our populations, we shall increase the integration of services between different parts of the NHS and between the NHS and social care. We shall not be diverted from this by concerns about anti-competitive behaviour. In the interests of transparency we will not engage in any contracts or negotiations which impose conditions of commercial confidentiality: will consult local communities before implementing any changes that affect them, and our Board will make all major decisions relating to services in public session."

102kk **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that CCG boards and their commissioning support companies are dictating that member GP practices cut budgets, reduce referrals of patients to hospital and abide by new contracts with private providers. The GPs will be blamed by the public for cutting and privatising services. But practices do not have to abide by CCGs agendas which adversely affects patients. This Meeting calls on BMA Council and GPC not to leave members to fight on their own, but to:-
i) fully support members who refuse to carry out CCG board agendas involving cuts and privatisation;
ii) ballot GPs for boycott of commissioning work;
iii) recommend GPs do not join CCG boards.

* 103 **Motion** by CITY & HACKNEY DIVISION: That this Meeting:-
i) notes and deplores the conflicts of interest apparent in Parliamentary debates and lobbying around the Health and Social Care Bill where MPs and peers have vested personal interests in passing the Bill;
ii) also notes that private health care companies have been involved in formulating aspects of the Health and Social Care Bill, particularly in areas involving competition, allowing greater entry of the private sector into NHS provision;
iii) instructs the BMA to demand that all MPs and peers make transparent their financial or personal interests in private healthcare companies, foundation trusts, health charities or other organisations which benefit from the passage of the Health and Social Care Bill;
iv) instructs the BMA to call for full disclosure of the input of private health care companies into the formulation of the Health and Social Care Bill.

103a **Motion** by NORTH THAMES RJDC: That this Meeting:-
i) is disgusted by the conflicts of interest apparent in Parliamentary debates and lobbying around the Health and Social Care Bill where MPs and peers have vested personal interests in passing the Bill;
ii) calls on the BMA to work for these MPs and peers to be named and shamed for failing to declare their interests in increasing private sector provision of NHS care.

103b **Motion** by CITY & HACKNEY DIVISION: That this Meeting:-
i) is troubled by the apparent conflicts of interest of some MPs and Peers and in particular by their advisors that have come to light as the Health and Social Care Bill has wound its way through the Houses of Commons and Lords;
ii) it calls on the BMA to lobby for full transparency and a declaration of all conflicts of interests of those involved in the passage of the Health and Social
Care Bill including their advisors.

103c **Motion** by CITY AND EAST LONDON LMC: That this Meeting deplores the malign influence of international management companies in the vision and (re)organisation of the health service. Any involvement should and must be transparent with clear declarations of conflict of interest.

* 104 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE MEDICAL STUDENTS CONFERENCE): That this Meeting believes that the NHS Health and Social Care Act will worsen health inequalities. This Meeting is appalled that the Act:-

i) does not extend to local authorities a statutory duty to reduce health inequalities;
ii) reduces the funding weighting for health inequalities;
iii) will damage patient care, particularly of vulnerable groups;
iv) does not place a duty on Clinical Commissioning Groups to promote population-wide health;
v) will damage public health provision;
vi) will lead to a more fragmented and bureaucratic NHS;
vii) does not require the Secretary of State for Health to specify how commissioners, regulators and local authorities will be held accountable for reducing health inequalities.

104a **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting, regard to the Health and Social Care Bill:-

i) welcomes the new duties on Secretary of State, NHS Commissioning Board and Clinical Commissioning Groups to have regard for the need to reduce health inequalities;
ii) recognises that these duties only apply to NHS services, the same duty not being placed on Local Authorities, who will – under the Bill – play a big role in health promotion and protection;
iii) is concerned that there is no duty on Clinical Commissioning Groups to promote population-wide health;
iv) notes that, with regard to the allocation of NHS funding, the weighting for health inequalities will be reduced from 15 to 10 per cent;
v) is concerned that the implications of the Bill will be damaging to the provision of public health and, in particular, action on health inequalities;
vi) calls on the BMA to lobby the government to:-
a) specify how the duties of the above bodies to reduce health inequalities will be fulfilled and b) to ensure that the above bodies are held accountable for reducing health inequalities;
vii) calls on the BMA to continue to support the UCL Institute of Health Equity to drive research in this area.

104b **Motion** by ROCHDALE AND BURY LMC: That this Meeting believes the way in which PCOs decommission services to achieve short term financial balance will have long term public health consequences.

104c **Motion** by GREENWICH, BEXLEY & BROMLEY DIVISION: That this Meeting opposes the Health and Social Care Bill, as we believe that the Bill will harm patient care, fragment the NHS, increase costs and bureaucracy and turn a public service into a competitive private market, leading to reduced access, grater inequity, reduced quality and worse outcomes.

104d **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes the Health and Social Care Act in England has the potential to lead to a more fragmented, bureaucratic and unequal NHS and calls on doctors to do all they can to work to limit the damage to our patients.

104e **Motion** by SHEFFIELD DIVISION: That this Meeting believes that the Health and Social Care Act will:-

i) damage the NHS;
ii) will fragment care and will in particular compromise the care of vulnerable groups such as the elderly and those with long-term conditions and complex care requirements;
iii) will damage the therapeutic relationship between GPs and patients due to the actual or perceived conflicts of interest inherent in GP commissioning of services with a limited budget.

104f **Motion** by EDGWARE & HENDON DIVISION: That this Meeting refutes the government's claim that the Health and Social Care Act will strip the NHS of tiers of administration, and believes that the Act will instead increase the numbers of organisational structures, bureaucracy and transaction costs in the NHS.

104g **Motion** by WESSEX RJDC: That this Meeting:-

i) believes that passing of the Health and Social Care Bill is detriment to the care of patients;
ii) deplores the government for failing to listen to the healthcare professionals;
iii) deplores the government's lack of transparency in not publishing the risk register to facilitate an informed debate;
iv) calls for the resignation for the Secretary of State for failing the British public.

The motion(s) below, in the shaded area, are unlikely to be reached

105 **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting believes that in respect of the Health and Social Care Act (2012), the Medical Royal Colleges (with the exception of the RCGP) failed:-
i) to provide the necessary leadership and actions to oppose and mitigate against the most damaging aspects of the Bill;
ii) to raise awareness amongst their fellows and members about the risks of the proposed legislation in a timely and meaningful way;
iii) to stand up and fight for medical professionalism despite the inherent dangers to the doctor-patient relationship posed by market driven policies enshrined within the legislation.

106 **Motion** by BIRMINGHAM DIVISION: That this Meeting regrets that the Health and Social Care Bill is too long and complex to be understood by health professionals, the public and even the media. This Meeting calls for a summary guide that makes clear its provisions written in plain English version in the style of the 'Highway Code'.

107 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting demands that the government explains exactly how and with what mechanisms the NHS Health and Social Care Act will result in improved health outcomes such as cardiac and cancer care , or better address the needs of an increasingly ageing population, given that the Bill was predicated and promoted on this basis.

108 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting whole-heartedly supports BMA Council in its rejection of the Health and Social Care Bill in its entirety.

109 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting believes that the Health and Social Care Bill de facto created chaos which reflects badly on the Health Secretary, who should consider his position as untenable.

110 **Motion** by ISLINGTON DIVISION: That this Meeting believes that persistence with the policy of 'critical engagement' contributed to the passage of the Health and Social Care Bill.

111 **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting believes that in respect of the Health and Social Care Act (2012), the Patients' Association and many other patient groups failed to look after the interests of patient care by their lack of public opposition to the NHS White Paper and the Bill.

112 **Motion** by SHROPSHIRE LMC: That this Meeting commends the health secretaries of Wales, Scotland and Northern Ireland for the way they have focussed on NHS service improvements rather than needless and expensive reorganisation.

113 **Motion** by CORNWALL AND ISLES OF SCILLY LMC: That this Meeting is disgusted at the campaign of misinformation that is being fed to the media and the public over the proposed changes to the NHS.

114 **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting believes that in respect of the Health and Social Care Act (2012), the coalition government has misled the public by saying there will be "no privatisation of the NHS".

115 **Motion** by WEST PENNINE LMC: That this Meeting begs government to direct that the NHS reforms are a bottom up exercise, truly representing local healthcare needs, with an empowered local clinical leadership, and not become a tool for privatisation and increased bureaucracy.

116 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting believes that the government has reneged on its White Paper's promise to "liberate the NHS" and the Act will instead reinforce top down control with an increase in structures and bureaucracy, and a perpetuation of a target culture via central performance management and financial levers.

117 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting calls upon government to declare the passage of the Health Bill as a Significant Untoward Incident on the basis of it:-
i) breaking an electoral pledge of no further top down NHS reorganisation, by publishing its White Paper within 6 weeks of taking office which proposed the greatest reorganisation of the NHS since its inception;
ii) requiring a wholly unnatural "pause" and "listening exercise";
iii) requiring 2000 amendments with a Bill longer than that required to establish the NHS;
iv) resulting in opposition across the spectrum of the medical workforce, and the majority of Royal Colleges;

v) proceeding without publishing of the Risk Register;
and steps must be taken to prevent such a damaging episode from ever being repeated in the future of the NHS.

118 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting fears that one of the implications of the Health Bill 2012 is to change the culture of the NHS mainly to look at profit making rather than to provide the best healthcare service to the patients free at the point of delivery.

A 119 **Motion** by ROCHDALE AND BURY LMC: That this Meeting recognises that forcing local hospital trusts into foundation trust status is not the best model for local healthcare.

Contingency time — Monday 12.30 – 12.35

WALES — Monday 12.35 – 12.50

120 **Receive**: Report by the Chairman of Welsh Council (Stefan Coghlan).

121 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting urges the Welsh Government to act quickly to improve the levels of literacy and numeracy in Wales to similar levels enjoyed by the other UK nations. Education can be a major determinant of social wellbeing and health and thus we are dismayed at the poor levels of educational attainment in Wales and its implications for the health of the nation.

The motion(s) below, in the shaded area, are unlikely to be reached

122 **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting urges the Welsh Government to monitor closely the effects of the Health and Social Care Act on Welsh patients being treated in England and ensure that Welsh patients are not disadvantaged by the damaging changes to the English NHS.

123 **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting demands that the Welsh government review its policy on the capital funding of primary care premises since the funding has been chronically insufficient. It recognises that without significant increases in capital expenditure, the Government's objective of delivering more care closer to the patient's home will fail.

124 **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting demands that BMA Cymru tell the Welsh Government that blocking study leaves applications for hospital doctors in the final quarter of the financial year is unacceptable since it could result in difficulties in achieving sufficient CPD to achieve revalidation.

125 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting wants to have a separate section devoted to the issues affecting Welsh NHS.

126 **Motion** by WELSH COUNCIL: That this Meeting:-
i) notes with concern the dramatic shortage of Public Health specialists employed in Wales to guide NHS Wales to meeting the population's health care needs; and
ii) demands that the Welsh NHS addresses this shortage by filling new consultant posts in Public Health forthwith.

127 **Motion** by WELSH COUNCIL: That this Meeting calls upon the Wales Postgraduate Deanery to ensure that each trainee is only placed with a training provider who has demonstrated their ability to deliver an effective, comprehensive training experience.

A 128 **Motion** by WELSH COUNCIL: That this Meeting calls upon the Welsh government to support clinical academia in Wales by ensuring that the terms and conditions under which medical academic staff work are not disadvantageous compared to their counterparts in the NHS.

The NHS in Wales **Monday 12.50 – 13.00**

* 129 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE CLWYD NORTH DIVISION): That this Meeting, with regard to the NHS in Wales, demands that the Welsh Government:-
i) publishes and takes responsibility for a strategic plan for reconfiguration of medical services across Wales after taking advice from Local Health Boards regarding local needs;
ii) engages with elected representatives of the profession in planning and implementation of service reconfiguration;
iii) ensures that local population need, and not the availability or otherwise of training grade doctors, drives the configuration of local services;
iv) ensures that Health Boards deliver the expected standards of care given the Welsh health minister's assertion that waiting times and standards will not slip despite budgetary constraints;
v) closely monitors the damaging effects of the Health and Social Care Act on patient care in England to ensure that harm inflicted on patients in England is not replicated in Wales.

129a **Motion** by CLWYD NORTH DIVISION: That this Meeting demands that the Welsh Government:-
i) publishes and takes responsibility for a strategic plan for reconfiguration of medical services across Wales after taking advice from Local Health Boards regarding local needs;
ii) consults on this plan with the public and the BMA;
iii) does not abrogate responsibility for the plan to Local Health Boards.

129b **Motion** by WEST GLAMORGAN DIVISION: This Meeting calls on the Welsh Government to engage with elected representatives of the profession in planning and implementation of service reconfiguration.

129c **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting recognises the damaging effects of the reconfiguration process in north Wales on patient care, whilst causing significant anxiety in the population.

129d **Motion** by WELSH COUNCIL: That this Meeting questions the competence of Local Health Boards (LHBs) in Wales for using Deanery led training reconfiguration to justify downgrading of local services irrespective of local population need. It calls on LHBs to ensure that local population need, and not the availability or otherwise of training grade doctors, drives the configuration of local services.

129e **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting urges the Welsh government to monitor closely the damaging effects of the NHS Bill on patient care in England and to ensure that harm inflicted on patients in England is not replicated in Wales.

129f **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting applauds the Welsh Health Minister's assertion that waiting times and standards will not slip despite budgetary constraints and urges her to ensure that the Health boards deliver the expected standards of care.

129g **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting warns that budget cuts to the Welsh Health Service will adversely impact on patient care.

The motion(s) below, in the shaded area, are unlikely to be reached

130 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting notes that the Welsh Health Service has been able to thrive without the changes being imposed on the English NHS.

131 **Motion** by WELSH COUNCIL: That this Meeting is saddened to see the British Prime Minister resort to unjustly attacking the Welsh NHS in a futile attempt to deflect criticism of the Health and Social Care Bill. We call on him to apologise.

132 **Motion** by CLWYD NORTH DIVISION: That this Meeting demands that every Accident and Emergency Department in Wales has a comprehensive range of acute emergency services on site including Paediatrics and General Surgery. Departments without these services available should be advertised to the public as Minor Injuries Units only.

A 133 **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting calls on the Welsh government to ensure that when services are transferred to primary care appropriate funding follows.

Session closes **Monday 13.00**

Victor Horsley scientific session 1
1pm: Chair: Professor Averil Mansfield, Chairman, BMA Board of Science. Stem cell therapy: fact or fiction? Professor Sir Ian Wilmut, Director, MRC Centre for Regenerative Medicine, University of Edinburgh.

TRAINING AND EDUCATION — Monday 14.00 – 14.40

* 134 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE CITY AND HACKNEY DIVISION): That this Meeting supports the principle of extending and enhancing GP training but insists that implementation must assure:-
i) high quality training posts tailored to training need;
ii) the supernumerary status of GP trainees in GP placements;
iii) that a strong incentive to provide high quality training is retained;
iv) funding sufficient to deliver all the aspirations of the proposals.

134a **Motion** by CITY & HACKNEY DIVISION: That this Meeting supports the principle of an extension to GP training and calls on the BMA to lobby to:-
i) ensure that any additional hospital posts are of high quality, are tailored to the educational needs of GP trainees and are not simply used to fill rota gaps;
ii) maintain the supernumerary status of GP trainees in GP placements;
iii) maintain the funding for GP trainers who provide training in GP placements.

134b **Motion** by PLYMOUTH DIVISION: That this Meeting calls for any proposal to lengthen GP training to ensure that GP practices are incentivised to provide good quality placements in sufficient quantities.

134c **Motion** by HOLLAND DIVISION: That this Meeting is concerned that extending GP training without funding provision for doing so, or by removing the trainer grant for the final year, will discourage GPs from undertaking the role of trainer, and calls for extended training to be adequately funded by Deaneries.

* 135 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE EAST DORSET DIVISION): That this Meeting fears that the future of high quality medical education and training is at serious risk from changes imposed by budget cuts and healthcare reform and that:-
i) the Health and Social Care Act will be detrimental to the training of future skilled medical practitioners;
ii) all providers of NHS services must be commissioned with contractual obligations to provide high quality education and training;
iii) commissioners and providers of NHS healthcare must guarantee the provision of education, training and research opportunities;
iv) the commissioning and provision of high quality training or research must be rigorously audited and reported;
v) local commissioning of education must remain under the aegis of a national system;
vi) national educational oversight systems must have representation from active clinicians.

135a **Motion** by EAST DORSET DIVISION: That this Meeting will push the government to protect the crucial medical education of future doctors in the face of proposed reforms and budget restrictions.

135b **Motion** by EAST AND NORTH HERTFORDSHIRE DIVISION: That this Meeting fears that the Health and Social Care Bill which encourages privatisation and competition in the NHS will be detrimental to the training of future skilled medical practitioners and calls upon the government to insist that all qualified providers are required to provide the highest standard of training to junior doctors.

135c **Motion** by UNIVERSITY OF LONDON: That this Meeting calls on the BMA to continue to uphold and promote the principle (as embodied in the Health and Social Care Act) that the Secretary of State and the National Commissioning Board have a responsibility to ensure:-
i) that both clinical commissioning groups and providers of NHS healthcare (both NHS and independent or third sector) guarantee the provision of education, training and research resources as an essential component in all future healthcare delivery agreements;
ii) that audit and evaluation of education, training and research activities is a made an integral part of quality monitoring and reporting in any such agreements.

135d **Motion** by CITY & HACKNEY DIVISION: That this Meeting:-
i) welcomes the focus on quality in "Developing the Healthcare Workforce: From Design to Delivery";
ii) calls on "Any Willing Providers" to maintain an obligation for education and training of their workforce and that this is written into their terms and conditions of employment;
iii) calls on the DoH to ensure that a least one clinically active doctor ideally more, is appointed to the Health Education England Board;
iv) calls for LETBs to remain under the aegis of Health Education England for the foreseeable future.

135e **Motion** by ISLINGTON DIVISION: That this Meeting believes that the recent paper 'Liberating the NHS: Developing the Healthcare workforce - From Design to Delivery' will seriously undermine post graduate medical education in England.

135f **Motion** by LAMBETH & SOUTHWARK DIVISION: That this Meeting believes that the Health and Social Care Act does not outline in sufficient detail how post-graduate medical education will be structured after the dissolution of the deaneries, and calls on the BMA to urgently press the government to provide a comprehensive account of its intentions, including a reassurance that existing trainees' education will not suffer as a result of the changeover, nor be sold to 'any willing provider'.

* 136 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE JUNIOR MEMBERS FORUM): That this Meeting recognises that many doctors' career paths will include a background of training in different branches of practice and specialties, acquiring skills that are transferable across specialities and training programmes. This meeting calls for those who design and oversee training programmes to:-
i) recognise previously attained knowledge skills and experience;
ii) allow greater flexibility in the construction of individuals' training programmes to avoid unnecessary repetition;
iii) allow greater flexibility in the construction of individuals' training programmes to address training needs.

136a **Motion** by JUNIOR MEMBERS FORUM: That this Meeting recognises that many doctors' career paths include time spent in different branches of practice acquiring skills that are transferable across specialities. We therefore call on the BMA to lobby the Royal Colleges and those who accredit and oversee training programmes to:-
i) consider trainees as individual professionals;
ii) allow some flexibility where possible in the path to CCT;
iii) try and avoid unnecessary repetition of comparable posts;
iv) recognise previously attained competencies.

136b **Motion** by SOUTH THAMES RJDC: That this Meeting notes that:-
i) increasing numbers of GP trainees are coming from a background of previous training in another speciality (paediatrics, accident and emergency, core medical training);
ii) GP training consists of a number of hospital rotations, which may include specialities a trainee already has considerable experience in and calls for
iii) greater flexibility in allowing trainees to choose their rotations, such that training needs are appropriately addressed.

* 137 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE WALTHAM FOREST DIVISION): That this Meeting has significant concerns about the establishment of Local Education and Training Boards (LETBs) and believes that:-
i) medical education should not be driven by local workforce needs;
ii) there will be a further deleterious effect on medical manpower planning;
iii) smaller specialties will be particularly affected by this change;
iv) postgraduate deaneries should be retained as special health authorities;
v) further development of LETBs be halted and replaced by a well researched and properly planned process.

137a **Motion** by WALTHAM FOREST DIVISION: That this Meeting believes that the current development and appointment of personnel to LETBs is haphazard, and demands that this activity be halted and replaced by a well researched and properly planned process.

137b **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting has significant concerns about the establishment of local education and training boards and believes that:-
i) medical education should not be driven by local workforce needs;
ii) there will be a further deleterious effect on medical manpower planning;
iii) smaller specialties will be particularly affected by this change;
iv) postgraduate deaneries should be retained as special health authorities.

The motion(s) below, in the shaded area, are unlikely to be reached

138 **Motion** by SOUTH WESTERN RJDC: That this Meeting opposes the introduction of further breakpoints into the current career pathways as this is likely to have a detrimental effect on the continued training of doctors to consultant level.

139 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting appreciates the importance of management and leadership skills at both junior and consultant levels, and calls upon the incorporation of such training within specialty training programs with immediate effect.

140 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting:-
i) believes that leadership and management skills are crucial to all doctors and medical students at all levels, as described in the GMC "Tomorrow's Doctors" guidance (2009);
ii) asks that the opportunities to develop leadership and management skills should begin at the commencement of medical training;
iii) that the Medical Leadership Competency Framework (MLCF) is incorporated into the curriculum of all UK medical schools;
iv) and asks that the Medical Student Committee lobbies the Medical Schools Council to ensure implementation of the MLCF.

141 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that strong medical leadership at all stages of medical practice is essential for the future success of the Health Service and therefore calls on the BMA to lead a campaign to develop and maintain leadership skills in doctors from undergraduate level right through to retirement.

142 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting calls on the BMA to lobby the appropriate bodies to ensure that the principles of medical leadership are included as a mandatory component in:-
i) undergraduate medical training;
ii) postgraduate medical training.

143 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting:-
i) believes that it is important to allow participation in available leadership opportunities early in a medical career;
ii) calls on medical schools and employers to give support and encouragement and to appoint a named person with responsibility for this.

144 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes that medical leadership needs should be strongly supported by the government. The BMA must persuade government to:
i) identify the role of medical leadership separate from non-medical clinical leadership (Nurse Managers);
ii) propose that Local Education and Training boards must take responsibility for providing leadership training to doctors in the region.

145 **Motion** by CONSULTANTS CONFERENCE: That this Meeting expresses grave concern at the freezing of study leave budgets, which equate to real-terms reductions in funding, training opportunities and potentially to the quality of patient care and calls for:-
i) agreed national (all four nations) study leave budgets for individual training and career grade doctors and for each specialty;
ii) study leave budgets to be increased taking account of inflation;
iii) the BMA to survey its members to assess the scale of the problem and support members in any appropriate action required if reasonable study leave is not fully funded by employers.

146 **Motion** by OXFORD DIVISION: That this Meeting expresses grave concern at the freezing of study leave budgets, which equate to real-terms reductions in funding, training opportunities and potentially to the quality of patient care and calls for:-
i) agreed national (all 4 nations) study leave budgets for individual training and career grade doctors and for each specialty;
ii) study leave budgets to be raised from 2005 levels to match RPI inflation since then;
iii) study leave budgets that are automatically increased annually to mach RPI inflation.

147 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting recognises the importance of clinicians participating in research, and encourages engagement by interested members. Therefore we ask the BMA to:-
i) liaise with UKFPO (UK Foundation Programme Office) and the Heads of Postgraduate deaneries to ensure non-academic Foundation Doctors and Specialty Trainees are supported with opportunities to

conduct research, within study leave allowances;
ii) liaise with the Heads of Postgraduate deaneries to offer all doctors formal research training.

148 **Motion** by SOUTH THAMES RJDC: That this Meeting notes the widespread use of mandatory electronic portfolios and calls upon trusts to provide:-
i) sufficient numbers of computers with internet access;
ii) wifi for personal devices where such computers are not available, for example in operating theatres so as to facilitate completion of work based assessments in real time.

149 **Motion** by RETIRED MEMBERS FORUM: That this Meeting tries to seek whether newly qualified doctors and medics may be interested in meeting retired doctors in their area who are prepared to act as mentors / advisers.

150 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting notes the variation and poor implementation within GP VTS release programs in certain regions (both within and across deaneries) across the country, and asks that those concerned to ensure a fair and robust teaching program across borders to give each trainee a similar training experience and an equal chance to pass the same exam.

151 **Motion** by CONSULTANTS CONFERENCE: That this Meeting calls on the health departments to raise the profile of medical leadership so that NHS organisations put medical leadership on the same level of importance as NHS management and thus allow medical leaders and NHS managers to work in equal partnership for the good of the NHS and its patients.

152 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting calls on the Health Departments to raise the profile of medical leadership so that NHS organisations put medical leadership at the centre of NHS management structures and thus empower medical leaders to work to improve the NHS for its patients.

153 **Motion** by GREENWICH, BEXLEY & BROMLEY DIVISION: That this Meeting is concerned about any possible clash of junior doctors' education and training with their service commitments, and urges the BMA Education Committee to find ways of safeguarding junior doctors' education and training.

154 **Motion** by OXFORD DIVISION: That this Meeting notes that doctors wishing to pursue dual medical and dental qualifications for training in Maxillo-Facial Surgery have to undertake the full dental course under EC directive 2005/36/EC instead of an accelerated one and asks that Council inform the government of the problems caused by this directive and to encourage their resolution.

155 **Motion** by WEST GLAMORGAN DIVISION: That this Meeting demands that the training, accreditation and re-accreditation of smear takers in primary and secondary care should be tailored to the needs of the individual professional groups rather than the current position of a single model of training for all health professionals.

156 **Motion** by SOUTH THAMES RJDC: That this Meeting believes that the opportunity to train in a clinical specialty at the same time as public health may be an attractive option to some medically qualified public health registrars and mandates the BMA to explore facilitating this option with the Faculty of Public Health and other relevant postgraduate bodies.

157 **Motion** by SOUTH THAMES RJDC: That this Meeting is deeply concerned about the potential loss of expertise and training opportunities in health services public health and requests the BMA to explore the potential for 'health services public health' to become a medical sub-speciality in order to protect trainees and consultants.

158 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting recognises that points are allocated for publications when applying for core and higher specialty training. However, acknowledgement is only given for publishing basic science research papers or review articles. Currently no credit is awarded for peer-reviewed chapters or books. We therefore call on the BMA to lobby the post-graduate specialty training bodies to broaden the points allocation system to include peer-reviewed chapters and books.

159 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting is concerned that anecdotally general surgical skills are not being handed down through current training, and suggests the BMA should help the profession refute this or reform training through appropriate research.

160 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting calls for needed facilities and opportunities provided for the newly qualified medical graduates UK to train and attain the skills needed in the field of medical speciality of their choice to fulfil their career ambitions.

STAFF, ASSOCIATE SPECIALISTS AND SPECIALTY DOCTORS

Monday 14.40 – 15.05

161 **Receive**: Report by the Chairman of the Staff, Associate Specialists and Specialty Doctors Committee (Radhakrishna Shanbhag).

* 162 **Motion** by HOLLAND DIVISION: That this Meeting believes that, despite the current financial situation and the continuing threat to Deanery structures:-
i) current provision of SAS career development funding should be maintained to enable career progression;
ii) SAS career development funding should be provided across the UK, and calls on the Northern Ireland administration to provide comparable funds to bring it in line with the other UK nations.

162a **Motion** by SOUTH WESTERN RSASC: That this Meeting is deeply concerned that SAS doctors employed by smaller NHS employers, and in particular by Social Enterprise Companies, are being denied access to SAS development funding and calls upon Strategic Health Authorities and the Department of Health to ensure that all employers are made aware of the funds and that they make full use of them to the benefit of all SAS doctors and their patients.

162b **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting is deeply concerned that SAS doctors employed by smaller NHS employers, and in particular by Social Enterprise Companies, are being denied access to SAS development funding and calls upon SHAs and the DH to ensure that all employers are made aware of the funds and that they make full use of them to the benefit of all SAS doctors and their patients.

163 **Motion** by NORTH WESTERN SASC: That this Meeting asks the BMA to actively negotiate with employers through the Joint Negotiating Committee (SAS) and local negotiating committees to also provide SAS doctors with two days additional leave following seven years of service.

The motion(s) below, in the shaded area, are unlikely to be reached

164 **Motion** by NORTH WESTERN RSASC: That this Meeting exhorts the BMA to lobby the GMC, professional bodies, the Departments of Health and employers to formally acknowledge and promote appropriately trained senior SAS doctors as Independent practitioners.

165 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon SASC to make every effort to enter into negotiations with NHS Employers and UK employers to re-open the Associate Specialist grade.

166 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon SASC to make every effort to enter into negotiations with NHS employers to create a new senior SAS role to replace the much missed Associate Specialist post.

167 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon SASC to make every effort to enter into negotiations with NHS employers to create a new grade which may or may not be called AS but which recognises the role of very senior SAS doctors working at a leval analogous to consultants.

168 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon SASC to renegotiate the specialty doctor contract so as to avert the recruitment and retention crisis that is imminent in many specialties by virtue of the essential unattractiveness of the grade.

MEDICAL STUDENTS

Monday 15.05 – 15.40

169 **Receive**: Report by the Co-Chairs of the Medical Students Committee (Marion Matheson and Elly Pilavachi).

* 170 **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting is appalled at the errors made by the Student Loans Company and Student Finance England in mistakenly awarding tuition fee loans to students doing medicine as a second degree, and then later deducting the payment from universities. We call for:-
i) Council to lobby for Parliamentary investigation into the errors; and
ii) Universities to give students more time to settle their fees in the event of such error coming to light.

170a **Motion** by LINCOLN DIVISION: That this Meeting is appalled at the errors made by the Student Loans Company and Student Finance England in mistakenly awarding tuition fee loans to students doing medicine as a second degree, and then later deducting the payment from universities. We call for Council to lobby for:-
i) parliamentary investigation into the errors, and
ii) universities to give students more time to settle their fees in the event of such error coming to light; and for Council and the Medical Students Committee to produce guidance for potential doctors of the future on the financial implications of Medicine as a career.

170b **Motion** by HOLLAND DIVISION: That this Meeting is alarmed at errors made by the Student Loans Company in England which has led to hardship for students undertaking medicine as a second degree, who have been awarded funding for fees which has then been clawed back.

171 **Motion** by MEDICAL STUDENTS FINANCE SUB COMMITTEE: That this Meeting:-
i) notes that the increase in tuition fees from 2012 will place significant strain on medical students through increased debt;
ii) believes the majority of graduate students who wish to undertake a 5 or 6 year medical degree will be unable to afford to do so, as they will have to pay £9000 of fees upfront in years 1-4;
iii) mandates the MSC to lobby for an affordable fee arrangement that allows graduates access to 5 year medical courses.

172 **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting:-
i) believes that there is a need for greater clarity regarding the actual number of medical students in each year group across each of the medical schools, set against the intake targets agreed by ministers;
ii) believes that, as funding provided to the NHS organisations to support the additional costs of teaching medical undergraduate students is linked to the target intake number, any places filled over and above agreed targets will place increased pressure on Additional Cost of Teaching (ACT) /Service Increment For Teaching (SIFT) funding, which could have damaging implications for the quality of teaching;
iii) calls on medical schools to publish up to date data showing the number of medical students in each year group, accounting for any discrepancy with intake targets set by ministers, and detailing how additional places will be funded.

The motion(s) below, in the shaded area, are unlikely to be reached

173 **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting is concerned about the limited experience of some medical students, especially male medical students, on Obstetrics placement and believes that medical and midwifery students should have equal access to experience in Obstetrics while on placement. This Meeting therefore calls upon the BMA to:-
i) lobby the Royal College of Obstetrics and Gynaecology (RCOG) in recognising this as a problem and work together in addressing it;
ii) lobby the Midwifery Council and other relevant bodies to recognise that medical and midwifery students both have equal rights to gain experience in Obstetrics;
iii) identify current barriers to accessing adequate experience, and suggest potential solutions;
iv) lobby the Medical Schools Council and other relevant bodies to implement these changes.

174 **Motion** by NORTH & MID STAFFORDSHIRE DIVISION: That this Meeting considers it essential, in light of the present organisation of the NHS, that the curriculum for medical students includes teaching of health economics. It instructs Council to ensure that this is communicated to the General Medical Council.

175 **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting:-
i) believes there is currently little training regarding management and rationing within medical schools in the context of doctors being involved in these issues;
ii) considers that in all fields of medicine the need to manage resources will be increased as financial constraints and the ongoing reforms change the NHS.

176 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting recognises that the stigma of mental health illness exists and might deter a student from seeking appropriate help and asks that advice should be readily available and calls on the Medical Student Committee to demand that Medical Schools designate a member of staff to act as a pastoral officer in each cohort.

177 **Motion** by HOLLAND DIVISION: That this Meeting insists that medical schools should fully prepare their students for their future roles as Foundation Doctors, and asks the relevant universities to carry out a survey of recently qualified doctors in order to gather information on how this could be achieved.

178 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting asks the BMA's Medical Students Committee to work with the GMC to ensure that future iterations of the undergraduate curriculum include critical appraisal skills.

179 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting recognises that medical graduates must be competent and safe when prescribing but is concerned that, when the Prescribing Skills Assessment for medical graduates is implemented in 2014, some students, if they fail the Assessment, might jeopardise their progress and calls on the Medical Students Committee to collaborate with medical schools to establish remedial classes.

180 **Motion** by RETIRED MEMBERS FORUM: That this Meeting considers that retired members have time, experience and skills to offer independent mentoring to medical students and asks the BMA to facilitate this.

181 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting applauds the diversity of medical student groups with academic and welfare interests but feels there is great variation in their support from medical schools and calls on the Medical Students Committee to negotiate with the medical schools to set up an infrastructure to assist in the formation and secure their representation within medical schools.

182 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting:-
i) is concerned about student health and well-being;
ii) recognises that students often have two co-existing addresses, namely at home and university;

183 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting notes the motion at the ARM in 2007 regarding the education of medical students about their interaction with the pharmaceutical industry and calls on the Medical Students Committee to publicise the resulting guidance produced in 2010.

A 184 **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting:-
i) confirms the importance of students having access to research journals and articles as part of their training;
ii) notes the high cost to institutions and individuals when accessing scholarly literature;
iii) proposes that this could hinder medical students in their development as 'The Doctor as the Scientist' as well as developing an evidence based clinical approach;
iv) welcomes and endorses the Right To Research Coalition's statement on Open Access to research literature.

GENERAL PRACTICE **Monday 15.40 – 16.15**

185 **Receive**: Report by the Chairman of the General Practitioners Committee (Laurence Buckman).

***** 186 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE EDGWARE AND HENDON DIVISION): That this Meeting believes that:-
i) the current amount of work being moved from secondary to primary care without appropriate movement of resources to support the work is unacceptable and unsustainable;
ii) local agreements must be made to define, control and resource hospital work shifted into the community before it takes place;
iii) any doctor deeming that a patient requires further investigation or treatment must take responsibility for arranging this and the follow up of results;
iv) commissioning bodies must recognise the significant workload pressures in general practice and that expecting practices to do more work without resources puts patients at risk;
v) in many cases premises are not fit for purpose to support this workload shift, and;
vi) the general practice workforce is demoralised by the incessant workload dumped on it.

186a **Motion** by EDGWARE & HENDON DIVISION: That this Meeting, while supporting the delivery of care "closer to home", is deeply concerned by the exponential, excessive, unresourced and often inappropriate transfer of workload from secondary care onto general practitioners, which is often putting pressure on GPs to provide care outside their competence, and without the capacity to deliver safe and effective care, and to the detriment of GPs' responsibility to provide essential primary medical services to their patients.

186b **Motion** by LEEDS LMC: That this Meeting believes that:-
i) the current amount of work being moved from secondary to primary care without appropriate movement of resources to support the work is unacceptable and unsustainable;
ii) local agreements must be made to define, control and resource shifted hospital work in to the community before it takes place;
iii) commissioning bodies must recognise the significant workload pressures in general practice and that expecting practices to do more work without resources puts patients at risk.

186c **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting is concerned about the shift of un-resourced workload from secondary to primary care and reminds all concerned that any doctor deeming that a patient requires further investigation or treatment must:-
i) make arrangements for appropriate treatment or investigation;
ii) follow up the results themselves;
iii) not rely upon remarks buried in a "discharge flimsy" in the expectation that the GP will pick up such work;
iv) such work has already been paid for by the PCO to be performed.

186d **Motion** by JUNIOR MEMBERS FORUM: That this Meeting:-
i) notes with concern the rising workload of GPs together with increasing rates of stress and emotional exhaustion amongst the profession;
ii) believes the current trend of increasing workload is unsustainable;
iii) believes that general practice should not be treated as the sump for all medical and social care.

* 187 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE EAST MIDLANDS REGIONAL COUNCIL): That this Meeting insists that the government must delay the roll out of NHS 111 until the data from the pilot sites has been independently evaluated to inform a reasoned decision about its safety, cost-effectiveness, and impact on in-hours and out of hours general practice, and further requires that this independent evaluation is published.

187a **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting believes that 111 must not be rolled out any further until:-
i) there has been independent peer review of the final pilot study;
ii) evidence has been published on the impact assessment on General Practice and Out of hours providers;
iii) Clinical Commissioning Groups are satisfied that it will not compromise their ability to make appropriate operational, financial, or clinical care pathway commissioning decisions.

187b **Motion** by WEST MIDLANDS REGIONAL COUNCIL: That this Meeting insists that the government must delay the roll out of the NHS111 until the data from the pilot sites has been properly evaluated to inform a reasoned decision about its safety and cost-effectiveness.

187c **Motion** by EDGWARE & HENDON DIVISION: That this Meeting believes that the governments NHS 111 proposals in England should formally be placed on hold, with no further procurements, due to serious concerns regarding the quality and safety of patient care, duplication and increased costs to the NHS, and increasing fragmentation in provision of urgent care.

187d **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting believes that 111 must not:-
i) operationally or financially de-stabilise in-hours general practice;
ii) operationally or financially de-stabilise existing out-of-hours general practice providers;
iii) operationally or financially compromise the ability of incoming CCGs;
iv) become a means to deny patients access to appropriate healthcare professionals.

* 188 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE LEICESTERSHIRE AND RUTLAND DIVISION): That this Meeting calls on the BMA to aid those who wish to return to general practice after a career break as they are a valuable resource and:-
i) believes that making an exam compulsory for re-entry to a Performers List is inappropriate for returning GPs who have already successfully completed UK GP training;
ii) recognises that clinical knowledge and skills may be maintained whilst working abroad;
iii) asks the Health departments to make available sustained help through funding and other support to assist these doctors.

188a **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting calls on the BMA to aid those who wish to return to general practice after a career break as they are a valuable resource and asks the DH to make available sustained help through funding and other support to assist these doctors.

188b **Motion** by WELSH COUNCIL: That this Meeting believes that making an exam compulsory for re-entry to the performers' list is inappropriate for returning GPs who have already successfully completed GP training and calls on the four governments to mandate a formative process without an entrance exam to facilitate returning qualified GPs to the workforce after a career break.

188c **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting demands that GPs who have not worked in the UK for two or more years and are no longer on the "Performers List" should be reinstated and allowed to work in a UK practice if they have maintained both their clinical knowledge and skills whilst they worked abroad.

188d **Motion** by MID-SURREY KINGSTON & ESHER DIVISION: That this Meeting regrets the lack of funding by Primary Care Organisations and Deaneries for the necessary retraining of GPs wishing to return to practice after a career break resulting in a waste of resources.

The motion(s) below, in the shaded area, are unlikely to be reached

189 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting demands that the BMA make certain that:-
i) sessional GPs be readily identified on medical performers lists to enable them to receive important national and local information relevant to their working practice;
ii) medical performers lists be made fit-for-purpose to allow sessional GPs to contact bodies that represent them and work with them.

190 **Motion** by SUFFOLK DIVISION: That this Meeting asks Council to negotiate with the DHS to ensure that the funding and the facilitation of GP IT systems, currently with the PCTs, is carried over to the new commissioning bodies and that the money for these services is ring-fenced.

191 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting demands that sessional GPs, because of their commitment and service to the NHS, should achieve recognition by making them eligible for seniority payments.

192 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting calls on the BMA to put pressure on the government to recognise the extra work being placed on General Practice resulting from the reclassification of disability for state benefits claimants, and ensure that GP's receive appropriate help and funding.

193 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting is concerned that there is no mechanism to compensate General Practice for ever increasing practice expenses, and calls on BMA council to press government to agree on a system that automatically recognises this in pay negotiations.

194 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting believes, that in order for general practice to make use of its of its own valuable workforce resources and continue to develop in the future, it demands that the DH recognise that succession planning should be an integral part of practice and commissioning group development.

195 **Motion** by MID-SURREY KINGSTON & ESHER DIVISION: That this Meeting deeply regrets the lack of career development opportunities for Non Principal GPs.

196 **Motion** by LOTHIAN DIVISION: That this Meeting:-
i) believes that the partnership model is one which has served General Practice well for over 60 years of the NHS;
ii) is dismayed by the reduced partnership opportunities available for newly qualified GPs;
iii) calls on the BMA to do everything in its power to promote the opportunity for partnerships in General Practice.

197 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that the Health and Social Care Act demands that all GPs join a CCG and abide by its rules on procurement and referrals. Instead of negotiation with the BMA, legislation is being used to change the fundamental nature of employment for general practitioners in England.
This Meeting calls on BMA Council and GPC to ballot for strike action to resist this change to contract, and to consider such actions as non-co-operation with CCGs plans, and days of action to promote a Save our Surgeries campaign at a much higher level.

198 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting accepts in full the recommendations of the Royal Benevolent Fund's (RMBF's) "Support for Sessional GPs" which support and revitalise sessional GP groups in the regions and urges the GPC to ensure that:-
i) Clinical Commissioning Groups (CCGs) and LMCs work in partnership to support sessional GP groups;
ii) the RCGP fulfils its promise to the RMBF to remove the professional isolation suffered by many sessional GPs.

199 **Motion** by HARROGATE DIVISION: That this Meeting:-
i) deplores the fact that some prisons do not have physical access to a GP out of hours;
ii) supports the widening of the remit of the prison GP rep on GPC to cover all secure environment GPs;
iii) calls for a numerical increase in secure environment GP representation within the BMA.

200 **Motion** by LEWISHAM DIVISION: That this Meeting calls on BMA to demand that both salaried GPs and GP partners should be eligible to vote in CCG elections and stand for election to CCG positions.

201 **Motion** by EAST DORSET DIVISION: That this Meeting requests the BMA to consider the effect of recent GMC guidance on Good Medical Practice on locum GPs with respect to cancellation of booked sessions.

202 **Motion** by LOTHIAN DIVISION: That this Meeting believes that the Quality and Outcome Framework Quality and Productivity indicators demoralise the profession and there is no evidence to justify them and that therefore these should be removed from future QOF.

203 **Motion** by SUNDERLAND DIVISION: That this Meeting strongly supports every doctor in GP practice being offered partnership after one year of a salary post as it gives stability to both to the practice and to the incoming doctor; and it provides confidence and better working atmosphere to all.

204 **Motion** by REDBRIDGE & STRATFORD DIVISION: This Meeting believes that the requirements demanded in the document "strategy for primary care" in London are unrealistic and unachievable as they will:-
i) it will cost enormous funds to bring practices up to CQC standards;
ii) will lead practices to bankruptcy and eventually to closure;
iii) the funds saved by GP commissioning must be reinvested in primary care.

205 **Motion** by ISLINGTON DIVISION: That this Meeting does not recognise the National Association of Primary Care, the NHS Alliance or the Family Doctor Association a representative of primary care.

206 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting demands that the BMA:-
i) ends the closet discrimination against female GPs which forces them to choose low paid salaried posts in return for maternity leave benefits;
ii) insists that salaried GPs should be employed on terms and conditions comparable to those in the salaried model contract;
iii) demands that salaried GPs are fairly paid.

207 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting believes that patients should have the right to purchase health care from any appropriate provider, especially relevant now with the ever increasing list of services no longer available on the NHS, including their provider of General Medical Services, and that any future negotiation of the GP contract should include this provision.

208 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting recognises that GP practices in London and other inner cities are responsible for the care of a disproportionate number of ethnic and migrant patients. This may leave them with lists including 'ghost patients'. While it is clearly appropriate for lists to be regularly updated and these 'ghost patients' removed, the consequent loss of revenue may render such practices financially unviable. This Meeting calls for the special circumstances of these practices to be recognised and additional alternative funding to be made available to reflect the special demands of caring properly for these patients.

209 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting condemns the wholesale removal of patients from the lists of GPs, particularly in London, and:-
i) wonders how a PCT can allow practices to supposedly accumulate 2000 or more "ghost" patients when there is a national computer data base for registrations;
ii) demands that a PCO prove that the patients are "ghosts" before they are removed from a practice list;
iii) asks BMA to highlight to the DH the adverse impact and risk of de-stabilisation of primary and secondary care if some 5-10% of the resident population suddenly " disappears".

210 **Motion** by CITY & HACKNEY DIVISION: That this Meeting notes that the 'Register Anywhere' pilots were intended to test arrangements for commuters to access general practice close to work rather than home. However there has been little consultation with GPs about these pilots, no clear guidance for practices participating, and no clear objectives formulated. The pilot does not improve on current provision, it multiplies bureaucracy and threatens continuity of care. This Meeting instructs the BMA to oppose 'Register Anywhere' pilots and instead to negotiate with the DH, on behalf of general practitioners, about the present system of immediate and necessary treatment.

211 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting is concerned that the continuity of narrative and care epitomised by the 'family GP' has been eroded recently such as to devalue the model of general practice, and believes it is for the profession lead by the BMA to restore this standard of continuity.

212 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting calls on the GPC to lobby the CCGs to include more sessional GPs in their CCG practices boards and CCG executive committees by ensuring adequate or proportionate representation of various contractual statuses of the GPs working within the CCG and further encourage individual practices to support this.

A 213 **Motion** by EDGWARE & HENDON DIVISION: That this Meeting affirms that NHS GPs and practices, whilst independent contractors, are first and foremost NHS providers of care, and this Meeting totally refutes and rejects the misguided interpretation and deliberate political propaganda of considering NHS GPs in the same vein as competitive commercial private healthcare providers.

CONSULTANTS **Monday 16.15 – 17.00**

214 **Receive**: Report by the Chairman of the Consultants Committee (Mark Porter).

215 **Motion** by NORTH & MID STAFFORDSHIRE DIVISION: That this Meeting is concerned at reports that consultant medical staff have been subject to disciplinary procedures (relating to both conduct and competence) when their only offence has been to challenge and resist service changes that have been introduced or proposed solely for financial reasons. This Meeting directs Council to seek a comprehensive report from BMA IROs to establish whether these reports have substance. If it does, it directs Council to raise this matter with the Department of Health and to consider raising it in the media.

***** 216 **Motion** by CONSULTANTS CONFERENCE: That this Meeting believes that an attack on Clinical Excellence Awards is an attack on delivering quality in the NHS and:-
i) that abolition of CEAs will lead to demotivation, loss of innovation and leadership while achieving only relatively small savings;
ii) deplores the government's delayed release of the 2011 DDRB Review on compensation levels, incentives and the Clinical Excellence and Distinction Award schemes and demands that this review and the government's response to it be published immediately;
iii) calls for the maintenance of a fair system for rewarding clinical excellence.

216a **Motion** by OXFORD DIVISION: That this Meeting should stress that Clinical Excellence Awards for senior hospital medical staff should continue to reward clinical excellence at least in numbers and in value pari passu with those before the recent cuts were made.

216b **Motion** by HOLLAND DIVISION: That this Meeting notes with concern the delay in the release of the DDRB report on Clinical Excellence Awards, and calls on the government to make this public.

216c **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting deplores the prolonged and wilful silence of the government on Clinical Excellence Awards. This has potential for doctors stopping doing extra work that brings excellence in clinical work, management and research. The BMA must compel government to:-
i) reveal the report of the DDRB review;
ii) instruct the ACCEA to open application for 2011-12 which are overdue by 3 months.

216d **Motion** by EAST DORSET DIVISION: That this Meeting will push the government to consider the adverse effects on consultants' motivation by the removal of the Clinical Excellence Awards, currently given for above-average performance and extraordinary working.

216e **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting deplores the governments delay in publication of and response to the doctors and dentists review body 2011 report on Clinical Excellence Awards, and calls for the maintenance of a fair system for rewarding clinical excellence.

216f **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting condemns the governments' delayed release of the DDRB's report on consultant award schemes and demands that the DDRB Report and the governments' response to it be published immediately.

217 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that transferability of consultants between the four UK countries is essential and therefore calls on the BMA to develop guidance on transferring accrued contractual rights and pension entitlements so that the process of movement of medical staff across the UK can be facilitated.

218 **Motion** by CONSULTANTS CONFERENCE: That this Meeting believes that cuts in administrative and clerical staff within the NHS mean that consultant staff pick up an increasing administrative burden, making their clinical work less efficient and productive. This Meeting calls upon the health departments to ensure that consultant staff have adequate administrative and clerical support to enable them to deliver a quality and timely service to their patients.

The motion(s) below, in the shaded area, are unlikely to be reached

219 **Motion** by CONSULTANTS CONFERENCE: That this Meeting, whilst recognising the benefits of a consultant delivered service, condemns the construction of job plans, which include extended working days and on-call rotas without incorporation of the European Working Time Directive requirements for adequate rest periods and calls upon the BMA to update nationally agreed job planning guidance accordingly.

220 **Motion** by OXFORD DIVISION: That this Meeting supports a consultant delivered service and asks the BMA to encourage increasing consultant numbers.

221 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that care in the NHS should be led and delivered by consultants to ensure that patients receive the highest quality care possible and therefore calls on government to make all training grade medical posts supernumerary and simultaneously expand the consultant grade to provide a quality consultant delivered service.

222 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting recognises that:-
i) it takes at least 13-14 years to train a NHS consultant from medical school entry to final appointment;
ii) throughout every working day, consultants make critical decisions that directly affect the lives of patients and their relatives;
iii) consultants provide vital leadership in the NHS, continually working to improve the quality of care to patients, often without reward ;
iv) the current remuneration in pay and pension entitlements of consultants is therefore fully justified considering the level of responsibility that consultants have for patients and the NHS;
v) demands the government does not seek to reduce the pay and pension of consultants.

223 **Motion** by OXFORD DIVISION: That this Meeting deplores the recent process whereby an NHS Trust made a substantive consultant appointment having only advertised it to internal candidates, and believes that this undermines the Department of Health's good practice guidance on consultant appointments and may rob the local population of the best applicants, and demands:-
i) that the Department of Health requires that all NHS career grade posts must be advertised nationally and in a manner that ensures easy access for all potential applicants;
ii) that Trusts that disregard the good practice guidance on the consultant appointments process should have sanctions placed upon them, including the withdrawal of approval and funding for training posts.

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i) that the Department of Health requires that all NHS career grade posts must be advertised nationally and in a manner that ensures easy access for all potential applicants;

ii) that hospitals that disregard the good practice guidance on the consultant appointments process should have sanctions placed upon them, including potentially the withdrawal of approval and funding for training posts.

225 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting calls on the BMA to produce guidance for consultants to assist them with developing portfolio consultant roles throughout their career.

226 **Motion** by CONSULTANTS CONFERENCE: That this Meeting believes that properly safeguarding children requires the involvement of enthusiastic, well trained consultants and asks the BMA to work with the RCPCH and employers to ensure universal access for consultants involved in child protection work to:-
i) a standardised refresher educational programme;
ii) mentoring support specific to their child protection work;
iii) a practical court skills training programme.

227 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that the pay and pensions of consultants are appropriate because they are "worth it".

228 **Motion** by CONSULTANTS CONFERENCE: That this Meeting, noting that LNCs have not historically been involved in negotiating medical managers pay, nor their terms and conditions of service, recognises that medical management is a branch of practice and as such, as a matter of urgency, medical managers should be able to benefit from the same level of support from LNCs that is afforded to other hospital doctors.

A 229 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting condemns employers who do not fully consult with consultants during service reconfiguration and then seek to impose job plan modifications without discussion or use of the job planning process and demands that employers do not make significant changes to job plans outside the job planning process without full and formal consultation with consultants.

JUNIOR DOCTORS — Monday 17.00 – 17.25

230 **Receive**: Report by the Chairman of the Junior Doctors Committee (Tom Dolphin).

231 **Motion** by LAMBETH & SOUTHWARK DIVISION: That this Meeting believes that the availability of different diary card systems and the variability in implementation of monitoring exercises by employers is detrimental to the quality of data received, and calls on the BMA to work with the Departments of Health to:-
i) revise the national guidance to provide clearer instructions to employers on how monitoring should be conducted;
ii) adopt or develop a single diary card system for use throughout the NHS.

232 **Motion** by BRISTOL DIVISION: That this Meeting believes that no junior should be out-of-pocket due to travel expenses necessitated by short-term, pre-allocated rotations within a training scheme and that the JDC must renew the fight for fair reimbursement of such expenses.

The motion(s) below, in the shaded area, are unlikely to be reached

233 **Motion** by OXFORD DIVISION: That this Meeting notes the tough financial circumstances surrounding junior doctors and expresses regret that Royal Colleges have not seen fit to take sufficient account of these when substantially raising fees imposed on junior doctors for courses and examinations. It asks that Council ask the Colleges to encourage a fairer and more equitable approach in the future.

Contingency time — Monday 17.25 – 17.30

CHAIRMAN OF COUNCIL'S QUESTION AND ANSWER SESSION — Monday 17.30 – 17.45

Session close — Monday 17.45

MEDICAL ACADEMIC STAFF

Tuesday 09.15 – 09.40

234 **Receive**: Report by the Co-Chairs of the Medical Academic Staff Committee (Peter Dangerfield and Michael Rees).

* 235 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting notes that the BMA has not been consulted prior to the decision being taken by the Vice-Chancellors of the Universities of Exeter and Plymouth to split up the Peninsula College of Medicine and Dentistry (PCMD) into two distinct medical schools in Exeter and Plymouth and asks the BMA to present our concerns to the GMC forthwith.

235a **Motion** by BRISTOL DIVISION: That this Meeting believes the proposed devolution of Peninsula Medical School will create two unsustainable medical schools due to medical student numbers. The BMA should take a strong stance to protect the future of medical education, training and research in the far South West, reminding all of the dedication to improving patient care and involvement in the community that were made during the creation of Peninsula Medical School.

235b **Motion** by SOUTH WESTERN RJDC: That this Meeting notes that the devolution of the Peninsula Medical School is likely to be unsustainable, as it depends on an increase in medical student numbers for the survival of at least one of the proposed new schools. The lack of consultation with stakeholders, staff and students, combined with hasty implementation will have a detrimental impact on the schools that will be established and, as a consequence on the education of current and future medical students in the far South West.

235c **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting recognises the significant news that Peninsula College of Medicine and Dentistry is to be divided due to the cessation of partnership by the parent universities and calls on the MSC to:-
i) contact both the medical school and the parent universities to deplore on behalf of the affected medical students:-
a) the complete lack of information prior to the split;
b) failure to provide any consultation with students on the separation before it being publicly announced;
c) the continual uncertainty perpetuated by the lack of definitive information on the division.
ii) ensure the provision of active support of the needs of the BMA members across the Peninsula in this difficult and uncertain time;
iii) work with both new medical schools, parent universities and stakeholders (including the GMC and relevant BMA branch of practices) to develop a substantiate future for both medical institutions;
iv) lobby the General Medical Council to maintain a tight regulation on the current medical school and its fledgling off shoots utilising information obtained by the BMA representatives to highlight developments or concerns;
v) actively publicise the good work to the members in the south west.

235d **Motion** by UNIVERSITY OF BRISTOL: That this Meeting believes the proposed splitting of Peninsula Medical School may create two unsustainable medical schools, due to inadequate medical student numbers, and difficulties in arranging and managing placements in the NHS from two medical schools. Whilst welcoming proposed investment in research and current reassurances on medical academic posts, this Meeting demands the protection of the future of medical education, training and research in the far South West, reminding all of the dedication to improving patient care and involvement in the community that was made during the creation of Peninsula Medical School.

236 **Motion** by UNIVERSITY OF LONDON: That this Meeting welcomes the establishment of the Health Research Authority (HRA) as a special health authority on 1 December 2011 and expresses the hope that the HRA will act as a national facilitator for appropriate and ethical participation in research by volunteers, patients and doctors.

The motion(s) below, in the shaded area, are unlikely to be reached

237 **Motion** by UNIVERSITY OF BRISTOL: That this Meeting notes the hard work that continues to be done in representing academics on the front line by academic representatives on Local Negotiating Committees (LNCs), and calls on the BMA to build on the guidance issued by MASC by:-
i) bringing together academic members of LNCs locally and nationally; and
ii) establishing a dedicated internet-based forum set up to support representatives.

238 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting:-
i) recognises that clinicians have an essential role to play in research;
ii) recognises that clinical research adds value to the clinician's professional development, patient care, medical education, and the UK economy;
iii) wishes to encourage the role of the clinicians involved by formally recognising clinician

participation; and therefore calls on the BMA to lobby medical employers to include in the incentive structure explicit recognition of time spent on research.

239 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting:-
i) recognises that UK medical schools, particularly those in the Russell Group, are placing more emphasis on research than on undergraduate medical education, with medical education now being provided on tight and shrinking budgets at many institutions;
ii) recognises this is due in part to the way these institutions are ranked and funded;
iii) believes that this imbalance must be redressed, so that schools invest more of their resources on attaining excellence in medical education as well as having a high output of quality research;
iv) believes that new measures for assessing the quality of medical education at a school will have to be devised;
v) believes that at a time when clinical academic numbers are in decline across the UK, we must produce and employ more clinical academics to teach.

PUBLIC HEALTH MEDICINE **Tuesday 09.40 – 10.00**

240 **Receive**: Report by the Chairman of the Public Health Medicine Committee (Richard Jarvis).

* 241 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE CAMBRIDGE, HUNTINGDON AND ELY DIVISION): That this Meeting believes that public health specialists working in public sector or third sector organisations should retain:-
i) the right to be appointed on NHS equivalent terms and conditions of service;
ii) access to NHS pension provision;
iii) a contractual duty to advocate on behalf of their patient; the population;
iv) a contractual right to speak out on matters of professional importance;
v) a primary duty to the population served above and beyond all other considerations.

241a **Motion** by CAMBRIDGE HUNTINGDON & ELY DIVISION: That this Meeting deplores that the transfer of public health doctors to local authorities:-
i) will result in the fragmentation of public health services;
ii) has resulted in some local authorities proposing to remove the name of consultant from medically qualified staff;
iii) has resulted in a dramatic decrease in medical trainees entering public health;
iv) will result in the demise of the medical specialty of public health and the specific benefits that that doctors bring to the service and calls upon the BMA to use all possible means to publicise and prevent further implementation of this retrograde step.

241b **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting believes that public health specialists working in public sector or third sector organisations should retain:
i) the right to be appointed on NHS equivalent terms and conditions of service;
ii) access to NHS pension provision;
iii) a contractual duty to advocate on behalf of their patient, the population;
iv) a contractual right to speak out on matters of professional importance;
v) a primary duty to the population served above and beyond all other considerations.

241c **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting is concerned that Directors of Public Health who are employed by local authorities may be prevented from giving views on current government health policies, and calls on the government to enable them to be employed within the NHS.

241d **Motion** by NOTTINGHAMSHIRE LMC: That this Meeting believes the transfer of public health to local authorities is one of the greatest flaws in the government's reforms and fears that it will:
i) reduce CCGs' access to necessary public health advice;
ii) reduce funding available to support necessary public health initiatives;
iii) further diminish public health as a medical specialty;
iv) potentially undo many of the valuable public health initiatives through which the health of the nation has been improved over the past decade.

241e **Motion** by EDGWARE & HENDON DIVISION: That this Meeting deplores the emasculation of public health doctors and the discipline of public heath from commissioning in the NHS in England as a result of the Health and Social Care Act, and believes that clinical commissioning groups must be required to have formal public health input in their commissioning decisions to ensure evidence based, and equitable use of their commissioning budget.

242 **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting welcomes plans to register and regulate public health specialists from professional backgrounds other than medicine on a statutory basis, and believes this should most appropriately take place under the Health Professions Council and to standards directly equivalent to those applied to public health doctors regulated by the General Medical Council and comparable to other health professions already regulated by the Health Professions Council.

The motion(s) below, in the shaded area, are unlikely to be reached

243 **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting believes that in order to maintain standards of practice in public health medicine, all appointments at consultant level including directors of public health should be subject to the Appointment of Consultants Regulations and the proper scrutiny of Advisory Appointments Committees, regardless of the appointing organisation.

244 **Motion** by BRISTOL DIVISION: That this Meeting believes that the opportunity to train in a clinical specialty at the same time as public health is becoming an increasingly attractive option to many medically qualified public health registrars and mandates the BMA to explore facilitating this option with the Faculty of Public Health and other relevant postgraduate bodies.

245 **Motion** by LINCOLN DIVISION: That this Meeting supports the arrangements introduced following the Shipman Inquiry to monitor the prescription, dispensing and destruction of controlled drugs, and believes that the role of the primary care trust accountable officer for controlled drugs should, from April 2013, best be fulfilled by a senior public health doctor employed by the relevant local authority, and we call for the Public Health Medicine Committee to lobby the Department of Health [England] for this change.

246 **Motion** by UNIVERSITY OF EAST ANGLIA: That this Meeting is concerned at the future of academic public health following the major re-organisation of public health services in England and fears for the future of public health as an academic specialty. This Meeting, therefore, calls for:-
i) all public health doctors that wish it to retain the right be appointed to honorary academic contracts with an appropriate local higher education institution;
ii) public health consultants being transferred to Public Health England on civil service terms and condition to retain the right to be primary investigators and to hold the relevant research budget;
iii) joint appraisal and job planning for public health academics, if necessary across the three sectors of NHS, local government and higher education.

SCIENCE, HEALTH AND SOCIETY **Tuesday 10.00 – 11.05**

247 **Receive**: Report by the Chairman of the Board of Science (Professor Averil Mansfield).

248 **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting urges:-
i) the BMA to adopt a policy of supporting mandatory fortification of flour with folic acid to prevent neural tube defects in line with the recommendations of the Food Standards Agency and the Scientific Advisory Committee on Nutrition;
ii) the UK nations to form legislation to make it a requirement for folic acid supplements to be in flour and flour based products.

* 249 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE PUBLIC HEALTH MEDICINE CONFERENCE): That this Meeting calls upon all UK governments to:
i) ensure that food labelling clearly indicates the potential health impact of all foodstuffs:
ii) ban sales of food containing partially hydrogenated fats;
iii) impose a levy on foodstuffs containing more than 2.3% saturated fats;
iv) impose a limit on salt in basic food items;
v) levy a new tax on unhealthy food;
vi) make nutritional education a compulsory component of the national school curricula.

249a **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting calls upon the UK governments to advocate at a UK level for a tax on unhealthy food, and a mandatory limit on salt in basic food items. This is in line with the findings of an exhaustive Australian study which found that such actions could potentially have a large impact on the control of obesity.

249b **Motion** by MERSEY RJDC: That this Meeting calls on the BMA to lobby the government to introduce a "fat tax", levying a surcharge on foodstuffs containing more than 2.3 per cent saturated fat in an effort to tackle Britain's growing levels of obesity.

249c **Motion** by CONFERENCE OF LMCS AGENDA COMMITTEE: That this Meeting believes that the obesity epidemic facing the UK needs to be tackled primarily by society as a whole and calls on all UK governments to:-
i) ensure that food labelling clearly indicates the potential health impact of all foodstuffs;
ii) make nutritional education a compulsory component of the national school curriculum;
iii) levy VAT on the purchase of unhealthy food;
iv) ban sales of food containing partially hydrogenated fats.

* 250 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE JUNIOR MEMBERS FORUM): That this Meeting believes that vitamin D deficiency in many groups within the UK population may be a significant underlying factor in a number of health problems, and:-
i) believes that deficiency is so common, particularly in those of South Asian ancestry, that this now represents a public health problem;
ii) notes the challenges facing clinicians in deciding when to test for vitamin D deficiency and in prescribing effective vitamin D supplements;
iii) asks the Board of Science to produce clear and simple guidance on the investigation and treatment of vitamin D deficiency.

250a **Motion** by JUNIOR MEMBERS FORUM: That this Meeting acknowledges "The Dangers of Vitamin D Deficiency Highlighted" document by the Four Chief Medical Officers on 6th February 2012, however believes lack of accompanying guidance has left Health Professionals without adequate support. We therefore call upon the Departments of Health to produce national guidance on the investigation, diagnosis and management of Vitamin D deficiency.

250b **Motion** by BRO TAF LMC: That this Meeting believes subnormal vitamin D levels are so common and particularly in those of South East Asian ancestry that this now represents a public health issue and as such requires a public health solution.

250c **Motion** by SCOTLAND SASC: That this Meeting believes that Vitamin D deficiency in many groups within the UK population is a significant underlying factor in a number of health problems and urges all four Health Departments in the UK to introduce a national programme of Vitamin D supplements.

250d **Motion** by SCOTTISH COUNCIL: That this Meeting believes that Vitamin D deficiency in many groups within the UK population is a significant underlying factor in a number of health problems and urges all four Health Departments in the UK to introduce a national programme of Vitamin D supplements.

* 251 **Motion** by SCOTTISH COUNCIL: That this Meeting calls on the UK governments:-
i) to promote the culture of children playing outside in view of the health benefits associated with outdoor play;
ii) to instruct local authorities to stop selling off outdoor play spaces for development purposes and instead invest in the development and maintenance of these spaces to ensure they are safe, stimulating and easily accessible to all children in the UK.

251a **Motion** by SASC CONFERENCE: That this Meeting calls on the UK governments:-
i) to promote the culture of children playing outside in view of the health benefits associated with outdoor play;
ii) to instruct local authorities to stop selling off outdoor play spaces for development purposes and instead invest in the development and maintenance of these spaces to ensure they are safe, stimulating and easily accessible to all children in the UK.

* 252 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE PUBLIC HEALTH MEDICINE CONFERENCE): That this Meeting calls on the government to commission an external evaluation of the impact of the 2012 Olympics on health in the short, medium and long term.

252a **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting calls on the Greater London Authority to commission an external evaluation of the impact of the Olympics on the short, medium and long term health of Londoners.

252b **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting welcomes the Olympic Games 2012 and applauds the hard work of the organisers. This Meeting calls on all relevant parties to ensure a long lasting Olympic legacy which will improve the public's health.

252c **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting calls on the government to publish a clear and measurable costed summary of the Olympic legacy beyond the infrastructure of the Olympic park and venues.

* 253 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE SOUTH CENTRAL REGIONAL COUNCIL): That this Meeting applauds the ready availability of voluntary and statutory services for basic and advanced life support and:-
i) notes the call by the BMA in 1999 for resuscitation to be taught in schools;
ii) regrets that the teaching of resuscitation in schools is not mandatory;
iii) applauds the efforts of healthcare and the third sector to provide such training;
iv) supports the call by the Resuscitation Council and the British Heart Foundation for this to become a mandatory component of the curricula of all schools in the UK and calls on the BMA to campaign for this;
v) calls for the governments to introduce the teaching of first aid in schools.

253a **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting, with regard to the inclusion of training in resuscitation skills for schoolchildren:-
i) notes the call by the BMA for this in 1999;
ii) regrets that this is still not a mandatory component of the curriculum in any of the nations of the United Kingdom;
iii) applauds the efforts of healthcare and 3rd sector groups to provide such training;
iv) supports the call by the Resuscitation Council and the British Heart Foundation for this to become a mandatory component of the curricula of all schools in the UK and calls on the BMA to campaign for this.

253b **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting, with regard to the inclusion of training in resuscitation skills for schoolchildren:-
i) notes the call by the BMA for this in 1999;
ii) regrets that this is still not a mandatory component of the curriculum in any of the nations of the United Kingdom;
iii) applauds the efforts of healthcare and 3rd sector groups to provide such training;
iv) supports the call by the Resuscitation Council and the British Heart Foundation for this to become a mandatory component of the curricula of all schools in the UK and calls on the BMA to campaign for this.

253c **Motion** by SCOTTISH COUNCIL: That this Meeting believes that the teaching of first aid should be introduced into the UK school curricula.

253d **Motion** by WELSH COUNCIL: That this Meeting applauds the ready availability of voluntary and statutory services, recently able to resuscitate Fabrice Muamba and we call on the BMA Board of Science to work with relevant persons and bodies, such as Vinnie Jones, to publicise and educate the public regarding CPR and immediate resuscitation techniques.

The motion(s) below, in the shaded area, are unlikely to be reached

254 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting calls on the BMA to adopt as principle the parity of esteem between physical and mental health.

255 **Motion** by BIRMINGHAM DIVISION: That this Meeting wishes to bring to the attention of the public that the medical profession is not updated on guidance regarding action to take or advice to give in the event of the release of nuclear radiation into the atmosphere. We believe that this leaves the public vulnerable to a major threat to public health and requests that the Health Protection Agency develops an effective strategy for dissemination of evidence-based guidance as a matter of urgency, to minimise harm to health in the event a nuclear incident.

256 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting has concerns about the conflict between the health care and retail functions of community pharmacies and demands:-
i) that unproven treatments are clearly labelled as such;
ii) that screening tests that fail to meet World Health Organisation standards are clearly labelled as such;
iii) the immediate removal of non-therapeutic high fat and high calorie foods and drinks from community pharmacies.

257 **Motion** by HARROGATE DIVISION: That this Meeting takes note of the recommendations of the Bailey Review of the Commercialisation and Sexualisation of Childhood and:-
i) endorses the recommendation to ensure 'that magazines and newspapers with sexualised images on their covers are not in easy sight of children';

ii) calls on the BMA to encourage progress in the industry's implementation of this recommendation.

258 **Motion** by FORENSIC MEDICINE COMMITTEE: That this Meeting regarding the Bailey Review of the Commercialisation and Sexualisation of Childhood:-
i) endorses the recommendation to ensure 'that magazines and newspapers with sexualised images on their covers are not in easy sight of children';
ii) calls on the BMA to lobby for the implementation of this recommendation.

259 **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting urges Her Majesty's coalition government to rapidly implement the recommendations of the innovation, universities, science and skills committee in 2008, which found that no one single organisation or minister had, or should have, the remit to oversee bio-security in the United Kingdom.

260 **Motion** by SUFFOLK DIVISION: That this Meeting urges the coalition government to rapidly implement the recommendations of the Innovation, Universities , Science and Skills Committee in 2008, which found that no one single organisation or Minister had, as should have, the remit to oversee biosecurity in the United Kingdom.

261 **Motion** by SOUTHERN RSASC: That this Meeting instructs the BMA to campaign for better regulation of the prescription of opioids by non-specialists in light of the increased levels of accidental overdose.

262 **Motion** by MANCHESTER & SALFORD DIVISION: That this Meeting:-
i) recognises the government's responsibility to reduce health inequalities by investing in public services such as the NHS and education;
ii) recognises the developed world's duty to provide humanitarian aid to the third world;
iii) recognises the urgency involved in tackling climate change and its threat to global health;
iv) applauds the call for a Financial Transactions Tax or 'Tobin Tax' to address the above by former BMA president Sir Michael Marmot, Oxfam, Medsin UK, 39 Members of Parliament (from all parties), UNISON, the NUT (National Union of Teachers), two Nobel prize winners for economics and the French and German governments;
v) calls upon the BMA to support a Tobin Tax of 0.05% on the banking sector to raise an estimated £20billion. This money would then be spent on public services (in particular the NHS), fighting climate change and overseas humanitarian aid;
vi) calls upon the BMA to lobby the government to implement the Tobin Tax.

263 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting calls on the pharmaceutical industry to align their pack sizes to evidence based prescribing in order to reduce wastage.

264 **Motion** by MANCHESTER & SALFORD DIVISION: That this Meeting in light of the proliferation of the advertising and promotion of vitamin supplements, including the use of celebrity endorsement, calls on the Board of Science to produce guidance to enable doctors to better understand the value of these supplements.

265 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes climate change:-
i) will have a massive impact on the health of people across the world;
ii) needs to be taken much more seriously by the UK government.

266 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting is alarmed that the development of new antibiotics is drying up, recognises the need to encourage the pharmaceutical industry to address the deficit of new antibiotics, and calls on the government to accelerate the approved licensing process for new antibiotics.

267 **Motion** by BIRMINGHAM DIVISION: That this Meeting requires the BMA Board of Science to undertake an urgent investigation into the health consequences of increasing the retirement age for doctors:-
i) with regard to the prevalence of degenerative conditions that may affect the efficacy of older medical staff and the consequent risks to patient safety and resulting litigation costs likely to fall on the NHS;
ii) on the life expectancy of doctors.

268 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting:-
i) believes that requiring doctors to work until a state retirement age of 67 or more years, in order to achieve their pension, is potentially unsafe in many specialties;
ii) calls on the BMA to investigate what evidence there is on the abilities of doctors in different

specialties to continue to perform at a high standard at advanced ages;
iii) calls on the NHS and governments to ensure that any changes to retirement age reflect an individual's physical and mental ability to carry out their work;
iv) requires the NHS and governments to ensure that sufficient safeguards are in place to protect the health and safety of doctors and their patients from the possible impact of the changes to retirement age, and to include, if necessary, the ability to retire early, with no abatement of pension, if appropriate work can no longer be safely performed.

A 269 **Motion** by WEST MIDLANDS REGIONAL COUNCIL: That in view of the increased financial constraints, the NHS should not fund homeopathy because it has an inadequate evidence base.

A 270 **Motion** by PUBLIC HEALTH MEDICINE CONFERENCE: That this Meeting notes:-
i) the findings of the Marmot review on health inequalities which found that those living in poorest areas live an average seven years less than those in the richest ones;
ii) that the Marmot report believes the provision of a good start for children, free from poverty, is the single most important recommendation it can make.
This Meeting believes that child poverty is unacceptable at any level in one of the world's richest countries and resolves to ask the governments across the UK to take action on this issue to ensure that it is addressed both in terms of policy and resources by the administrations in London, Edinburgh, Belfast and Cardiff.

A 271 **Motion** by SASC CONFERENCE: That this Meeting believes that men tend to ignore their health. The incidence of testicular cancer accounts for 1% of all cancers that occur in men and the number of cases in England and Wales has doubled over the last two decades. The BMA and media should support an awareness campaign as early detection of these tumours has much better outcomes.

A 272 **Motion** by SOUTHERN RSASC: That this Meeting instructs the BMA to explore the possibility of making the Hepatitis B vaccination universal to be part of the childhood immunisation programme.

A 273 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting notes the risk to women's health from cervical malignancy and the most significant risk factors, namely Human Papilloma Virus (HPV) strains 16 and 18. We call on the BMA to advocate the beneficial use of the HPV vaccine internationally and to share our expertise in area of cervical cancer prevention via the World Health Organisation.

A 274 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting asks the government to carry out a cost benefit analysis of replacing HPV bivalent vaccine to HPV quadrivalent. Pending on the analysis extend the quadrivalent vaccine to both sexes to counter growing incidence of genital warts.

A 275 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting demands adequate resources to support doctors and patients in making decisions regarding genetic testing.

A 276 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting recognises that with advanced years of age, it may be increasingly difficult for doctors to undertake onerous on call duties and maintain their health, and therefore calls on the Board of Science to produce a report examining the effects of on-call duty in the out of hours period on doctors in the later stages of their careers.

A 277 **Motion** by WEST GLAMORGAN DIVISION: That this Meeting believes that in view of the continuing emergence of antibiotic resistant organisms, the use of antibiotics in healthy farm animals as growth promoters must be banned as a matter of emergency.

Alcohol, tobacco and other dangerous drugs — Tuesday 11.05 – 11.25

***** 278 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE LEICESTERSHIRE AND RUTLAND DIVISION): That this Meeting, with regard to the UK government policy on alcohol, this Meeting:
i) calls for the abandonment of the failed "responsibility agreements" relying on the drinks industry to promote responsible drinking;
ii) calls for a separation of driving from drinking by banning the sale of alcohol at garage forecourt retail outlets;
iii) calls for a campaign against binge drinking culture in the UK;
iv) believes the latest proposals for the minimum price per unit of alcohol are too low;
v) instructs the BMA to raise awareness of the increased risks related to alcohol consumption during pregnancy and increased incidence of foetal alcohol syndrome;
vi) demands that the BMA redoubles its efforts to convince the government to take more decisive action.

278a **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting regards the strategy of the Department of Health to promote responsible drinking as flawed because it relies on the drinks industry putting public health before profit and also believes its latest proposal to introduce 40p as the minimum price per unit of alcohol as too low and demands that the BMA redoubles its efforts to convince the government to take more decisive action in this tragic situation.

278b **Motion** by WALTHAM FOREST DIVISION: That this Meeting regrets that the government policy on alcohol has not been finalised and demands that the government must now address urgently issues such as pricing and availability and create a viable strategy.

278c **Motion** by GLASGOW LMC: That this Meeting welcomes for the Scottish Government's reintroduction of the Minimum Price Alcohol Bill to the Scottish parliament and urges other UK nations to adopt similar legislation.

278d **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting applauds HM governments support for a minimum retail price per unit of alcohol in England and:-
i) believes that cheap imports of beers and ciders will be immune from this and that such imports may proliferate (the white van effect);
ii) calls for a limit of imports per person from EEC countries into the UK to a maximum of 48 x330ml per person of beer and ciders;
iii) calls for a separation of driving from drinking by banning the sale of alcohol at garage forecourt retail outlets.

278e **Motion** by SOUTHERN RSASC: That this Meeting instructs the BMA to raise awareness of the increased risks related to alcohol consumption during pregnancy and increased incidence of foetal alcohol syndrome.

278f **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting notes the publication of the University of Sheffield's updated 2012 data on the beneficial effects of a mandatory minimum price for a unit of alcohol to improve health and other outcomes. This Meeting calls on the Westminster government to abandon the failed "responsibility agreements" and to move without delay to legislate for an effective minimum price for a unit of alcohol of no less than 45p/unit.

278g **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting notes the publication of the University of Sheffield's updated 2012 data on the beneficial effects of a mandatory minimum price for a unit of alcohol to improve health and other outcomes. This Meeting calls on the Westminster government to abandon the failed "responsibility agreements" and to move without delay to legislate for an effective minimum price for a unit of alcohol of no less than 45p/unit.

* 279 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE OCCUPATIONAL MEDICINE COMMITTEE): That this Meeting, in light of the increasing use of "electronic cigarettes" ("e-cigarettes") and statements from the WHO and US Food and Drugs Administration, this Meeting calls on the BMA to:-
i) explore the impact of electronic cigarettes on individual users and the wider population;
ii) if deemed necessary, call on the UK administrations to regulate their use.

279a **Motion** by OCCUPATIONAL MEDICINE COMMITTEE: That this Meeting calls on the UK administrations to regulate electronic cigarettes and to extend smoke-free public places legislation to include second-hand vapours from electronic cigarettes.

279b **Motion** by SOUTH THAMES RJDC: That this Meeting notes:-
i) the increasing popularity of "electronic cigarettes" or "ecigarettes";
ii) the statements by the US Food and Drug Agency and WHO;
iii) that the UK currently has no regulation on e-cigarettes;
This Meeting therefore calls on the UK administrations:-
i) to regulate electronic cigarettes;
ii) to extend smoke-free public places legislation to include second-hand vapours from electronic cigarettes.

The motion(s) below, in the shaded area, are unlikely to be reached

280 **Motion** by EALING, HAMMERSMITH AND HOUNSLOW LMC: That this Meeting in the light of the evidence, believes that the inability of councils to regulate the alarming growth in shisha pipe smoking by young and other adults is undermining the work of general practice government policy on cancer, and strongly recommends that:-
i) all necessary action is taken by UK governments, national and local, to reduce the risk shisha-related smoking diseases with their associated costs to health budgets;
ii) local authority health and wellbeing boards and public health departments in affected areas work

collaboratively with local communities, schools, GPs and other and health professionals to inform and reduce the risks from primary and secondary shisha smoking.

281 **Motion** by BIRMINGHAM DIVISION: That this Meeting regrets the harm to health that results from excessive consumption of alcohol and calls on DH to increase investment in alcohol treatment services in proportion to the number of people presenting for treatment, seeking out and adopting best practice around the world.
This Meeting urges the BMA Board of Science to contribute by reviewing the evidence of effectiveness of alcohol treatments across Europe.

282 **Motion** by WALES SASC: That this Meeting urges the UK government and devolved administrations to campaign against binge drinking culture in the UK and to charge for the treatment of patients in accident and emergency for alcohol induced collapse.

283 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting urges the UK government that in its effort to stop binge drinking, together with increasing the prices of alcohol, the government should charge patients for the treatment of alcohol induced collapses in A&E.

A 284 **Motion** by BRISTOL DIVISION: That this Meeting believes that tobacco manufacturers should be liable for damage caused by their products in both civil and criminal law as with any other commodity. We ask the BMA to campaign for legislation to ensure this is the case.

WORKFORCE

Tuesday 11.25 – 12.15

***** 285 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE WELSH COUNCIL): That this Meeting notes the reports from the Centre for Workforce Intelligence and the BMA Cross Branch of Practice Consensus Statement on workforce planning and:-
i) calls for an immediate reduction in the number of medical student places such that the number of medical students graduating is better aligned with the requirement for training posts and subsequently career grade posts;
ii) calls for a restriction on the development of further medical schools in the United Kingdom unless it becomes clear that there is a need to increase medical student intakes to maintain the workforce;
iii) calls on the BMA to undertake detailed modelling of future healthcare workforce, to inform debate and facilitate honest advice for those in training.

285a **Motion** by WELSH COUNCIL: That this Meeting calls for an immediate reduction in the number of medical student places such that the number of medical students graduating is better aligned with the requirement for training posts and subsequently career grade posts.

285b **Motion** by SOUTH THAMES RJDC: That this Meeting believes that the number of medical students graduating and able to apply to foundation posts should be closely aligned with the number of foundation posts available which should be closely aligned with specialty recruitment post numbers which should themselves be closely aligned with the number of senior career grade doctors and qualified general practitioners required by the service.

285c **Motion** by SCOTTISH COUNCIL: That this Meeting calls on the BMA to lobby the UK and devolved administrations to reduce medical student intake numbers in line with the projected future number of career grade vacancies, within a two year timescale.

285d **Motion** by NORFOLK LMC: That this Meeting asks the GPC to work, as a matter of urgency, with those responsible for medical education to bring about a higher degree of accuracy in the numbers of places in medical schools to properly reflect the needs across all medical specialities in the future, especially taking into
account the likely variations that will affect an average career timetable of a 21st century GP.

285e **Motion** by JUNIOR DOCTORS CONFERENCE: That this Meeting calls on the BMA, in light of the anticipated oversupply of doctors in the United Kingdom, to adopt a policy suggesting:-
i) a decrease in medical students being admitted to United Kingdom medical schools;
ii) a restriction on the development of further medical schools in the United Kingdom unless it becomes clear that there is a need to increase medical student intakes to maintain the workforce.

285f **Motion** by EAST DORSET DIVISION: That this Meeting urges the government to be honest with junior doctors and tell them that as a consequence of NHS reforms and poor work-force planning they may not have jobs in future (as consultants or GP principals).

285g **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting notes the Centre for Workforce Intelligence's report: "Shape of the Medical Workforce – starting the debate on the future consultant

workforce". In light of that and other evidence, this Meeting calls on the BMA to press for an immediate, sustained, and significant reduction in the number of medical student places in the United Kingdom.

285h **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting notes the Centre for Workforce Intelligence's report "Shape of the Medical Workforce – starting the debate on the future consultant workforce". In light of that and other evidence, this Meeting calls on the BMA to press for an immediate, sustained, and significant reduction in the number of medical student places in the United Kingdom.

285i **Motion** by BRENT DIVISION: That this Meeting calls on the BMA to lobby for maintenance of medical student numbers in the UK with the aim of providing enough doctors to work in the UK in the future.

285j **Motion** by BRISTOL DIVISION: That this Meeting calls on the BMA to undertake detailed modelling of future healthcare workforce, with the explicit aim of providing numbers which can inform the debate on the future number of medical students.

* 286 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE SCOTTISH COUNCIL): That this Meeting believes that every eligible medical graduate from a UK medical school should have the opportunity to obtain full GMC registration, and:-
i) believes it to be unacceptable for a UK medical graduate not to have the chance of an FY1 place and therefore not be able to obtain full GMC registration;
ii) calls on the Department of Health and devolved governments, the UKFPO and the Medical Schools Council to ensure sufficient foundation training programmes for all eligible UK graduates;
iii) calls for consideration of a coupling of the first year of the Foundation Programme with the undergraduate medical course.

286a **Motion** by SCOTTISH COUNCIL: That this Meeting:-
i) recognises that it is very likely there will be a significant oversubscription to the foundation programme in 2013 of at least 400 applicants;
ii) believes it to be unacceptable for a UK medical graduate not to have an FY1 place and therefore not obtain full GMC registration;
iii) calls on the UKFPO and medical schools to make clear to medical students the likely scale of any oversubscription at the earliest opportunity;
iv) calls on the Department of Health and devolved governments, the UKFPO and the Medical Schools Council to ensure that sufficient foundation training programmes for all UK graduates are in place before the start of the 2013 foundation programmes.

286b **Motion** by WELSH COUNCIL: That this Meeting thinks it only right that every medical graduate from a UK medical school should have the opportunity to obtain full GMC registration. It therefore calls for a coupling of the first year of the Foundation Programme with the undergraduate medical curriculum.

286c **Motion** by OXFORD DIVISION: That this Meeting believes that increasing medical student numbers are now causing oversubscription to the foundation program. This Meeting believes that there should be a Foundation Post for every graduating UK medical student to allow them to achieve registration with the GMC, and that the number of places for medical students at UK universities should be reduced immediately to avoid such unnecessary very expensive wastage.

* 287 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE NORTH THAMES RJDC): That this Meeting notes with concern the predicted oversupply of CCT holders expected over the coming decade, but recognises that this provides opportunities in addition to challenges. This Meeting calls on the BMA to:-
i) support the conclusion of the Academy of Medical Royal Colleges' report 'The Benefits of Consultant-Delivered Care' that there is evidence across a wide range of specialist medical fields that consultants deliver better patient outcomes and improved efficiency of care;
ii) develop and promote an appropriate description of consultant presence, for patient and service needs over the next decade;
iii) lobby the Department of Health and devolved administrations to fully consider this evidence and recognise that a move to a consultant present service would significantly improve the quality of care.

287a **Motion** by NORTH THAMES RJDC: That this Meeting notes with concern the predicted oversupply of CCT holders expected over the coming decade, but recognises that this provides opportunities in addition to challenges. Therefore calls on the BMA to:-
i) create a suitable definition of 'consultant present service';
ii) advocate a 'consultant present' service throughout the week in the interests of patient care;
iii) maintain parity of terms and conditions of service for those newly qualified CCT-holders relative to their more experienced colleagues.

287b **Motion** by SCOTTISH JDC: That this Meeting:-
i) is concerned that workforce projections anticipate an oversupply in some specialties of doctors qualified to CCT when compared with available consultant posts;
ii) supports the conclusion of the Academy of Royal Colleges' report 'The Benefits of Consultant-Delivered Care' that there is evidence across a wide range of medical fields that consultants deliver better patient outcomes and improved efficiency of care;
iii) calls on the department of health and devolved nation governments to fully consider this evidence and recognise that a move to a consultant delivered service would significantly improve the quality of care.

287c **Motion** by EASTERN RJDC: That this Meeting notes the CfWI's predictions for an unsustainable over-supply of CCT holders under current workforce plans. In the light of this, we ask that the BMA:-
i) should continue to strenuously resist any erosion of the consultant grade;
ii) should continue to defend the status of the CCT/CESR as a marker of a fully trained, independent doctor;
iii) should undertake its own robust workforce modelling to verify, or dispute, the CfWI case;
iv) should have a coherent policy for workforce planning from medical school to CCT.

288 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting acknowledges that doctors are not always safe to drive home after night shifts. Therefore the BMA is strongly urged to campaign for free access to hospital accommodation / transport for doctors, upon completing a night shift.

289 **Motion** by SCOTTISH COUNCIL: That this Meeting:-
i) recognises that there are misconceptions about working when pregnant, particularly out-of-hours and emergency hospital work;
ii) acknowledges that there is evidence that night-work is harmful to pregnant mothers and their unborn children;
iii) is concerned that there are limited guidelines or recommendations for doctors on safe working practice while pregnant;
iv) calls on the BMA to develop guidelines for doctors on working while pregnant and share this with NHS employers in order to raise awareness among all involved of the available evidence and to improve working conditions.

The motion(s) below, in the shaded area, are unlikely to be reached

290 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting is anxious that health care reform will negate any improvements to the position of women in medicine, hard won through Baroness Deech's national report and calls on the Political Board of the BMA to revisit progress and to suggest further strategy, in the light of the Health and Social Care Act.

291 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting believes that current limits on working hours, as a result of the European Working Time Directive, continue to have a significant negative impact upon medical training, medical professionalism and patient safety. We note that present BMA policy in this area appears to be out of step with the views of the vast majority of doctors in training in the United Kingdom, as evidenced by recent survey data. We therefore call on the BMA to:
i) urgently revise its stance on the European Working Time Directive and the 48 hour limit on working hours;
ii) work towards better representation of the views of its members in negotiations, including future pay deal negotiations, in order to achieve appropriately remunerated working in excess of 48 hours per week for doctors in training.

292 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that the European Working Time Directive is not suitable for doctors training or for the continuity of the patient care.

293 **Motion** by CITY & HACKNEY DIVISION: That this Meeting believes that the 48 hour EWTD is harmful to junior doctors' training and is leading to deprofessionalisation. This Meeting therefore instructs the BMA to lobby the government for a profession-wide opt-out of the restrictive 48 hour per week European Working Time Directive (EWTD).

294 **Motion** by OXFORD DIVISION: That this Meeting believes the current limits on working hours, as a result of the EWTD, continue to have a significant negative impact upon medical training, medical professionalism and patient safety. The present BMA policy in this area appears to be out of step with the views of the vast majority of doctors in training in the United Kingdom, as evidenced by recent survey data e.g. Remedy Surgical Trainee Survey 2011 (1), Remedy Foundation Survey 2011 (2), GMC National Trainee Surveys (3).
This Meeting thus calls on the BMA to:-
i) urgently revise its stance on the EWTD and the 48 hour limit on working hours;
ii) work towards better representation of the views of its members in negotiations, including future pay deal negotiations, in order to achieve working beyond 48 hours per week for doctors in training.
(1)Surgeons and training time. BJF Dean, EAC Pereira. BMJ Careers 26 October 2011.
(2)Remedy Survey of Foundation trainees (unpublished as yet). Carried out 2011-12. 1065 responses from doctors who have been through FY training. 0% desired hours <40/wk, 22% 40-48hrs/wk, and 78% >48hours/wk.
(3)GMC National Trainee Surveys. http://www.gmc-uk.org/education/surveys.asp.

295 **Motion** by WEST GLAMORGAN DIVISION: That this Meeting calls upon governments to review the policy on training non-medical prescribers which in the main appears to have been a costly failure.

296 **Motion** by CONSULTANTS CONFERENCE: That this Meeting is anxious that healthcare reform will negate any improvements to the position of women in medicine, hard won through Baroness Deech's national report and calls on the Political Board of the BMA to revisit progress and to suggest further strategy, in the light of the Health and Social Care Bill.

297 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting supports the RCN in their demand for increasing the proportion of fully trained nurses in the care of patients, in particular the elderly.

298 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting acknowledges and values the important role of medical psychotherapists in patient care and psychiatric training, and calls on the BMA to support our colleagues at a time when their jobs are at threat.

299 **Motion** by OXFORD DIVISION: That this Meeting believes that disciplinary procedures for senior medical staff should confirm to agreed national patterns.

300 **Motion** by LINCOLN DIVISION: That this Meeting notes that the recommendations made in the 2005 Board of Science report "Healthcare in a Rural Setting", on recruitment and retention of healthcare professionals, accessibility and the impact of distance, and sustainability of services in rural areas, have largely been ignored by successive governments, and that future NHS changes are likely to disadvantage rural areas further. We call for the Board of Science to look again at the plight of healthcare professionals in rural areas, and make recommendations to the Health Departments on supporting them.

301 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes the term "middle grade" when referring to medical staff is meaningless and is used purposefully to mask the seniority of members of staff necessary to fulfil service requirements at senior level. It is discriminatory, derogatory, humiliating, pejorative and is misleading to staff of all levels and patients and requires condemnation. We call upon the BMA to ensure that:-
i) the use of the term "middle grade" is condemned and;
ii) this term is expunged from the medical vocabulary.

302 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting condemns the removal of child care vouchers, which are widely used by many doctors with young children, is worried that an unintended consequence may be the discouragement of women doctors to work in medicine to their full potential, and demands that the government reconsiders their removal.

303 **Motion** by CITY & HACKNEY DIVISION: That this Meeting notes with concern the predicted oversupply of CCT holders expected over the coming decade. This Meeting calls on the BMA to negotiate with all Trusts for a nationally agreed pathway for newly qualified CCT holders.

304 **Motion** by LOTHIAN DIVISION: That this Meeting believes that in light of the current attitude of governments to doctors, the level of student debt and the erosion of pay and pensions that applying to study medicine in the UK cannot currently be recommended.

305 **Motion** by EAST AND NORTH HERTFORDSHIRE DIVISION: That this Meeting believes that the current system of locum provision to the hospitals by the agencies is expensive and inefficient and could be improved by having a national NHS bank of existing NHS employees.

306 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting believes that the BMA should lobby the GMC to collect and make accessible data from relevant stakeholders to allow:-
i) a UK wide interactive tool based on specialty, revealing competition ratios by region;
ii) the BMA to quantify the number of doctors who are self-defined trainees, without national training numbers.

307 **Motion** by WORCESTERSHIRE DIVISION: That this Meeting believes that rigid adherence to the European Working Time Regulations is unhelpful for both continuity of care and junior doctor training and calls on the BMA to change its position of opposition to these regulations.

308 **Motion** by LOTHIAN DIVISION: That this Meeting believes that all health professionals have the right to manifest their religious beliefs through the wearing of symbolic clothing or jewellery whether it is required within their religion or not.

309 **Motion** by LOTHIAN DIVISION: That this Meeting believes that all Christian health professionals have the right to manifest their religious belief through the wearing of a cross in the workplace, and that this right is upheld by the UN International Covenant on Civil and Political Rights, article 18.

310 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting is dismayed at a NHS North quality report (March 2012) commenting on staff surveys indicating the majority of staff feel dissatisfied with the quality of work or care they are able to deliver and are reluctant to recommend their trusts as a place to work or receive treatment and interpret this as global measure of staff morale and:-
i) believes the recent pay freeze, worries about pensions and other benefits, a general unease created by the period of transition and the pressure created by the need for cost improvement in all NHS organisations may all be contributing to dissatisfaction;
ii) calls on BMA Council to alert the Secretary of State for Health and HM government the impact poor staff morale has on quality and delivery of patient care, particularly as staff would not commend their own Trusts as places to work or receive care.

311 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting calls on the BMA to review and strengthen its support for 'whistle blowers' at this time when austerity measures and pressures on budgets may compromise safe clinical care of patients, and instructs BMA Council to ensure that:-
i) 'whistle blowers' are not penalised;
ii) systems investigating the claims of 'whistle blowers' are transparent and fair;
iii) patient safety is always given the highest priority.

312 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that increasing numbers of doctors are being suspended inappropriately for many years, without a hearing or pay. The BMA must insist on the principle that no doctor should be suspended without full rights of natural justice; without knowing the charges made against them and the opportunity to test the case made against them and prove their innocence. This Meeting calls on the BMA to make it the union's responsibility that its members have a hearing and representation as soon as it is informed of the case.

313 **Motion** by SOUTH TYNESIDE DIVISION: That this Meeting is of the opinion that, patient safety is compromised with limited junior doctors working over the weekends and nights. This Meeting recommends that the BMA should negotiate with Department of Health to have adequate staffing all the time.

314 **Motion** by OXFORD DIVISION: That this Meeting is appalled by the large number of fully trained post CCT Trauma and Orthopaedic surgeons who have not yet been able to secure a substantive NHS consultant post and calls for the urgent resumption of consultant expansion and more robust workforce planning in the future.

315 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that whistleblowing in the Health Service is an essential element of patient safety, welcomes the set-up of the confidential whistleblowing helpline in England and insists that confidential whistleblowing helplines are available throughout the UK.

A 316 **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting recognises the importance of the contribution to public safety made by the BMA when it supports members who whistle blow on poor quality or dangerous services and urges BMA Council to also recognise this wider contribution to the safety and wellbeing of the public by deploying additional resources to support members finding themselves in this invidious position.

A 317 **Motion** by WORCESTERSHIRE DIVISION: That this Meeting believes that all doctors should have the right to protection from the consequences of appropriate whistle blowing where they have identified an issue of concern regarding standards of care and service provided to patients.

A 318 **Motion** by SCOTTISH COUNCIL: That this Meeting:-
i) believes that in order to protect NHS workers safety, free, designated parking close to hospital entrances should be provided for NHS staff working out of hours;
ii) believes that free designated parking for NHS staff undertaking duties at multiple hospital sites should be provided by all NHS employers at each site.

A 319 **Motion** by SHEFFIELD DIVISION: That this Meeting calls on the BMA to prepare for close monitoring of the response of NHS Employers (and the equivalent bodies in the devolved nations) to the needs of the ageing medical workforce.

Contingency time — Tuesday 12.15 – 12.20

ANNUAL GENERAL MEETING — Tuesday 12.20 – 12.25

CHARITIES — Tuesday 12.25 – 12.30

320 **Receive**: Report by the Chairman of the Charities Committee (Michael Wilks).

BRANCH OF PRACTICE QUESTION AND ANSWER SESSION — Tuesday 12.30 – 12.45

Session closes — Tuesday 12.45

Victor Horsley scientific session 2
1pm: Chair: Professor Averil Mansfield, Chairman, BMA Board of Science.
The physical health of people with mental health problems, Professor Linda Gask, Professor of Primary Care Psychiatry, National Primary Care Research and Development Centre.

INTERACTIVE SYMPOSIUM ON SOCIAL AND HEALTH INEQUALITIES
14.30 - 16.30: A two hour interactive debate on the subject of Health Inequalities will take place on Tuesday afternoon when the effects of the global financial crisis on health inequalities will be discussed. Professor Sir Michael Marmot, Director, UCL Institute of Health Equity and former President of the BMA (2010-2011) will give the keynote address which will look at the evidence that is emerging of how severe austerity measures are impacting on health and well-being.
Dr Saul Marmot, a GP, will talk about the Bromley by Bow Centre. Health and well-being are at the core of the Centre's activities. Tackling the social and economic causes of chronic ill-health is central to their objectives and many of the Centre's wider aspirations are underpinned by the need to build a healthier community for the diverse socio-economic population they serve.

It is also hoped that one or two of our international guests will participate and give their country's perspective on how the health and well-being of the most vulnerable populations are being affected by the international economic downturn.

Installation of the President
6.00pm for 6.30pm, Pavilion Theatre, Westover Road, Bournemouth BH1 2BU.

SCOTLAND — Wednesday 09.30 – 09.45

321 **Receive**: Report by the Chairman of Scottish Council (Brian Keighley).

322 **Motion** by LOTHIAN DIVISION: That this Meeting condemns as irresponsible, unrealistic and unattainable the proposals for radiographers to undertake 80% of all plain film reporting by 2013 across NHS Scotland.

NORTHERN IRELAND — Wednesday 09.45 -10.00

323 **Receive**: Report by the Chairman of Northern Ireland Council (Paul Darragh).

324 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting insists that the Department of Health in Northern Ireland reinstate Clinical Excellence Awards for consultants so that consultants can be incentivised to seek to implement the essential healthcare reform that Northern Ireland so badly needs.

A 325 **Motion** by NORTHERN IRELAND SASC: That this Meeting calls on the Department of Health, Social Services and Public Safety in Northern Ireland to make the development of SAS doctors a priority, in line with the minister of health's Vision for Quality Healthcare in Northern Ireland (Quality 2020) which recognises the need to develop all staff.

MEDICAL ETHICS — Wednesday 10.00 – 11.35

326 **Receive**: Report by the Chairman of the Medical Ethics Committee (Tony Calland).

327 **Motion** by NORTH THAMES RJDC: That this Meeting:-
i) recalls the important role the BMA played in the abolition of capital punishment in the UK;
ii) condemns the use of capital punishment, wherever in the world it takes place;
iii) believes that it is unethical for doctors to be involved in the process of execution;
iv) notes that many executions are carried out using pharmaceuticals produced by multi-national pharmaceutical companies;
v) commends the decision by the UK Government to halt export of pharmaceuticals from the UK for use in executions abroad;
vi) calls on the BMA International Committee, Ethics Committee and other relevant bodies to work with relevant international organisations (including the WMA and WHO) to prevent the export and use of pharmaceuticals for the purpose of execution.

***** 328 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE HARROGATE DIVISION): That this Meeting:-
i) supports the universal availability of neutral counselling for women considering abortion;
ii) believes that any counselling provided for women considering abortion should accord with NHS standards;
iii) believes that women considering abortion should be able to access counselling that is independent of the abortion provider;
iv) deplores picketing and intimidation around abortion services.

328a **Motion** by HARROGATE DIVISION: That this Meeting:-
i) requests that the BMA publicly support the universal availability of optional counselling for women considering abortion;
ii) emphasises that any counselling provided for women considering abortion should accord with NHS standards;
iii) requests that women considering abortion should be able to access counselling that is independent of the abortion provider, if they so wish.

328b **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting notes that for some women the decision to have a termination of pregnancy may have long term psychological consequences and asks the government to amend abortion law so that all women are given counselling with time and space for consideration, which is independent of abortion providers and is thus free from coercion.

328c **Motion** by ISLINGTON DIVISION: That this Meeting notes in the 45 years since the 1967 Abortion Act allowed abortion under certain conditions, doctors have learnt that the woman herself is the only person who can decide whether or not to continue a pregnancy after she is given relevant information. We believe that it is time that abortion is decriminalised and treated like any other operation as was done in Canada in 1988 and South Australia in 2011 with no adverse consequences for society. This would prevent the

threats to doctors exemplified by the recent Daily Telegraph sting and subsequent actions by politicians and managers whose understanding of the law was incorrect.
We call upon the BMA: -
i) to survey its membership as to their views about decriminalisation of abortion;
ii) and if the survey confirms this view, to lobby Parliament for abortion to be decriminalised; and
iii) to work with the RCOG to lobby for abortion to be decriminalised;
and
iv) to work with pro-choice groups such as DWCA and Abortion Rights to lobby for abortion to be decriminalised.

328d **Motion** by LEWISHAM DIVISION: That this Meeting deplores the actions of 'pro-life' groups in picketing abortion clinics. This may be intimidating, and risks a loss of confidentiality.
It may discourage women from attending a clinic, and thus undermine their right to have a legal termination of pregnancy. This Meeting calls on the BMA to condemn such practices and to reassert its support for a woman's right to a legal and safe termination.

328e **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting notes that for some women the decision to have a termination of pregnancy may have long term psychological consequences and urges all abortion providers in the NHS and private sectors to provide access to comprehensive counselling services pre- and post-termination.

328f **Motion** by NORTH THAMES RJDC: That this Meeting:-
i) recognises that women make a difficult and sad decision when choosing to terminate a pregnancy;
ii) condemns campaigning and the filming of women outside abortion clinics in the UK by anti-abortion activists, including 40 Days For Life;
iii) repudiates the decision by some states in the USA to require an ultrasound examination before termination of pregnancy can be offered, particularly where this will require transvaginal sonography;
iv) supports efforts to reduce the need for abortion, but does not support efforts to reduce access to abortion services.

328g **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting calls on providers of termination services, in cases requiring two medical signatures, to ensure that the two medical signatories sign the forms before the procedure and:-
i) this should be verifiable by timing signatures on forms and subject to internal and external audit;
ii) considers it best practice that both medical signatories will have seen and spoken to the woman;
iii) if not possible, then one must have seen and spoken to the woman and the other discussed the case with the cosignatory;
iv) considers it inappropriate for the anaesthetist performing sedation or anaesthesia for the procedure to sign the form;
v) calls on Council to petition the Departments of Health to:-
a) amend certification forms to include times of signature and confirmation of a discussion having occurred if the second signatory
has not seen the patient and;
b) facilitate audit.

* 329 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE GREENWICH, BEXLEY AND BROMLEY DIVISION): That this Meeting believes that abortion on the grounds of gender alone is unacceptable and demands that :-
i) such practice should cease forthwith;
ii) the law should be changed to make this practice illegal in the UK.

329a **Motion** by GREENWICH, BEXLEY & BROMLEY DIVISION: That this Meeting believes that abortion on the grounds of gender is unacceptable and holds that termination should only be carried out for evidence based reasons, which should be properly audited and published.

329b **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting deplores the scandal of abortion services operating outside the limits of the law which was revealed by the Daily Telegraph and demands:-
i) that the government to check all UK abortion providers are operating within the confines of the law;
ii) close those departments which are breaking the law.

330 **Motion** by NORTH THAMES RJDC: That this Meeting believes that the use of so-called "kettling" for containment of peaceful crowds by police at demonstrations can be dangerous and inhumane and calls for its use to be limited or discontinued.

* 331 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE JUNIOR MEMBERS FORUM): That this Meeting wholeheartedly supports evidence-based population screening but believes that:-
i) non-targeted "human MOT" tests are ethically unsound;
ii) providers of direct-to-consumer testing must provide appropriate pre- and post- test counselling;
iii) providers of direct-to-consumer testing must communicate results to the patient's GP;
iv) providers of untargeted screening tests remain clinically responsible until the point of diagnosis;
v) providers of untargeted screening tests remain financially responsible until the point of diagnosis.

331a **Motion** by JUNIOR MEMBERS FORUM: That this Meeting wholeheartedly supports evidence-based population screening but believes that non-targeted "human MOT" tests are ethically unsound.

331b **Motion** by JUNIOR MEMBERS FORUM: That this Meeting believes that any provider of untargeted screening tests is liable until the point of diagnosis.

331c **Motion** by JUNIOR MEMBERS FORUM: That this Meeting notes the increased availability of direct to consumer genetic testing and calls upon the proper regulation and standardisation of such providers with regards to:-
i) pre-and post- test counselling;
ii) communication with the patient's GP.

* 332 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE SHROPSHIRE DIVISION): That this Meeting:-
i) believes that assisted dying is a matter for society and not for the medical profession;
ii) believes that the BMA should adopt a neutral position on change in the law on assisted dying.

332a **Motion** by SHROPSHIRE DIVISION: That this Meeting supports the philosophy of the Department of Health: 'No decision about me without me' and further recommends that:-
i) all possible measures should be taken to improve patient autonomy and choice up to and including the very end of life;
ii) adequate resources should be made available to ensure good quality, patient-centred palliative care throughout the UK which must support reasonable patient choice as to where they wish to die;
iii) assisted dying is a matter for society and not the medical profession and therefore recommends that this meeting adopts a neutral position on the principle of a change in the law on Assisted Dying for the mentally competent, terminally ill adult patient;
iv) in the event of any change in the law on Assisted Dying, the Medical Ethics Committee and Council should define what safeguards must be in place, taking into account the evidence from other jurisdictions.

332b **Motion** by RETIRED MEMBERS FORUM: That this Meeting acknowledges that 33% of GPs, in a recent survey, were in favour of legalised assisted dying for themselves and this Meeting believes that:-
i) there is a strong case for providing the choice of assisted dying for terminally ill people;
ii) good quality end of life care should be available in all settings;
iii) Assisted Dying is a matter for society and not for the medical profession;
iv) the BMA should adopt a neutral position on the principle of a change in the law on Assisted Dying for the mentally competent, terminally ill adult patient;
v) the BMA insists that there must be adequate safeguards to protect the vulnerable in the event of any change in the law;
vi) the Medical Ethics Committee and BMA Council, in the light of the evidence from other jurisdictions, take steps to define what safeguards are required.

332c **Motion** by NORTH WEST REGIONAL COUNCIL: That this Meeting supports good quality, patient-centred end of life care and recommends:-
i) that all possible measures should be taken to improve choice as to the location where the patient wishes to die;
ii) further improvement in palliative care throughout the UK;
iii) there must be effective social support and protection for more vulnerable people;
iv) the BMA should adopt a neutral position on the principle of a change in the law on Assisted Dying for the mentally competent, terminally ill adult patient and insists that there must be adequate safeguards to protect the vulnerable in the event of any change in the law;
v) that the Medical Ethics Committee and Council, in the light of the evidence from other jurisdictions, define what safeguards must be in place.

332d **Motion** by NORTH WEST REGIONAL COUNCIL: That this Meeting acknowledges that 33% of GPs, in a recent survey, were in favour of legalised assisted dying for themselves and therefore:-
A. Recommends:-
i) there is a strong case for providing the choice of assisted dying for terminally ill people;
ii) good quality end of life care should be available in all settings;
iii) legalisation of Assisted Dying is a matter for society as a whole and not for the medical profession;
iv) the BMA should adopt a neutral position on the principle of a change in the law on Assisted Dying for the mentally competent, terminally ill adult patient and insists that there must be adequate safeguards to protect the vulnerable in the event of any change in the law;
v) that the Medical Ethics Committee and Council , in the light of the evidence from other jurisdictions, shall define what safeguards are required.

332e **Motion** by RETIRED MEMBERS FORUM: That this Meeting supports the philosophy of the department of health: 'no decision about me without me' and that the BMA demands that:-
i) all possible measures should be taken to improve choice at the end of life and particularly that of the location where a patient wishes to die;
ii) there is further improvement in palliative care for all patients throughout the UK;
iii) the BMA should adopt a neutral position on the principle of a change in the law on Assisted Dying for the mentally competent, terminally ill.

332f **Motion** by BRISTOL DIVISION: That this Meeting believes that in terminal illness:-
i) that not all suffering at the end of life can be satisfactorily alleviated;
ii) that at these times it is reasonable to see death as a release from suffering;
iii) that at times it may be the wish of patients to choose this release rather than continue suffering;
iv) that it is not always unethical for doctors to support this release by assisting;
v) we request the Medical Ethics Committee to publish a document exploring the issues that would need to be addressed for this to be safely legalised.

332g **Motion** by ISLINGTON DIVISION: This Meeting notes that polls have shown that the majority of the general public support assisted dying and believes that it is unjust that those with the means to travel to Switzerland can make this choice whereas poorer people cannot afford to do so. We believe that it is not the role of doctors to make this decision but for society to decide through a change in the law debated in parliament.
We call upon the BMA to:-
i) adopt a neutral position towards a change in the law to allow assisted dying, (with adequate safeguards for the vulnerable), for mentally competent terminally ill adults;
ii) conduct a survey of the membership to ascertain their views about a change in the law and the role of doctors, should the law be changed to allow assisted dying.

332h **Motion** by NORTH WEST REGIONAL COUNCIL: That this Meeting believes that, arising from the Dept. Health 'End of Life Care Strategy' (2011):-
i) all forms of discrimination in end of life care should be ended;
ii) government investment in improving end of life care must be increased;
iii) assisted dying for the terminally ill should be debated in parliament;
iv) the BMA should adopt a neutral position on the principle of a change in the law on assisted dying for the mentally competent, terminally ill adult patient and insists that there must be adequate safeguards to protect the vulnerable in the event of any change in the law;
v) that the Medical Ethics Committee and Council, in the light of the evidence from other jurisdictions, define what safeguards must be in place.

332i **Motion** by SUFFOLK DIVISION: That this Meeting believes that the current BMA position of opposition to doctor-assisted dying is no longer tenable and does not represent the view of the population in the UK. Consequently the BMA position should at least change to neutrality on this subject rather than opposition.

332j **Motion** by NORTH WEST REGIONAL COUNCIL: That this Meeting notes that there is overwhelming public support for allowing a doctor to end the life of patients who are suffering unbearably from terminal illness and whose symptoms are not relieved by optimal palliative care and this Meeting recommends:-
i) that there should be increased choice of the location where the patient wishes to die;
ii) that there should be further improvement in palliative care throughout the UK;
iii) that terminally ill patients with uncontrolled symptoms who are mentally competent should have the right to choose the timing of their death;
iv) the decision for allowing a doctor to end the life of a terminally ill patient with uncontrolled symptoms is one for society as a whole;
v) that the BMA should therefore adopt a neutral position on the principle of a change in the law on Assisted Dying for the mentally competent, terminally ill adult patient and should insist that there must be adequate safeguards to protect the vulnerable in the event of any change in the law;
vi) that the Medical Ethics Committee and Council and, in the light of the evidence from other jurisdictions, should take steps to define what safeguards are required.

The motion(s) below, in the shaded area, are unlikely to be reached

333 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting recognises the vulnerability of seriously-ill patients, is clear that a doctor's role in providing clinical care must focus on protecting the patient from harm and self-harm, and rejects the involvement of doctors in any proposals for the legalisation of euthanasia or assisted suicide.

334 **Motion** by CITY & HACKNEY DIVISION: That this Meeting deplores the continued involvement of doctors in executions of convicted criminals in other countries. This Meeting calls upon the BMA to work with its international partner organisations e.g. the World Medical Association to ensue that doctors are not involved in such executions.

335 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon the BMA to oppose vehemently the Welsh government's plans for an opt out system for organ donation.

336 **Motion** by SHROPSHIRE DIVISION: That this Meeting:-
i) demands that child safeguarding procedures must apply to all children without gender discrimination and irrespective of the beliefs or social status of the child's parents or guardians;
ii) notes the increasing evidence of significant complications from childhood male circumcision, including meatal stenosis, bleeding, infection, scarring and adult psychosexual dysfunction;
iii) endorses the May 2010 position statement of the Royal Dutch Medical Association (KNMG) which called non-therapeutic circumcision of male minors a violation of children's rights to autonomy and physical integrity;
iv) notes the GMC guidance in respect of the responsibilities of registered medical practitioners in the matter of female genital mutilation (FGM) (0-18 years; Guidance for all doctors; end notes reference 15) - and as set down in the 2003 FGM legislation;
v) insists on equality between GMC policies for doctors concerning females and males in respect of non-therapeutic genital surgery;
vi) calls for no further commissioning or funding of non-therapeutic circumcision of male minors in the NHS.

337 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting urges the government to improve pathways, counselling and support for women having unplanned pregnancies so that they might be able to consider adoption a reasonable option.

338 **Motion** by MID MERSEY LMC: That this Meeting believes that dignity in death should remain the fundamental right of all and should not be compromised by overbearing bureaucracy.

339 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the BMA should clarify the position of the Association in relation to assisted dying by asking the membership of the Association in an e-referendum.

340 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting is encouraged by the support given by the House of Commons to the guidelines issued by the DPP, Keir Starmer on "assisted dying " earlier this year and asks that the BMA gives its support to assisted dying based on the Oregon experience where:-
i) the patient must be terminally ill with a life expectancy of less than 6 months;
ii) the patient must make a written request and two oral requests to a physician;
iii) the patient must request a second physician to endorse the request; and
iv) a physician prescribes the necessary medication which must be self administered.

341 **Motion** by HARROGATE DIVISION: That this Meeting:-
i) welcomes the GMC's draft guidance on dealing with doctors accused of encouraging or assisting suicide;
ii) calls on the GMC to maintain its clear stance against doctors' involvement in encouraging or assisting suicide.

342 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting supports the view of the Royal College of Physicians London, as advised to the Director of Public Prosecutions, that "clinicians' duties of care entail active pursuit of alternative solutions to assisted suicide, not its facilitation" and that the involvement of doctors in providing assistance with suicide is "open to misinterpretation or cynical manipulation" and re-affirms the Association's opposition to the legalisation of these practices within clinical care.

343 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting rejects the view of the self-styled commission on assisted dying that any future regime that may be agreed for providing assisted suicide should be embedded within the existing framework of health care.

344 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting welcomes the Director of Public Prosecution's statement that doctors should not be involved in assisted suicide.

345 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting acknowledges that:-
i) the UK public understands and supports the need for assisted dying at the end of life;
ii) the BMA should come into line with this public understanding by supporting moves to create a legal structure to enable this safely.

346 **Motion** by ROCHDALE DIVISION: That this Meeting demands action to stop coercion of doctors into involvement with torture and facification of the cause of death.

347 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting notes the many reports in the media of patients with motor neurone disease travelling to the Dignitas clinic and asks the media in respect of balanced reporting to also state that 94 % of patient's with MND die quietly, peacefully and with dignified care from their disease and that in no study has there been a documented case of choking.

A 348 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting wants the government to take necessary legal steps and actions against persons to protect UK female children undergoing female genital mutilation here in this country or abroad.

Contingency time **Wednesday 11.35 – 11.40**

INTERNATIONAL AFFAIRS **Wednesday 11.40 – 12.05**

349 **Receive**: Report by the Chairman of the International Committee (Terry John).

***** 350 **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting:-
i) acknowledges and praises the contribution that international medical students and doctors have made to the NHS for decades;
ii) notes that the percentage of international students at UK medical schools should not exceed 7.5%;
iii) is dismayed that this percentage is being exceeded by multiple medical schools across the UK to the detriment of local applicants;
iv) suspects that the high proportion of international medical students at UK medical schools is due primarily to revenue generation through often very high, occasionally extortionate, fees.

350a **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting:-
i) acknowledges and praises the contribution that international medical students and doctors have made to the NHS for decades;
ii) notes that the percentage of international students at UK medical schools should not exceed 7.5%;
iii) is dismayed that this percentage is being exceeded by multiple medical schools across the UK to the detriment of local applicants;
iv) suspects that the high proportion of international medical students at UK medical schools is due primarily to revenue generation through often very high, occasionally extortionate, fees;
v) is appalled that places at UK medical schools for UK-domiciled school leavers are being restricted increasingly;
vi) notes that contrary to popular belief, that most of these international graduates from UK medical schools return to their country of origin after completion of the foundation programme, many remain in the UK for specialty training with relative ease;
vii) believes that their countries of origin are being disadvantaged as these graduates are not returning home with their medical expertise;
viii) believes that in order to avert a UK-wide medical workforce planning crisis, the Home Office should restrict the number of Tier 2 visas available to international graduates of UK medical schools from 2020 onwards.

350b **Motion** by MEDICAL STUDENTS EXECUTIVE SUB COMMITTEE: That this Meeting:-
i) notes the increasing complexity of the relationship between UK medical schools and international students, particularly regarding international students studying in overseas medical schools offering UK primary medical school qualifications;
ii) notes that UK medical schools often do not include these students in the 7.5% cap on international students attending, as defined by the GMC for workplace planning, despite many undertaking a number of their undergraduate years of study in the UK;
iii) is concerned that some of these students feel there is insufficient information or that they have been misinformed about their right to work in the UK following graduation, and therefore may feel their degree has been mis-sold;
iv) calls for the MSC to lobby UK medical schools, the UKFPO and the GMC to ensure these prospective and current students are given up-to-date, timely and clear information regarding UK visa arrangements, GMC registration and their future prospects of working in the UK as a doctor, particularly the application pathway into the Foundation Programme.

* 351 **Motion** by LOTHIAN DIVISION: That this Meeting insists radiographic exposures to assess age of asylum seekers and refugees only be used when such an examination can be shown to be of proven accuracy in determining the question at issue, and then only with the informed consent of the subject.

351a **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting is appalled at the proposals for establishing the age of asylum seekers by investigating dental/bone age and believes that:-
i) this is contrary to well established ethical principles of consent;
ii) fails to take into account the UN convention on the rights of the child;
iii) risks exposing children to unnecessary radiation exposure;
iv) should be opposed.

The motion(s) below, in the shaded area, are unlikely to be reached

352 **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting:-
i) applauds the government's support of the UN Millennium Development Goals as a means of fighting poverty, especially Goal 6: 'Combat HIV/AIDS, malaria and other diseases';
ii) aligns with Médecins Sans Frontières in their concern over the cancellation of the Global Fund for HIV/AIDS, tuberculosis and malaria treatment in the developing world;
iii) lobbies the government to increase the percentage of Gross National Income spent on the Millennium Development Goals from 0.55% to the 0.7% as recommended by the UN.

353 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting is horrified by the wide-scale abuse of human rights in Syria and urges the United Nations and Arab league to act to protect civilians.

354 **Motion** by BRISTOL DIVISION: That this Meeting supports the development of entrepreneurial UK based healthcare companies to compete in the emerging international health services market

355 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting calls on the BMA to call for the lifting of the blockade of Gaza, as it is severely affecting the health of the people.

BRITISH MEDICAL JOURNAL **Wednesday 12.05 – 12.20**

356 **Motion** by: Report by the Chairman of the BMJ Publishing Group (Michael Chamberlain).

* 357 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting notes the high rate of gift authorship in biomedical sciences and the pressure on junior doctors to facilitate this practice. We therefore call for gift authorship to be actively resisted.

357a **Motion** by UNIVERSITY OF BIRMINGHAM: That this Meeting believes that gift / ghost authorship of articles intended for publication is highly prevalent, while the size of the problem remains unappreciated by journal editors. We applaud efforts to mitigate this, such as the introduction of contributorship statements, and:-
i) call on the BMA to affirm that gift / ghost authorship amounts to scientific fraud;
ii) demand that the BMA makes representations to the General Medical Council to designate both the practice of, and acquiescence to, gift / ghost authorship within the profession as probity issues;
iii) call on the BMJ to redouble its efforts to lobby publicly, as well as through the International Committee of Medical Journal Editors, for mandatory implementation of contributorship statements.

The motion(s) below, in the shaded area, are unlikely to be reached

358 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting acknowledges the importance of incorporating evidence into clinical practice and calls on the BMA to facilitate this by:-
i) including free electronic access to Clinical Evidence as a membership benefit;
ii) exploring the feasibility of providing free access to all BMJ Evidence Centre resources as a membership benefit.

359 **Motion** by MID-SURREY KINGSTON & ESHER DIVISION: That this Meeting appreciates the work of BMJ staff but recommends that queries received by the Journal should always be logged so that a response is never omitted.

MEDICO-LEGAL AFFAIRS **Wednesday 12.20 – 12.35**

360 **Receive**: Report by the Chairman of the Medico-Legal Committee (Jan Wise).

* 361 **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting notes with concern the growing practice of certain Medical Defence Organisations to raise indemnity premia to unmanageable and uneconomic levels for those doctors who have had any formal sanction or investigation by regulatory authorities. The BMA is requested to take this matter up with a view to ensuring that only those who truly are a risk to patients are prevented from practising.

361a **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting notes with grave concern the reported practice of Medical Defence Organisations collaborating in the maintenance of a "blacklist" of individuals they have agreed mutually not to indemnify.

361b **Motion** by DERBYSHIRE LMC: That this Meeting notes with concern the growing practice of certain medical defence organisations to raise indemnity premia to unmanageable and uneconomic levels for those doctors who have had certain formal sanctions or investigations by regulatory authorities. The BMA is requested to take this matter up with a view to ensuring that only those who truly are a risk to patients are prevented from practising.

361c **Motion** by DERBYSHIRE LMC: That this Meeting notes with grave concern the reported practice of medical defence organisations collaborating in the maintenance of a 'blacklist' of individuals they have agreed mutually not to indemnify.

The motion(s) below, in the shaded area, are unlikely to be reached

362 **Motion** by HOLLAND DIVISION: That this Meeting believes that, following road traffic accidents, motor insurance companies should, in addition to the fee payable for first medical attendance, also pay reasonable costs of initial medical treatment and of any necessary subsequent investigations.

363 **Motion** by MID-SURREY KINGSTON & ESHER DIVISION: That this Meeting is concerned that the public may be misled by the title of "Doctor" being increasingly used by non medical practitioners. Council is asked to investigate the potential problem.

364 **Motion** by NORTH WEST LONDON RCSC: That this Meeting believes that whilst a chaperone may be necessary at an independent medical examination it should not be the patients treating doctor; as this may introduce conscious or unconscious biases.

Session closes **Wednesday 12.35**

Ethical Procurement Video **Wednesday 12.35**

(The film has been produced by the International Department. The aim of the film is to raise awareness amongst NHS staff of labour standards issues in medical supply chains (e.g. surgical instruments, latex gloves, textiles) and how these can be addressed by ethical procurement.)

Victor Horsley scientific session 3

12.45pm: Chair: Professor Averil Mansfield, Chairman, BMA Board of Science. Doctors assisting at sporting events. Dr Rod Jaques, Director of Medical Services, English Institute of Sport.

FINANCES OF THE ASSOCIATION **Wednesday 14.00 – 14.25**

365 **Receive**: Report by the Treasurer (Andrew Dearden).

366 **Motion** by TREASURER: That the standard rate of subscription be increased by 2% according to the subscription ranges set out in Appendix III with effect from 1 October 2012.

367 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting requires the BMA Treasurer to look carefully at its membership charges for all doctors with a view to improving recruitment using an income link.

The motion(s) below, in the shaded area, are unlikely to be reached

368 **Motion** by UNIVERSITY OF LONDON: That this Meeting notes that:-
i) too many doctors that undertake PhDs are subsequently lost to medical academia, and that this particularly seems to be the case for women doctors;
ii) no organisation seems to be tracking the career progress of doctors that have undertaken PhDs; and
iii) the BMA has no separate membership record for those doctors undertaking full-time PhDs and equivalent courses.
This Meeting, noting that doctors undertaking PhDs are almost invariably earning less than £34,000, therefore, calls on the BMA to:-
i) establish a separate membership category for doctors undertaking full-time research degree courses with its own subscription rate set at the same rate as the Salary Link B rate; and
ii) take active steps to populate the new membership category so that doctors undertaking PhDs and other research degrees can be surveyed.

369 **Motion** by UNIVERSITY OF BANGOR: That this Meeting notes:-
i) the BMA's mission to increase the number and proportion of UK doctors in membership; and
ii) that at just over 50%, the proportion of medical academics in membership is significantly below the average across the profession.
This Meeting believes that raising the proportion of doctors in membership amongst medical academics and the other smaller groups of doctors should be an easy win for the Association.
This Meeting, therefore, calls for:-
i) the BMA's Marketing and Membership departments to work with the relevant branches of practice to set up a targeted membership campaign for these groups of doctors; and
ii) consideration of a reduced rate of membership for doctors, such as medical academics and civil service doctors, for whom the BMA does not have either national or local negotiating rights, along the lines of that offered for Armed Forces doctors.

BMA STRUCTURE AND FUNCTION **Wednesday 14.25 – 15.25**

370 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the BMA Council failed to maximise the voice and influence of the profession by its failure to seek the views of the membership of the Association directly, over the recent Health and Social Care Bill.

* 371 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE SOUTH WEST REGIONAL COUNCIL): That this Meeting believes that employment advisory services are a core trade union function of the BMA and:-
i) any providers of these services must not have conflicts of interest in running services for BMA members;
ii) as a point of principle must not be outsourced;
iii) calls on the BMA to terminate outsourced contracts for employment advisory services at the earliest opportunity.

371a **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting believes that employment advisory services are a core trade union function of the BMA and:-
i) any providers of these services must not have conflicts of interest in running services for BMA members;
ii) as a point of principle must not be outsourced;
iii) calls on the BMA to terminate any outsourced contracts for employment advisory services at the earliest opportunity.

371b **Motion** by SOLIHULL DIVISION: That this Meeting notes with concern the appointment of a private organisation (SERCO) to run 'Ask BMA' and seeks reassurance from BMA Council that there are no conflicts of interest (with Serco's role as an NHS provider) in running the service for BMA members.

371c **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting is shocked to discover that subsidiary of SERCO, is running ask – BMA. We call on the BMA to stop outsourcing its trade union functions, and return askBMA to in-house provision.

372 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting calls for the deliberations of BMA to be transparent. It proposes that motions on medical political and trade union issues at BMA Council be recorded, so that members can see what council members stand for.

373 **Motion** by LINCOLN DIVISION: That this Meeting congratulates the Communications Directorate on the new website, and its associated microsites, and welcomes the enablement of improved direct communication between the BMA's local and regional structures and its members.

* 374 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE EAST MIDLANDS REGIONAL COUNCIL): That this Meeting notes the challenges of communicating with BMA members by electronic means and:-
i) notes the BMA is a membership organisation which exists to serve its members;
ii) is concerned that the present arrangements hinder the effective working of honorary secretaries of divisions and regional councils;
iii) believes that the reactivation of dormant divisions could be assisted by the ability to directly email their members with local information;
iv) calls on the BMA to develop arrangements which enable more effective divisional and regional communications with members;
v) believes that honorary secretaries should be entitled to an annual postal mailing to members.

374a **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting:-
i) notes the difficulties which Hon Secs of Divisions and Regional Councils have in communicating with members using modern electronic means;
ii) recognises the constraints of the various data protection acts in such matters;
iii) notes that the BMA is a membership organisation there to serve its members;
iv) knows that it is not impossible to devise a scheme to allow such communication by elected officers with the membership yet conforming with the law
and mandates council to make such arrangements necessary to facilitate such communications by the ARM 2013.

374b **Motion** by MID-SURREY KINGSTON & ESHER DIVISION: That this Meeting is concerned that members who have not elected to receive correspondence by e-mail or through surface mail are devoid of some BMA information and Council is asked to resolve the situation.

374c **Motion** by GLOUCESTERSHIRE DIVISION: That this Meeting questions the BMA's insistence on all correspondence between it's Divisions and members being electronic, when it will not accept the electronic or fax submission of nomination papers for BMA elections.

374d **Motion** by GLOUCESTERSHIRE DIVISION: That this Meeting believes that BMA divisions should be entitled to (at least) an annual mailing to members advertising divisional activities in order to maintain and encourage member participation at a divisional level.

374e **Motion** by ISLINGTON DIVISION: That this Meeting notes that due to data protection rules the BMA honorary divisional secretaries are not currently allowed access to the email addresses of the divisional members, which impedes communication with grassroots BMA members. This Meeting asks that when the BMA updates its membership list, it asks members whether they give permission for their contact details to be shared with divisional secretaries, so that those members that agree can be contacted directly by the secretary for their division, facilitating communication with the membership.

374f **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting is concerned that figures made available to Divisional Honorary Secretaries on the number of members with a valid email address are not an accurate representation of the number of Division members who actually receive email correspondence sent out by Honorary Secretaries. We also highlight the disparity which prevents Regional Council Honorary Secretaries from emailing members within the region in a timely manner and calls for the Organisation Committee to make recommendations to Regional Services and the Information Technology Department on:-
i) extending the scope of direct emailing to include Regional Councils;
ii) extending statistics on the BMA division webpage to include a category for opted-out members;
iii) restoring postal mailings to members without a valid email address.

374g **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting believes that the reactivation of dormant divisions could be helped if members in that locality could be emailed directly with details of any relevant meetings, and asks Regional Services to facilitate this.

375 **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting reasserts the value to Regional Councils of their Regional Co-ordinators, thanks the Regional Co-ordinators for the work done on behalf of Councils yet to have a co-ordinator appointed, and calls on the Treasurer to complete the rollout of co-ordinators begun by his predecessor within 12 months.

* 376 **Motion** by LINCOLN DIVISION: That this Meeting highlights the fact that, at the 2011 Cardiff ARM, some 76 motions relating to BMA structure and function were relegated to the grey section unlikely to be debated. We view this as indication that the Representative Body feels that there are problems with the structure and function of the Association, and call on the ARM Agenda Committee to allocate more time to this section in future agenda.

376a **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting highlights the fact that, at the 2011 Cardiff ARM, some 76 motions relating to BMA structure and function were relegated to the grey section unlikely to be debated. We view this as indication that the Representative Body feels that there are problems with the structure and function of the Association, and call on the ARM Agenda Committee to allocate more time to this section in future agendas.

376b **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting is appalled at how little debating time is given to considering the internal governance of the Association in the Agenda of the Annual Representative Meeting, and instructs the Agenda Committee to give considerably more time to debate issues of concern regarding the structures and functions within the Association.

The motion(s) below, in the shaded area, are unlikely to be reached

377 **Motion** by GREENWICH, BEXLEY & BROMLEY DIVISION: That this Meeting would like to propose that the ARM motions are circulated to all members (and not to representatives only) as an attachment to the BMJ, prior to the meeting, for the benefit of all members.

378 **Motion** by MID-SURREY KINGSTON & ESHER DIVISION: That this Meeting considers that there should be at least one guaranteed opportunity for a member of the ARM to address the meeting. Council should make appropriate arrangements.

379 **Motion** by WORCESTERSHIRE DIVISION: That this Meeting believes outdoor sporting activities are a healthier way to encourage cooperation and networking between delegates than high fat alcohol fuelled dinners, and as such demands the re-institution of the annual golf and cricket matches at the ARM as a first step, with rounders and a fun run to follow.

380 **Motion** by RETIRED MEMBERS FORUM: That this Meeting asks the BMA to investigate the grounds for setting up of a doctors' house swap website to facilitate free house swaps between medical members of the BMA to enhance the lives of retired members and members in active medical practice.

381 **Motion** by SOUTH TYNESIDE DIVISION: That this Meeting is of the opinion that, BMA representatives who attend the ARM should attend not less than 70% of business of the meeting to justify expenses.

382 **Motion** by SHEFFIELD DIVISION: That this Meeting believes that other than money specifically donated for charitable purposes, the BMA should not use its funds to donate to charities.

383 **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting believes that, since Honorary Secretaries are not currently remunerated for the work undertaken, completion of any necessary documentation should not require duplication of information submitted.

384 **Motion** by SUNDERLAND DIVISION: That this Meeting feels very strongly that the secretary should be provided, contact details of division members to facilitate better attendance, to improve and motivate members to get involved in division work and direct contacts help better input.

385 **Motion** by BRISTOL DIVISION: That this Meeting believes that given the current debate on the future of the NHS, the BMA needs to widen its professional activities to include a dedicated group working on health economics within the remit of the Board of Science. This new group should have the aim of developing a set of resources on health economics which can be disseminated to both members and the wider public.

386 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon the BMA to:-
i) seek to monitor medical message boards (such as Doctors Net) with a view to addressing the real negativity towards the Association on these fora;
ii) instruct the Press Office to develop a strategy to address this.

387 **Motion** by WELSH COUNCIL: That this Meeting calls on the BMA to retain the services of Mr Bob Crow, General Secretary of the RMT union (one of Britain's fastest growing trade unions) in a consultative role, to advise on organising assertive and effective trade union activities. We particularly support his comments "It wasn't our members who created the downturn and we will not be bullied into accepting that they should be forced to pay for an economic crisis that was cooked up by the bankers and the politicians."

388 **Motion** by EAST DORSET DIVISION: That this Meeting urges the BMA to stop discrimination against locums by causing them to suffer a significant loss-of-earnings if they wish to actively participate in the Association.

389 **Motion** by OXFORD DIVISION: That this Meeting reaffirms its support to BMA Divisions, notes their value in making elections to the ARM and asks that the BMA provides help for the Divisions particularly with secretarial work such as sending out notices of meetings, events, etc. It also notes with pleasure that BMA News is printing short notes about some of these meetings.

390 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting requires the BMA to consider some form of affiliation to the TUC.

391 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting calls on the BMA to be affiliated to the Trades Union Congress.

392 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon Council to prevail upon all healthcare providers and branches of practice to ensure all medical staff committee reflect all grades of medical staff within the service.

393 **Motion** by ISLINGTON DIVISION: That this Meeting notes that in November 2011 the BMA Council passed a motion calling for a public campaign against the Health and Social Care Bill. Given that BMA Council is the supreme policy making body the meeting asks why its decision was overridden.

394 **Motion** by ISLINGTON DIVISION: That this Meeting calls upon the Council of the BMA and its chair to uphold the primacy of the ARM to make policy as stated in section 57 of the Article of Association and to implement these decisions as soon as possible.

395 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the BMA should explore the potential of creating an arms length, not for profit company, to deliver expert commissioning support to Clinical Commissioning Groups (CCGs) in England, in order to preserve the ethos of the NHS and reduce the need for CCGs to seek this support from the private sector.

396 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting believes that even if any of the constituent nations were to gain independence in the future, the BMA should remain a quadrinational Association.

397 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting notes its enviable legacy and grassroots appeal and believes that it has an enduring function as well as an evolving role within the wider BMA. With this in mind we call on the Association to:-
i) maintain adequate resources to support its activities for the foreseeable future;
ii) explore the feasibility and practicalities of opening up the Forum to non-members within the medical profession;
iii) strengthen the Forum's representation at the Annual Representative Meeting.

398 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon the BMA to review the support provided by First Point of Contact as the service is not coming up to the high expectations members have.

399 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the BMA Council should end the unwritten rule that consultants and GPs alternate as Council Chairman, as it is contrary to any concept of equal opportunities and may fail to ensure that the best available candidate is elected.

400 **Motion** by OXFORD DIVISION: That this Meeting believes the BMA should encourage more cooperation between GPs and consultants via the Divisions.

401 **Motion** by WEST MIDLANDS REGIONAL COUNCIL: That this Meeting is concerned that the interval between publication of the 2012 ARM agenda and the deadline for receipt of amendments is too short to allow proper consideration, especially as it includes an extended public holiday, and requests that in future the interval be a minimum of ten working days.

402 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting welcomes the increased use of telemeeting and videomeeting facilities for BMA committee meetings and calls on the Organisation Committee to clarify the Articles and Bye-laws of the BMA to ensure that committee members attending such meetings by electronic means have the same voting rights as if they had attended in person.

403 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the BMA should change the Bye-laws of the Association to reflect changes in Information Technology and to allow its business, including Divisional meetings and AGMs to be carried out through virtual meetings and/or conference calls.

404 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that there is a serious governance issue for BMA Council due to the high number of non-voting Directors of the Association who sit on Council who have no ability to vote to influence BMA Council policy and therefore calls on the BMA's Organisation Committee to produce proposals to ensure that the number of non-voting members on Council is greatly reduced and only allowed if absolutely necessary.

405 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting calls on the BMA's Organisation Committee to examine the structure of UK Council and the election structure of directors of the Association and produce proposals to enhance the representativeness of BMA Directors.

406 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that, in order that the interests of the devolved nations are appropriately recognised in the BMA, it is essential that the Chairs of the National Councils of the devolved nations have voting seats on the UK Council of the BMA and therefore asks the Organisation Committee to bring proposals forward to incorporate this in the Articles and Bye-laws of the BMA.

407 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the BMA should change the Bye-laws of the Association to ensure that the Chairman of Council is elected by the whole membership of the Association and not just by BMA Council.

408 **Motion** by CITY & HACKNEY DIVISION: That this Meeting is dissatisfied with the way that the Chairman of the BMA is currently elected i.e. solely by BMA Council members. This is undemocratic and disenfranchises the entire BMA membership. This Meeting calls upon the BMA to reform the mechanism of election for BMA Chairman and adopt a one member, one vote system.

409 **Motion** by SHROPSHIRE DIVISION: That this Meeting welcomes the diversity of BMA members. This Meeting:-
i) supports the decision of the ARM organisers to cease to provide the traditional BMA 'Act of Worship';
ii) calls on the organisers of the ARM to justify continued use of BMA funds to host the 'Reflection and Thanksgiving Meeting', which was billed in 2011 as 'offering readings from different faiths and belief systems' which is not business of the ARM;
iii) instructs that formal BMA-sanctioned services or meetings for Reflection and Thanksgiving should be discontinued, and that members of RB with a religious, or personal belief interest should be encouraged to arrange such meetings privately at their own expense.

410 **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting notes the on-going work by the BMA on topical issues important to our members. However, there have been issues regarding communicating and liaising with local divisions about events organised centrally. Therefore this Meeting calls for:-
i) all BMA departments who are running events in localities with an active division to inform the division honorary secretary prior to the event being organised;
ii) all BMA departments to coordinate with divisions to co-present events and therefore improve turnout.

411 **Motion** by ISLINGTON DIVISION: That this Meeting believes that the BMA should use the opportunities offered by new Information Technology to increase the voice and influence of the membership of the Association on important or contentious issue. This should include the use of e-referenda, on-line surveys, virtual meetings and conference calls.

412 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting, with regard to the BMA's Regional Services:-
i) applauds the excellent work done to support individual and groups of members with employment issues;
ii) believes that the need for support for individual and groups of members has and will continue to increase;
iii) believes that Regional Services require increased personnel to sustain the workload and the high quality of their work;
iv) calls for the further roll out of regional co-ordinators to support and complement the valuable work being done by Regional Councils.

413 **Motion** by NORTH EAST REGIONAL COUNCIL: That this Meeting recognises the ever increasingly important role that Regional Councils have within the BMA structure in England and demands:-
i) a more formal and integrated link is developed within the National Council and Regional Council structure;
ii) regular communication between Council and Regional Councils must be addressed and made more robust;
iii) priority is given to the investment and involvement of Regional Coordinators in all Regional Councils.

414 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting fears that a lack of investment in Regional Services staff is losing a valuable resource to the Association and requires Regional Services to evaluate and consider the training and support of employment advisers and to publish statistics on recruitment, retention and promotion of these staff both within the Association and outside.

415 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting, with regard to the BMA's Regional Services:-
i) applauds the excellent work done to support individual and groups of members with employment issues;
ii) believes that the need for support for individual and groups of members has and will continue to increase;
iii) believes that Regional Services require increased personnel to sustain the workload and the high quality of their work.

416 **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting applauds the hard work that the Regional Council Coordinators do for their respective Councils and BMA members but recognises that not all Regional Councils have dedicated Coordinators. Commends BMA Council to ensure those remaining Regional Councils who do not have Coordinators have Coordinator appointments made as quickly as is possible to support Councils and promote equity amongst Regional Councils.

417 **Motion** by LAMBETH & SOUTHWARK DIVISION: That this Meeting as a result of the Health and Social Care Bill and the likely fragmentation of healthcare providers, urges the BMA to increase the allocation of resources to its trade union function in order to provide a more proactive, personal and supportive service to doctors with employment problems.

418 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting calls upon Council to require that Regional Services increases the ratio of IROs to Employment Advisers.

419 **Motion** by SCOTTISH COUNCIL: That this Meeting believes that the BMA must develop a federal structure, so that UK issues are dealt with in UK committees and each of the four nations deal with their own issues through their own national committees.

420 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting requires Council to address the under provision of employment advisers to the devolved nations which is putting these staff under unbearable work pressures and indeed compromises the support available to members in the devolved nations.

A 421 **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting believes the BMA should make a concerted effort to reactivate inactive divisions.

A 422 **Motion** by LEWISHAM DIVISION: That this Meeting agrees that the BMA should have a register of interests for the BMA Council and its officers.

A 423 **Motion** by WELSH COUNCIL: That this Meeting calls on the BMA to ensure that all members are adequately informed, in good time, of how to apply for ARM seats prior to the 2013 ARM.

A 424 **Motion** by SCOTTISH COUNCIL: That this Meeting calls on the BMA to ensure that video-conferencing facilities are available in all its national offices' main meeting rooms.

PROFESSIONAL REGULATION AND THE GMC

Wednesday 15.25 – 16.05

***** 425 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE EAST MIDLANDS REGIONAL COUNCIL): That this Meeting:-
i) deplores the attempt by the Secretary of State to take powers personally to control the appointment of members of the General Medical Council;
ii) opposes the proposals to reduce the size of GMC Council from 24 to 8 members;
iii) opposes the proposal that the Chairman of the GMC be an elected post from outwith the Council;
iv) calls on BMA to lobby the government and appropriate stakeholders to remove the cost burden of running the GMC from doctors if changes are imposed.

425a **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting deplores the attempt by the Secretary of State to take powers personally to control the appointment of members of the General Medical Council. If professional self-regulation is to continue to be funded by doctors, we demand:-
i) the ability to elect medical members of the Council;
ii) a body independent of government be made responsible for the appointment of non-medical members;
iii) restoration of the medical majority on the GMC.

425b **Motion** by LOTHIAN DIVISION: That this Meeting believes that proposals to reduce the size of GMC Council from 24 to 8 members, and for the Chairman of the GMC to be an elected post from outwith the Council would truly be the end of self regulation of the medical profession and therefore the medical profession should then cease to fund the GMC.

425c **Motion** by CITY & HACKNEY DIVISION: That this Meeting is dismayed at proposed changes to the GMC Council structure, and calls on the BMA to oppose the move from the current GMC Council structure to an Executive Board which changes the GMC from a self regulatory body towards a statutory body without a professional majority.

425d **Motion** by NORTH THAMES RJDC: That this Meeting recognises that current GMC funding is based on the principle that 'the beneficiary pays,' is dismayed at proposed changes to the GMC Council structure, and calls on the BMA to:-
i) oppose the move from the current GMC Council structure to an Executive Board;
ii) lobby the government and appropriate stakeholders to remove the cost burden of running the GMC from doctors if these changes are approved.

***** 426 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE CLWYD NORTH DIVISION): That this Meeting:-
i) considers that a complaint or referral to the GMC can be extremely damaging;
ii) insists that the General Medical Council urgently review its screening processes to ensure they do not cause avoidable harm and distress to the health and well-being of the doctor.

426a **Motion** by CLWYD NORTH DIVISION: That this Meeting considers that an inappropriate complaint or referral to the GMC is as damaging as a physical assault and that appropriate responses should be developed.

426b **Motion** by MORGANNWG LMC: That this Meeting insists that the General Medical Council urgently reviews its screening processes to ensure they do not cause unnecessary and undeserved harm and distress to the health and reputation of the doctor.

* 427 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE PLYMOUTH DIVISION): That this Meeting, while supporting the principle of professional revalidation; requires:-
i) that the BMA liaise with the GMC to ensure that the revalidation is fair, transparent and easy to implement;
ii) that the cost of revalidation should be borne by the state and not by individual doctors;
iii) revalidation must not be introduced until there is clarity about the source of funding for remediation;
iv) remediation must not add financially to the burden of doctors who need it;
v) that multisource feedback must be fit for purpose and role specific;
vi) that it must not go ahead without the proper arrangements for all doctors.

427a **Motion** by PLYMOUTH DIVISION: That this Meeting:-
i) insists that the cost of revalidation should be borne by the state and not by individual doctors;
ii) that multisource feedback is fit for purpose and craft specific.
iii) revalidation must not be introduced until there is clarity about the source of funding for remediation;
iv) remediation must not add financially to the burden of the doctors who need it.

427b **Motion** by BIRMINGHAM DIVISION: That this Meeting fully supports the introduction of a system of professional revalidation for doctors capable of systematically improving patient care and assuring patient safety but demands that the current proposed system for revalidation of doctors be halted immediately due to its inability to contribute towards these objectives in any measurable way.

427c **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting notes that the BMA in Scotland has written to the GMC explaining that it does not believe that NHS Scotland can implement revalidation to the GMC's timetable starting later this year. This Meeting commends the analysis of BMA Scotland, and calls on the whole BMA to clearly express similar views publicly, and privately to all organisations regarding the implementation of revalidation in all nations of the United Kingdom.

427d **Motion** by DERBYSHIRE LMC: That this Meeting instructs the BMA and branch of practice committees not to agree the start of revalidation until remediation is available to all doctors on an equal basis.

427e **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting demands that revalidation should not proceed without a transparent, full debate on the business case for it, to clarify whether it will produce value-for-money. Therefore this Meeting insists that the BMA be involved in that debate, including detailed discussion of the draft business case being prepared for ministers, before a final ministerial decision is made.

427f **Motion** by HOLLAND DIVISION: That this Meeting believes that the government and the GMC should agree both mechanism and funding for a remediation process for any doctors who require this as a result of revalidation, and believes revalidation should not be introduced until these measures are confirmed.

427g **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting demands that revalidation should not proceed without a transparent, full debate on the business case for it, to clarify whether it will produce value-for-money. Therefore this Meeting insists that the BMA be involved in that debate, including detailed discussion of the draft business case being prepared for ministers, before a final ministerial decision is made.

427h **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting notes that the BMA in Scotland has written to the GMC explaining that it does not believe that NHS Scotland can implement revalidation to the GMC's timetable starting later this year. This Meeting commends the analysis of BMA Scotland, and calls on the whole BMA to clearly express similar views publicly, and privately to all organisations regarding the implementation of revalidation in all nations of the United Kingdom.

427i **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting insists that a fully funded remediation scheme is an integral and indispensable part of revalidation, and must be provided before revalidation becomes mandatory.

427j **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting believes that if a patient survey and a colleague survey/multi source feedback are to be required for revalidation that:-
i) approved and validated survey tools should be made available that can be used and analysed by individual doctors;
ii) survey tools should be available at no cost to individual doctors.

427k **Motion** by SCOTTISH COUNCIL: That this Meeting does not believe that the current proposals for revalidation are practicable.

427l **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting demands that the BMA liaise with the GMC to ensure that the revalidation process is fair, transparent and easy to implement.

427m **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting demands that the BMA tell the GMC to halt the revalidation process until funding for the process has been identified and negotiated in all four nations.

427n **Motion** by LOTHIAN DIVISION: That this Meeting believes that as currently proposed revalidation is not fit for purpose and calls on the BMA to oppose its implementation in 2013.

427o **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting calls for revalidation and remedial costs to be fully funded by the employer or central funds.

427p **Motion** by CIVIL AND PUBLIC SERVICES COMMITTEE: That this Meeting believes that all doctors, including those engaged within the public and civil services sector, must:-
i) be given appropriate support in preparing for revalidation and must not be disadvantaged on account of any particular setting in which they are engaged;
ii) receive protected time within their contract for ongoing professional development in preparation for revalidation.

427q **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting believes that revalidation should not be introduced until:-
i) the BMA and GMC have agreed a process for remediation;
ii) an equitable remediation process is in place;
iii) the government has agreed to provide all funding for remediation.

427r **Motion** by CIVIL AND PUBLIC SERVICES COMMITTEE: That this Meeting believes that any doctor engaged within the civil and public services sector who is not recommended for revalidation by their Responsible Officer be supported by their employing or contracting authority in their efforts to remedy this by way of making available the appropriate resources to facilitate such further efforts/ remediation.

427s **Motion** by CONSULTANTS CONFERENCE: That this Meeting notes that the BMA in Scotland has written to the GMC explaining that it does not believe that NHS Scotland can implement revalidation to the GMC's timetable starting later this year. This Meeting commends the analysis of BMA Scotland, and calls on the whole BMA to clearly express similar views publicly and privately to all organisations regarding the implementation of revalidation in all nations of the United Kingdom.

427t **Motion** by CONSULTANTS CONFERENCE: That this Meeting:-
i) commends Responsible Officers in seeking to ensure that doctors at risk of not being revalidated, are given advanced notification and support to achieve the required standard and remedial help;
ii) calls on the Departments of Health to ensure that adequate ring-fenced funding is available to Medical Directors and Responsible Officers for revalidation and if this is not the case, for revalidation to be abandoned.

427u **Motion** by YORKSHIRE REGIONAL COUNCIL: That this Meeting, with regard to revalidation, insists that:-
i) it must not go ahead without adequate arrangements for remediation which are no more burdensome for GPs than for other doctors;
ii) It must not go ahead without proper arrangements for all types of GPs, including Sessional and prison GPs;
iii) doctors must be called for on a random basis;
iv) arrangements for Responsible Officers are independent of their own organisation;
v) requirements for periods of less than 5 years need to be reduced pro rata so as not to discriminate.

428 **Motion** by WALTHAM FOREST DIVISION: That this Meeting believes that the GMC has been silent for far too long on the practical application of appraisal and revalidation, thus allowing local enthusiasts to develop complex and confusing agendas, and insists that the GMC must now take charge of the situation in an effective way.

The motion(s) below, in the shaded area, are unlikely to be reached

429 **Motion** by EASTERN REGIONAL COUNCIL: That this Meeting believes that Good Medical Practice is a seminal document for doctors and:-
i) regrets the GMC believes that Good Medical Practice should be rewritten every five years;
ii) believes any changes made must be necessary, appropriate, reasonable and proportionate ;
iii) believes that the draft recently consulted on risks being undermined by the inclusion of some paragraphs that many doctors either do not believe in or may ignore;
iv) believes that Good Medical Practice must continue to be representative of the shared conscience of the profession.

430 **Motion** by EASTERN REGIONAL COUNCIL: That this Meeting notes that the GMC in their 'Leadership and Management for all doctors' guidance states that 'all doctors should be willing to take on a mentoring role for more junior doctors and other healthcare professionals' and demands that the GMC ensures that the role of mentor should only be undertaken by those doctors with the appropriate skills and training, and that the training and mentoring are adequately resourced.

431 **Motion** by MERTON, SUTTON & WANDSWORTH DIVISION: That this Meeting believes that because the Health and Social Care Bill will abolish the Appointments Commission, which appoints members to the GMC Council, we should once more have elected medical members of the GMC with a two thirds majority.

432 **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting feels that a large number of doctors are loosing their faith in the GMC because:-
i) it is run by the appointed members like a quango but funded by the fee paying members;
ii) it acts as a prosecutor, judge, jury and executor when dealing with complaints against doctors;
iii) spends a large amount of legal fees in the process and yet loses cases in the High Court.

433 **Motion** by CROYDON LMC: That this Meeting believes the GMC should have a legal right to test the language competency of doctors wishing to join the UK medical register.

434 **Motion** by ROCHDALE DIVISION: That this Meeting demands action from the GMC, Royal Colleges and NHS about the linguistic problems in the fields of medicine requiring excellent command of English language such as in psychiatry and histopathology reports.

435 **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting believes that because the Health and Social Care Bill will abolish the Appointments Commission, which appoints members to the GMC, we should have elected medical members of the GMC with a two thirds majority.

436 **Motion** by BIRMINGHAM DIVISION: That this Meeting demands that any doctor who is the subject of a complaint should be fully informed and involved in all aspects of the complaints procedure, including all locum doctors in all settings including General Practice. Every doctor has the right to defend their reputation.

437 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting is appalled by the current handling of complaints about GPs by PCTs which have a degrading and even destructive effect on morale and, although there is no place for negligence, every complaint is treated as serious and the GP guilty regardless of how trivial and spurious the complaint may be and therefore asks the BMA to recognise:-
i) that there is a lack of understanding amongst some of the more vociferous complainants who are ignorant of the limitations of medical science and the constraints from due diligence in considerations of risk;
ii) that it is a dereliction of our duty to regulate ourselves to devolve that vital function to the laity no matter how well trained a non-doctor is in medical science and negligence; and
iii) demands that the BMA and GMC negotiate an improvement in disciplinary procedures.

438 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting demands that the GPC ensures that the local Deanery networks of tutors be retained to provide vital support:-
i) for quality assurance of appraisal systems;
ii) to enable motivated and hard working GPs to achieve revalidation.

439 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting insists that Responsible Officers (ROs), Appraisal Leads and Appraisers understand types of acceptable supporting information specified in GMC guidance that sessional GPs may submit for appraisal.

440 **Motion** by RETIRED MEMBERS FORUM: That this Meeting requests the General Medical Council, in collaboration with the BMA, clarify the arrangements for providing Responsible Officers for retired members who work independently.

441 **Motion** by WELSH COUNCIL: That this Meeting notes that that under GMC guidance of Good Medical Practice, all doctors must put public/patient need before corporate/employer benefits, therefore demands:-
i) that within the Welsh Medical Appraisal for Revalidation Scheme doctor s must confirm that their contract permits them to speak and act independently of their employer in patient interests and that their employer has not attempted to limit this duty;
ii) the GMC to require Responsible Officers to report annually the number of doctors who cannot

make such an affirmation, to both the GMC and the MD of the employer;
iii) the GMC to list on their website those employers where no such return has been submitted and where doctors have been restricted from protecting patients.

442 **Motion** by NORTH WESTERN RSASC: That this Meeting demands that the GMC requires employers to mandatorily incorporate information systems to provide personalised (and individualised) workload and outcome data to support and facilitate their employee's contractual and professional requirement to remain revalidated.

443 **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting notes the current attempts by some deaneries, SHAs, PCTs and other NHS Authorities within the British Isles to introduce enhanced appraisal for General Practitioners by the backdoor and it:-
i) insists that such attempts have no legal basis;
ii) insists that such attempts have no contractual basis;
iii) demands that the GMC publicly clarifies the matter;
iv) encourages appraisees to report all such attempts to their LMC, LNC, BMA division or regional council for action;
v) instructs the BMA and its branch of practice committees to negotiate accordingly.

444 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting notes the emerging findings of the Francis Public Inquiry into the events at Mid-Staffordshire NHS Trust. This Meeting:-
i) has no confidence that revalidation as currently envisioned by the GMC will contribute meaningfully to enhancing patient safety;
ii) believes that revalidation as currently envisioned by the GMC may, by diversion of medical resources and diverting emphasis from improving systemic clinical governance, actually increase risk to patients.
This Meeting calls on the BMA to clearly state this in private meetings with all stakeholders and in public.

445 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting notes the emerging findings of the Francis Public Inquiry into the events at Mid-Staffordshire NHS Trust. This Meeting:-
i) has no confidence that revalidation as currently envisioned by the GMC will contribute meaningfully to enhancing patient safety;
ii) believes that revalidation as currently envisioned by the GMC may, by diversion of medical resources and diverting emphasis from improving systemic clinical governance, actually increase risk to patients;
This Meeting calls on the BMA to clearly state this in private meetings with all stakeholders and in public.

Contingency time **Wednesday 16.05 – 16.10**

DOCTORS' PAY AND CONTRACTS **Wednesday 16.10 – 16.30**

* 446 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE ENFIELD AND HARINGEY DIVISION): That this Meeting notes that the government seeks to impose locally determined pay on public sector workers. This Meeting believes that:-
i) it would only be a matter of time before it is applied to doctors;
ii) the aim of this policy is to undermine national terms and conditions for public sector workers, including pay and pensions;
iii) this is part of the ongoing plan to dismantle public services and outsource them to private companies;
iv) it would inhibit the free movement of doctors around the country during their careers;
v) it would have a negative effect on the training of doctors;
vi) it would create recruitment problems in deprived areas;
vii) it would lead to wasted time and resources in negotiating local contracts;
viii) it would be the "final nail in the coffin" of a comprehensive NHS;
ix) BMA Council should campaign to maintain national contracts;
x) BMA Council should ballot on strike action if local negotiations on pay are imposed.

446a **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting believes that this coalition government seeks to impose local pay on public sector workers. It would only be a matter of time before this could be imposed on doctors too. In that case, this Meeting mandates Council to ballot for strike action to defend national pay and conditions.

446b **Motion** by ROTHERHAM DIVISION: That this Meeting instructs the BMA to continue to support a national pay structure.

446c **Motion** by CITY & HACKNEY DIVISION: That this Meeting:-
i) notes the government's move to locally determined public sector pay;
ii) is concerned on the impact this would have on doctors pay and terms and conditions;
iii) calls on the BMA to campaign to maintain a national contract in order to protect terms and conditions of service.

446d **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting notes that the coalition government has made clear that it wants to dismantle all the public services and outsource their provision to private companies. As part of that privatisation programme, it is attacking the national terms and conditions of public sector staff, such as pensions and national pay. This Meeting calls on BMA Council to stand up for doctors by defending pensions and maintaining national pay by balloting for strike action in their defence.

446e **Motion** by NORTHERN IRELAND CONSULTANTS COMMITTEE: That this Meeting believes that if doctors do not resist the current proposals to modify their pensions, that it is inevitable that the government will seek to further reduce the pay and pension of doctors in the future and therefore calls on all doctors to stand together to take a robust stance in defence of their pay and pension.

446f **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting recognises that regional pay is not in the best interests of the NHS, doctors or their patients and insists that regional pay schemes are not imposed on UK doctors.

446g **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting calls on the BMA to resist any attempts by the governments to introduce regional pay across the four nations since it will harm patient care.

446h **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting believes that if HM government's plans to abolish national pay-scales for public sector workers is applied to doctors, this will be another "nail in the coffin" for a comprehensive NHS, and:-
i) it would inhibit the free movement of doctors around the country during their careers;
ii) it would increase the "postcode lottery" and further reduce the quality of services in deprived areas;
iii) it would have a negative effect on the training of doctors;
iv) it would result in wasted time and resources in negotiating local contracts;
v) calls on the BMA to continue to fight for preservation of national terms and conditions for doctors.

446i **Motion** by EALING DIVISION: That this Meeting believes that freezing medical pay for over three years and degrading the NHS pension scheme is demoralising and likely to deter young doctors from practising in the UK. We call on the BMA to undertake any action deemed necessary to demonstrate to the government that failure to listen to and to respond appropriately to our concern will harm the NHS.

446j **Motion** by LOTHIAN DIVISION: That this Meeting calls on the BMA to support national NHS payscales for doctors throughout the UK so that doctors can move post without detriment.

446k **Motion** by NORTH WESTERN RJDC: That this Meeting notes with concern the government's proposals for locally determined public sector pay and believes that terms and conditions of service should continue to be negotiated nationally and consistent across the four nations. We therefore:-
i) call on the JDC to reject any proposals for regional variations to the terms and conditions of service for doctors in training;
ii) call on the Association to provide the appropriate support to Local Negotiating Committees, with increased resources if needed, to deal with the increasing challenges to local terms and conditions that they are likely to face.

446l **Motion** by GLOUCESTERSHIRE DIVISION: That this Meeting totally opposes any proposal for regional or local pay variation for doctors. This would inevitably worsen recruitment to certain posts across the UK and divert more medical time to pay negotiation to the detriment of patient care.

* 447 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE HOLLAND DIVISION): That this Meeting deplores the erosion of Supporting Professional Activities (SPA) time in the job plans of both new and existing posts. We recognise that this may have an adverse impact on an individual's ability to provide evidence for revalidation and:-
i) insist that SPAs are detailed within the job description of new posts and that there should be a job plan review within 6 months of commencement;
ii) call on royal college representatives who approve job descriptions for new posts and/or who sit on appointments committees to insist that the nature of the SPA work is fully specified in job plans in line with the SPA Guidance from the Academy of Medical Royal Colleges;
iii) remind employers that the quality of education and training will be at risk;
iv) demand that the contractual position on SPAs is protected.

447a **Motion** by HOLLAND DIVISION: That this Meeting believes that the financial pressures within the NHS is leading to secondary care employers cutting time in job plans for supporting professional activities (SPA) , and that this:-
i) may have an adverse impact on individual's ability to provide evidence for revalidation;
ii) will affect quality of educational training provided;
and calls on the BMA to remind employers that adequate SPA time should be provided.

447b **Motion** by CONSULTANTS CONFERENCE: That this Meeting deplores inadequate provision of SPA time in new job plans and calls on:-
i) employers to ensure that the exact purpose of the funded SPA time is specified in detail in job plans for new posts;
ii) employers to ensure there is a formal job plan review within six months of commencing the post;
iii) royal college representatives who approve job plans for new consultant posts and/or who sit on Consultant Appointment Panels to insist that the nature of the SPA work is fully specified in job plans in line with the SPA Guidance from the Academy of Medical Royal Colleges.

447c **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting believes that the financial pressures within the NHS are leading to secondary care employers cutting time in job plans for supporting professional activities (SPA) , and this may have an adverse impact on individual's ability to provide evidence for revalidation, and on quality of training provided. This Meeting therefore calls on the BMA to remind employers that adequate SPA time should be provided.

447d **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting believes that those secondary care employers who are cutting Supporting Professional Activity time for consultants and SAS grade staff due to financial pressures are likely to:-
i) adversely affect the ability of those individuals to revalidate;
ii) have impact on delivery of training;
and calls on the BMA to highlight this to NHS Employers.

447e **Motion** by ROTHERHAM DIVISION: That this Meeting insists that the BMA should continue to support the SPA/PA ratio in the consultant contract and oppose its erosion by trusts.

447f **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting condemns the inadequate allocation of SPA time in contracts for new jobs and calls on Royal College representatives who approve job plans for new consultant posts and / or who sit on Consultant Appointment Panels to insist that the nature of the SPA work is fully specified in job plans in line with the SPA Guidance from the Academy of Medical Royal Colleges.

447g **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting deplores the actions of some NHS Trusts and Foundation Trusts that seek to place blanket restrictions of below 2.5 programmed activities for supporting professional activities in consultant job plans.

The motion(s) below, in the shaded area, are unlikely to be reached

448 **Motion** by CAMBRIDGE HUNTINGDON & ELY DIVISION: That this Meeting notes the various attempts to undermine the present terms and conditions of doctors of all grades and calls upon the BMA to resist any movement towards implementing Agenda for Change for doctors.

449 **Motion** by CLWYD NORTH DIVISION: That this Meeting calls upon consultants to support, protect and look after junior and SAS doctors involved in any legally taken industrial action.

450 **Motion** by CAMBRIDGE HUNTINGDON & ELY DIVISION: That this Meeting regrets that the implementation of the proposed pension reforms is unjust in view of the successful 2008 negotiation and:-
i) is likely to precipitate mass withdrawal from the scheme with a subsequent drastic reduction in the Treasury income necessary to fund existing pension obligations;
ii) therefore expects the DDRB to recommend increases in pay proportional to the increased contributions and the decreased future benefits, given the DDRBs historic regard of doctors pensions as deferred pay.

451 **Motion** by NORTH WEST REGIONAL COUNCIL: That this Meeting recognises the importance of the parity of doctors' pay and insists that:-
i) employers ensure that all NHS medical activity is paid according to the same pay schedule, regardless of specialty, or site;
ii) the NHS Standard Acute Contract is modified to ensure that pay parity is assured for all NHS work performed in the private sector.

452 **Motion** by EAST AND NORTH HERTFORDSHIRE DIVISION: That this Meeting believes that doctors have the right to use annual leave and study leave in a way that maintains work life balance and CPD requirements without the responsibility of providing cover for their absence and calls upon the BMA to urge NHS employers to prevent enforcement of this non contractual obligation of prospective cover by the trusts.

HEALTH INFORMATION MANAGEMENT AND IT

Wednesday 16.30 – 16.40

* 453 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting calls on the BMA to condemn the practice operated by some insurance companies to request a copy of the patient's entire medical record rather than commission an appropriate medical report.

453a **Motion** by CLEVELAND LMC: That this Meeting condemns the misuse of the Data Protection Act by insurance companies and demands that the Information Commissioner takes appropriate action.

The motion(s) below, in the shaded area, are unlikely to be reached

454 **Motion** by OXFORD RSASC: That this Meeting agrees that electronic patient records are a valuable resource in principle and urges NHS trusts to learn from pilot sites prior to implementation, but be prepared for decreased productivity both from management and clinicians as a result of time required for accurate and detailed record keeping. The Meeting calls on the BMA to monitor and issue guidelines regarding the impact of the electronic patient records on the job plans of all career grade doctors.

455 **Motion** by EAST KENT DIVISION: That this Meeting feels that the sharing of prompt easily accessible information between health care providers (Primary, Secondary and Private Sectors) is essential to ensure high quality, value for money care of patients and calls on the BMA to work with the Department of Health to develop an effective solution.

456 **Motion** by LIVERPOOL LMC: That this Meeting believes that IT systems need to be developed that enable relevant clinical information and investigations to be shared safely between NHS providers to prevent unnecessary duplication.

457 **Motion** by SUFFOLK DIVISION: That this Meeting in view of the importance of facilitating the exchange of clinical information between health care professionals caring for a patient at the time, this meeting strongly endorses the concept of chief information officers.

458 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting believes when appropriate patient information needs to be shared, it is seamlessly transferred electronically:-
i) between primary care providers;
ii) between primary and secondary care providers;
iii) between secondary care providers.

459 **Motion** by BIRMINGHAM DIVISION: That this Meeting expresses outrage at the incompleteness, inconsistency and unreliability of clinical data across England despite the billions of pounds spent by NHS authorities on information systems over the past decade. This Meeting believes that accurate and reliable clinical data is essential in order to assure patient safety and systematically improve clinical care and is a pre-requisite of any effective system of professional revalidation for doctors.

460 **Motion** by SHEFFIELD DIVISION: That this Meeting believes that concerns of relatives are not always fully recorded in medical notes because of misplaced concerns over patient access to medical records. We ask the GMC to remind doctors that third party information does not form part of the disclosable medical record and should be carefully recorded and noted as not to be disclosed.

461 **Motion** by SUFFOLK DIVISION: That this Meeting notes with concern the proliferation of for-profit organisations within the NHS and asks Council to negotiate with the government to ensure that suitable probity measures are in place, especially where these organisations might have access to patient data.

462 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting insists that unless there are very exceptional circumstances no information relating to a patient should be released or disclosed to any non-medical third party for any reason without the patient's express permission.

FORENSIC MEDICINE — Wednesday 16.40 – 16.45

463 **Receive**: Report by the Chairman of the Forensic Medicine Committee (Michael Wilks).

The motion(s) below, in the shaded area, are unlikely to be reached

464 **Motion** by HARROGATE DIVISION: That this Meeting calls for the teaching of Clinical Forensic Medicine in UK medical schools to include:-
i) the incorporation of the basics of General Forensic Medicine into the core curriculum;
ii) the incorporation of the basics of Sexual Offence Medicine into the core curriculum;
iii) the development of Student Selected Components.

465 **Motion** by MORGANNWG LMC: That this Meeting recognises the benefits of the improved treatment of offenders with substance misuse problems within many English prisons and calls on the home office to ensure similar services are available in all prisons in England and Wales.

466 **Motion** by FORENSIC MEDICINE COMMITTEE: That this Meeting:-
i) calls for the Forensic Medicine Committee to lobby for the incorporation of Clinical Forensic Medicine into the core undergraduate curriculum;
ii) calls for the development of Student Selected Components in Clinical Forensic Medicine.

467 **Motion** by ROCHDALE AND BURY LMC: That this Meeting believes there is a need for government to appoint a national HM Coroner to ensure national standards and protocols.

ARMED FORCES — Wednesday 16.45 – 17.00

468 **Receive**: Report by the Chairman of the Armed Forces Committee (Brendan McKeating).

469 **Motion** by PLYMOUTH DIVISION: That this Meeting recognises the recent announcement by the Royal Navy regarding redundancies of medical staff and mandates the BMA Council and the Armed Forces Committee to:-
i) liaise with the Royal Navy and Ministry of Defence to establish an optimal outcome in the current economic climate minimising unnecessary loss of
skilled staff;
ii) achieve this in part by encouraging the option of interforces transfer from those on the redundancy list.

470 **Motion** by ARMED FORCES COMMITTEE: That this Meeting urges the NHS to consider the looming problem of the continued support for veterans, and in particular amputees with expensive prostheses.

The motion(s) below, in the shaded area, are unlikely to be reached

471 **Motion** by PLYMOUTH DIVISION: That this Meeting recognises the excellent work undertaken by the MOD across the world. However, is aware of:-
i) discrepancy between specialties having time in Afghanistan recognised as official training, most noticeably Emergency Medicine (EM);
ii) and calls on the BMA's Armed Forces Committee to engage with the relevant Royal Colleges to get EM acknowledged as official training rather than 'out of programme time'.

A 472 **Motion** by ARMED FORCES COMMITTEE: That this Meeting urges the MoD to ensure that the proposed changes to the DMS do not adversely affect the training and future career choices of medical cadets and junior doctors.

PROFESSIONAL FEES **Wednesday 17.00 – 17.05**

473 **Receive**: Report by the Chairman of the Professional Fees Committee (John Canning).

The motion(s) below, in the shaded area, are unlikely to be reached

474 **Motion** by CARDIFF AND VALE OF GLAMORGAN DIVISION: That this Meeting believes that the current involvement of GPs and Department for Work and Pensions on Work Capability Assessments are not sustainable in the interests of our patients. This Meeting urges the GPC to negotiate with the Department for Work and Pensions to stop providing certification and reports for Work Capability Assessments.

475 **Motion** by BRO TAF LMC: That this Meeting requests the BMA to review the Criminal Injuries Compensation Authority (CICA) fee scales, to redress the imbalance between the recommended fees for GPs and consultants.

PRIVATE PRACTICE **Wednesday 17.05 – 17.30**

476 **Receive**: Report by the Chairman of the Private Practice Committee (Derek Machin).

***** 477 **Motion** by LOTHIAN DIVISION: That this Meeting believes that non-NHS providers who provide treatments to patients must take full financial responsibility for adverse events resulting from that treatment and calls upon the departments of health to insist that the NHS will not foot the bill for remedial treatment except in life threatening emergency.

477a **Motion** by HULL AND EAST YORKSHIRE LMC: That this Meeting believes that providers carrying out cosmetic surgery on a private basis should be required to obtain insurance to reimburse the NHS against costs incurred arising from anticipated or unanticipated aftercare.

477b **Motion** by SCOTTISH SASC: That this Meeting believes that non-NHS providers who provide treatments to patients must take full financial responsibility for any adverse event resulting from that treatment and calls upon the departments of health to insist that the NHS will not foot the bill for that remedial treatment except in emergency.

***** 478 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting welcomes the Office of Fair Trading (OFT) market healthcare report and its proposed decision to recommend that the Competition Commission (CC) undertakes a market investigation, but is extremely concerned that the policies of some private healthcare insurance companies are preventing or restricting patients exercising choice about:-
i) the consultants who treat them;
ii) the hospital at which they are treated;
iii) making top up payments to cover any gap between the funding provided by their insurance company and the cost of their chosen private treatment
We call on the Competition Commission to fully investigate these concerns as part of their market review, and to make recommendations that will ensure that patients are fully informed when making choices about private healthcare insurance.

478a **Motion** by OXFORD DIVISION: That this Meeting welcomes the Office of Fair Trading (OFT) market healthcare report and its proposed decision to recommend that the Competition Commission (CC) undertakes a market investigation, but is extremely concerned that the policies of some private healthcare insurance companies are preventing or restricting patients exercising choice about:-
i) the consultants who treat them;
ii) the hospital at which they are treated;
iii) making top up payments to cover any gap between the funding provided by their insurance company and the cost of their chosen private treatment.
This Meeting recommends that the Competition Commission fully investigate these concerns as part of their market review, and to make recommendations that will ensure that patients are fully informed when making choices about private healthcare insurance.

478b **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting welcomes the BMA response to the Office of Fair Trading (OFT) market healthcare report and its proposed decision to recommend that the Competition Commission undertakes a market investigation and supports the BMA activities on this issue, which are being led by the Private Practice Committee.

TREASURER'S QUESTION AND ANSWER SESSION — Wednesday 17.30 – 17.45

Session closes — Wednesday 17.45

OCCUPATIONAL MEDICINE — Thursday 09.30 – 09.45

479 **Receive**: Report by the Chairman of the Occupational Medicine Committee (Paul Nicholson).

* 480 **Motion** by LEWISHAM DIVISION: That this Meeting in respect of Work Capability Assessments (WCA) as performed by Atos Healthcare, believes that:-
i) the inadequate computer-based assessments that are used have little regard to the nature or complexity of the needs of long term sick and disabled persons;
ii) calls on the BMA to demand that the WCA should end with immediate effect and be replaced with a rigorous and safe system that does not cause avoidable harm to some of the weakest and most vulnerable in society.

480a **Motion** by SCOTTISH CONFERENCE OF LMCS: That this Meeting in respect of work capability assessments (WCA) as performed by Atos Healthcare, believes that:-
i) the inadequate computer based assessments that are used have little regard to the nature or complexity of the needs of long term sick and disabled persons;
ii) the WCA should end with immediate effect and be replaced with a rigorous and safe system that does not cause avoidable harm to some of the weakest and most vulnerable in society.

The motion(s) below, in the shaded area, are unlikely to be reached

481 **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting, in connection with new government proposals to grant workers taken ill whilst on leave compensatory extra time off work:-
i) insists that such proposals shall not generate extra sickness certification burdens for doctors;
ii) reminds both employers and employees that doctors can only certify those matters of which they have prima facie confirmatory medical evidence;
iii) instructs the BMA, PFC and GPC to negotiate accordingly.

482 **Motion** by CITY AND EAST LONDON LMC: That this Meeting is very concerned at the high level of successful appeals following on from DLA assessments and calls for an urgent audit and review of quality of the initial assessments.

CIVIL AND PUBLIC SERVICES COMMITTEE — Thursday 09.45 – 09.50

483 **Receive**: Report by the Chairman of the Civil and Public Services Committee (Alan Mitchell).

COMMUNITY CARE AND MENTAL HEALTH — Thursday 09.50 – 10.25

484 **Receive**: Report by the Chairman of the Committee on Community Care (Helena McKeown).

* 485 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE BIRMINGHAM DIVISION): That this Meeting is concerned about the care provided to housebound patients and patients in geriatric hospitals, nursing homes and residential homes. This Meeting calls for both an increase in investment and available services for these groups of patients, including:-
i) enhanced primary medical care;
ii) domiciliary specialist care;
iii) psychiatric services;
iv) occupational therapy and physiotherapy;
v) minimum nursing staff levels in applicable settings.

485a **Motion** by BIRMINGHAM DIVISION: That this Meeting shares the public's concern about the poor care in geriatric hospitals and nursing homes and agrees with those that point out that this is the inevitable result of inadequate staffing levels. Consequently, this Meeting asks the Care Quality Commission to set a minimum whole time equivalent nursing staff to patient ratio in these settings that will be mandatory for CQC registration.

485b **Motion** by SALISBURY DIVISION: That this Meeting demands more investment in the care of housebound patients and patients in residential homes including:-
i) more access to routine preventative and ongoing occupational and physiotherapy;
ii) more domiciliary specialist medical care;
iii) more rapid psychiatric acute assessments by psychiatrists or where appropriate delegated to community mental health members overseen by psychiatrists;
iv) more ongoing follow-up by psychiatrists or overseen by psychiatrists and delivered by mental health team workers;
v) enhanced primary medical care including routine chronic disease management and preventative care.

485c **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting demands more free at-the-point-of-delivery resources for:-
i) patients in nursing homes;
ii) individuals in care homes who are unable to leave their home for routine medical and preventative care;
iii) permanently housebound patients.

485d **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting urges negotiation of:-
i) resource to provide enhanced medical care to patients in nursing homes;
ii) resource to provide enhanced primary and specialist care beyond to patients who are unable to travel out of residential home;
iii) transport for patients to attend GP surgeries who are unable to venture out of residential homes when well, for routine and preventative care;
iv) resource for domiciliary primary and specialist care beyond for housebound patients.

* 486 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE LINCOLN DIVISION): That this Meeting believes that one of the primary goals of any society is to promote the welfare of children and protect them from harm, and that doctors have a key role in this regard. This Meeting therefore believes:-
i) it is essential that the dissolution of primary care trusts and their replacement by Clinical Commissioning Groups does not damage multi-agency arrangements to safeguard children;
ii) that Clinical Commissioning Groups should be required to fund an appropriate number of sessions for a Designated Doctor for Safeguarding Children, and a Named Public Health Professional for Safeguarding Children, in each area served by a Local Safeguarding Children Board;
iii) that the BMA should work with other relevant stakeholders to ensure that doctors undertaking child protection work have comprehensive access to appropriate training and mentoring programmes.

486a **Motion** by LINCOLN DIVISION: That this Meeting believes that one of the primary goals of any society is to promote the welfare of children and protect them from harm, and that doctors have a key role in this regard. This Meeting therefore believes:-
i) it is essential that the dissolution of primary care trusts and their replacement by Clinical Commissioning Groups does not damage multi-agency arrangements to safeguard children;
ii) that Clinical Commissioning Groups should be required to fund an appropriate number of sessions of a Designated Doctor for Safeguarding Children, and a Named Public Health Professional for Safeguarding Children, in each area served by a Local Safeguarding Children Board.

486b **Motion** by MANCHESTER & SALFORD DIVISION: That this Meeting notes the recent GMC consultation on new child protection guidance for doctors and believes that properly safeguarding children requires the involvement of enthusiastic, well trained doctors. This Meeting therefore asks the BMA to work with the GMC, the Academy of Medical Royal Colleges, and any relevant individual colleges, employers and other relevant bodies to ensure that doctors have comprehensive access to:-
i) a standardised educational programme relevant to the level of child protection work they are involved in;
ii) mentoring support specific to their child protection work;
iii) a practical court familiarisation programme for those doctors who need to attend court as part of their child protection work.

487 **Motion** by MANCHESTER & SALFORD DIVISION: That this Meeting asks the BMA to highlight the under- investment in transition care for disabled children (from the paediatricians to adult physicians) and actively promote investment in transition by commissioners.

The motion(s) below, in the shaded area, are unlikely to be reached

488 **Motion** by GLOUCESTERSHIRE DIVISION: That this Meeting deplores the policies of successive governments which have overlooked the resource that community hospitals give to local patients in being accessible and run by local doctors, and calls for an end to competitive tendering which discourages local doctors from running them.

489 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting is aware of the very different and potentially conflicting interests of the various stakeholders involved in community hospitals and calls for frank and open local discussion between all interested parties in order to protect their viability where feasible, and maximise their potential for patients.

490 **Motion** by DERBYSHIRE LMC: That this Meeting believes that the double cost of patients transferred to a community hospital from a foundation trust, incurring a second payment, has the potential to cause the closure of many community hospitals. To stop this happening, there must be a way of splitting the tariff between the organisations providing care in a single episode of illness.

491 **Motion** by OXFORD RJDC: That this Meeting believes that:-
i) the House of Lords should be applauded for amending the Health and Social Care Bill to include parity of esteem for mental health;
ii) NICE should withdraw a separate quality standard for patients in mental health as it is unnecessary and increases stigma related to mental health, and should produce a single standard for physical and mental health;
iii) the Health and Social Care Bill and the potential fragmentation of services it may entail must not lead to the loss of care and funding for treatment of complex cases including vulnerable patients with severe and enduring mental illness;
iv) acute trusts and mental health trusts need to work with commissioners and primary care providers to initiate, develop and improve liaison psychiatry services.

492 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting notes the assurances by the Secretary of State for Health that CCGs will not be forced to go out to tender in every commissioning decision, and believes that the CCGs must be enabled to determine how best to commission services for community hospitals based on local need.

493 **Motion** by CITY & HACKNEY DIVISION: That this Meeting calls on the BMA to undertake a study of the benefits and drawbacks of personal healthcare budgets to enable the medical profession to have input into the debate before this system is rolled out widely.

494 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting believes that the freezing or reducing of local authority social care budgets will significantly impact on those in greatest need of such services, and that personalised care budgets will lead to further fragmentation of services and are not deliverable or desirable for the whole population. We call for a significant uplift in social care funding to take account of the increasing numbers of the population with complex care needs and for this funding to be ring fenced.

495 **Motion** by SOUTH WEST REGIONAL COUNCIL: That this Meeting demands the BMA investigates and propagates opinion and debate on the ethical merits of choice of GP verses the economic and better care of a single practice providing care to residents who are unable to normally leave the home for routine and preventative primary care.

496 **Motion** by BRISTOL DIVISION: That this Meeting is concerned that the universally supported, long standing government policy of integration of mental health and social care services is being reversed by the tendering process initiated by the marketisation of services. We are concerned that integration is protected and ask the BMA to take this up with parliament.

497 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting rejects the mantra that care in the community is always cheaper than care in the hospital sector, and calls for this mantra to be dispensed with by the UK departments of health governments, and replaced with a proper, sophisticated and complete financial analysis before any national or local changes to services are made.

498 **Motion** by JUNIOR MEMBERS FORUM: That this Meeting notes the passing of the welfare reform into law and:-
i) believes that the Work Capability Assessment is not fit for purpose to assess mental health illness;
ii) calls upon the Department of Work and Pensions (DWP) to ask decision makers (to) place consideration on medical reports from claimants' own doctors;
iii) calls upon the BMA to lobby for robust regulation of private agencies providing the assessments.

499 **Motion** by RETIRED MEMBERS FORUM: That this Meeting insists that the BMA actively promotes person and people centred healthcare by affirming the whole person of the patient be at the centre and goal of clinical care and health promotion at both individual and community levels.

PENSIONS

Thursday 10.25 – 11.00

500 **Receive**: Report of the Chairman of the Pensions Committee (Alan Robertson).

* 501 **Motion** by THE AGENDA COMMITTEE (MOTION TO BE PROPOSED BY THE HOLLAND DIVISION): That this Meeting is appalled at the proposed changes to the NHS pension scheme and deplores the government's betrayal of trust in reneging on an agreed deal. This Meeting rejects the proposed changes to the NHS pension scheme.

501a **Motion** by HOLLAND DIVISION: That this Meeting believes that the proposed changes to the NHS pension scheme are unjustified given that:-
i) the NHS pension scheme is not in deficit;
ii) there is inequity between the employee contributions paid within the NHS and in other public sector schemes for similar pensions;
iii) significant agreed changes to the NHS Pension scheme were made in 2008 which put the onus of covering any future shortfall within scheme on the employee;
iv) a Career Average Revalued Earnings scheme should not require tiered levels of contributions,
and calls on the government to return to the negotiating table.

501b **Motion** by BRISTOL DIVISION: That this Meeting supports the BMA's opposition to proposed changes in the NHS pension scheme and believes that doctors should withdraw from involvement in NHS commissioning until agreement is reached between the government and the profession

501c **Motion** by JUNIOR MEMBERS FORUM: That this Meeting is furious regarding the current wide-ranging assault on NHS pensions and supports the BMA in continuing action to stand up for doctors' pensions.

501d **Motion** by CONSULTANTS CONFERENCE: That this Meeting rejects the government's current proposed changes to the NHS pension scheme and believes that the changes made with the introduction of the 2008 section of the NHS pension scheme went far enough, are fair and affordable to both NHS staff and to taxpayers, and should certainly not be changed again while they continue to provide an annual surplus to the Treasury.

501e **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that doctors' pensions are worth fighting for and calls on doctors to stand up for their rights and take whatever action is necessary.

501f **Motion** by LOTHIAN DIVISION: That this Meeting with respect to the government's proposed reforms to the NHS superannuation schemes:-
i) notes that the long term financial stability of the schemes was secured in 2008 following the agreement negotiated at that time;
ii) notes that significant increases in contributions to the schemes were agreed in 2008 and considers further increases in contributions to be unjustified;
iii) rejects the government proposals;
iv) demands that the government returns to negotiations with the BMA and other trade unions in order to reach a fair and equitable solution.

501g **Motion** by WREXHAM BOROUGH DIVISION: That this Meeting deplores the Westminster government's actions in tearing up the pensions agreement signed only four years back.

501h **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that if doctors do not resist the current proposals to modify their pensions, that it is inevitable that government will seek to further reduce the pay and pension of doctors in the future and therefore calls on all doctors to stand together to take a robust stance in defence of their pay and pension.

501i **Motion** by EAST DORSET DIVISION: That this Meeting presses for a U-turn on proposed NHS pension reforms, so that hard-working doctors receive the pension that they expected when they decide to retire.

501j **Motion** by REDBRIDGE & STRATFORD DIVISION: That this Meeting applauds the stance taken by the BMA as a trade union of all doctors over the governments unilateral changes in pensions and fights to retain previous agreement made by the government with the profession in 2008.

501k **Motion** by CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS: That this Meeting supports the BMA position of opposition to proposed changes in public sector pension schemes.

501l **Motion** by CONSULTANTS CONFERENCE: That this Meeting believes that doctors' pensions are worth fighting for and calls on doctors to stand up for their employment rights.

501m **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting is appalled at the betrayal of trust displayed by the government in making further changes to the financially healthy NHS pension scheme following the negotiated agreement made in 2008 and imposing them on all NHS employees. We believe that:-
i) this is likely to result in doctors exercising their personal choice to stop paying into the scheme and/or to take their pensions early with the risk of destabilising the whole scheme;
ii) this is an additional tax on NHS workers;
iii) this is a further attempt to undermine the financial position of UK General Practice;
iv) this is an additional step towards privatisation of the NHS in England and GP service in particular;
v) the introduction of a new career average scheme significantly disadvantages non GPs by failing to take into account delays in career progression, comparatively low superannuable pay for doctors in training and the nature of the consultant pay scale;
vi) the proposed link to the state retirement age will further delay career progression;
vii) the government should return to negotiation on public sector pensions and agree a way forward that is fair across the whole of the public sector.

501n **Motion** by ENFIELD AND HARINGEY DIVISION: That this Meeting sees the defence of national terms and condition for doctors as a key role of this trade union in standing up for doctors. It therefore mandates Council to ballot for national strike action to defend pensions in opposition to government imposed changes. This ballot should give members the chance to consider all forms of strike action including "emergencies only" and non-co-operation with CCG plans.

501o **Motion** by CITY & HACKNEY DIVISION: That this Meeting:-
i) repudiates attempts by commentators and the government to link BMA policy on pensions to the BMA's opposition to the Health and Social Care Bill;
ii) calls on the BMA to press ahead with further industrial action, doing whatever is necessary, while protecting patients from harm, to defend the NHS pension scheme.

501p **Motion** by OXFORD DIVISION: That this Meeting rejects the government's current proposed changes to the NHS pension scheme and believes that:-
i) the changes made with the introduction of the 2008 section of the NHS pension scheme went far enough, are fair and affordable to both NHS staff and to taxpayers, and should certainly not be changed again while they continue to provide an annual surplus to the Treasury;
ii) equality between the NHS pension scheme and other public sector pension schemes should be fully sorted out before any further changes to the NHS scheme are proposed.

501q **Motion** by LINCOLN DIVISION: That this Meeting deplores the changes proposed to the NHS Pensions Scheme, which are:-
i) unjustified in a scheme which currently generates profit for the Treasury, and for the country;
ii) penalising NHS professionals more than other public sector workers;
iii) likely to precipitate a manpower crisis as NHS professionals retire earlier than planned,
and calls for Council to make available to members information resources to use in the workplace to make patients aware of members concerns.

501r **Motion** by CONFERENCE OF LMCS AGENDA COMMITTEE: That this Meeting calls on the government to reconsider its proposed reforms to the NHS superannuation schemes, and return to negotiations, given that:-
i) the reforms are unnecessary as the schemes are financially healthy following the review in 2008;
ii) NHS workers are being asked make disproportionate superannuation contributions compared with other public sector workers;
iii) the schemes may be destabilised due to workers choosing to retire early or choosing to cease making contributions to the schemes;
iv) a cohort of workers may continue with demanding high intensity work despite no longer being mentally or physically fit enough to do so;
v) there is a danger of workers of all ages leaving the NHS and destabilising healthcare in the UK.

501s **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting believes that regarding a final salary pension scheme for secondary care doctors:-
i) it is affordable;
ii) it is sustainable;
iii) it is highly cost-effective for the NHS;
iv) it incentivises sustained service to the NHS;
v) changing to a career-average scheme will lead to serious recruitment and retention problems for secondary care, unless the governments and employers agree to a significant renegotiation of the career salary structure such that higher pay is reached much earlier in a career.

501t **Motion** by HOLLAND DIVISION: That this Meeting is concerned about the potential loss of senior medical staff from the NHS as a result of the proposed pensions changes and calls on the government to amend their final offer.

501u **Motion** by EALING DIVISION: That this Meeting is outraged that the government has reneged on the agreement on the changes to the NHS pension scheme made in 2008, which all parties agreed made the scheme afordable and sustainable, and support the BMA's actions aimed at bringing the government back to the negotiating table.

* 502 **Motion** by LOTHIAN DIVISION: That this Meeting believes the proposed reforms of the NHS superannuation schemes will result in a cohort of workers being under pressure to continue working in demanding jobs despite no longer being fit enough to do so.

502a **Motion** by EAST KENT DIVISION: That this Meeting believes that forcing doctors to work to the age of 68 is potentially dangerous.

502b **Motion** by ROTHERHAM DIVISION: That this Meeting believes that a retirement age in excess of 65 is inappropriate and not in the public interest.

502c **Motion** by CLWYD NORTH DIVISION: That this Meeting recognises that the experience built up over years of practice is invaluable, but with increasing age, the ability to work under pressure declines. This should be taken into account as retirement age is extended and when employing staff beyond retirement age.

502d **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that if consultants are required to work to the age of 68, that continuing to work with the current consultant career structure to retirement will lead to detrimental effects on their health and therefore calls on the BMA to examine in detail possible changes to the consultant work throughout the consultant career to minimise any negative impact on the health and wellbeing of consultants.

502e **Motion** by NORTHERN IRELAND CONSULTANTS COMMITTEE: That this Meeting believes that if consultants are required to work to the age of 68, that continuing to work with the current consultant career structure to retirement will lead to detrimental effects on their health and therefore calls on the BMA to examine in detail possible changes to the consultant work throughout the consultant career to minimise any negative impact on the health and wellbeing of consultants.

502f **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that if the normal pension age of doctors is raised up to 68 years of age, that the BMA should negotiate to increase opportunities for sabbaticals for doctors to prevent "burn out" in their considerably lengthened careers.

502g **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that the current pension proposals to match Normal Pension Age to State Pension Age risk creating a workforce "time bomb" due to the sudden increase in the Normal Pension Age leading to the waste of a whole cohort of current medical students and junior doctors who will be unable to obtain medical employment in the UK and demands that, for doctors, the Normal Pension Age is not linked to the State Pension Age.

502h **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that if the normal pension age of doctors is increased up to 68, that after any transitional period, this means that for a considerable number of years, there will be a lack of retirements of doctors thus creating a situation in which large numbers of current junior doctors and medical students will be unable to gain employment in the UK and be forced to emigrate to obtain medical work.

502i **Motion** by SALISBURY DIVISION: That this Meeting:-
i) rejects the linking of our pensionable age to the to the state pension age;
ii) affirms that once we have signed a contract defining the age at which we are eligible for our pension that this contract cannot be reneged upon.

503 **Motion** by BRISTOL DIVISION: That this Meeting is alarmed at the cost to our members and the Treasury that will be incurred as new employees of burgeoning numbers of social enterprises lose access to the superannuation scheme. This will erode the scheme's income leaving the treasury to pick up its liabilities. We ask the BMA to negotiate access to the superannuation scheme for all who treat NHS patients regardless of their employing organisation.

The motion(s) below, in the shaded area, are unlikely to be reached

504 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting believes that part time workers may be unduly affected by the current pension proposals and calls on the BMA to produce specific pension guidance for part time working doctors.

505 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting rejects the governments current proposed changes to the NHS pension scheme and believes that:-
i) the changes made with the introduction of the 2008 section of the NHS pension scheme went far enough, are fair and affordable to both NHS staff and to taxpayers, and should certainly not be changed again while they continue to provide an annual surplus to the Treasury;
ii) equality between the NHS pension scheme and other public sector pension schemes should be sought before any further changes to the NHS scheme are proposed.

506 **Motion** by SUNDERLAND DIVISION: That this Meeting:-
i) fully supports the BMA on its full commitment on stance on pension policy;
ii) notes Sunderland Division is against total strike action;
iii) fully supports industrial action, as long as care of patients is not affected.

507 **Motion** by REDBRIDGE & STRATFORD DIVISION: That this Meeting believes the government's unilateral changes to pensions, in negating the agreement with BMA and profession will result in making NHS unattractive to young hopefuls entering into medical profession.

508 **Motion** by EAST MIDLANDS REGIONAL COUNCIL: That this Meeting deplores the changes proposed to the NHS Pensions Scheme, which:-
i) are unjustified in a scheme which currently generates surplus for the Treasury, and for the country;
ii) follow significant agreed changes made in 2008 which put the onus of covering any future shortfall within scheme on the employee;
iii) should not require tiered levels of contributions in a Career Average Revalued Earnings;
iv) creates inequity between the employee contributions paid within the NHS and in other public sector schemes for similar pensions;
v) are likely to precipitate a manpower crisis as NHS professionals retire earlier than planned.
and calls on the government to return to the negotiating table.

509 **Motion** by SOLIHULL DIVISION: That this Meeting asks the BMA to campaign for equitable years of service, retirement age and pension contributions across comparable sections of the public sector.

510 **Motion** by LEICESTERSHIRE & RUTLAND DIVISION: That this Meeting demands that the GPC ensure that the NHS Information Centre makes an adjustment to the published figures for average GP remuneration following a rise in pension contributions if these do not result in any material benefit.

511 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting is extremely concerned at the poor understanding of pension benefits among NHS employees and demands that any revised scheme include an annual statement for all members of accrued rights and projected benefits.

512 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting calls on the government and NHS pension schemes to release accurate data on the average age of death of doctors drawing a pension from the schemes over relevant time periods over the last twenty years, and for them also to release their projections of ages of death over similar time periods over the next 40 years, so that the true effects of an increase in the normal pension age for doctors on the likely period in which they will be able to benefit from their pensions in payment can be understood.

513 **Motion** by SOLIHULL DIVISION: That this Meeting asks the BMA to make available to the membership the legal advice it has obtained in respect of the government imposition of the new and less favourable pension arrangements for the majority of the membership.

514 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting notes that the Default Retirement Age was abolished to allow for continued employment after the normal retirement age, and calls for the removal of the current regulation that requires scheme members to resign their posts to access their pensions so that members can remain in continued employment while accessing their pensions.

515 **Motion** by MEDICAL STUDENTS CONFERENCE: That this Meeting notes existing policy provides more information to students regarding pensions. Therefore this Meeting:-
i) notes the great challenge that engaging students with information on pensions is;
ii) notes that a majority of students are not aware or do not understand the latest round of pension changes;
iii) calls on the MSC to consider new and improved ways of passing on the information and engaging students;
iv) mandates the MSC to continue working with the BMA pensions department to carry out this work;
v) notes that the current government pensions offer has changed from a final salary scheme to a career average and that this will adversely affect the pensions received by a number of groups including women who take maternity leave and those who have chronic illnesses;
vi) mandates the BMA to lobby against any such prejudices a new pensions scheme may give.

516 **Motion** by SOUTH CENTRAL REGIONAL COUNCIL: That this Meeting calls on the government and NHS pension schemes to release accurate data on the average age of death of doctors drawing a pension from the schemes over relevant time periods over the last twenty years, and for them also to release their projections of ages of death over similar time periods over the next 40 years, so that the true effects of an increase in the normal pension age for doctors on the likely period in which they will be able to benefit from their pensions in payment can be understood.

517 **Motion** by CLWYD NORTH DIVISION: That this Meeting calls upon retired members who are opposed to the BMA stance on pensions to donate the equivalent difference from their won pensions to either the NHS or to support junior doctors taking industrial action so that they can show solidarity with current and future members of their profession.

518 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting insists that all doctors who are members of the NHS pension scheme must have annual pension entitlement reports to detail their accrued pension benefits.

519 **Motion** by SALISBURY DIVISION: That this Meeting believes that in light of the inability of the Pensions Agency to supply all members with pensions estimates by their deadline for responses to the "Choice" exercise that:-
i) the government should have deferred the final date for replies until equal information was available to all members;
ii) the BMA should have demanded a deferral of the date for responses;
iii) some members were disadvantaged by less information in the "Choice" they made and demands a re-run of the "Choice" exercise after we know the final outcome of the pensions dispute.

520 **Motion** by CONSULTANTS CONFERENCE: That this Meeting is extremely concerned at the poor understanding of pension benefits among NHS employees and demands that any revised scheme include an annual statement for all members of accrued rights and projected benefits.

521 **Motion** by SALISBURY DIVISION: That this Meeting recognises population demographics and deplores the false media portrayal that doctors are not prepared to save hard for pensions and demands to hear alternative offers that the BMA has made in negotiations on contributing to our pensions.

522 **Motion** by NORTHERN IRELAND COUNCIL: That this Meeting recognises the wishes of UK doctors to protest against unilateral changes to their pensions and fully supports calls for doctors to take whatever legal action is necessary, including industrial action, in defence of pension entitlements.

523 **Motion** by CONSULTANTS CONFERENCE: That this Meeting believes that if the normal pension age of doctors is increased up to 68, that after any transitional period, this means that for a considerable number of years, there will be a lack of retirements of doctors thus creating a situation in which large numbers of current junior doctors and medical students will be unable to gain employment in the UK and be forced to emigrate leading to a 'brain drain' from the UK.

524 **Motion** by MAIDSTONE DIVISION: That this Meeting urges industrial action in the dispute with the government on pensions in the form of a withdrawal from clinical commissioning activity.

525 **Motion** by BUCKINGHAMSHIRE DIVISION: That this Meeting believes that doctors remain well respected by patients and the public at large but that this trust may evaporate if doctors take industrial action to protect their pensions and as the public associate doctors with rationing decisions as we become more directly involved in the commissioning of services. We therefore call on the BMA to mount an effective and high profile publicity campaign covering all media, to correct the public's misconceptions regarding doctors' remuneration and pensions, and to emphasise our deeply ingrained altruistic motivations in caring for the sick and needy.

526 **Motion** by SOUTH EAST COAST REGIONAL COUNCIL: That this Meeting believes that regarding a final salary pension scheme for secondary care doctors:-
i) it is affordable;
ii) it is sustainable;
iii) it is highly cost-effective for the NHS;
iv) it incentivises sustained service to the NHS;
v) changing to a career-average scheme will lead to serious recruitment and retention problems for secondary care, unless the governments and employers agree to a significant renegotiation of the career salary structure such that higher pay is reached much earlier in a career.

CHOSEN MOTIONS — Thursday 11.00 – 11.35

Contingency time — Thursday 11.35 – 11.40

MOTIONS ARISING FROM THE ARM — Thursday 11.40 -12.40

APPROVAL OF THE ANNUAL REPORT OF COUNCIL — Thursday 12.40

527 **Motion** by THE CHAIRMAN OF COUNCIL: That the Annual Report of Council be approved.

PROVISIONAL APPROVAL OF THE MINUTES

528 **Motion** by THE CHAIRMAN OF COUNCIL: That the Chairman of the Representative Body be empowered on behalf of the Meeting to approve the minutes of the meeting.

ARM ENDS — Thursday 13.00

ANNEX
Bye-Law 29

REPRESENTATIVE BODY
The Representative Body shall consist of the following:

(1) The Chairman of the Representative Body, Deputy Chairman of the Representative Body, the President of the Association and the respective chairmen of all standing committees for the time being in existence, all of whom shall be ex officio (non voting);

(2) The members of Council for the time being in office or elected to take office (non-voting).

(3) Voting members of the Association elected or appointed by the electing bodies set out in Bye-laws 31 to 34 and such other electing bodies as Council shall from time to time determine.

(4) As voting members, members of the ARM Agenda Committee elected to serve on the committee at the previous year's Annual Representative Meeting.

(5) All representatives shall have been elected or appointed no later than one week before the Annual Representative Meeting at which they are due to take up office.

BMA Divisions:

280 Representatives of Divisions;

Representatives of branches of practice:

62 Representatives of general practitioners;

59 Representatives of consultants;

58 Representatives of junior doctors;

12 Representatives of doctors in the staff, associate specialist and specialty doctors;

3 Representatives of doctors in public health medicine;

4 Representatives of doctors in academic medicine;

3 Representatives of doctors in the armed forces;

3 Representatives of doctors in occupational health;

3 Others in practice, but not covered by those above (National Councils)

39 Representatives of medical students;

20 Representatives of retired doctors;

*Unfilled Division seats will be reallocated to the regional and national councils to fill.

Other electing bodies:

2 Representatives of the Conference of Honorary Secretaries of BMA Divisions;

4 Representatives of the Junior Members Forum;

4 Representatives of minority groups;

4 Representatives of overseas branches.

Appendix I

STANDING ORDERS

CONTENTS

STANDING ORDERS

INTERPRETATION

1 In these Standing Orders the words and expressions following have the meanings hereinafter assigned to them respectively:-

"Representative" means the duly appointed Representative of a constituency, or in his/her absence, the deputy duly appointed in his/her stead, in attendance at the meeting.

"Prescribed" in relation to any form means prescribed by the returning officer unless and until the Representative Body shall adopt or approve any such form, whereupon the word "Prescribed" shall refer to the forms so adopted or approved.

"Constituency" means any body or group of members of the Association entitled to elect or to have appointed a Representative or Representatives to the Representative Body.

"Session" means the period from the commencement of proceedings each day until the lunchtime adjournment, or from the resumption of proceedings after the lunchtime adjournment until the evening adjournment, or on the last day of the meeting to the conclusion of business.

A "Motion" is a primary statement of an issue put forward for debate.

An "Amendment" shall be either: to leave out words; to leave out words and insert others (provided that a substantial part of the motion remains); to insert words to alter the statement; or be in such form as shall be approved of by the Chairman.

A "Rider" shall be to add words as an extra to a seemingly complete statement; provided always that the rider be relevant to the motion on which it is moved and be not equivalent to the direct negative thereof.

A "simple" majority shall be when the number of votes 'for' the motion is greater than the number of votes 'against' the motion.

"A 'two-thirds' majority shall be two-thirds of representatives present and voting. Those voting will include those voting 'for' and 'against' the motion."

Abstentions will not be used for the calculation in either case.

These Standing Orders are subject to the provisions of the Articles and Bye-Laws of the Association.

WHO MAY ATTEND REPRESENTATIVE MEETINGS AND WHO MAY VOTE

2 **Who may attend**

(i) The elected and voting or appointed members of Council *(ex-officio)*.

(ii) The elected or appointed Representatives of the constituencies of the ARM determined by Bye-Law 29 (see Annex).

(iii) The movers of motions or reports from constituencies not otherwise represented at the ARM.

(iv) Observers.

3 **Who may vote**

(i) In debates and on matters relating to the Standing Orders, the elected or appointed members of the Representative Body specified in Bye-Law 29 (see Annex).

(ii) In elections for the President, the Chairman and the Deputy Chairman of the Representative Body and the Treasurer, all members of the Representative Body as specified in Bye-Law 29 (see Annex).

BUSINESS OF ARM

4 **To elect**

(i) Chairman of Representative Body.

(ii) Deputy Chairman of Representative Body.

(iii) Treasurer.

(iv) President. (The above officers to be nominated and elected by the Representative Body as a whole.)

(v) Honorary Members.

(vi) Members of Committees and the Board of Science and Education. (To be nominated and elected by members of the Representative Body as indicated on the individual nomination and voting papers.)

(vii) Members of the Representative Body Agenda Committee. (To be nominated by any member of the Representative Body, elected by the Representative Body as a whole.)

5 Returning Officer - The Chief Executive / Secretary or, in his/her absence, a nominated deputy, shall act as returning officer in connection with all elections.

6 Nominations - where a nomination is made by a Representative entitled to attend the Representative Meeting and he/she is subsequently prevented from so attending, the nomination shall remain valid.

7 Forms - Nominations on the prescribed form, and voting papers shall be distributed and collected at such times as the Meeting shall direct.

8 Publication of Results - The results of all elections shall be reported to all candidates and notified to members of the RB.

9 To appoint a place at which the next Annual Representative Meeting shall be held.

10 To consider

(i) The Balance Sheet and Income and Expenditure Account, Estimate and Reports presented by the Council.

(ii) The reports of committees instructed to report to such Meeting.

(iii) Any motions relating to the adoption of the said reports in whole or in part.

(iiv) The reports of branch of practice conferences.

11 To make alterations to the Bye-Laws and recommend to a General Meeting alterations to the Articles.

12 To consider any resolution relating to the promotion of the medical or allied sciences or to the maintenance of the honour or interests of the Association or the promotion of the achievement of high quality health care which shall have been approved and submitted to the Representative Body by the Council or the Joint Agenda Committee from a body or group of members entitled to elect or appoint a Representative or Representatives to the Representative Body or any of the conferences listed in Bye-Law 53. Provided always that if any such resolution (i) proposes material alteration of the policy of the Association, (ii) proposes alteration of or addition to the constitution or (iii) involves special expenditure it shall only be considered if it has been published in the agenda for the Annual Representative Meeting unless the RB shall otherwise decide.

AGENDA COMMITTEE

Composition

13 There shall be an Agenda Committee to make recommendations to each meeting of the Representative Body on the most expeditious method of dealing with the agenda, including the order and grouping of motions for debate and open debate. This Committee shall consist of:

the Chairman of the Representative Body, who shall be Chairman of the Agenda Committee

the Chairman of Council

the Treasurer

the Deputy Chairman of the Representative Body

Branch of practice Chairmen and Board of Science Chairman (or their nominees).

as non-voting members (save that the Chairman of the Representative Body shall have a casting vote)

eight members elected by the Representative Body from its own number, of whom at least two (a) shall not have served on a UK branch of practice committee with delegated authority* in the preceding session; or (b) be candidates for election to such committees. In the event that such members serve on such committees in the ensuing session then membership of the agenda committee shall lapse forthwith.

* Armed Forces Committee, Committee for Public Health Medicine, Consultants Committee, Forensic Medicine Committee, General Practitioners Committee, Junior Doctors Committee, Medical Academic Staff Committee, Medical Students Committee, Occupational Health Committee, Private Practice Committee, Professional Fees Committee and Staff, Associate Specialists and Specialty Doctor Committee.

14 There shall also be two deputies elected in a like manner who shall be the unsuccessful candidates receiving the highest number of votes in the election of the Agenda Committee. The elected and voting members of the Agenda Committee must be members of the Representative Body at the time of election. If a member of the Agenda Committee is unable or ineligible to carry out his/her duties, a deputy shall act in his/her stead. The Committee shall have power to invite chairmen of Association committees to take part in discussion of their own sections of the Agenda and it shall also have the power to request Representatives to clarify in writing motions submitted by their constituencies.

Meetings

15 The Committee shall meet prior to every meeting of the Representative Body, and shall present its recommendations in accordance with these Standing Orders.

16 The Committee shall meet as necessary to review the progress made at Representative Meetings and the business still outstanding and shall advise the Chairman, and recommend modifications of the previously agreed order of business.

Joint Agenda Committee

17 For the purposes of Representative Meetings, there shall be a Joint Agenda Committee consisting of:

the Chairman for the time being of the Representative Body, who shall be Chairman of the Joint Agenda Committee
the Deputy Chairman of the Representative Body

two members of the Representative Body's Agenda Committee elected by the Agenda Committee from among its number.

two members of their respective Agenda Committees appointed by each of the Annual Conference of Representatives of Local Medical Committees, the Annual Conference of Representatives of Senior Hospital Staff, the Hospital Junior Staff Conference, the Public Health Medicine Conference, the Conference of Medical Academic Representatives, the Staff, Associate Specialists and Specialty Doctor Conference and the Medical Students Conference and such other branch of practice conferences as the Representative Body shall from time to time specify.

18 The functions of the Joint Agenda Committee shall be as follows:

(i) to receive and collate all motions submitted for debate whether to the Representative Body or to any of the said conferences;

(ii) to refer motions to the appropriate agenda committees;

(iii) to ensure that any motions intended or suitable for debate by any two or more of the said Body and conferences shall so far as possible, be expressed in a common form of words;

(iv) generally to endeavour to eliminate unnecessary duplication of debates.

Augmented Agenda Committee:

19 There shall be an Augmented Agenda Committee which shall consist of:

the members of the Agenda Committee,

the chairmen of each of the branch of practice conferences and of the relevant branch of practice committees referred to in Standing Order 17.

20 The Chairman of the Committee shall be the Chairman of the Representative Body and he/she shall have only a casting vote. The Chairman of Council, the Deputy Chairman of the Representative Body and any representatives of the branch of practice conferences and branch of practice committees shall be non-voting. If the chairman of a branch of practice conference or a branch of practice committee is unable to carry out his duties, he/she shall be entitled to appoint a deputy to act in his/her stead.

21 The decisions of each of the branch of practice conferences shall be reported to the Augmented Agenda Committee who shall decide which decisions (if any) shall be referred to the Representative Body for debate.

AGENDA

Who may submit motions

22 Motions may be submitted to the Joint Agenda Committee by any Body or group of members entitled to elect or appoint a Representative or Representatives to the Representative Body or to any of the Conferences listed in Standing Order 17 or by any of the conferences themselves.

Who may submit amendments

23 Amendments to the printed agenda may be submitted by the following:

(a) Any two members of the Representative Body;

(b) BMA divisions;

(c) Any of the branch of practice conferences listed in Standing Order 17.

Timing of submission of motions

24 Subject to the provisions of Standing Order 26, any motion submitted by a constituency for inclusion in the Agenda must be notified to Head Office by a date to be determined annually by the Council, being not more than 80 days and not less than 42 days before the Monday of the week in which the Annual Representative Meeting takes place.

25 Any amendment or rider submitted by a constituency must be notified to Head Office by 12 noon on the Tuesday of the week preceding the week in which the Annual Representative Meeting takes place.

26 Subject to Standing Order 27 the Agenda Committee may include in the agenda any motion relating to a report of the Review Body on Doctors' and Dentists' Remuneration, provided that it is received by the date determined under Standing Order 25.

Motions requiring three weeks' notice

27 Unless, in accordance with Article 61(5), the Representative Body otherwise decide, a motion involving special expenditure of the Association's money or other resources shall be considered only if it has been published in the agenda for the ARM not less than three weeks before the Meeting. A report on all matters so published (including estimates of the amount of expenditure involved) shall be submitted by Council to the Meeting. Such motions shall require a majority of not less than two-thirds of the votes given thereon.

Rescission of Resolutions

28 No motion, amendment or rider purporting to rescind any resolution of a Representative Meeting shall be in order at any subsequent Representative Meeting unless at least three weeks' notice thereof shall have been given in the agenda for the Annual Representative Meeting and that notice has appeared in the Journal that the agenda has been published on the BMA's website.

Amendments to Motions requiring three weeks' notice

29 If an amendment is proposed to a motion of which three weeks' notice is required under Article 61(5) and three weeks' notice of such amendment has not been given under such Article, the Chairman (acting on the advice of the Agenda Committee) shall rule whether the amendment is one of substance; and if the Chairman shall so rule the amendment shall not be moved as a substantive motion, but if the Chairman shall rule that the amendment is not one of substance the amendment may be accepted notwithstanding that notice has not been given as aforesaid.

Motions and amendments not published in the Agenda

30 Motions not included in the Agenda shall not be considered by the Meeting with the exception of:-

(i) Motions covered by Standing Orders 32-35 (Order of Business); 42 (Emergency Motions); 67-69 (Motions for Adjournment, or that the question be now put, or that the Meeting proceed to the next business); 51 (Time limit of speeches); 78 (Withdrawal of Strangers); and 79 (Suspension of Standing Orders).

(ii) Motions relating to votes of thanks, messages of congratulation or of condolence.

(iii) Motions to correct drafting errors.

(iv) Composite motions replacing two or more motions already on the Agenda and agreed by Representatives of the constituencies concerned.

(v) Motions arising from matters referred to the Meeting for consideration by a branch of practice conference.

(vi) Motions arising from matters dealt with in the report of a branch of practice conference upon which two-thirds of the members of the Representative Body present and voting have demanded a debate.

31 Subject to the provisions of Standing Order 59 and at the discretion of the Chairman of the Representative Body, no amendment or rider which has not been included in the printed Agenda shall be considered by the Meeting unless a written copy of it has been handed to the Chairman, with the names of the proposer and seconder, before the end of the session immediately prior to that in which the motion is due to be moved, except that an amendment or rider to a motion due to be moved in the first session of the Meeting shall be handed to the Chairman before the commencement of that session.

General order of sessions

32 At the start of each session the Meeting shall consider motions, if any, relating to the order of business.

Hours of sessions

33 These shall be as set out in the time-table of the Meeting, unless varied by consent of the Meeting.

Varying order of business

34 The order of business may, in exceptional circumstances, be varied at any time by the vote of two-thirds of those present and voting.

Conclusion of Meeting

35 A definite time for the conclusion of the Meeting shall be published with the Agenda.

"P", "C", "A" and "AR" Motions

36 The Agenda Committee may prefix with the letter "P" any motion which it deems of outstanding importance. Any such motion shall be given priority in debate, in line with Standing Order 40.

37 During the first session of the Meeting, a ballot of Representatives shall be conducted to enable them to choose motions, ("C" motions), for debate. Each Representative may choose up to three motions to be given priority in debate using the prescribed form only which must be signed. The five motions which receive most votes shall be debated.

38 The Agenda Committee may prefix with the letter "A" any motion which the chairman of the committee or body concerned has recommended to it as likely to be non-controversial and acceptable without debate. The chairman shall formally move that each such motion be accepted without debate.

39 The Agenda Committee may prefix with the letter "AR" motions relating to new matter which the Chairman of Council is prepared to accept without debate as a reference to Council.

Block allocation of time

40 The Agenda Committee shall recommend to the Meeting a block allocation of time for each section of the Agenda, in the light of the business to be dealt with, and shall propose a provisional timetable for the commencement of each section of the Agenda. Within each section, any priority items (given the prefix "P") shall be debated first. The agreed starting times of each section shall be strictly observed (save that if one section shall have finished early, another section may be started ahead of the schedule). Motions included in a block which cannot be debated in the time allocated may, at the discretion of the Chairman, be debated in any unused time allocated to another block. At the discretion of the Chairman, contingency time shall be reserved in each session for the consideration of unfinished business in sections already dealt with.

41 The motions chosen under Standing Order 37 shall normally be debated in the block of time allocated for this purpose by the Agenda Committee. The prefix "A" or "AR" shall be deleted from any motion which is chosen by ballot.

"Other" Motions

42 Time shall be set aside by the Agenda Committee for debate on matters of urgency or emergency which have arisen after the last date for submission of motions, as specified in Standing Order 24. This time shall be used at the discretion of the Chairman.

Motions, amendments or riders on the same subject

43 Subject to the provisions of Standing Order 36, the Agenda Committee shall group items covering substantially the same ground, and shall mark with an asterisk that item which it recommends for debate. If the Committee considers that no motion, amendment or rider in the group adequately covers the ground, the Committee shall have power to draft a composite motion, amendment or rider. The mover of an Agenda Committee composite motion shall be the constituency whose motion is first in the bracket immediately below the Agenda Committee's motion

44 Composite motions constructed by the Agenda Committee shall have their several parts designated (i), (ii), (iii) or (a), (b), (c), etc.

45 Motions submitted under Standing Order 22 which, in the opinion of the Agenda Committee, are relevant to the subject of a designated open debate shall be grouped into a timed section of the agenda relating to the subject of the open debate. A motion taking account of the debate may be prepared at the direction of the Agenda Committee and submitted for consideration by the meeting at a time designated in the agenda having been circulated in advance to the meeting normally before close of business on the preceding day. The Chairman shall open and close the open debate in accordance with the times published in the agenda.

(i) notwithstanding the provisions of standing orders 24, 25, 26, 28, 30 motions relating specifically to the subject of the open debate and arising from that open debate may be submitted for inclusion by the agenda committee in that timed section of the agenda relating to the subject of the open debate.

(ii) such motions may be submitted to the Agenda Committee from the time of the conclusion of the open debate until a time that the Chairman shall notify to the meeting in advance of the open debate.

Instructions to Council

46 Each motion, amendment, or rider which is of the nature of an instruction or reference to any central executive body, other than a committee appointed by the Representative Body, shall be moved in the form of an instruction or a reference to the Council.

REPORTS

Form of reports

47 Reports of Council and reports, if any, of committees to the Representative Body shall include a list of matters referred by the Representative Body to the Council or committee; any specific recommendations by the Council or committee; a short report of all action taken by the Council or committee in furtherance of the decisions of the Representative Body; and a list of matters under consideration but not completed.

Presentation of reports

48 The Report of the Council or of a committee shall be presented by the Chairman or, in his/her absence, by another duly authorised spokesman of the Council or committee.

49 A report of each branch of practice committee on the work of the committee during the session shall be presented orally by the chairman of that branch of practice committee or in his/her absence by a duly authorised spokesman.

RULES OF DEBATE

Procedure for proposing of Motions by non-members of the Representative Body

50 Any motion, amendment or rider shall be introduced by a Representative (or by a member) of the body proposing it, notwithstanding that that Representative or member may not otherwise be entitled to attend and speak at the Meeting; provided that in such case he/she shall cease to take any further part in the proceedings at the conclusion of the debate upon the said item nor shall he/she be permitted to vote thereon. In the absence of the authorised mover, any other member of the Meeting deputed by the authorised mover may act on his/her behalf, and if no member shall have been so deputed, such motions shall be moved formally by the Chairman.

Time limits of speeches

51 Save as stated below, the chairman of a committee or other duly authorised spokesman of the Council shall be allowed to speak for five minutes in presenting a report. A member of the Meeting shall be allowed to speak for three minutes in moving any motion, amendment, or rider. No other speech shall exceed two minutes. In exceptional circumstances, any speaker may be granted such extension of time as the Meeting itself shall determine. The Meeting may at any time reduce the time to be allowed to speakers (during the remainder of that session).

Seconding Motions, amendments, or riders

52 No seconder shall be required for any of the motions, amendments, or riders printed in the Agenda of the Meeting. All others must be proposed and seconded before being debated.

Conduct of speakers

53 A member of the Meeting shall normally stand when speaking and addressing the Chair. An alternative microphone will be provided for those unable to stand or reach the podium. If the Chairman should so request, by rising or otherwise, all members except the Chairman must sit.

54 A speaker shall direct his/her speech strictly to the motion, amendment, or rider under discussion, or to a question of order. The Chairman shall have power to take such steps as he/she deems necessary to prevent tedious repetition.

55 In speaking and voting upon any matter, the Representative or Representatives of any constituency shall have regard and so far as may be conform to the preponderance of opinion of the members of that constituency so far as such opinion is known to him/her or them.

56 Members of the Representative Body have an overriding duty to the whole membership of the BMA. If a member has a conflict of interest in any question which the Representative Body is to debate, this interest should be declared in advance of any contribution to the debate and the member should seek to act and speak in the interest of the membership as a whole.

57 A member shall not address the Meeting more than once on any motion, amendment, or rider, but the mover of any such item may reply, and in his/her reply shall strictly confine him/herself to answering previous speakers and shall not

introduce any new matter into the debate; provided always that a member may speak to a point of order or, by consent of the Meeting, in explanation of some material part of a speech made by him/her which he/she believes to have been misunderstood.

Amendments and Riders

58 To a motion that the report be received, no amendment or rider shall be moved.

59 No amendment or rider shall be moved to a priority motion unless such amendment or rider is published in the supplementary agenda or is made by the Chairman of the Representative Body or by the Agenda Committee.

60 To a motion that a recommendation be adopted, amendments or riders may be moved.

61 To a motion that a report, or a specified paragraph thereof, be approved, an amendment may be moved to the effect that the Meeting do disagree with, or do refer back to the Council or committee, any specified portion thereof; or an amendment or rider may be moved to the effect that with reference to the report or paragraph, the Meeting do express an opinion in terms stated.

62 A motion, amendment, or rider once moved and seconded shall not be altered or withdrawn without the consent of the Meeting.

63 Whenever an amendment or rider has been moved no second or subsequent amendment or rider shall be moved until the first amendment or rider shall have been disposed of.

64 If any amendment or rider be rejected, other amendments or riders may, subject to the provisions of Standing Order 31, be moved on the original motion. If an amendment or rider be carried the motion as amended or extended shall take the place of the original motion and shall become the question upon which any further amendment or rider may be moved.

"A" and "AR" Motions

65 If any member wishes an "A" or "AR" motion to be debated or to propose an amendment to an "A" or "AR" motion he/she shall submit his/her request in writing, indicating his/her reasons to the Chairman of the Representative Body before the end of the session immediately prior to that in which the motion is due to be moved, except when the motion is due to be moved in the first session of the Meeting, in which case the request must be submitted before the commencement of that session. The Chairman shall have discretion either to cause the motion or the amendment to be debated normally, or else, at the appropriate time, he/she shall allow the member concerned to address the Meeting, for not longer than two minutes, and shall thereafter ascertain the wishes of the Representative Body.

66 If the proposal that the motion be accepted without debate be defeated the motion shall be debated in the normal way.

Curtailment of debate

67 If it be proposed and seconded that the Meeting do now adjourn, or that the debate be adjourned, or that the Meeting do proceed to the next business, or that the question be now put, such motions shall be put to the vote without discussion, except as to the period of adjournment, provided always that the Chairman shall have power to decline to put any such motion to the Meeting.

68 Any such motion if accepted by the Chairman shall be put to the vote immediately except that, before a motion to proceed to the next business is put, the proposer of the motion, amendment, or rider under discussion at the time shall have the right to speak against the proposal to pass to the next business. In the event of a proposal to pass to the next business being defeated, the Chairman shall have power to permit the proposer of the motion or amendment under discussion to reply to the debate.

69 Further, in the event of the proposal "that the question be now put" being carried, the Chairman of Council, and/or the chairman of the appropriate committee or other duly authorised spokesman of the Council, shall be permitted to speak, and the proposer of the motion, amendment, or rider under discussion at the time shall have the right of reply to the debate.

Procedure for open debates

70 An open debate may be introduced by one or more invited speakers at the discretion of the Chairman. Representatives shall address the Chair from the floor. Speakers will be invited to speak in turn at the discretion of the Chairman. Only one

speaker may address the meeting at any one time and speeches shall be limited to two minutes. Speakers shall address only the topic of the open debate.

VOTING

Provisions of Articles

71 Article 64 provides that:

(i) Those entitled to vote at a Representative Meeting shall be the elected or appointed members specified in Bye-law 29, save that all members of the Representative Body shall be entitled to vote at an election of the President, the Chairman, and the Deputy Chairman of the Representative Body and the Treasurer.

(ii) For the purpose of electing the President votes shall be recorded at such time and in such manner as the representative meeting may decide.

(iii) For the purpose of electing the Chairman and the Deputy Chairman of the Representative Body, the Treasurer, and the members of any committees and boards required to be elected by the Representative Body the single transferable voting system shall be used.

(iv) Except as aforesaid, voting shall ordinarily be by show of hands or by the use of an electronic voting system unless before the vote is taken 50 or more Representatives present request a recorded vote, in which event the vote shall be taken by a system of recorded voting.

(v) The Chairman shall in the case of an equality of votes have a casting vote, but would normally be expected to vote with the status quo and shall not otherwise be entitled to vote.

Motions with subsections

72 Motions expressed in several parts and designated by numbers (i), (ii), (iii) etc or by letters (a), (b), (c) etc shall automatically be voted on separately.

73 In order to expedite business, the Chairman may, at his/her discretion, seek the assent of the Representative Body (by a simple majority) to waive this requirement for any single motion.

Two-thirds majority

74 A two-thirds majority of those present and voting shall be required to carry a proposal:

(i) that the Meeting do proceed to the next business;

(ii) that the question be now put;

(iii) that Standing Orders be suspended;

(iv) that substantial expenditure of the Association's funds be incurred;

(v) that an amendment to the Articles be recommended;

(vi) that an amendment to the Bye-laws be made.

CONDUCT OF MEETINGS

Chairman

75 Bye-law 54 provides that, at every Representative Meeting, the Chairman of the Representative Body, when present, and in his/her absence the Deputy Chairman of the Representative Body, when present, shall preside. In the absence of both the Chairman and the Deputy Chairman, the Meeting shall appoint a Chairman from its own number.

Attendance

76 Members of the Meeting shall not leave the precincts of the Meeting (which shall be prescribed by the Chairman at the commencement of the Meeting), except for brief absences, without permission from the Chairman. If it shall at any time appear to the Chairman that a quorum is not present, the Chairman shall direct that an attendance bell shall be sounded in such manner as he/she shall direct. Two minutes after the sounding of the attendance bell, the roll shall be called and

those members of the Meeting found then absent without permission from the Chairman, shall be deemed to have been absent from that session of the Meeting.

Quorum

77 No business shall be transacted unless there are present at least one third of the number of Representatives registered to attend the meeting (Article 63).

Withdrawal of strangers

78 A member of the Meeting may at any time move that any or all of the following persons, not being members of the Meeting, should withdraw: (i) those not members of the Association staff, (ii) those not duly appointed Association advisers, (iii) those not Association members. It shall rest at the discretion of the Chairman to submit or not to submit such a motion to the Meeting.

Suspension of Standing Orders

79 Any one or more of the Standing Orders, in any case of urgency, or after notice duly given, may be suspended at any Meeting, so far as regards any business of such Meeting, provided that two-thirds of those present and voting shall so decide.

Distribution of papers and announcements

80 In the Meeting or in the precincts thereof no papers or literature shall be distributed or announcements made or notice displayed except by the staff of the Association, acting with the approval of the Chairman.

Smoking

81 Smoking shall not be permitted during sessions.

Mobile Telephones

82 If used, mobile phones and other portable electronic devices should be configured in a way so as not to disturb the meeting. In the event of any noise from a mobile phone, other portable electronic devices or any other disruption the member will be asked to make a donation to BMA Charities.

ACTION ON ARM DECISIONS

Implementation of Resolutions

83 As soon as reasonably practicable (and in any case within six months) after the passing of every resolution of the Representative Body (except a resolution relating solely to the procedure of the Meeting and except as otherwise provided in the Articles) the Council shall consider such resolutions.

84 The Council may resolve that such resolution does not properly represent the wishes of the Association and that a referendum is expedient as provided in the Articles, but such a decision may only be taken if not less than one-half of the members of the Council be present at the Meeting whereat it is proposed and not less than two-thirds of those present and voting vote in favour of such decision.

85 If no decision is made by the Council that a referendum is expedient it shall be incumbent upon the Council to take all reasonable action to implement the resolution of the Representative Body. Provided always that, should the Council subsequently decide that implementation of any resolution would be either untimely or undesirable in the interests of the Association or of its members because of changed circumstances, it may resolve to defer implementation or call for a referendum on the Resolution, or for a plebiscite on related matters, but such a decision may only be taken if not less than one-half of the members of Council be present at the meeting whereat it is proposed and not less than two-thirds of those present and voting vote in favour of such decision.

86 In the event of the Council resolving to defer implementation of any resolution, it shall be incumbent upon the Council to include a full account of the deferment in its Annual Report of the proceedings of the Association.

87 If the Council shall not have considered any such resolution of the Representative Body within the said period of six months, or if the requisition prescribed by the Articles shall not have been issued within 14 days, the resolution shall come into operation immediately upon the expiration of the said period of six months or of the said period of 14 days and the facts of the resolution having so become operative shall be forthwith published in the Journal. Save as aforesaid, the resolution shall have no operation unless and until it shall have been approved either by the Council or on a referendum or as determined by a plebiscite as hereinafter provided, and if and when so approved the same shall come into operation as a valid and effectual decision of the Association.

Reference to Council

88 A "reference to Council" does not constitute BMA policy. It means that the Council shall consider the resolution, taking into account any points raised in debate, and act in the best interests of the Association.

Motions not dealt with

89 Should the Representative Meeting be concluded without all the Agenda having been considered, any motions not considered shall be referred back to the sponsoring constituency. If the sponsoring constituency wishes such a motion to be pursued, it shall be entitled to submit a written memorandum for the consideration of the Council or appropriate Committee, and/or to submit oral representations.

MINUTES

90 A copy of the minutes of every Representative Meeting, after provisional approval by the Chairman (under Article 66), shall be sent, as soon as practicable, to every member of the Representative Body and to the honorary secretary of every division and each constituency. Such minutes shall require final confirmation by the Representative Body. Not less than 14 days' notice in writing shall be given to the Secretary of the Association of any motion to amend or question the accuracy of the minutes; such motions shall be published in a supplementary agenda.

CHAIRMAN'S DISCRETION

91 Any question arising, in relation to the conduct of the Meeting, which is not dealt with in these Standing Orders shall be determined by the Chairman at his/her absolute discretion.

REPRESENTATIVES OF THE PRESS

92 Representatives of the Press shall be admitted to the Representative Meeting only on the understanding that they will not report any matters which the Meeting decides should be regarded as private.

DURATION OF STANDING ORDERS

93 These Standing Orders shall remain in force until amended or repealed by the Representative Body.

APPENDIX II

Amendments to the Bye-Laws

BYE-LAW REFERENCE	RECOMMENDED CHANGE	EXPLANATION
Junior Doctors Committee		
Second Schedule to the Bye-laws	Second Schedule to the Bye-laws - Column 5 to read:- '4 appointed as non-voting representatives on the following basis: 1 by the Consultants Committee; 1 by the General Practitioners Committee; 1 by the Medical Academic Staff Committee, 1 by the Staff, Associate Specialists and Specialty Doctor Committee'.	It has been custom and practice for only one non-voting representative to be appointed from the Consultants Committee and not two. It was noted that there is a discrepancy between the number of representatives and the breakdown of representatives listed. It is recommended that the number of representatives from the Consultants Committee to be reduced to one.
Audit Committee		
First Schedule to the Bye-laws	First Schedule to the Bye-laws – Column 6 to read:- 'To consider the appointment of the external auditor and any matters relating thereto *and including the conduct and outcomes of the external audit and any matters related thereto*; to consider the annual report of the Directors and financial statements prior to their submission to Council; to consider any statement on the Association's system of internal financial control (including financial, operational and regulatory compliance and risk management controls) prior to its inclusion in the annual report of the Directors and financial statements; to monitor the establishment of an internal audit function' *and including the appointment of any internal auditors and any matters relating thereto*'; to review the internal audit programme and ensure co-ordination between the internal and external auditors; to ensure that the resources, and standing within the Association, of the internal audit function enable it to achieve its objectives; to monitor the implementation and the on-going effectiveness of the governance structure *and including the internal control framework and risk management processes*. To consider other topics as	The additional wording in italics are clarifications requested by the Audit Committee and approved by the Organisation Committee and Council which aim to remove ambiguity and reflect existing practice of committee activities.

	directed by Council. The committee may obtain external financial, legal or other independent professional advice and request the attendance of external advisers with relevant experience and expertise if it considers this necessary. The committee shall have the power to invite observers to its meetings and the Treasurer, the Chairman of the Board of BMJ Publishing Group Ltd and the BMA's Finance Director shall normally attend meetings as observers.'	
Northern Ireland Council		
First Schedule to the Bye-laws	First Schedule to the Bye-laws – Column 5 to read:- '(a) **Five** members whose primary branch of practice is general practice of whom: Four shall be GPs; 1 from East; 1 North; 1 South; 1 West. If none of the four above is a GP locum or salaried GP, then the fifth seat will allocated to the highest polling GP locum or salaried GP. If none of the four above is a GP principal, then the fifth seat will be allocated to the highest polling GP principal. (b) **Five** members whose primary branch of practice is consultant of whom: 2 shall be from East; 1 shall be from North; 1 shall be from South; 1 shall be from West (c) **Two** members whose primary branch of practice is staff and associate specialist with no more than one from any NI divisional area. (d) **Five** members whose primary branch of practice is junior doctor of whom shall be from each of the four NI divisions: East, North, South and West**.** The fifth seat should be allocated to a GP trainee. If a GP trainee does not stand then the fifth seat should be reallocated to another Junior Doctor. (e) **Two** members whose primary branch of practice is medical student. **One** member whose primary branch of	It was considered appropriate that the seat previously allocated to a PHM member should be converted to an additional seat for consultants from the Eastern Division bearing in mind the overwhelming majority of consultants reside in this Divisional area. Junior Doctors invariably rotate around the Divisional areas during the course of their training over the three year period and the geographical constraint was therefore inappropriate. The majority of medical students reside in the Eastern Division and the geographical constraint is therefore inappropriate. Bearing in mind the small number of Public Health Medicine members it was considered that it was more appropriate for this branch of practice to be covered by the seat for smaller groups of doctors along with, for example, medical academic members.

	practice is either (f) academic, or (g) armed forces, or (h) occupational medicine, or (i) public health medicine or (j) other members in practice but not covered by (a)-(i) above. (k) **One** member who is a retired member (l) **Three** members who shall be the top 3 polling doctors/students regardless of branch of practice or divisional area, over and above the members directly elected as set out above. **Note:** East means Eastern Division of the BMA in Northern Ireland; North means Northern Division of the BMA in Northern Ireland; South means Southern Division of the BMA in Northern Ireland; West means Western Division of the BMA in N Ireland.' First Schedule to the Bye-laws – Column 2 to read:- 'Without voting rights: The President of the BMA Chair of UK Council Chair of the Representative Body Treasurer Members of UK Council whose registered address is in Northern Ireland. With voting rights: Chair of NI Consultants Committee Chair of NI General Practitioners Committee Chair of NI Staff & Associate Specialists Committee Chair of NI Junior Doctors Committee Chair of NI Medical Students Committee Chair of NI Medical Academic Staff Committee Chair of NI Public Health Policy Virtual Committee.'	
Board of the Professional Activities Directorate		
First Schedule to the Bye-laws	First Schedule to the Bye-laws – Column 6* to read:- 'To be the centre of excellence for the pursuit of issues involving ethical, scientific, research, educational and international matters. To co-ordinate the professional activities of the Association in accordance	This reflects changes in BMA structure and function since the Board was established. ** Following changes made to column 6 were:* ▪ *The Career Progress of Doctors*

	with the instructions of Council. To receive reports from the Board of Science, the Equality and Diversity Committee, the Medical Ethics Committee, the International Committee, the Conferences Subcommittee, the Information Technology Committee and the Patient Liaison Group. To agree the directorate's organisation and process and the role, constitution and membership of supporting committees. To oversee communications policy relating to the professional work of the Association. The Board will have the power to deal, on behalf of Council, with other matters requiring urgent action which do not fall within the terms of reference of the Oversight and Finance Committee or the Political Board. The Board may be consulted by any standing committee or committee of Council. The Board will submit reports of its own business direct to Council.' First Schedule to the Bye-laws – Column 5** to read:- 'The Chairman of Council (who shall be Chairman of the Board), the Chairman of the Representative Body, the Treasurer, the Chairmen of the Board of Science, the Equality and Diversity Committee, the International Committee, the Information Technology Committee, the Medical Ethics Committee, the Patient Liaison Group, the Secretary, the head of function in the Secretariat.'	*Committee no longer existed (it had been subsumed into the Equality and Diversity Committee) so omitted.* ▪ *The Joint Formulary Committee no longer reported to the BMA so omitted.* ▪ *The Equal Opportunities Committee was now the Equality and Diversity Committee.* ▪ *The Patient Liaison Group needed to be included.* ▪ *The BMA Charitable Trust was an independent charity and could not legally report to the Board so omitted.* *** Following changes made to column 5 were:* ▪ *The Career Progress of Doctors Committee no longer existed (it had been subsumed into the Equality and Diversity Committee) so omitted.* ▪ *The Equal Opportunities Committee was now the Equality and Diversity Committee.* ▪ *The Patient Liaison Group needed to be included.*

APPENDIX III Subscriptions table

Motion by TREASURER: by the Treasurer: That the standard rate of subscription be increased by 2% according to the subscription ranges set out below with effect from 1 October 2012

	2011/12	2012/13
STANDARD RATE	£425	£434
CONCESSIONARY RATES		
Member in 1st year after qualification (See Note 1)	£109	£111
Member in 2nd, 3rd or 4th year after qualification	£214	£218
Member in 5th, 6th or 7th year after qualification (See Note 2)	£317	£323
Armed Forces within UK except those within 7 years of Qualification (See Note 3)	£374	£381
Member resident in Channel Islands or Isle of Man	£374	£381
except those within 7 years of qualification		
Overseas member resident outside the UK, including:	£265	£270
• Ships surgeons • Armed Forces members posted for a period exceeding 12 months and not within 4 years of qualification		
Dental surgeons except those within 4 years of qualification	£265	£270
Salary Link A (See Note 4)	£157	£160
Salary Link B (See Note 5)	£214	£218
Spouse/partner of member (See Note 6)	£214	£218
Permanently retired from medical practice	£157	£160
Medical Missionary/Voluntary Worker (See Note 7)	NIL	NIL
Member for more than 50 years (Life Member)	NIL	NIL
STUDENT		
Standard	£40	£ 41
Non Fresher 1st Year, 2nd, 3rd Year	£34	£ 35
Freshers	NIL	NIL

NOTES:

1. Members within 7 years of qualification can claim the appropriate rate for their role, providing they are no more than 2 years 'out of programme' who provide suitable evidence
2. Members who are equivalent to Principals in general practice under pre 2004 contracts pay the standard subscription (£434) irrespective of the year of qualification
3. The Armed Forces rate is available to Military Reservists who provide proof of status
4. Salary Link A can be claimed by any member whose gross professional income is not expected to exceed £9,212. A separate claim must be made each year
5. Salary Link B can be claimed by any member whose gross professional income is not expected to exceed £34,061. A separate claim must be made each year
6. The spouse/partner concessionary rate is available to married couples or to unmarried partners with financial interdependence and a joint home:
   - The reduction is granted only to one partner. If both partners qualify for a concession, this rate will be applied to the partner who otherwise would have paid the lesser rate
   - A separate copy of the BMJ/BMA News will not be sent to the member claiming the concession unless they submit a written request
7. The voluntary worker rate cannot be claimed by a member in paid employment. Suitable evidence of employment must be provided

INCOME TAX ALLOWANCE ON MEMBERSHIP SUBSCRIPTIONS

Employed and Self Employed members may be able to claim income tax relief on their subscriptions. Members' should contact their financial adviser or HMRC (www.hmrc.gov.uk) for further information.

BMA 2012 BOURNEMOUTH
Annual Representative Meeting