TITLE: RESOLUTIONS - 2017 ANNUAL REPRESENTATIVE MEETING

To: Council – 13 July 2017

Author: Council Secretariat / policy director

Purpose: To receive the resolutions of the 2017 ARM, which have been allocated to committees, national councils and departments for action.

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<th>ARM agenda No.</th>
<th>Medicine and government</th>
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| 11             | That this meeting deplores the current blame culture in the NHS and:-
|                | i) believes that the woeful government underfunding of the NHS coupled with continued austerity cuts is the greatest threat to quality and safety in the NHS;
|                | ii) believes that the crisis in NHS hospitals has been consciously created by the government, in order to accelerate its transformation plans for private sector takeover of health care in England;
|                | iii) firmly believes this scapegoating is a deliberate attempt to distract the public from an under-funded service under severe and intense strain. |
| 12             | That this meeting:-
|                | i) supports the principle of integration of health and social care;
|                | ii) calls on politicians from all parties UK-wide to stop raising false expectations regarding what integration can achieve when it comes to reducing the admissions of elderly patients to hospital;
|                | iii) calls for government to provide enough hospital beds and social care to meet the demands being placed on these services;
|                | iv) calls for government to acknowledge that integration of health and social care cannot be done properly without adequate additional funding;
|                | v) calls for government and NHS lead bodies to have an open dialogue with the public and patients about what services the NHS should provide for the funding available and what services can no longer be provided by the NHS. |
| 13             | That this meeting reminds governments and healthcare organisations that they serve and are accountable to patients and the public. This meeting calls upon healthcare organisations to:- |
i) conduct business in public, with open and free access to reports and papers so that appropriate scrutiny can be undertaken;
ii) provide verifiable evidence for changes to practice and/or services before decisions are made;
iii) stop extrapolating claims beyond evidence and applying hyperbole to justify their actions without appropriate evaluation;
iv) publish full accounts where services are paid for through general taxation in order to provide public accountability. (PART iv AS A REFERENCE)

14 That this meeting mandates council to lobby for the restoration of the duty of provision of universal health care to the secretary of state for health.

National Health Service

16 That this meeting recognises the acknowledged links between poor medical engagement with risks to patient safety and poor outcomes for patients and:-
   i) recognises that promoting greater medical involvement in the design and planning of healthcare is crucial in ensuring that improved patient services are properly designed and effectively implemented;
   ii) calls for radical change of the management culture in the NHS from the current hierarchical focus on narrowly based targets towards a clinically based system adapted to the needs of patients;
   iii) calls for all NHS organisations to agree and sign up to a new medical engagement charter that will facilitate the positive involvement and engagement of doctors who are willing to work in close cooperation with other clinical and non-clinical healthcare staff.

17 That this meeting notes with concern the increasing numbers of patients resorting to crowdfunding their own wheelchairs due to delays and cuts in wheelchair services, and the recent suggestion from Muscular Dystrophy UK that a 'postcode lottery' pervades such services across the country. We call on the BMA to work with NHS England, the Association of Directors of Adult Social Services and other relevant bodies to ensure that would-be wheelchair users have timely access to chairs suitable for their individual conditions.

18 That this meeting condemns any proposal to deny patients prescriptions for medicines available over the counter:-
   i) recognises that such a move would further increase inequalities, in relation to medical conditions, age and socio-economic status;
   ii) believes that this will increase risks to patients;
   iii) calls for the withdrawal of any such plans. (MOTION 18 AS A REFERENCE)
19 That, with regard to referral management systems, this meeting:-
   i) notes with concern that many Clinical Commissioning Groups operate referral management systems to constrain referrals of patients to acute care;
   ii) notes that these systems have the potential to undermine sharing decision-making and to harm patients by delaying their management;
   iii) deplores the blanket application of referral management policies;
   iv) calls on the BMA to publicise tick-box referral management systems as rationing;
   v) calls upon the BMA to lobby for the abolition of referral management systems.

20 That this meeting supports the concept published in the GPC document "Quality First" that one specialist should be able to use their professional acumen to refer directly to another specialist and asks for its promotion and implementation by NHS England and the devolved departments of health.

21 That this meeting condemns the wide variation in commissioning by clinical commissioning groups of end-of-life and palliative care services in England and calls on the government to support the Access to Palliative Care Bill.

**Workforce**

23 That this meeting is concerned about the health and wellbeing of our medical colleagues particularly; stress, fatigue, burnout, substance abuse and low morale. This meeting:-
   i) congratulates the BMA and the Royal Medical Benevolent Fund on establishing the pilot DocHealth programme and supports an extension, following successful evaluation of the pilot;
   ii) calls for the establishment of a comprehensive workplace policy and code of conduct, within the framework of health and wellbeing, to help prevent and reduce the risk of harm caused by alcohol and substance misuse amongst employees;
   iii) calls for a fully functional and resourced occupational health service for all NHS staff;
   iv) calls on the government to raise morale amongst NHS staff.

24 That this meeting recognises that in an increasingly stretched and resource-starved health service, doctors are increasingly asked to work beyond their capacity, and that in so doing mistakes, errors and oversights become inevitable. We call on the BMA to lobby the GMC to amend its guidance to acknowledge that even good and competent doctors may cause harm to patients when working in such
an environment, and to acknowledge that such mistakes can be a product of the environment and not the fault of the practitioner.

25 That this meeting demands that the UK government act to avert future crises in workforce availability including reviewing the Shortage Occupation List and investments into specialties at particular risk including: - emergency medicine, general practice and paediatrics.

26 That this meeting mandates the BMA to work with relevant bodies to ensure that where extended role practitioners (ERPs) and doctors share clinical duties: - i) there is an evidenced need to recruit an ERP; ii) the training needs of both groups are fully considered and clearly defined; iii) both groups have appropriate supervision, responsibility and safeguards in their roles.

27 That this meeting calls on health organisations training physician associates or similar non-medical staff to: - i) make sure that learning outcomes are clear to trainers and supervisors; ii) make sure that patients do not mistake such students as doctors in training; iii) plan sufficiently to ensure that such clinical placements do not affect medical student teaching adversely.

28 That this meeting welcomes the BMA’s commitment to care workers receiving a living wage and through exploring with our fellow trade unions how we can support them to improve the terms and conditions for care workers.

29 That this meeting does not support the existing practice of charging NHS employees to park at their place(s) of employment, especially as this payment typically does not guarantee space. It also demands that the NHS sites better monitor parking facilities to ensure they are adequately maintained, secure and safe for all staff at all hours of work.

30 That this meeting welcomes the BMA’s commitment to care workers receiving a living wage and exploring with our fellow trade unions how we can support them to improve the terms and conditions for care workers.

**Armed Forces**

33 That this meeting is deeply concerned by the persistent and increasing faults with the Defence Medical Information Capability Programme (DMICP), which affect patient safety and undermine the professionalism of clinicians. We call on the BMA to lobby the Ministry of Defence to take urgent action to rectify the following issues: -
i) insufficient number of available IP addresses resulting in delayed start-up or an inability to access the system entirely without frequent software crashes or total loss of IT;
ii) failure of the system to load previous history, as well as save current consultations;
iii) system failure with regard to printer integration, leading to potential patient safety and confidentiality issues;
iv) lack of secure integration with NHS IT systems.

34 That this meeting requires the BMA to request that Defence Medical Services research is fully supported to ensure that military clinicians are able to provide the best medical care to patients on and off operations, both now and into the future.

35 That this meeting requires the BMA to ensure that junior doctors within the Defence Medical Services are not disadvantaged against civilian junior doctors employed in the same department. This specifically includes, but is not limited to, ensuring that military junior doctors:
   i) have access to the guardian and exception reporting;
   ii) are not allocated more out of hours work than civilian counterparts;
   iii) are not used disproportionately to cover gaps in rotas shared with civilian junior doctors;
   iv) are appropriately remunerated for extra hours worked in a manner akin to civilian junior doctors.

**NHS Finances / Financing**

36 That this meeting demands governments urgently rectify the severe and chronic underfunding of health and social care which:
   i) places extreme pressure on services and the workforce;
   ii) puts at risk services to patients and the health of the public;
   iii) undermines sustainable, publicly provided, universal healthcare;
   iv) is not addressed by the unrealistic savings of sustainability and transformation plans.

38 That this meeting calls on UK governments to commit to funding the NHS to at least the average levels spent on healthcare by comparable leading European countries.

40 That this meeting believes that NHS funding allocations should take account of:
   i) the increased costs in rural areas of providing, and for patients of accessing, NHS services;
   ii) the increasing costs of financial compensation for clinical negligence consequent on the changes to the discount rates.
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<td><strong>NHS Sustainability and Transformation Plans (STPs)</strong></td>
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| 41 | That this meeting believes that sustainability and transformation plans have not produced a sustainable funding model for the NHS in England, and the BMA calls for:-  
   i) the maintenance and improvement of the quality of patient care to be the absolute priority;  
   ii) patients and the public to be consulted on realistic, evidence-based STPs;  
   iii) there to be no further reduction in inpatient beds until after a comprehensive assessment of the clinical needs of the local population;  
   iv) clinical education and training to be protected and promoted;  
   v) any service reconfiguration to be clinician-led;  
   vi) at least one doctor appointed by regional councils to be engaged in a meaningful clinical forum with each STP;  
   vii) STPs to be fully funded to achieve true transformation. |
| 42 | That this meeting condemns the woeful manner in which STPs have been progressed, turning them into vehicles to try to legitimise further cuts to vital NHS services, and proposes STPs are abandoned. |
|   |   |
| **Bye-law changes to structure and election of council** |   |
| 44 | That this meeting approves the bye-law amendments to the membership and election to UK council in the manner shown in appendix III of document ARM 1A. |
|   |   |
| **BMA Structure and Function** |   |
| 45 | That this meeting wishes to see increased BMA policy feedback and engagement locally and asks the BMA to consider a move to an element of regional representation on council. |
| 46 | That this meeting congratulates the association on its ‘Living Our Values’ campaign, and urges the BMA to:-  
   i) produce a code of conduct for all members and representatives;  
   ii) review how the articles and byelaws should be amended to support members working together constructively.  
(PART ii) AS A REFERENCE) |
| 47 | That this meeting congratulates the association on the progress made through the Member Voice and Democratic Structures review, and calls for:-  
   i) the treasurer to report to the 2018 ARM on the outcome of the recently-begun pilot of direct reimbursement of divisional expenditure through Concur;  
   ii) the treasurer to report on the lessons learned from phases 1 and 2 of the local engagement pilots; |
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<td>iii) once evaluated, prompt roll-out of the local engagement programme across all parts of the UK. (PART iii) AS A REFERENCE)</td>
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<td>That this meeting believes that retired members need more recognition in the structures of the BMA if their potential is to be realised and their membership retained.</td>
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<td><strong>Medical Ethics</strong></td>
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| 50   | That this meeting:-  
|      | i) supports the principles set out in part three of the February 2017 BMA discussion paper on decriminalisation of abortion;*  
|      | ii) believes that abortion should be decriminalised in respect of health professionals administering abortions within the context of their clinical practice;  
|      | iii) believes that abortion should be decriminalised in respect of women procuring and administering the means of their own abortion;  
|      | iv) believes that decriminalisation should apply only up to viability in respect of health professionals;  
|      | v) believes that decriminalisation should apply only up to viability in respect of women procuring and administering the means of their own abortion;  
|      | vi) believes that abortion should be regulated in the same way as other medical treatments.  

(PART iv) AS A REFERENCE)  
(PART v) AS A REFERENCE)  

* (Footnotes)  
1. Abortion must only be permitted in cases where the woman gives informed consent, or in cases where the woman lacks capacity and an abortion is determined to be in her best interests.  
2. Health professionals must have a statutory right to conscientiously object to participating in abortion.  
3. There should be a central collection of abortion data (subject to agreed appropriate confidentiality protections) to ensure future services are fit for purpose.  
4. There must be clarity about what is, and what is not, lawfully permitted, so that health professionals are clear about the scope of their clinical discretion.  
5. There should be robust clinical governance in settings where abortion care is provided.  
6. There should be the continuation of some degree of regulation and the setting of professional standards in the provision of abortion services’.  

52   | That this meeting:-  
|      | i) believes that the Human Rights Act is fundamental to the primary role of doctors in advocating and caring for patients; |
ii) urges the UK government not to repeal the Human Rights Act.

53 That this meeting is concerned by limitations to healthcare provision in immigration and detention centres in the UK and calls for government:-
   i) to invest further in provision for those who must be detained;
   ii) to limit the use of detention to only those cases where not doing so represents a threat to public order and safety;
   iii) to replace the use of immigration detention completely with alternate more humane means of monitoring individuals facing deportation.

(PART i) AS A REFERENCE)
(PART ii) AS A REFERENCE)

54 That this meeting opposes the use of isolation for children and young people who have been detained within the criminal justice system, save where such measures are used for their safety or protection, and calls for the government to similarly condemn this practice.

55 That this meeting believes, in respect of eligibility for NHS treatment of overseas visitors:-
   i) government publicity about the cost of treating overseas visitors is a distraction from the under resourcing of the NHS;
   ii) urgent clinical care should not be delayed or prevented by eligibility checks;
   iii) medical staff should not beed in ascertaining eligibility of patients for NHS treatment.

56 That this meeting notes the recommendations from the review of revalidation by Sir Keith Pearson and:-
   i) particularly welcomes the recommendation that local organisations should “avoid using revalidation as a lever to achieve local objectives above and beyond the GMC’s revalidation requirements; and
   ii) calls on the BMA, medical royal colleges and GMC to reflect these recommendations in their guidance on appraisal;
   iii) demands that the appraisal process is made simpler and less time-consuming;
   iv) requires that the revalidation process be equally accessible to all doctors, regardless of the context of their medical practise;

57 That this meeting demands, following the statement from the GMC and the joint statement from the BMA and the RCGP, that the government enacts legislation such that within the Medical Register general practitioners are
treated equally with doctors in other specialties and are listed as specialists in their own right.

| 58 | That this meeting, with respect to Care Quality Commission inspections, calls for:  
|    | i) the BMA to challenge unrealistic standards;  
|    | ii) recognition of the context and resources in which services are delivered;  
|    | iii) clarity of requirement for necessary data collection to be undertaken before the inspections. |

### Professional Regulation, Appraisal and the GMC

| 59 | That this meeting:  
|    | i) recognises that the hallmark of a profession is self-regulation;  
|    | ii) deplores the increasing regulation of the profession through unelected and unaccountable members of the GMC and;  
|    | iii) supports the return to the election of a majority of licensed medical practitioners to the GMC by the profession. |

| 60 | That this meeting instructs BMA council to resist all attempts to create a single regulator for the health professions. |

| 61 | That this meeting recognising that decisions made by non-clinical managers in the NHS and other health service providers affect the health of our nations, this meeting calls for a system of regulation for such staff, in line with the manner in which clinical staff are regulated by professional bodies. |

### Community and Mental Health

| 63 | That this meeting believes that mental health is in crisis, and that there has to be a root and branch review by the UK government of commissioning arrangements, beds and community provision. |

| 64 | That this meeting notes that the BMA safeguarding vulnerable adults toolkit was last reviewed in 2011 and recognises that the Care Act 2014 placed adult safeguarding on a statutory footing and makes certain requirements of local authorities as the lead agency. We therefore call for:  
|    | i) the BMA safeguarding vulnerable adults toolkit to be updated to reflect new legislation, case law, and standardised processes as required by the Care Act 2014;  
|    | ii) the BMA to be a participant in any update of the national framework for adult safeguarding (Association of Directors of Social Services 2005). |

| 65 | That this meeting believes that parity between physical and mental health will only be achieved if the stigma against
mental health problems among medical professionals is addressed. We call on the BMA to create a national campaign to eliminate mental health stigma among medical professionals.

**General Practice**

67 That this meeting believes the current workload pressure in general practice is unsafe and unsustainable, that a rapid expansion in the general practice workforce is required to deal with this and therefore calls for sustained investment above the commitments made in the GP Forward View to be made available as a matter of urgency.

68 That this meeting applauds NHS England for the changes to the primary and secondary care interface within the standard hospital contract which came into effect on 1st of April 2016, with subsequent additional requirements in 2017. However it is dismayed to note that despite the national levers, there are trusts and CCGs that do not appear to acknowledge or enforce these changes. We call on the BMA to create a communications work stream which is focussed on reaching out to trusts, CCGs, different branches of practice to communicate the interface changes.

69 That this meeting notes the regular declarations of “black alert” by hospitals and demands that a similar reporting system be created for general practice to indicate that maximum safe capacity has been reached and conference instructs BMA council and the GPC to construct such a system with or without government cooperation.

70 That this meeting feels that the Multispecialty Community Provider contract framework does not go far enough in:-

i) protecting the liability of individual contract holders from the implications of pooled budgets;

ii) preserving the tenure of GMS and PMS contracts;

iii) protecting GPs from further unfunded work being transferred from secondary care.

**HEALTH INFORMATION MANAGEMENT AND IT**

71 That this meeting notes and deplores the recently signed memorandum of understanding between the UK Department of Health, NHS Digital and the Home Office, which agrees to the transfer of patient administrative details including address for the purposes of immigration enforcement, without the consent of the patient and the knowledge of the GP. This meeting believes:-

i) this is a breach of patient confidentiality that undermines trust between patient and doctor;

ii) this is not justified by the public interest;

iii) that this may result in patients not coming forward for treatment with consequences for public health;
iv) and calls on council to call on the Department of Health to cease this practice.

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<th>That this meeting believes that there is an urgent need for the development of an electronic prescription service for hospitals, to enable hospital clinicians to prescribe remotely for patients to collect their prescription from a nominated community pharmacist, thereby enabling clinical responsibility to rest with the prescribing clinician, as well as reducing inappropriate demands on GPs to prescribe outside their competence.</th>
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### Health Information Management and IT

| 73 | That this meeting:—
| | i) recognises the critical part that IT infrastructure plays in delivery of health care;  
| | ii) is aware that vast parts of the United Kingdom have inadequate broadband links;  
| | iii) calls on the four UK governments to accelerate the provision of fast broadband to all areas of the country. |

### Science, Health and Society

| 75 | That this meeting welcomes the working party report “Every breath we take: the lifelong impact of air pollution” produced by the Royal College of Physicians [London] and Royal College of Paediatrics and Child Health, and we call for:—
| | i) further research into the economic impact of air pollution;  
| | ii) clearer information for consumers on emissions produced by new vehicles, including information on ultrafine particles and oxides of nitrogen;  
| | iii) effective monitoring of air quality and pollution;  
| | iv) the NHS to become an exemplar for clean air and safe workplaces;  
| | v) empowerment of local authorities to take remedial action when air pollution levels are high. |

| 76 | That this meeting:—
| | i) notes the widespread problems of abuse and addiction with pregabalin amongst users of illicit drugs;  
| | ii) notes the contribution of pregabalin to bullying and violence in prison populations;  
| | iii) calls for the BMA to lobby the appropriate authorities to make pregabalin a controlled drug. |

| 77 | That this meeting in the wake of the measles outbreak that swept Europe in March 2017:—  
| | i) condemns anti-vaxxers who deny immunisations to their children;  
| | ii) calls upon the BMA to present a position paper to the government on the potential advantages and |
disadvantages of childhood immunisation being made mandatory under the law.

**PART i AS A REFERENCE**

**PART ii AS A REFERENCE**

| 78 | That this meeting acknowledges the global threat to human health posed by antimicrobial resistance and the firm linkage to inappropriate usage both in human health and in agriculture. As such we call on the BMA:

i) to continue supporting the vision of the UK 5-Year Antimicrobial Strategy (2013-2018);

ii) to support stakeholders in making sure that there is a subsequent strategy following on from 2018;

iii) to support the One Health approach to antimicrobials, recognising that usage in human health only accounts for 50% of usage worldwide and encouraging responsible use in agriculture, engineering and other industries aside from human health;

iv) to recognise their own part to play by ensuring, where possible, that subcontracted catering suppliers used for BMA meetings use antimicrobial-free produce by preference.

**PART iv AS A REFERENCE**

| 80 | That this meeting congratulates the work of the Rotarians in their campaign PURPLE4POLIO for the complete eradication of polio.

**Northern Ireland**

| 82 | That this meeting extends its full support to the GPs of Northern Ireland for their robust defence of the provision of safe care to their patients.

| 83 | That this meeting believes that reconfiguration of services in Northern Ireland must:

i) be evidence based and result in better outcomes for patients;

ii) be carried out in an integrated way, taking patients’ primary, secondary and social care needs into account and not confined to local HSC trust level;

iii) include full and meaningful clinical engagement with doctors at all levels.

| 84 | That this meeting recognises that the lack of full implementation of the recommendations from numerous workforce planning reviews has contributed directly to the current shortage of doctors in Northern Ireland. This meeting believes that the Department of Health in Northern Ireland:

i) must be held accountable for ensuring there is the appropriate medical workforce to deliver care to the population of Northern Ireland;
must recognise that increased investment in the medical workforce is required to ensure that Northern Ireland is an attractive place to work.

**WALES**

86 That this meeting notes the observations of the OECD in its 2016 report comparing health systems of the four UK nations that:-
   i) Welsh health boards do not have sufficient institutional and technical capabilities and capacities to drive meaningful change;
   ii) a stronger central guiding hand may be needed. This meeting therefore calls upon the Welsh government to take what steps are necessary to provide such a central guiding role, thereby ensuring that health boards and NHS trusts are subject to greater direction, scrutiny and accountability so they are clearer and better able to deliver what is expected of them.

**Scotland**

88 That this meeting:-
   i) commends BMA Scotland for setting up a ‘respect at work’ helpline to offer support and advice to members with problems relating to bullying, harassment, discrimination and dignity at work;
   ii) calls on the rest of the BMA to follow this example.

**Finances of the Association**

94 That this meeting believes that the expenses, reimbursements and honoraria of all BMA committee and council members should be made available to:-
   i) individual members on personal request;

95 That this meeting is seriously concerned by the major impacts that fossil fuels have on health via air pollution and climate change, and is aware of the role of divestment in strengthening the advocacy position of the BMA, and calls on the BMA to:-
   i) take advice from suitably qualified financial advisers to develop a policy to divest from fossil fuels, to include those investments currently in pooled funds, and substantially reduce exposure to the financial and reputational risks associated with climate change causation;
   ii) heed the recommendation of the World Medical Association in its 2016 statement on divestment to "begin a process of transferring their investments, when feasible without damage, from energy companies whose primary business relies upon extraction of, or energy generation from, fossil fuels to those generating energy from renewable energy sources".
### Doctors’ pay, pensions and contracts

| 97 | That this meeting:-  
|    | i) recognises the significant contributions and personal sacrifices made by medical students and junior doctors during the course of their degree and further medical education;  
|    | ii) recommends that the government should seek to understand why junior doctors might leave the NHS;  
|    | iii) rejects the secretary of state’s proposal that doctors should be required to work for the NHS for 4 years after registration or pay back the “cost of their training”;  
|    | iv) opposes any move to impose a minimum period of NHS employment. |

| 98 | That this meeting notes the on-going gender pay gap and consistent under-representation of women in leadership positions and:-  
|    | i) insists that employment contracts do not contain clauses which discriminate against women;  
|    | ii) insists that equality impact assessments have equal status to other documents when considering contracts;  
|    | iii) calls for the BMA to encourage improved diversity in representation locally, regionally and nationally. |

| 99 | That this meeting is appalled by the delays that are being reported by practitioners, in payment of doctors’ pension lump sum and even delays of payments of regular pension payments and calls on the BMA to:-  
|    | i) undertake a full inquiry into the size of the problem and reasons for these delays;  
|    | ii) ensure that doctors are awarded full financial compensation for any loss as a result of any delay;  
|    | iii) ensure that the NHS Pensions Agency pays interest on delayed pension lump sums. |

| 100 | That this meeting recommends that members who are forced to withdraw from the NHS pension scheme on breaching their Life-Time Allowance should be refunded future NHS employer contributions. |

| 101 | That this meeting believes the NHS funding crisis cannot continue to be managed by pay restriction. |

### Staff, Associate Specialists and Speciality Doctors

<p>| 103 | That this meeting warmly welcomes the publication of the document “SAS Doctor Development” in partnership with the Academy of Medical Royal Colleges, Health Education England and NHS Employers and calls upon all these agencies to use their collective best endeavours to ensure that the principles outlined in the document are fully realised such that the disadvantaging of SAS doctors in terms of career development and leadership opportunities becomes a thing of the past. |</p>
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| **104** | That this meeting has concerns that currently there is a lack of SAS representation on the Local Education and Training Boards and the appointments of Associate Deans for SAS doctors are not being continued. It therefore calls on Health Education England to ensure that:-  
  i) there is appropriate SAS representation on the Local Education and Training Boards and;  
  ii) the appointments of Associate Deans for SAS doctors continue and that they are appointed from within the SAS grades. |
| **105** | That this meeting congratulates UK SASC on the successful acceptance of the SAS charter by NHS employers and calls for the BMA and NHS employers to ensure its universal implementation in NHS. |
| **Medico-Legal Affairs** |   |
| **107** | That this meeting, in the light of increasing personal injury awards and rapidly increasing medical indemnity costs:-  
  i) supports the introduction of a system of no-fault compensation for medical injuries;  
  ii) supports the principle of annual care payments to the injured, rather than lump sum payments;  
  iii) seeks the direct reimbursement by government of medical indemnity costs relating to NHS treatment. |
| **Forensic Medicine** |   |
| **110** | That this meeting regarding the mental state examination of children under arrest in police custody suites:-  
  i) is concerned at the lack of forensic physicians possessing membership of the Faculty of Forensic and Legal Medicine;  
  ii) considers that it is non-equivalent compared with the care given to non-detained children;  
  iii) calls for increased out of hours provision of child and adolescent mental health services (CAMHS) and youth offending teams to facilitate prompt liaison and diversion. |
| **111** | That this meeting supports the Royal College of Psychiatrists’ urging of the government to amend the Prison and Courts Bill to include a statutory requirement of prisons to protect the mental and physical health of offenders. [MOTION 111 AS A REFERENCE] |
| **Medical Students** |   |
| **113** | That this meeting calls on the BMA to improve awareness of student mental health in medical schools. The BMA should do this by:-  
  i) utilising its growing local networks to host mental health talks and events for local medical students;  
  ii) calling upon medical schools to improve support for students with symptoms of mental health illness. |
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<td>iii)</td>
<td>reporting back on progress and responses from medical schools.</td>
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| 114    | That this meeting, in light of the NHS medical recruitment crisis, is appalled by the decrease in medical student applications and calls for:--  
  i)  places to be given on merit without financial barriers;  
  ii) the cost of a 5-year medical degree to be realigned to meet the cost of an average undergraduate degree in a comparable subject;  
  iii) the government to increase medical student numbers and resource universities appropriately.  
  **(PART ii) AS A REFERENCE)** |
| 115    | That this meeting condemns the proposed increase in tuition fees and calls on the BMA to:--  
  i) support other organisations campaigning against the proposals;  
  ii) oppose excessive rates of interest charged on student loans and lobby for any interest charges to be in line with the governments’ long-term borrowing costs. |
| 116    | That this meeting believes that undergraduate medical training should include knowledge of the structure and framework, funding and resource prioritisation of the NHS. We therefore call upon the BMA medical students committee to work with the education subcommittee of the Medical Schools Council and other relevant bodies, including the Health Foundation and the GMC, to ensure that this training is compulsory in the core curriculum of all medical schools in the UK. |
| Junior Doctors | That this meeting continues to support junior doctors, and:--  
  i) calls upon consultant members of the BMA to endorse exception reporting as a tool for the improvement of terms and conditions of trainee doctors;  
  ii) asks its members not to suppress in any way the fair use of the exception reporting mechanism by junior colleagues. |
| 119    | That this meeting calls for a mandatory nationally agreed minimal period of protected administrative time (relevant to the level of training and duties) built into junior doctors work schedules. This would be above and beyond that protected for teaching and training and intended for the purpose of completing paperwork tasks, mandatory training, portfolio tasks, audit, guideline reviews and other required educational, teaching or management tasks currently having to be completed in that doctors own time without recognition or pay.  
  **Occupational Medicine** |
| 122    | That this meeting notes the publication of the green paper 'Improving Working Lives' and:--  
  i) regrets the short timescale for consultation; |
ii) supports initiatives which encourage occupational health support and workplace assessments for employers designed to keep people in employment through periods of ill health or to enter the workplace where possible; iii) believes that any additional burden of workload and costs with respect to implementation of the recommendations should fall to the DWP and not the NHS.