Public health medicine conference – agenda and guidance notes
8 June 2018, BMA House
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Agenda and programme

9.00 – 10.00am  Registration and refreshments

Registration will take place in the Courtyard Suite, with refreshments available.

9.30 – 10.00am  Teach-in for new representatives

Led by Tha Han, London Regional Public Health and Dino Motti, Public health medicine registrars subcommittee chair

In the Paget Room

Please advise Alex Young if you would like to attend: ayoung@bma.org.uk
Introduction and welcome

Paget Room

10.00 – 10.10am  Chair’s welcome

1 Receive: Introduction by the chair of conference, professor Kevin Fenton, including a report on the procedures for the conference.

10.10 – 10.20am  Formal welcome and introduction

2 Receive: Formal welcome by Dr Anthea Mowat, chair of the representative body

Constitution and standing orders

3 Receive:
   i. The public health medicine conference constitution and standing orders Appendix 1.
   ii. Under chair’s discretion, motions will normally be proposed from the lectern, but other contributions to the debate may be given by representatives from the floor. Those wishing to contribute should raise their hand and, having been called by the chair, will be provided with a microphone. Speakers should identify who they are and where they come from. Where there is no mover of a motion available, the chair may move a motion formally, with debate continuing as normal.
   iii. Order of business as set out in this document in accordance with standing order 10.
   iv. Report that motions making the same or similar points on the same subject have been grouped and the motion marked by an asterisk will be debated and those bracketed with it not taken. The main motion will often be a composite of the motions received.

Composition of conference

4 Receive: List of representatives to the conference, to be available at registration on the day of the conference.

Public health medicine conference list-server

5 Receive: Report that all representatives will be added to the annual public health medicine conference list-server (an e-mail group for representatives). Please inform the secretariat if you do not wish to be added to the list-server.

BMA Charities

6 Receive: BMA charities annual report and gift aid envelope included in delegate packs

Information on BMA charities is available on the BMA website: www.bma.org.uk/about-us/who-we-are/bma-charities

Public health medicine conference policy

7 Receive: Previous policy passed by the Public Health Medicine Conference can be found on the BMA Policy Database online at by www.bma.org.uk/about-us/how-we-work/writing-a-good-motion/policy-database and clicking ‘Public health medicine’
8 **Elections**

**Chair of the Public Health Medicine Conference 2019**
Receive: Report that the chair of the public health medicine conference 2019 will take office at the end of this Conference until the termination of the next Annual Conference. Nominations for chair of conference will close at **10.30**.

The elections will be run through the BMA’s online elections system through which you should nominate yourself at [www.bma.org.uk/collective-voice/committees/online-elections](http://www.bma.org.uk/collective-voice/committees/online-elections). Please refer to your *Guide for Representatives* for more information.

**Deputy chair of the Public Health Medicine Conference 2019**
Receive: Report that the Deputy Chair of the Public Health Medicine Conference 2019 will take office at the end of this Conference until the termination of the next Annual Conference. Nominations for deputy chair of conference will close at **1.15pm**.

The elections will be run through the BMA’s online elections system through which you should nominate yourself at [www.bma.org.uk/collective-voice/committees/online-elections](http://www.bma.org.uk/collective-voice/committees/online-elections). Please refer to your *Guide for Representatives* for more information.

**Members of the public health medicine conference agenda committee for 2019**
Receive: Report that in accordance with paragraph 2 of the Public Health Medicine Conference Standing Orders (appendix 1), it is the business of the public health medicine conference to appoint three members of the conference agenda committee for the 2019 conference. Nominations for members of the conference agenda committee will close at **1.15pm**.

The elections will be run through the BMA’s online elections system through which you should nominate yourself at [www.bma.org.uk/collective-voice/committees/online-elections](http://www.bma.org.uk/collective-voice/committees/online-elections). Please refer to your *Guide for Representatives* for more information.

10.20–10.30am **Debate of motions on healthcare data**

9 **Motion from South East Regional Public Health:**
That this conference notes that the Memorandum of Understanding between NHS Digital and the Home Office is still in place, despite representation from many bodies. The MoU allows information collected for the purpose of healthcare provision to be systematically interrogated by the Home Office, for the prevention of relatively minor crime – something which, if done by a doctor, would be a clear breach of Good Medical Practice.

Conference:
- Believes that this policy will discourage people who are entitled to NHS care from coming forward for treatment – including those with notifiable communicable diseases, who pose a health risk to the wider population
- Believes that this is unethical
- Believes that the requirement is there more to pacify xenophobic voices than because it is of any real value
- Calls for the MoU to be abolished immediately.

10 **Motion from North East Regional Public Health:**
That this conference recognises the importance of having good quality data to support reducing health inequalities. It calls on barriers for sharing between organisations to be reduced for that purpose within newly redesigned health and care systems, as per the findings of the Health Select Committee.

11 **Motion from North East Regional Public Health:**
That this conference recognises the importance of having high quality reliable information on gender and ethnicity for measuring and improving health, and calls on data such as on ethnicity and first language to be utilised for routine pro-active access to language/translation services as well as relevant communications to patients and residents from institutions such as local authorities, and the NHS.
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| 10.30 – 10.40am | **The year in review: The State of the Nation’s Public Health**  
|               | i. Report by Dr Peter English  
|               | BMA public health medicine committee chair                                |
| 10.40 – 10.50am | ii. Report by Professor John Middleton  
|               | President, Faculty of Public Health                                        |
| 10.50 – 11.20am | **Panel discussion: the state of the public’s health**  
|               | Dr Peter English, public health medicine committee chair  
|               | Professor John Middleton, President, Faculty of Public Health             |
|               | Dr Emma Pearce, Public Health Trainee                                     |
| 11.20 – 11.35am | **Debate on motions on the role of public health**                      |
| 15 | **Motion from North East Regional Public Health:**  
|    | That this conference believes that:  
|    | i. Public Health within local government represents an enormous opportunity to improve the health and wellbeing of the population, supported by the foundations built within the NHS, but  
|    | ii. Reflects that this is a largely missed opportunity in England as local authorities have failed to recognise Specialist public health expertise as agents for change and improvement of all services, and enabled health in all policies and services, not just public health ones |
| 16 | **Motion from the Public Health Medicine Committee:**  
|    | That this conference fears for the future of health care public health medicine and clinical leadership in population medicine within the NHS. Many doctors who were trained to provide this leadership are likely to retire within the next 10 years, with many opting to retire early at 60.  
|    | Conference notes that NHS services are no longer defined in terms of a public health service and that many local authorities do not want their public health staff too involved in supporting the NHS. The move to bring doctors from other specialties into population roles in the NHS has been welcome. But rather than being an addition to CPHM they have largely replaced them but without any requirement or opportunity to undertake training in population medicine.  
|    | Conference further notes that the proposed accountable care organisations will have significant population health functions with respect to health care services.  
|    | Conference, therefore, calls on:  
|    | i. The Faculty to define the training requirements in population medicine for doctors who hold roles with a population health remit and stimulate the development of postgraduate certificates in population medicine for those working in the NHS;  
|    | ii. The BMA to analyse the impact of the unique contribution of public health doctors lost from the workforce of the NHS.  
| 17 | **Motion from North East Regional Public Health:**  
|    | That this conference calls on the NHS to employ more Public Health doctors to help them address the challenge the NHS faces in Preventing ill-health, reducing unfair variation in access and outcome to care, and place-based integration.  

**Debate of motions on funding of public health**

18  
*Motion from the Conference Agenda Committee:*
That this conference, taking account of the BMA report, ‘Feeling the squeeze: The local impact of cuts to public health budgets in England’ calls on local authorities to:

i. Routinely audit the whole health impact of any changes to services through any re-procurement process (involving a change in budget of 20% or more, for a service meeting the OJEU threshold), and

ii. Publish these impact assessments annually (preferably in the Annual Report of the Director of Public Health).

Conference further calls on Public Health England to:

i. Ensure, via their annual returns, that Directors of Public Health routinely publish health impact assessments and subsequent audits of service changes or new contracting arrangements where more than 20% of the budget or staff are subject to alteration;

ii. Routinely audit these health impact assessments and publish their findings.

19  
**Motion from North East Regional Public Health:**
That this conference, taking account of the BMA report, ‘Feeling the squeeze: The local impact of cuts to public health budgets in England’:

i. Calls on Public Health England and the BMA to Audit the whole health impact of any changes to services through any re-procurement process

ii. Calls on Public Health England to ensure, via their annual returns, that Directors of Public Health routinely publish, in their Annual Reports, health impact assessments and subsequent audits of service changes or new contracting arrangements where more than 20% of the budget or staff are subject to alteration.

20  
**Motion from North East Regional Public Health:**
That this conference, taking account of the BMA report, ‘Feeling the squeeze: The local impact of cuts to public health budgets in England’

i. Calls on all local authorities to routinely audit the whole health impact of any changes to services through any re-procurement process (involving a change in budget of 20% or more, for a service meeting the OJEU threshold), and

ii. Publish these impact assessments annually (preferably in the Annual Report of the Director of Public Health), and

iii. Calls on Public Health England to routinely audit these health impact assessments and publish their findings (with BMA support)

21  
**Motion from London Public Health:**
That this conference is extremely concerned about the end of ring-fenced public health budget after 2019/20 when local public health work will be funded alongside many other functions through business rates. Since local authorities that will receive lower amount of income from business rates have higher levels of deprivation, this new regime is clearly going to increase the health inequality gap. The misuse of public health funding at Northampton County Council added to this concern that financially challenged local governments do not see public health as a need.

For the benefit of population health, this Conference asks the policy makers to ensure that public health funding continues to be ring-fenced and the allocation is proportionate to need. Healthy citizens are the greatest asset any country can have, and public health plays a vital role in breaking the vicious cycle of poverty. The Conference also urges professional bodies such as the Faculty of Public Health, the Academy of Medical Royal Colleges, the Association of Directors of Public Health, and Royal Society of Public Health to support to join our call.
22 **Motion from North West Public Health Medicine Registrars:**
That this conference welcomes the recent increase in funding for perinatal mental health services but notes that there is wide variation in provision nationally and that more could be done to reduce the stigma that this group of mothers face. Conference, therefore, believes that
i. No mother and baby should ever be separated for lack of a bed in their area;
ii. Where a baby is removed by social services either due to no bed being available or because of the severity of mental illness meaning it would be unsafe to keep mother and baby together a medical professional must always be involved in planning appropriate care for the mother;

We, therefore call on:
   i. The BMA to work with stakeholders such as the DH, RCPsych, RCGP, RCOG, RCPCH and Royal College of Midwives to develop guidelines on best practice in supporting mothers who have babies removed, ensuring they have the right support and improving training for staff involved with these mothers and babies.
   ii. Local authorities to ensure that there are appropriate post-removal support services available for mothers who have had a baby removed from their care.

11.50 – 12.35pm 23 **Keynote address**
Keynote address from Professor Neil Squires, Director of Global Health, Public Health England on Sustainable Development Goals, The UK’s Response and Implications for Public Health including a Q&A

12.35 – 12.45pm 24 **Motion from North East Regional Public Health:**
That this conference recognises the harm to health arising from plastic pollution, and calls on government to introduce an evidence-based way of radically reducing its prevalence in the environment.

25 **Motion from the UK Consultants Conference:** That this conference recognises the commitment made last year to support the O’Neill ambitions to tackle the global threat of antimicrobial resistance and calls on the BMA to fund and develop learning materials for medical students and doctors to help address the knowledge gap in clinical practice and acknowledging the One World approach to this wide-reaching topic.
12.45 – 1.15pm  Debate of motions

Brexit

26  Motion from South East Regional Public Health:
That this conference notes that public health needs a set of conditions to exist in order to be maintained or improved and that these include: a thriving economy; the codifying and protection of human rights, including workers’ rights; regulations on environmental protection; effective licensing of medicines and medical devices; international co-operation; and protections against overweening commercial interests.

Conference further notes that all of these conditions are likely to be impaired by Brexit by:

i. Damaging the economy, leading to further austerity and thus exacerbating existing public health consequences of poverty and economic failure;

ii. Reducing the rights of workers and citizens and of environmental protection in the name of deregulation with a relaxation of these protective standards being harmful to health;

iii. Reducing our ability to provide secure and timely licensing of medicines and devices;

iv. Diminishing international cooperation on health issues and the UK’s capacity to deal with cross-border public health outbreaks and events;

v. Reducing the counterweight to corporate and commercial interests which protects community and individual rights from potentially negative public health outcomes;

vi. Reducing access to a trained workforce required to meet the UK’s public health, health and social care needs.

Conference therefore believes that:

i. Leaving the European Union in the absence of visible and detailed plans for establishing comparable and credible new arrangements poses a serious threat to public health, and to healthcare provision generally.

ii. It is in the best interests of public health and the health of nation generally for the UK to remain in the European Union.

1.00 – 1.10pm  NHS

27  Motion from South East Regional Public Health: That this conference notes the recently introduced requirements for patients to prove they are eligible for NHS secondary care. Conference:

i. Believes that the requirements as implemented by many NHS Trusts frequently exceed the statutory requirements for eligibility, so that people who are eligible for NHS treatment are denied it, or told they must pay for it.

ii. Believes that these requirements cause distress to many patients who are eligible for treatment, discouraging some from coming forward for treatment – or doing so late, when it is harder (and more costly) to treat their condition.

iii. Calls for the requirements to be greatly simplified and brought in line with the actual eligibility criteria in the regulations.

28  Motion from the UK LMC Conference:
That conference insists that a mechanism must be established to enable services to be directly commissioned from GP Federations.
29 **Motion from the UK Consultants Conference:**
This conference notes NHS England’s planned substantial reform of services through ACOs (Accountable Care Organisations); ACOs’ vulnerability to private tender; and the lack of consultant engagement in their planning.

This conference therefore asks that:
1. The BMA opposes any further privatisation of services through the introduction of ACOs.
2. The BMA lobbies for a system similar to Scottish Health Boards (responsible for protecting and improving a population’s health and publicly delivering medical care) to be introduced in England.
3. The Health Secretary issues a directive to ACOs to engage front line clinicians, including consultants and GPs, in designing patient-focused care.
4. The BMA opposes the introduction of ACOs unless legally ring-fenced from privatisation.

30 **Motion from North East Regional Public Health:**
That this conference calls on HM Government to reduce its use of outside private Consultants, and calls on it to develop its own function, recognising that many of those skills are present in Public Health Consultants.

1.10 – 1.15pm **Regulation of the profession**

31 **Motion from the Public Health Medicine Agenda Committee:**
That this conference notes the longstanding policy of the Association for non-medical public health trainees and specialists to be on NHS medical and dental terms of service and pay provided that they have appraisal, revalidation and CPD requirements comparable to those of doctors.

Conference, therefore, believes that once they are on medical and dental terms of service non-medical public health trainees and specialists should be able to join the BMA as Associate Members and be able to take part in elections to and the work of the Public Health Medicine Committee and its subcommittees and conferences and in the wider public health work of the Association.

32 **Motion from Gee Yen Shin:** That this conference notes a loss of confidence in the GMC by the medical profession. We call on the BMA to lobby relevant government departments (DHSC) to restore the medical majority to the GMC’s governing Council as an initial, but potentially quite significant, confidence-building measure.

33 **Motion from the UK Consultants Conference:** This conference condemns any effort to diminish the value of a CCT by the introduction of credentialing.

1.15 – 2.00pm **Lunch**

2.00 – 3.00pm **Parallel sessions**
When delegates registered for conference they were asked to select one of the below sessions:
- Public Health England, Department of Health, NHS England and other Arms-Length Bodies
- Local government
- The devolved nations
- Public health trainees
- Academics and Global Health
- Private Sector, NGOs

There will be a reminder which sessions delegates have chosen to attend within delegate packs.

3.00 – 3.15pm **The year in review: public health registrars subcommittee**
By Dr Dino Motti, chair

3.15 – 3.25pm **Debate of motions on terms and conditions**
36 **Motion from Public Health Medicine Registrars Committee.**
That this conference recognises that:

i. Public Health Medicine is a specialty that benefits from the experience of senior members of the clinical and academic community

ii. Public Health can be a career choice for those that want to retrain to enact systemic change on the basis of the insight gained working in another specialty.

iii. The loss of pay protection with the new junior doctors contract represents an existential threat to Public Health as it will penalise more experienced medical candidates and dissuade them from retraining.

iv. Pay protection should be reinstated for Public Health.

v. Mechanisms should be found to financially reward previous valuable experience.

37 **Motion from Public Health Medicine Committee.** That this conference is concerned about a small but significant number of public health doctors and practitioners that are becoming sole traders; not by choice but because of other working circumstances (poor working environment, redundancy, or a lack of job opportunities).

In addition, because of the significant reduction in income many sole traders face, some doctors are relinquishing their license to practice prematurely and they fall off the radar as public health doctors.

Conference believes that:

i. This small group of doctors will have unique needs and that the PHMC and the BMA should take steps to identify those needs and how best to meet them;

ii. The PHMC should use its powers of co-option to ensure representation from public health doctors acting as sole traders.

38 **Motion from Public Health Medicine Registrars Committee:**
That this conference recognises:

i. The value of generalism in Public Health training

ii. The need for Public Health Consultants as agents of change across the political, health and social care systems.

iii. The potential threat posed by the mechanism of credentialing to the survival of the specialty as we know it.

iv. Credentialing, if adopted, should be used sparingly and should not replace on-the-job training.

v. Credentialing should be solely considered for very specific, narrow or niche subsets of Public Health that tend to fall beyond the curriculum and not for wide and mainstream areas or even whole pillars of Public Health as it has been proposed.

3.30 – 4.15pm

39 **Keynote address:**

Keynote address from Dr Jennifer Dixon, Chief Executive of the Health Foundation on Sustainability in an era of uncertainty, devolution, and localism: What are the opportunities for Public Health? Including a Q&A.

4.15 – 4.25pm

**Debate of motions of public health in local authorities**

40 **Motion from North East Regional Public Health:**
That this conference:

i. Deplores the vulnerability of Directors of Public Health within local authorities in England to the short-term vicissitudes of political and financial expediency

ii. Recognises and condemns that the reduced span of control and influence exercised by public health consultants within local government in England as being harmful to the health of the population, and

iii. Deprecates the deteriorating terms and conditions of employment of Consultants in Public Health within local government in England and seeks an audit of these across the country
41 **Motion from North East Regional Public Health:**
That this conference calls on the Faculty of Public Health to work with the BMA and the public health community to set and audit standards for Public Health working within local government, based on an aspirational perspective and calls on research to be commissioned to look at the lessons to be learned from the increasing variation between the home nations in terms of impact on health and wellbeing, particularly with respect to the influence, capability and capacity of the public health specialist (Consultant) workforce working in local government.

4.25 – 4.45pm **Motions on public health policy**

42 **Motion from Public Health Medicine Committee:**
That this conference notes the recent outbreaks of measles around the UK, as a consequence of years of failing to vaccinate enough of the population, and the importance of vaccination as one of the most successful medical interventions.

Conference therefore calls upon the government to:

i. Bring in measures to ensure that ‘every contact counts’, and that the vaccination status every patient seen in a healthcare setting is checked and, if not fully up-to-date, arrangements made for them to receive the appropriate vaccines, preferably before they leave the facility. (This should include the additional vaccines required for those with underlying medical conditions.)

ii. Ensure patient record systems can accurately capture vaccination status, and encourage to be recorded so this policy can be implemented

iii. Provide the additional resources needed so all partners in vaccine delivery can meet these standards

43 **Motion from Public Health Medicine Registrars Committee:**
That this conference recognises the risk that mobile devices like smartphones represent for drivers and calls on government to mandate manufacturers of cars and phones to deploy automatic systems to reduce distractions while driving, like Apple has recently done on iOS.

44 **Motion from the UK LMC Conference:**
That Conference believes the HPV vaccination should be offered to all school age children of both sexes and should be administered at Primary school to be more effective.

4.35pm **Drugs and alcohol**

45 **Motion from the Conference Agenda Committee:**
That this conference believes that the UK’s prohibitionist drug policies have failed, are ineffective in reducing individual and societal harm caused by drug misuse, create barriers to effective treatment of drug addiction and associated health complications, hinder the development of therapeutic treatments derived from drugs and disproportionately penalise the most vulnerable members of our society.

Conference recognises evidence that the policies of decriminalising drug use and rehabilitating drug users have resulted in public health benefits in Portugal. Therefore, this conference calls upon the BMA to:

i. Support decriminalising possession of personal use quantities of drugs;

ii. Lobby the government to increase funding for services that treat drug addiction;

iii. Lobby the government to reduce barriers to research into currently banned substances;

iv. Create educational resources to enable medical students and doctors to better understand and meet the needs of patients with drug addiction; and

v. Review existing drug policies and replace them with an evidence-based approach.

46 **Motion from the Medical Students Conference:**
This conference recognises evidence that the policies of decriminalising drug use and rehabilitating drug users have resulted in public health benefits in Portugal. Therefore, this conference calls upon the BMA to:

i. Publicly announce support for decriminalising possession of personal use quantities of drugs

ii. Lobby the government to increase funding for services that treat drug addiction

iii. Lobby the government to reduce barriers to research into currently banned substances

iv. Create educational resources to enable medical students and doctors to better understand and meet the needs of patients with drug addiction.
Motion from the Junior Doctors Conference:
With respect to the UK’s prohibitionist drug policies, this conference believes these policies:

i. have failed
ii. are ineffective in reducing individual and societal harm caused by drug misuse
iii. create barriers to effective treatment of drug addiction and associated health complications
iv. hinder the development of therapeutic treatments derived from drugs
v. disproportionately penalise the most vulnerable members of our society
vi. should be reviewed and replaced with an evidence based approach.

Motion from the Staff and Associate Specialist Conference:
That this conference welcomes the introduction of minimum unit pricing of alcohol legislation in Scotland and calls on other nations of the United Kingdom to consider doing the same.

Motion from North East Regional Public Health: That this conference supports the use of a Public Health approach to knife and gun crime, noting the use of the approach in Glasgow.

Motion from Public Health Medicine Registrars Committee: That this conference:

i. Condemns the arrest of Council members of the Turkish Medical Association in January 2018 for speaking out against the ‘irreparable physical, psychological, social and environmental damages’ caused by war;
ii. Calls for all charges against the released TMA Council members to be dropped;
iii. Believes that national medical associations, their representatives and the wider medical profession must be free to speak out against all actions affecting health issues without fear of intimidation or retaliation, and adverse consequences following such statements are a gross violation of international human rights norms, particularly rights to freedom of expression and opinion;
iv. Reaffirms our support for the BMA to challenge and actively oppose regimes which threaten the right of health professionals to freedom of expression and opinion in the strongest possible terms.

Motion from PHE LNC: That this conference deplores the continued civil war in Syria with immeasurable levels of human suffering. We specifically condemn the attacks on hospitals and medical facilities by all sides and call for the sanctity of hospitals to be respected by all combatants. Conference calls on the BMA to lobby the government to call for an independent investigation of potential war crimes/crimes against humanity by Syrian government forces and all the various fighting forces engaged in combat in Syria by the International Criminal Court.

Motion from North East Regional Public Health: That this conference seeks the abolition of car parking charges and prescription charges in hospitals, as they add costs onto the sick, the weak and the poorest in society.

Motion from the UK LMC Conference: That conference urges GPC to press government for stricter regulation of private health ‘screening’ services, to allow patients to make fully informed choices and prevent unnecessary and escalating demand on general practice.

Urgent business

Extract from the Conference Standing Orders:
‘If the Agenda Committee exercises its power to recommend a block allocation of time, then it shall set aside contingency time during each session for urgent or unexpected business: if this time is not so needed, it may be used at the chair’s discretion.’

Any motions not reached in their allocated block of time maybe debated here in accordance with standing order 10.
5.00 – 5.10pm  55  **Closing remarks**

Receive: Summary of the day from Professor Kevin Fenton and announcement of the results of the elections.

5.10 – 6.00pm  **Networking drinks reception**
Appendix 1

Standing Orders

1. Constitution
The following groups of doctors shall be invited to attend the annual conference of public health medicine as voting members:
   a. All BMA members engaged exclusively or predominantly in public health medicine; and
   b. Non-BMA members engaged exclusively or predominantly in public health medicine, on payment of a small fee to be determined annually by the conference secretariat.

Non-voting observers may be invited at the discretion of the Agenda Committee.
The total number of members shall be subject to a maximum to be determined annually by the conference secretariat.

2. Agenda committee: composition
There shall be an agenda committee to make recommendations to each meeting of the conference on the method of dealing with the agenda. This committee shall consist of the chair (or chair designate) and deputy chair of the conference, together with the chair and deputy chairmen of the public health committee of the BMA and 3 members of the conference elected by the conference from its own number. If a member of the agenda committee is unable, or for some reason ineligible, to carry out their duties they may appoint a deputy to act in their stead. The committee shall have power to invite the Honorary Secretary of the constituency of the proposer to clarify motions submitted by their constituencies.

3. Agenda committee: meetings
a. The committee shall meet prior to every meeting of the conference, and shall present its recommendations in accordance with these Standing Orders.
   b. The committee may meet to review the progress made at any meeting of the conference and the business still outstanding and may advise the chair, and recommend modification of the previously agreed order of business.

4. Agenda: notice of motions
During the morning session free ranging debates shall be held on broad areas suggested by conference members. The chair will select speakers without the need for speaking slips. At the conclusion of each debate the motions on these subjects which have been submitted in advance shall be voted upon without further discussion, on the understanding that the debate covers the motions. Members of the conference shall be invited to submit further motions and amendments on these subjects by the lunch interval for debate before the close of the conference.
   a. Any motion submitted by a member for inclusion in the Agenda must be notified to the conference secretariat by a date determined annually by the agenda committee.
   b. Any amendment or rider submitted by a member to any items submitted under Standing Order 4(a) or to any recommendation appearing in any supplementary report of the PHMC must be notified to the conference secretariat before the commencement of the session in which the motion is due to be moved.
   c. The agenda committee may include in the agenda any motion received from the public health medicine committee, a regional committee for public health, the public health representatives from Scotland; the Welsh public health medicine committee, the Northern Ireland public health medicine committee, the Public Health England LNC the PHMC Registrars Subcommittee and any motions referred to the Conference by the Joint Agenda Committee. The Committee may also 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 4(b).
   d. No seconder shall be required for any motion, amendment, or rider printed in the Agenda of the Meeting. All others must be proposed and seconded before being debated.

5. Motions not published in the agenda
Motions not included in the Agenda shall not be considered by the Conference with the exception of:
   a. Motions covered by Standing orders 14 (Time Limit of Speeches), 15(j) (Motions for Adjournment), or that the question now be put, or that the Conference proceed to the next business, 20 (Suspension of Standing Orders), 21 (Withdrawal of Strangers), 22 (General Order of Sessions), 24 (Varying Order of Business), 25 (Conclusion of Conference).
   b. Motions relating to votes of thanks, messages of congratulations and condolences.
   c. Motions to correct drafting errors.
   d. Composite motions replacing two or more motions already on the Agenda and agreed by the members concerned.
   e. Motions arising out of general discussion on a broad area scheduled by the agenda committee.

6. Motions, amendments or riders on the same subject
a. ‘Grouped Motions’. The agenda committee shall group items covering substantially the same ground, and shall have power to make with an asterisk an item which it recommends for debate.
b. ‘Composite Motions’. If the Agenda Committee considers that no motion, amendment, or rider in the group adequately fulfils the purpose, the Committee shall have power to draft and include in the Agenda a composite motion, amendment, or rider. The members concerned shall be informed of the proposal of the Agenda Committee, and may speak to the composite motion, amendment or rider, which shall be moved by one of those members or by the chair.

7. Ad hoc meetings
The chair (or chair designate) of the conference shall have the power to convene ad hoc meetings of members submitting motions, amendments, or riders on any given section of the Agenda before or during conference with a view to reaching a large measure of agreement or clarifying points of difference. Any re-worded motions arising there from shall be circulated to the conference.

8. ‘A’ and ‘AR’ motions
a. The agenda committee may prefix with the letter ‘A’ any motion or amendment which the chair of the PHMC, or other appropriate committee, has recommended to it as likely to be non-controversial and acceptable without debate. Such motions or amendments will be moved by the chair of the Conference or by the member concerned and shall normally be passed without debate.
b. The agenda committee may prefix with the letters ‘AR’ motions relating to new matter which the chair of the PHMC, or other appropriate committee, is prepared to accept without debate as a reference to the committee.
c. If any member wishes an ‘A’ or an ‘AR’ motion to be debated or to propose an amendment to an ‘A’ or an ‘AR’ motion, they shall submit their request in writing to the chair of the conference before the start of the day’s business. The Chair shall have discretion either to cause the motion or the amendment to be debated in the usual way, or else, at the appropriate time, s/he shall allow the member concerned to address the Conference for not longer than two minutes and shall thereafter ascertain the wishes of the Conference.
d. If the proposal that the motion is debated is defeated, the motion shall be accepted in the normal way as an ‘A’ motion.

9. Modification or withdrawal of motions
Whenever it appears to the agenda committee that a motion, amendment or rider:
a. may contain a drafting error or ambiguity;
b. merely repeats existing policy or relates to matters already under active consideration;
c. could either (i) with minor modification or (ii) by being rephrased as a reference to the PHMC be recommended by the Chair of the Committee for acceptance as an ‘A’ motion; proposer shall be so informed and given the opportunity of rephrasing, withdrawing or submitting the item to debate as originally drafted. Any such rephrased motion shall be printed on a Supplementary Agenda, and shall take the place of the original motion.

10. Block allocation of time
The agenda committee shall have the power to recommend to the Conference a block allocation of time for portions of the agenda based upon the business to be dealt with and when exercising such power shall propose a provisional time-table for the commencement for each section of the agenda. The agreed starting times of each section shall then be strictly observed (save that if one section shall have finished early another section may be started ahead of schedule). Motions included in the block which cannot be debated in the time allocated to that block may, at the discretion of the Chair, be debated in any unused time allocated to another block. If the agenda committee exercises its power to recommend a block allocation of time, then it shall set aside contingency time during each session for urgent or unexpected business: if this time is not so needed, it may be used at the Chair’s discretion.

11. Amendments and riders
a. To a motion that the report be received, no amendment or rider shall be moved.
b. To a motion that a recommendation be adopted, amendments or riders may be moved.
c. To a motion that a report, or a specified paragraph thereof, be approved, an amendment may be moved to the effect that the Conference do disagree with, or do refer back to the PHMC, any specified portion thereof; or an amendment or rider may be moved to the effect that with reference to the report or paragraph, the Conference do express an opinion in terms stated.

12. Procedure as to other motions
Any motion, amendment or rider shall be introduced by its proposer, notwithstanding that that person may not otherwise be entitled to attend and speak at the conference; provided that in such case s/he shall cease to take any further part in the proceedings at the conclusion of the debate upon the said item nor shall s/he be permitted to vote thereon. In the absence of the amendment’s proposer, any other member of the Conference deputed by the authorised proposer may act on their behalf, and if no member shall have been deputed, such motion shall be made formally by the chair.

13. Motions not dealt with
Should the conference be concluded without all the Agenda having been considered, with the exception of ‘A’ motions which must all be voted on, any motions not considered shall be deemed to have been referred to the PHMC.
14. Time limits of speeches
Save as stated below, the Chair of the PHMC or appropriate Subcommittee shall be allowed to speak for ten minutes in presenting
a report. A proposer of a motion, amendment or rider shall be allowed to speak for three minutes and two minutes for subsequent
speeches, with the exception of a Chair of Committee. In exceptional circumstances, any speaker may be granted such extension of
time as the Conference itself shall determine. The Conference may at any time reduce the time to be allowed to speakers, during the
remainder of that session.

15. Rules of debate
a. A member of the Conference shall stand when speaking and address the Chair.
b. The speaker shall direct their speech strictly to the motion, amendment or rider under discussion, or to a question of order. The
Chair shall have the power to take such steps as s/he deems necessary to prevent tedious repetition.
c. A member shall not address the Conference more than once on any motion, amendment, or rider, but the mover of any such item
may reply and in their reply shall strictly confine themselves to answering 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 Conference.
d. A motion, amendment or rider once moved and seconded shall not be altered or withdrawn without the consent of
the Conference.
e. An amendment shall be so defined: to leave out words; to leave out words and insert or add others (provided that a substantial part
of the motion remains); to insert words; or be in such form as shall be approved of by the Chair. A rider shall be to add words as an
extra to a seemingly completed statement; provided always that the amendment or rider be relevant to the motion on which it is
moved and be not equivalent to the direct negative thereof.
f. No amendment or rider which has not been included in the printed Agenda shall be considered by the Conference, unless a written
copy of it has been handed to the Chair, with the names of the proposer and seconder before the commencement of the session in
which the motion is due to be moved.
g. 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.
h. If an amendment or rider be rejected, other amendments or riders may be moved on the original motion subject to the provision of
Standing Order 15(f). 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 amendments or rider may be moved.

i. If it be proposed and seconded that the meeting do now adjourn, or that the debate be adjourned or that the Conference
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 Chair shall have the power to decline to put any such
motion to the meeting.
ii. Any such motion, if accepted by the Chair, 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.
iii. In the event of a proposal to pass to the next business being defeated, the Chair shall have the power to permit the proposer of
the motion or amendment under discussion to reply to the debate.
iv. Once all members wishing to speak have been heard, the Chair of the PHMC and any BMA Chief Officers present shall be
permitted to speak if they wish. The proposer of the motion, amendment or rider under discussion at the time shall then have the
right of reply to the debate.
v. A two-thirds majority of those present and voting shall be required to carry a proposal `that the meeting do proceed to the next
business’ or ‘that the question be now put’.
vi. A ‘simple’ majority shall be when the number of votes ‘for’ the motion is greater than the number of votes ‘against’ the motion.

16. Voting
Voting shall normally be by show of hands. All members of the Conference shall be entitled to vote, subject always to the provision of
Standing Orders 1 and 12.

17. Recision of resolutions
No motion to rescind any resolution of the Conference shall be in order at any subsequent Conference unless notice is received by
the Secretary of the PHMC not less than two months before the date of the Conference. Except in the case of England, notice must
also go to the appropriate national committee.

18. Quorum
No business shall be transacted by the Conference unless there be present at least one-third of the total number of members
registered to attend the Conference.
19. Question arising
Any question arising in relation to the conduct of the Conference, which is not dealt with in these Standing Orders, shall be
determined by the Chair.

20. Suspension of standing orders
Any one or more of the Standing Orders may be suspended by the meeting provided that two-thirds of those present and voting shall so decide.

21. Withdrawal of strangers
A member of the Conference may move at any time that any or all of the following persons should withdraw: (a) those not members of
the Association staff, (b) those not duly appointed as Association advisers. It shall rest at the discretion of the Chair to submit or not to
submit such a motion to the Conference.

22. General order of sessions
At the start of each session the Conference shall consider motions, if any, relating to the order of business.

23. Hours of sessions
These shall be as set out in the time-table of the Conference, unless varied by consent of the Conference.

24. Varying order of business
The order of business may, in exceptional circumstances, be varied at any time by the vote of two-thirds of those present and voting.

25. Conclusion of meeting
A definite time for the conclusion of the Conference shall be published with the Agenda.

26. Smoking
The smoking or use of tobacco, and the use of e-cigarettes, including vaping or similar, shall be prohibited at all BMA events, whatever
their nature and venue.
Appendix 2

Terms of Reference of the Public Health Medicine Committee

Member ex officio
The Chairs of the Welsh and Northern Ireland committees for public health medicine (with voting rights). The public health committee of Scottish council chair (without voting rights). The annual conference of public health medicine chair (without voting rights). The chair (or his/her representative) of the local negotiating committee of public health England (without voting rights). Members of council in public health medicine and community health if not otherwise elected (without voting rights). The immediate past committee chair, if not otherwise elected or appointed, may remain a member for a period of one year (without voting rights).

Members elected or appointed by the representative body
3, engaged exclusively or predominantly in public health medicine.

Members elected or appointed by the council
N/A

Otherwise elected or appointed
12, engaged exclusively or predominantly in public health medicine, to be elected by public health physicians in the established and training grades (of whom 1 shall be elected from Scotland, 1 from Wales, 1 from Northern Ireland, and 1 from each of the 9 government regions in England).

Where no representative is elected who is employed either by a local authority, or by PHE, the committee may co-opt an additional representative from the missing constituency (with voting rights).

One by the specialist registrars subcommittee; the specialists registrars subcommittee chair; one by the board of science, one by the consultants committee (non-voting); one by the general practitioners committee (non-voting); one by the junior doctors committee (non-voting); one by the staff, associate specialists and specialty doctor committee (non-voting); one by the medical students committee (non-voting); an academic consultant in public health medicine, to be appointed by the medical academic staff committee (non-voting).

Duties and powers
To deal with all matters affecting public health medicine and public health physicians in the established and training grades.

The committee shall have power to co-opt up to three additional members without voting rights.

Doctors from each of the British overseas territories and Crown dependencies shall be allocated by public health medicine committee (UK) to an appropriate regional or national constituency.

The body entitled to appoint one or more representatives to the committee shall be entitled to appoint an additional representative to be a member of the committee during any period for which a representative appointed by such body shall hold office as chair of the committee.

Any member of the public health medicine committee specialist registrars subcommittee may attend a meeting of the committee as an observer (non-voting) provided they are already taking part in other BMA business on the day of the meeting.

The PHMC has the following subcommittees and associated committees:
Specialist registrars subcommittee
Conference agenda committee
Public health medicine consultative committee
Appendix 3

Report of the Public Health Medicine Committee 2018

Introduction
The 2017-18 session has been a time of change for the Committee and its Registrars Subcommittee with a new Chair for each and a largely new officer team. Iain Kennedy stepped down as Chair of the Committee over the summer and members bade him a fond farewell at his last meeting on 15 May, thanking him for all the work he had done on behalf of the Committee and Subcommittee over the last decade.

At the Committee’s first meeting of the session in September Peter English was elected the new Chair of the Committee with deputy chairs Sohail Bhatti, Richard Jarvis and Penny Toff emerging over the subsequent weeks covering Local Government, Workforce and Regulation and Policy and Advocacy respectively. Peter has built on the legacy of Iain Kennedy in formalising a PHMC Executive, holding an away-day in December and a further meeting that together produced a detailed workplan for the two years of Peter English’s first term.

Public Health Trainees
The Registrars Subcommittee has new officers in Dino Motti (Chair) and Emma Pearce (Deputy Chair). It was also very welcome that all the regional representative places on the Subcommittee were filled this year and with a good balance of representatives. The main focus of the Subcommittee’s work has been monitoring the impact of the new Junior Doctor contract in the NHS and preparing for the review of the contract due later in 2018. Dino as the new Chair is also keen to reach out to trainees in the regions and has started a programme of attending the regional trainees’ meetings and talking about the work of the Subcommittee. Consideration has also been given to the issue of indemnity of trainees on out of hours rotas and relations with the lead employer. Both the Committee and Subcommittee have been lobbying HEE for a resolution to this problem. It is hoped that formal representative arrangements can be put in place for the trainees in the West Midlands and the East of England whose lead employer is now St Helens and Knowsley.

Brexit
The Committee has worked closely with the Brexit team in the BMA’s policy directorate and Public Affairs team to help develop the BMA’s response to the UK’s proposed exit from the European Union. Detailed papers have been prepared highlighting the possible impacts on public health and health promotion and pointing out what features of EU membership we need to retain. This has led to the Chair, Peter English, being invited to a round-table meeting with ministers from the Department of Health and other stakeholder organisations.

The Committee has considered the impact of the loss of current EU staff and access to future recruits from the European Union and has written to the Civil Service Commission about the position of EU citizens working in civil service organisations such as Public Health England. A statement outlining the Committee’s views on the likely impact of Brexit on public health was pulled together by the Chair of the Committee and will be put to the annual Public Health Medicine Conference for endorsement.

Terms and Conditions of Service
The terms and conditions of service of doctors in the Public Health realm are safeguarded and advanced through two different fora: the PHE Local Negotiating Committee chaired by Evdokia Dardamissis and the Public Health Working Group of the Local Government Association on which the Committee is represented by Sohail Bhatti. Supported by IRO Patrick Boardman, the LNC has an effective working relationship with PHE management and has generally managed to retain NHS terms in spirit and in practice.

The position in local government is more fluid and it is proving harder to ensure that local government employers stick to previous NHS terms and adhere to best practice. Sohail is building positive relations with the other trades unions in the sector in the hope that by working together we can protect public health teams in local government. Any members with concerns about their pay and terms and conditions of service are encouraged to contact First Point of Contact by phone on 0300 123 1233 or by email support@bma.org.uk.
Gender Issues in Public Health Medicine
The committee is very conscious of and concerned by the fact that, despite being a branch of medicine that is majority women, the Committee is predominantly male. The committee is keen to rectify this and has been grappling with possible solutions over the last few months. These may require a change to its terms of reference and this the support of the ARM.

The committee would like to encourage women in public health medicine to stand in the forthcoming elections and for any men who are successfully elected to identify a female deputy who can attend in their absence. Individual members of the Committee are keen to provide mentoring and support for new or potential members. If you are interested in getting involved please contact the Committee on info.phmc@bma.org.uk. The Committee is also part of the BMA's Visitors' Scheme: www.bma.org.uk/about-us/equality-diversity-and-inclusion/get-involved-help-influence/committee-visitors-scheme/taking-part-in-the-visitor-scheme.

Public Health Funding
The committee has worked with staff in the Science and Public Health in the preparation of their paper on Public Health funding in local authorities. Deputy chair Sohail Bhatti also contributed a blog on the subject: www.bma.org.uk/connecting-doctors/public_health/b/weblog/posts/a-doctor-on-the-frontline-of-public-health-funding-cuts.
Appendix 4

Welsh committee for public health medicine – end of session report 2017-2018

The Welsh committee for public health medicine continues to meet three times a year. The last meeting of each session is an open meeting where any public health doctor working in Wales is invited to attend. This session, the committee has considered a number of matters relating to public health in Wales and those affecting public health doctors. In addition to the standard meetings, an Extraordinary Meeting of the WCPHM was also held in March 2018 to discuss the Health Impact Assessment element of the Public Health (Wales) Act.

Over the session, the WCPHM have welcomed various visitors and speakers including:

- **Professor Andrew Grant, Dean of Medical Education, Swansea University Medical School and Dr Brendan Mason, Consultant in Communicable Disease Control, Public Health Wales**
  Updated the WCPHM on the public health component of the graduate entry medicine curriculum in Swansea University.

- **Mr Paul Laffin, EU Policy Manager, Public Affairs, BMA**
  A BREXIT overview and its potential impact upon public health issues was provided to the Committee members.

- **Ms Liz Green, Principle Health Impact Assessment Development Officer, Public Health Wales**
  Ms Green presented to the Committee on the Health Impact Assessment element relating to the Public Health (Wales) Act. An update was provided on the evolution of Health Impact Assessments in Wales. Due to circumstances around the Public Health (Wales) Act 2017, planning for HIAs can be challenging. However, Draft Regulations will be consulted on later this year. The Committee were updated on the Wales Health Impact Assessment Support Unit (WHIASU) which is an independent specialist unit in Public Health Wales. The Committee look forward to working together to address this element of the Public Health (Wales) Act.

- **Dr Frank Atherton, Chief Medical Officer for Wales**
  The final meeting of the session took place on 24 April 2018, and this was an Open Meeting. The Chief Medical Officer for Wales, Dr Frank Atherton, was in attendance and updated the Committee on his first eighteen months in post. Dr Atherton also continued previous discussions with the WCPHM on Health Care Public Health and Recruitment and Retention of Consultants. Also discussed were topics such as Obesity, Brexit and Medical Engagement.

Other agenda items over the session included:

- **Electronic staff record**
  Having raised concerns previously about inaccuracies in the electronic staff record (ESR) system, and although now most Members have access to the ESR system, WCPHM continues to monitor the situation and welcomes all feedback.

- **Core Principles**
  The Public Health Wales Web Page for Core Principles is now active but the committee are keen to make sure that these principles are adhered to and will monitor progress on a feedback questionnaire that will be sent out to staff.

- **Our Space Project**
  There are still concerns surrounding open plan working within the new Public Health Wales offices in Caerleon, Gwent. Issues surrounding privacy continue to be raised at the Joint Medical and Dental Negotiating Committee (JMDNC) along with the logistics of open plan working.

- **Medical Engagement Scale Survey**
  Following the implementation of recommendations to deliver improvements within Public Health Wales, there were thirty-two actions and all have been completed except for eight. The eight remaining appear to be the most challenging, one of which is on-call equity. There are currently around twenty Consultants who take part in the on-call rota and twenty that do not. On-Call remains a big topic for the WCPHM and by working closely with the Joint Medical and Dental Negotiating Committee (JMDNC), they strive to make change.

- **Tobacco Control Strategic Board**
  The Chairman of WCPHM, Dr Michael Thomas, attends the Tobacco Control Strategic Board. The Board is Chaired by Dr Frank Atherton, Chief Medical Officer for Wales. The most recent meeting was held in February 2018 where the smoking cessation targets for 2020 were discussed. With changes to services, there is concern that there will not be appropriate support to address these targets.

- **Recruitment and Retention**
  BMA Membership remains at a high level for Welsh Public Health Medicine Consultants.

- **Job Planning**
  Most Public Health Wales medical staff and managers have now attended a job planning training session and positive feedback has been received. The WCPHM continue to work closely with Public Health Wales NHS Trust to ensure that timely job planning training is delivered to all consultants and managers.
Appendix 5

Public health in Scotland
The BMA in Scotland provides advice, evidence, comment, support and opinion on public health matters. The terms and conditions interests of Scottish public health doctors are covered by the relevant branch of practice committees. Under the current approach, public health issues (e.g. health inequalities, alcohol, smoking, obesity) are covered by securing input into briefings, consultations and statements from all branches of practice. Scottish Council ensures there is support to public health consultants to contribute effectively on public health policy matters.

Alcohol
The first of May was a significant date for the BMA, as Scotland became the first place in the world to implement a minimum price per unit for alcohol, a policy the BMA played a key role in securing. All alcohol sold in Scotland must now cost at least 50p per unit of alcohol contained.

Legal delays by the alcohol industry had held up implementation of the policy for six years, since the passage of legislation in 2012. But the long journey to minimum unit pricing stretches even further back, to the previous parliamentary term when a similar bill was defeated in 2010 and the years of campaigning leading up to it.

Throughout that time, the BMA’s support for minimum unit pricing has provided significant weight to calls for action, but we have by no means been a lone voice in our support for minimum unit pricing.

Together with Alcohol Focus Scotland, Scottish Health Action on Alcohol Problems (SHAAP) and Scottish Families Affected by Alcohol & Drugs, we have worked to build an informal advocacy coalition on alcohol issues in Scotland. This has meant regularly meeting our counterparts, sharing intelligence, coordinating our communications, campaigning, and lobbying activity and as far as possible presenting a united front on policy asks.

While this coordination was born out of our organisations’ shared support for minimum unit pricing, it has extended into a much broader range of alcohol policies and is still under way. Last year we published joint recommendations for the Scottish Government’s coming alcohol strategy refresh and we will continue working with our partners to pursue these in the months and years ahead.

The success that we have had in working closely with other organisations on alcohol issues in Scotland is a great example of how the BMA has been able to work in partnership with other groups to increase our influence and secure policy change.

Food/obesity
The BMA has called for a range of action to improve diets and reduce obesity. Responding to the Scottish Government’s current consultation on proposals for action to reduce obesity in Scotland, the BMA has made a number of recommendations:

– Additional restrictions on sales promotions that encourage purchasing of unhealthy food
– An end to sponsorship and marketing of unhealthy food and drink products at events aimed primarily at children and in schools
– A requirement to provide calorific information for food purchased in shops and restaurants
– Changes to planning policy to reduce the over-concentration of fast-food outlets around schools
– Efforts to increase children’s intake of fruit and vegetables by providing a free portion of fruit or veg every day to each primary school pupil in Scotland
– The provision of readily accessible specialist multi-disciplinary weight management units

The Scottish Government is expected to publish its new diet and obesity strategy this summer. Ahead of publication, the Scottish Government has announced that it aims to halve the rate of obese children in Scotland by 2030. The BMA welcomed that commitment, although warned that achieving this new target will require substantive action.

Health inequalities
The BMA in Scotland has called for urgent action on health inequalities, the latest report on long-term monitoring of health inequalities.

This reveals that significant health inequalities persist in almost every indicator (apart from healthy birth weight). In particular, it shows that the inequality gap is widening in deaths from coronary heart disease and cancer, and alcohol-related deaths.
The statistics show that women in the most deprived areas of Scotland have a healthy life expectancy of 49.9 years, compared to 72 years in the least deprived; healthy life expectancy for men in the least deprived areas is 69.8 years, compared to 43.9 years in the most deprived areas. The BMA is clear that far greater action is needed to address Scotland’s health inequalities. That means stronger public health measures to address issues like obesity and alcohol misuse, but it also requires action to address problems like low pay, poor educational outcomes, and inadequate housing.’

New public health body

Regular meetings are being held with the Scottish Government lead on the development of a new suite of public health priorities, which are expected to be published shortly, and on the related plans for the development of a new, single public health body in Scotland.

There are concerns from BMA members working in public health that an increasing central and local government focus on the wider societal determinants of health beyond the NHS potentially undervalues the key role of healthcare public health in addressing amenable mortality, i.e. that which can be reduced through better healthcare and which in Scotland still stands at 14%.

It is at present unclear how many doctors currently employed by NHS boards will transfer to the new national public health body, and the extent to which it will operate as an NHS body, offering NHS terms and conditions of service. We continue to highlight the need for appropriate consultation and engagement with all those doctors who might be affected, and with the BMA as their representative trade union. Links have also been developed with the sole partnership representative (from Unison) on the group overseeing the establishment of the new body.

Separately, a number of BMA members have raised concerns around an ongoing review of plans for on-call arrangements in health protection, including proposals for a move to a regional approach. A BMA meeting was held on 26 April for BMA public health members to come together and share concerns, ahead of an options appraisal group meeting the following day at which BMA Scotland was represented.
Appendix 6

Public Health in Northern Ireland

NI public health medicine committee
On the 21 June, BMA will aim to reconstitute the NI public health medicine committee with the aim of bringing together public health doctors in Northern Ireland to discuss the important issues in public health medicine. If you would like to know more information about the work of this committee please contact Hilary Nesbitt at hnesbitt@bma.org.uk who will be able to provide you with further information.

Devolved administration
Conference representatives will be aware that there is currently no devolved administration in Northern Ireland or ministerial oversight of individual Government Departments. This has been the case since the beginning of 2017 and a resolution has yet to be found. Emergency legislation such as passing of a budget to enable key services to function has had to be taken to Westminster by the Northern Ireland Secretary of State. However, in the absence of an Executive and departmental Ministers, there is no specific mechanism for the implementation of new policies. Much of the work around the transformation of the health service is continuing at civil service level but key decisions that require ministerial and/or Executive approval cannot proceed.

Voluntary sector organisations with a public health and community development role also have uncertain futures as key decisions around grants are also being stalled.

Representatives may also be aware of the topical issue of the border between Northern Ireland and the Republic of Ireland arising from the UK’s intended exit from the European Union and, amongst other things, the potential impact this would have on public health and health care more generally in the future.

Regional Issues
In 2009 there was a restructuring of the Health and Social care sector with the creation of a regional Health and Social Care Board (HSCB) and Public Health Agency (PHA). The HSCB is due to be abolished by 2019/20 and many of its functions will be absorbed into the Department of Health. The PHA will continue largely in its current form with a few changes, such as taking on the social care strategy and advice, and will continue to provide public health services across the three domains of public health. Specialist capacity is currently an issue within the PHA and it carries a significant number of vacancies in health protection and health service, public health in particular.