UK consultants conference 2019

Agenda

To be held on

Wednesday 27 February 2019

At BMA House, London WC1H 9JP

Chair
Dr Stephen Austin

Deputy chair
Dr Anil Jain

Conference agenda committee
Dr Philip Banfield
Mr Simon Barker
Dr Shantanu Datta
Dr Phillip De Warren-Penny
Dr Helen Fidler
Dr Robert Harwood
Dr Kevin O’Kane
Dr Vishal Sharma
Dr Anne Thorpe
Dr Gary Wannan
A brief guide to the 2019 consultants conference

Function of conference
The primary purpose of the consultants conference is to provide policies for the consultants committee (CC) to take forward over the coming year.

Agenda outline
The conference agenda outlines the schedule for the day, with the morning session comprised of motions for debate, a keynote address by the chair of the committee and a guest speaker followed by a Q&A session. The afternoon is comprised of workshops and further debates.

Motions are received from a number of constituent bodies such as medical staff committees (MSCs) regional consultants committees (RCCs) and from the subcommittees of the CC. In addition, motions from other BMA conferences are sometimes transferred to the consultants conference for consideration if they are directly relevant to consultants. The deadline for receipt of motions was 12pm on 18 January 2019.

What is a motion?
A motion is a proposal for action or statement of opinion which, if passed, becomes CC policy.

How are the motions organised?
A number of motions are received each year from our constituent bodies. These are grouped and prioritised for debate by the conference agenda committee. This year a number of key topics were identified for debate and the majority of motions are based around these areas.

In the agenda, each new topic appears in bold with the time allocation alongside. Similar motions on a specific element of that topic are grouped in a bracket (appearing as a thick black line to the left) with only the starred motion being debated and voted on. As such, the starred motion is the only motion that has the potential to become policy. Any constituent is able to speak in a debate although the chair will usually give priority to speakers from constituencies with motions within the bracket. Greyed out motions signify motions that are unlikely to be reached for debate.

You may object to the choice of starred motions either because you do not agree with what the motion is proposing or you feel that another motion within that bracket would be preferable. In such instances, you are able to suggest changes to the bracketing/starring. These must be received by noon on Monday 25 February 2019. In addition, conference can vote to prioritise three further motions for debate. A ballot paper for this purpose is issued with the agenda.

Types of motion
- ‘A’ motions are in line with accepted BMA policy and are therefore not debated.
- ‘P’ motions are motions which are to be given priority. They are debated with a short opening speech from the proposer of the motion and then the debate is opened out to the entire conference with speakers being able to speak for a maximum of one minute each at open microphones positioned around the hall. At the conclusion of the debate, the motion is voted on in the usual manner.
- Topical motions consider issues which have arisen since the deadline for receipt of motions and which could not have reasonably been considered before that date. If you wish to submit a topical motion, the deadline is noon on 26 February 2019.

Revision of the agenda post-publication
Amendments to the motions on the agenda must be submitted to the agenda committee by noon on Monday 25 February 2019. You can do this by emailing info.cc@bma.org.uk.

An updated Supplementary Agenda will be issued on the day of conference. The agenda committee continues in session through conference to help and guide you through the day and to advise and provide the chair with a list of speakers for each debate. Withdrawn motions or minor clarification on the day must be in writing for approval by conference.
How is the debate conducted?

- In order to take part in a debate you will need to complete a speaker’s slip (with the exception of ‘P’ motions – see above). These are provided in the conference packs. You should complete the speaker slip as appropriate; indicating whether you are the proposer, speaking for or against, and if you have any particular expertise in the area of debate.

- Hand in your speaker slips for the motions you would like to speak on to the agenda committee table.

- Please note that filling out a speaker slip does not mean that you are obliged to speak. You may decide not to speak when the time comes and in such cases it is possible to pass when you are called.

- The agenda committee will provide a list of speakers for the chair. The conference chair balances debate by calling speakers both for and against. The proposer speaks up to three minutes whilst other speakers have two minutes. The chair of CC then has the opportunity to respond to the debate.

- The proposer has the right to reply to the debate in up to two minutes. However, no new points may be made in the reply. To help move the debate along, proposers may be asked to waive the right of reply.

(a) Proposing a motion:

- Move to the waiting area near to the podium as your motion’s time approaches in order to minimise delay.

- Try to communicate your point as briefly as possible; the debate is time-limited. It is useful to back your point up with supporting evidence in order to communicate your message as effectively as possible.

- Avoid defamation. We would like to remind all representatives and members of conference that this is a public arena and they are prohibited from making any allegations and/or statements direct or indirect, towards any individual or organisation or any other entity which could give rise to a claim in defamation.

- In the event that any comments made give rise to any such claim or result in damages or any other costs to any third party then the member or representative making the comment will be deemed to take sole responsibility and liability in respect of the consequences.

- Having proposed a motion, listen to and note the debate as you may wish to reply before the vote to the points raised.

- If there are concerns from other speakers about parts of your motion, consider taking your motion ‘as a reference’ to the CC to see if a part of it can be enacted.

(b) Speaking for or against

- If you are called to speak for or against a motion, the chair will call for you to approach the podium.

- You will be given two minutes to speak on the points that the proposer has raised, or the motion as a whole.

- Debate ends when time runs out or a call of ‘vote be taken’, or ‘to pass to next business’ is agreed.

- A vote is taken on the motion, normally by a show of hands or voting cards. Motions that have more than one part may be voted on separately.

- The chair may order that a count be made. The chair has a casting vote if necessary.

- Most decisions are made upon a simple majority. Some motions however required a two-thirds majority such as: ‘rescinding a resolution of conference’, ‘proceed to the next business’, ‘vote be taken’, ‘Standing Orders be suspended’, or if substantial expenditure of the Association’s funds be incurred.

- The chair can rule that if a motion is carried linked subsequent motions are either covered or fall.

After motions have been passed, they are referred to the CC for consideration and action. Some can also be referred to the BMA’s annual representative meeting for further debate.

New attendees

Before the start of the conference, there will be an introductory session for new representatives to outline the format of the day, set out how the conference works and to answer any questions.
Notes
Under standing order 7, in this agenda are printed all notices of motions for the annual conference received up to noon on 18 January 2019. Although 18 January was the last date for receipt of motions, any RCC, MSC or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the secretariat by noon on Monday 25 February 2019 prior to the conference (info.cc@bma.org.uk).

The agenda committee has acted in accordance with standing order 17 to prepare the agenda, grouping together motions or amendments, which cover substantially the same ground and marking with an asterisk in the agenda, or forming a composite motion or amendment, on which it proposes that discussion should take place.

The committee has identified the most important topics in the agenda and selected for priority in debate an appropriate number of motions or amendments on those topics that it deems to be of outstanding importance. Representatives are also able to indicate motions (other than those already scheduled to be discussed) which they would like to see given preference for debate during the meeting. Ballots for chosen motions will be included in your delegate pack on the day. The ballot closes at 11am on Wednesday 27 February.
# Schedule of business

**Wednesday 27 February 2019**

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1. **Return of representatives**
   Return of members attending the conference (CAC 19, to be tabled).

2. **Minutes**
   Minutes of the last conference held on 28 February 2018 (CAC 20, enclosed herewith).

3. **Report of the agenda committee**
   i. That the agenda committee is charged under standing order 17 with recommending the order of the agenda and selecting for priority in debate an appropriate number of motions or amendments on those topics which it deems to be of outstanding importance;
   ii. That in accordance with standing orders 16 and 17, the conference agenda committee, having considered those resolutions due to lapse as policy, recommends the following continue to be policy (CAC 21, herewith).

4. **Report by acting chair of consultants committee**
   Report from Dr Gary Wannan, acting chair of consultants committee

5. **Healthcare policy and commissioning**
   10.00–10.05

   **H1053** Motion BY SCOTTISH consultants committee This conference calls on the Scottish Government to ensure that the implementation of its new healthcare waiting times improvement plan does not distort clinical priorities or disadvantage patients awaiting review appointments.

6. **H1062** Motion BY NORTHERN IRELAND consultants committee That this conference calls on the Secretary of State for Northern Ireland, Karen Bradley, in the absence of a Health Minister, to prioritise health and particularly transformation and take the key decisions needed to progress the actions set out in Health and Wellbeing 2026.

7. **H1035** Motion BY NORTH WEST RCC That this conference supports many of the ambitions contained within the NHS Long Term Plan and asks the BMA to continue to press for an adequate funding settlement without which those ambitions will remain largely unachievable.

8. **H1005** Motion BY NORTH WEST LONDON RCC That this conference is pleased to see that the NHS Long Term Plan proposes ditching the mandatory competition and tendering of services that was introduced in the Health & Social Care Act 2012, as the BMA has consistently called for, but notes that much of the plan is aspirational rather than realistic; for example, preventing 150,000 heart attacks, strokes and dementia cases.

9. **H1034** Motion BY NORTH WEST RCC That this conference is encouraged by the Secretary of State for Health and Social Care’s commitment to improving the information infrastructure of the NHS but wishes to remind him that Information Technology is not magic and requires significant investment.

10. **H1036** Motion BY NORTH WEST RCC That this conference has a long history of failing to have confidence in the Secretary of State for Health (and of late, Social Care). Matt Hancock has so far done nothing which suggests he will escape that fate.
**Agenda**

### Workforce

11 H1013 Motion **BY LONDON SOUTH RCC.** This meeting calls upon BMA council to lobby that, for the purposes of immigration, all doctors should be placed on the equivalent of the ‘Shortage Occupations List’ in the event of the UK’s leaving the European Union.

12 H1040 Motion **BY NORTH WEST RCC.** That this conference believes that the health surcharge imposed on doctors arriving from non-EU countries is having a deleterious effect on recruitment. It asks the BMA to find a solution by working with NHS Employers and other stakeholders, that will remove this burden from staff who are urgently needed to address the crisis in medical recruitment and retention.

13 H1041 Motion **BY NORTH WEST RCC.** That this conference urges the BMA to demand that the Departments of Health and the GMC make a more concerted effort to retain senior doctors in the NHS.

14 H1055 Motion **BY NORTHERN IRELAND consultants committee.** That this conference calls on the Department of Health, Northern Ireland to implement the recommendations of the medical workforce plans by speciality and to appoint the appropriate number of consultants needed to provide quality patient care.

15 H1006 Motion **BY NORTH WEST LONDON RCC.** That this conference believes that no amount of apps and digital technology can compensate for the massive shortage of staff in the NHS.

16 H1007 Motion **BY NORTH WEST LONDON RCC.** That this conference believes that the government’s stated intention of training more doctors to be ‘generalists’ and fewer to be ‘specialists’ is contrary to the direction of travel in a world where knowledge is increasing exponentially. A combination of adequately resourced primary care and systems that support collaboration between specialists within secondary care will provide the best outcomes for patients.

### Wellbeing

17 H1038 Motion **BY NORTH WEST RCC.** That this conference notes that there is a surfeit of evidence that the mental health and well-being of doctors is being undermined by the pressures of professional practice. It welcomes the evidence that the Association and others have already gathered, but now insists that this is translated into a systematic, tangible plan of action, by taking a lead on the coordinated engagement of all relevant stakeholders.

18 H1043 Motion **from specialty lead for emergency medicine:**

NHS consultants are working harder than ever before to deliver safe and high-quality emergency care in a system that is being pushed to breaking point by a combination of rising demand and inadequate funding from the government. This conference:

i. recognizes that this is unsustainable and that ‘burnout’ and ill-health are inevitable consequences of working under this pressure

ii. calls on the BMA to demand that the government take seriously the need for future consultant working patterns to be sustainable and contain safeguards to ensure the wellbeing of consultants

iii. insists that any new consultant contract must contain safeguards that adequately protect all consultants from working excessive antisocial hours

iv. insists that any new consultant contract ensures that those consultants who work the most antisocial hours receive enhanced time in which to rest and recuperate.
Motion from specialty lead for emergency medicine:

Consultants in emergency medicine suffer higher rates of ‘clinical burnout’ than any other specialty. In addition to our moral obligation to address this, the NHS cannot afford to lose these hugely valuable assets from an emergency care system that is stretched to breaking point. This conference:

i. calls for the BMA to increase its work in highlighting the issue of burnout and in promoting wellbeing in the consultant workforce
ii. insists that any future consultant contract is consistent with the need for flexibility in the proportion of DCC to SPA over the span of a career
iii. insists that any future consultant contract supports paid sabbaticals periodically throughout a career

Motion BY WELSH consultants committee This conference expresses concern that insufficient progress appears to have been made in enhancing the provision of occupational health services for NHS Wales staff since the publication in 2012 of the recommendations of a review undertaken by Professor Sir Mansel Aylward on behalf of the Welsh Government, and in particular expresses concern at the on-going lack of occupational health consultants in Wales.

This conference therefore calls on the Welsh Government, Welsh NHS employers and Health Education and Improvement Wales (HEIW) to look at undertaking specific initiatives to tackle such recruitment difficulties and to increase the number of training places in Wales for occupational health consultants.

Mental health

Motion BY AGENDA COMMITTEE (OXFORD RCC PROPOSING)

That this conference calls upon the Department of Health and Social Care to commit to:

i. increasing mental health funding incrementally over the period of the 10 Year Plan to reach a minimum of 25% of overall budget in line with mental health treatment need and activity levels.

ii. parity of resource, access, and outcome for mental and physical health services rather than esteem.

iii. Requiring those commissioning local services to allocate adequate, ring fenced funds for mental health promotion and prevention in line with the 10 year plan

Motion BY OXFORD RCC That this conference calls upon the department of health and social care to commit to increasing mental health funding incrementally over the period of the 10 year plan to reach a minimum of 25% of overall budget in line with mental health treatment need and activity levels.

Motion BY OXFORD RCC That this conference calls upon the department of health and social care to commit to parity of resource, access, and outcome for mental and physical health services rather than esteem.

Motion BY OXFORD RCC That this conference calls upon those commissioning local services to allocate adequate, ring fenced funds for mental health promotion and prevention in line with the 10 year plan.

Motion BY NORTHERN IRELAND consultants committee That this conference recognises the unacceptably high suicide rate in Northern Ireland, with more people having died by suicide since the Good Friday Agreement 1998 than the total number of lives lost due to the Troubles and calls on the government to fund mental health services and other stakeholders adequately, in order to address this.
### Quality and patient safety

**Motion** BY WELSH consultants committee

This conference notes:

i. the introduction in 2016 of Freedom to Speak Up Guardians within the NHS in England following a review undertaken in 2015 by Sir Robert Francis which advised on the need to create an appropriate culture so that raising concerns becomes part of normal routine business and that staff feel able to do so in a culture that is free from bullying and other oppressive behaviours.

ii. that the role of Freedom to Speak Guardian has not so far been introduced within the NHS in Wales.

Recognising the importance of facilitating NHS staff to feel safe in raising concerns, and to have greater confidence that their concerns will be listened to and acted upon, this conference calls on the Welsh Government and Welsh NHS employers to introduce a similar role of Freedom to Speak Guardian within the NHS in Wales.

**Motion** BY WELSH consultants committee

This conference notes with concern the publication in October 2018 of a report by the Wales Audit Office (WAO) entitled ‘Management of follow up outpatients across Wales’ which showed that, since a previous report published in 2015, there had been:

i. a substantial (12%) increase in the overall number of patients across Wales on outpatient follow-up waiting lists from 941,000 to 1,059,000

ii. a substantial (55%) increase in the number of patients across Wales whose follow-up appointment had been delayed from 240,108 to 376,229

This conference therefore calls on the Welsh Government and Welsh NHS organisations to prioritise whatever actions is necessary at both national and local level, including by actioning the recommendations put forward by the WAO, in order to address this unacceptable and worsening situation.

### Regulation

**Motion** BY SCOTTISH consultants committee

This conference recognises that the revalidation burden remains significant and there is a lack of evidence to support its efficacy and calls for the revalidation cycle to be extended to 10 years.

**Motion** BY NORTHERN IRELAND consultants committee

That this conference recognises that current service design does not always incorporate enough time to ensure adequate informed consent and calls on the GMC to consider this upon review of current consent guidance.
Education and training

11.40 – 11.45

31 H1046 Motion BY LONDON NORTH EAST RCC That this conference
Motion from Northeast London RCC:

The vast majority of post mortems (PMs) are performed in England and Wales under the jurisdiction of Her Majesty's Coroner. The Coroner PM examination and the storage of tissue removed during PM examination do not require consent from the family of the deceased. However once the coroners authority has ended, consent is required from the deceased relatives to retain the slides and tissue. In practice this results in most histology slides and paraffin blocks of tissue taken at Coroners PMs are disposed of and are lost for teaching, educational and audit purposes. This conference
i. Believes this a loss to medical education and maintaining good medical practice.
ii. Asks the BMA to discuss with the Royal Colleges, Coroners Society and other stakeholders the need to change the rules.
iii. Asks the BMA to lobby for a change in the Human Tissue Act and Coroner Rules in England and Wales to facilitate retention of the histology slides and paraffin blocks taken at Coroner's autopsy for teaching, education and audit without the need of deceased relatives' consent.

32 H1059 Motion BY NORTHERN IRELAND consultants committee That this conference recognises that reduced elective activity has an extremely detrimental effect on training and the upkeep of surgical skills and impacts negatively on patients and our ability to retain experienced clinicians, as elective care is sacrificed in order to meet acute needs. This conference calls on the BMA to lobby the Department of Health, Northern Ireland to urgently address this.

33 H1030 Motion BY NORTH WEST RCC That this conference recognises the long and appropriate gap between medical student recruitment and the certification of fully trained consultants. However, it does not believe that dumbing down clinical roles is the solution to staff shortages. We call on the BMA to lobby for mandatory, transparent identification of all healthcare workers' roles and qualifications.

34 H1063 Motion BY NORTHERN IRELAND consultants committee That this conference recognises the benefits of study leave to enable consultants to remain up to date on best practice and support them in delivering the best high quality, evidence-based care. We call upon the Department of Health and the employing Trusts to look at funding for study leave, which has frozen - while the cost of accommodation, travel and conferences has increased. It is important that consultants in Northern Ireland have access to the same high-quality educational opportunities as their colleagues in the rest of the UK.

35 H1025 Motion BY SOUTHERN RCC That this conference notes that the Westminster government has mandated that resuscitation training shall be a part of the national curriculum in schools in England and
a. Congratulates the Westminster government on that decision;
b. Urges the government to immediately implement other parts of BMA policy, namely that teaching about simple medical conditions and appropriate use of medicines (including antibiotics) be part of the national curriculum.
**Pensions**

**Motion** BY CONFERENCE AGENDA COMMITTEE (NORTHERN RCC TO PROPOSE).

That this conference notes the significant numbers of consultants who are subject to both the lifetime and complex annual allowance tax charges and calculations with the resultant damaging effect on the retention of NHS consultants noting that many consultants are no longer taking on additional work due to punitive effective rates of taxation and therefore demands that:

i. the NHS Business Authority should routinely issue pension statements relating to pension growth and potential annual allowance charges on an annual basis to all doctors.

ii. the BMA should lobby HMRC, DHSC and the Treasury (and the respective departments within the devolved Nations) to alter the annual allowance calculation so that high earning public sector workers are not subjected to excessive rates of taxation.

iii. all NHS employers should pay the employers pension contributions to employees who have opted out of the NHS pension scheme due to annual allowance or lifetime allowance tax charges, as part of the ‘Total Reward Package’

iv. the BMA note the successful legal action by judges and fire fighters against some of the deleterious changes to their pensions;

v. the BMA fully support, including with any external legal or analytical support required, the consultants committee in mounting such legal action as is determined by the consultants committee to be necessary against deleterious changes to consultants’ pensions.

**Motion** BY NORTH WEST LONDON RCC. That this conference:

welcomes the publication of the BMA survey that showed that the current tax regime for annual allowance:

i. presents a huge disincentive for consultants to work even a 40 hour week

ii. pushes them into retiring earlier than they otherwise would

We urge the government to recognise how damaging this tax regime is to the NHS, especially in view of the desperate national shortage of medical staff, and to take urgent corrective action.

**Motion** BY NORTHERN IRELAND consultants committee. That this conference notes the damaging effect that the pension annual and lifetime allowance changes are having on retention of senior consultants in Northern Ireland, and calls on Department of Health, Northern Ireland, Department of Finance and HMRC to consider a range of options to ameliorate this to the benefit of the health service.

**Motion** BY NORTHERN RCC. That this conference notes the significant numbers of consultants who are subject to both the lifetime and annual allowance tax charges. We are dismayed by the complex nature of the annual allowance tax calculation in particular. We note that many Consultants are no longer taking on additional work due to punitive effective rates of taxation. We demand:

i. That the NHS Business Authority should routinely issue pension statements relating to pension growth and potential annual allowance charges on an annual basis to all doctors.

ii. That the BMA should lobby HMRC, DHSC and the treasury to alter the annual allowance calculation so that high earning public sector workers are not subjected to excessive rates of taxation.

iii. That all NHS employers should pay the employers pension contributions to employees who have opted out of the NHS pension scheme due to annual allowance or lifetime allowance tax charges.
40 H1024 Motion BY SOUTHERN RCC. That this conference:

a. Believes that the reduction in benefit from, increased employee contribution to, and punitive annual and lifetime tax allowances are unfair and unjustified;
b. Believe pension issues are a major reason for current and future reduction in work by, and early retirement of, consultants;
c. Calls on the Westminster government to significantly improve the pension and taxation situation of NHS staff;
d. Notes the successful legal action by judges and fire fighters against some of the deleterious changes to their pensions;
e. Calls on the BMA to fully support, including with any external legal or analytical support required, the consultants committee in mounting such legal action as is determined by the consultants committee to be necessary against deleterious changes to consultants’ pensions.

41 H1045 Motion BY LONDON NORTH EAST RCC. That this conference

Motion from Northeast London RCC:

NHS consultants who are working harder than ever before to support an inadequately resourced health service, whilst suffering a 25-30% real-terms pay cut over the last 10 years are now being faced with changes to taxation and pension made by the government which mean that increasing work above a certain number of hours does not result in ANY more take-home pay. This is driving many consultants into early retirement or less than full time working in order to avoid doing unpaid work. This conference:

i. Deplores the changes made by the government to taxation and pensions which have resulted in the ludicrous situation of doctors doing work that is effectively unpaid

ii. Asks the BMA to demand that the government makes changes to taxation and pensions so that doctors are no longer faced with doing unpaid work in the NHS

iii. Asks the BMA to demand that the government produces a strategy to mitigate the evolving consultant work force crisis driven by their ill-considered changes to taxation and pensions

42 H1022 Motion BY SOUTH WEST RCC. That this conference requires the BMA to develop a fit for purpose pensions calculator to allow members to assess their potential liabilities with respect to the annual allowance charge. Should this fail to have been done by the 2019 ARM then the reasons why must be given to CC.

43 H1031 Motion BY NORTH WEST RCC. That this conference condemns the proposed significant increase in employers’ pension contributions and asks the BMA to oppose the inevitable impact on NHS funding.

Keynote speaker – Professor Michael West: 12.05–12.30
Compassionate and Collective Leadership for High Quality Care Cultures.

Speaker Q&A 12.30–12.45

Lunch 12.45–13.30

Workshop sessions 13.30–14.20

Workshop sessions 14.20–15.10

Pay 15.10–15.30
44 H1048  **Motion** BY SCOTTISH consultants committee. This conference deplores the deliberate degradation of UK doctors remuneration by 30% in real terms take home pay over past decade and calls for the governments across the UK to address this urgently.

45 H1033  **Motion** BY NORTH WEST RCC. That this conference is appalled by the significant erosion of consultant salaries – via pay freezes, uncompensated inflation and pension changes – over the last 10 years. It calls on the BMA to actively publicise this fact to its relevant members and the general public.

46 H1008  **Motion** BY NORTH WEST LONDON RCC. That this conference is outraged by the paltry pay award of 2018, which, for consultants, was the lowest in the public sector. This will impede recruitment and retention at a time when a shortage medical staff is already severe and is likely to be further adversely affected by Brexit.

47 H1010  **Motion** BY LONDON SOUTH RCC. This meeting calls for hospital consultants to formally pull out of the Doctors’ & Dentists’ Review Body mechanism.

48 H1054  **Motion** BY NORTHERN IRELAND consultants committee. That this conference deplores the fact that consultants in Northern Ireland are still waiting for the implementation of the DDRB recommendations for 2018-19 and we believe that this is contributing to the recruitment and retention issues in Northern Ireland. We call on the Department of Health, Northern Ireland, to ensure consultants in Northern Ireland are treated equitably compared to consultants in the rest of the United Kingdom.

49 H1049  **Motion** BY SCOTTISH consultants committee. Scotland has a worsening exodus of frontline consultant medical staff due to declining remuneration, increasing workload and a sense of being devalued. This conference
   a. deplores Scottish Government’s 2018 real terms pay cut for consultants
   b. regrets the breach of trust by Scottish Government in its failure to implement even the modest recommendations of the DDRB in 2018 for the second year running
   c. calls upon the Scottish Government to restore pay and conditions for its frontline consultant staff or be honest with the public about the consequences.

50 H1009  **Motion** BY LONDON SOUTH RCC. This meeting calls upon BMA Council to convene a Special Representative Meeting in 2019 to address doctors’ pay and pensions.

51 H1021  **Motion** BY OXFORD RCC. That this conference calls upon the BMA to only enter into negotiations that consider pay agreements directly alongside pension taxation and contribution arrangements to put an end to the current practice of stealth reductions.

52 H1014  **Motion** BY LONDON SOUTH RCC. This meeting notes that consultants have suffered from more than a decade of pay attrition and that five years of contract negotiations and on-going engagement with the DDRB has not improved the situation and been treated with derision. Consequently, this meeting calls upon the National Consultants’ Committee to immediately:
   i. Formally withdraw from the DDRB mechanism
   ii. Terminate national consultant contract negotiations

   And, in the event of there being no formal and binding commitment by the Government to correct our 15 years of pay attrition by June 1st, to:
   iii. Ballot consultants on industrial action on consultants’ remuneration.

53 H1047  **Motion** BY CC ANAESTHETICS SPECIALTY. That this conference is appalled by the high marginal taxation rates which many senior consultants experience. It calls on the BMA to actively publicise this fact to its members, in order that they can improve their work-life balance and avoid onerous and poorly rewarded job plans.
Terms and conditions of service

15.30–16.00

54 1064 **Motion** BY AGENDA COMMITTEE (NORTHERN IRELAND CONSULTANTS COMMITTEE PROPOSING)
That this conference notes the positive impact that flexibility and annualization can have on work-life balance but demands that:

i. Consultants using annualised job plans must be protected to prevent short notice alterations to regular commitments not specifically agreed by the consultant.

ii. The BMA ensures that LNCs have robust policies in place to prevent short notice alterations to regular commitments occurring.

55 H1056 **Motion** BY NORTHERN IRELAND consultants committee. That this conference notes the positive impact that flexibility and annualization can have on work-life balance but deplores their use to effectively create zero hours contracts in certain specialties and calls on the BMA to ensure that LNCs have robust policies in place to prevent this.

56 H1017 **Motion** BY SOUTH WEST RCC. Consultants using annualised job plans must be protected to prevent short notice alterations to regular commitments not specifically agreed by the consultant.

57 H1027 **Motion** BY NORTH WEST RCC. That this conference demands that the BMA produces clearer guidance as to what work constitutes Supporting Professional Activities within job planning.

58 H1029 **Motion** BY NORTH WEST RCC. That this conference believes wholeheartedly in nationally recognised terms, conditions and medical job titles. It condemns the use of confusing and arbitrary terms like ‘associate consultant’ and calls on the BMA to lobby against posts without national recognition.

59 H1052 **Motion** BY SCOTTISH consultants committee. This conference calls on all 4 nation’s departments of health to recognise their obligation to provide safe parking or taxis for their staff to get to/from work:

a. when their hours frequently but unpredictably extend beyond the working day or
b. involve transit during hours where there is no appropriate public transport option or

60 H1011 **Motion** BY LONDON SOUTH RCC. This meeting recognises that five years of national negotiations on consultant contracts have failed to produce any progress on consultants’ pay and calls for our immediate formal withdrawal from further negotiations.

61 H1032 **Motion** BY NORTH WEST RCC. That this conference believes in the central role of job planning for our members and condemns any managerial pressure to reduce consultants’ pay via this avenue. It congratulates the BMA on the development of its Dr Diary job planning app and encourages consultants to make use of it to defend their position as pivotal providers of secondary and tertiary care.
BMA structure and function

62 H1042 Motion BY NORTH WEST RCC. That this conference regrets that there are no national minimum standards for facilities time and remuneration for LNC chairs and members. It therefore asks the BMA to work in conjunction with NHS Employers and other stakeholders to produce suitable guidance that can be disseminated to organisations and their LNCs.

63 H1028 Motion BY NORTH WEST RCC. That this conference understands that hospital mergers can increase the workload of their LNCs to a large extent. It calls upon the BMA to review the terms of reference for the annual LNC conference, enabling proportional representation.

64 H1026 Motion BY SOUTHERN RCC. In order to encourage engagement of senior medical staff at a local level this conference calls on the BMA to:
   a. Review the boundaries of all regional committees
   b. Revise the boundaries of regional craft committees so that each committee falls within a single regional council area
   c. Investigate the practicality of changing regional consultants committee boundaries where they differ from LNC Fora boundaries to facilitate co-location of meetings
   d. Report back to all relevant national committees within 12 months with the review results and proposed changes.

Chosen motions

'A' motions

65 H1000 Motion BY WELSH consultants committee Whilst regretting that, once again, the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) recommended a below-inflation pay rise for consultants for 2018-19, this conference nonetheless expresses its thanks to the Welsh Government for at least implementing the DDRB’s recommendations in full for doctors in Wales, including by back-dating the pay rise to the start of the 2018-19 financial year.

66 H1037 Motion BY NORTH WEST RCC. That this conference believes that the burden of bureaucracy imposed upon doctors is unacceptable and detrimental to clinical care in the United Kingdom. It asks the BMA to systematically address the problem by gathering evidence, highlighting its impact on doctors’ professional lives, and working with key stakeholders to develop a systematic action plan to reverse this alarming trend.

67 H1039 Motion BY NORTH WEST RCC. That this conference commends the work of the BMA’s Policy secretariat on mental health and urges the Association to continue to give it all necessary support and resource.

68 H1051 Motion BY SCOTTISH consultants committee. This conference believes that no fault compensation has not been given a full evaluation in the UK and calls for a pilot scheme to be set up.

Any other business

Close
Appendix I

Consultants conference 2018
Resolutions passed

5  H1125 Motion BY CONFERENCE AGENDA COMMITTEE. That this conference recognises that the NHS ‘winter crisis’ is predictable and is precipitated by underfunding and understaffing and calls upon government to:

i. recognise and apologise for the lack of planning for the current crisis which has led to cancellation of tens of thousands of operations

ii. cease wilfully misrepresenting data on the NHS

iii. put in place proper annual plans for future seasonal variations in health and social care demand in order to avoid the drastic measures of cancelling elective operations

iv. provide an immediate cash injection and subsequently fund the NHS to the European average spend per capita.

In December we undertook work to analyse this issue. Our analysis suggests hospital emergency care departments in England are on course for their worst winter on record and that up to 10,000 additional hospital beds will be needed for patients to be cared for safely.

The analysis also shows that over 300,000 patients could be left waiting on hospital trolleys in emergency care departments for more than four hours before being admitted.

The new figures build on a recent BMA analysis of NHS England data from the past seven years. This painted a picture of rising pressure on emergency care departments, with the most recent winter showing record levels of admissions. 200,000 more patients were left stranded on hospital trolleys in emergency care departments than in the same period in 2011 while new lows were registered for other key indicators, such as the four hour wait to be seen on arrival.

By analysing bed occupancy rates and trends from previous winters, the BMA has produced a likely picture for January to March 2019 and predictions on how many beds the NHS in England needs. This analysis suggests:

Bed demand: 10,000 extra beds needed

Last winter, bed occupancy in general and acute beds peaked at 96.1% in February 2018, despite guidance from the National Audit Office suggesting occupancy should not exceed 85% to avoid impacting on the quality of care. NHS Improvement has said that above 92%, the deterioration in emergency care standards begins to accelerate.

High bed occupancy leads to issues across all hospital departments and is often a decisive factor in the decision to cancel planned operations (for example last winter, which saw tens of thousands of operations cancelled with little warning). It can also delay patients moving from the emergency department to a ward. On the 20th February 2018, over 5,000 general and acute escalation beds were open in English hospitals. These figures are contained in NHS England’s Winter Data report for winter 2017/18.

To even maintain occupancy at this high rate, the NHS had to open between four and five thousand temporary escalation beds from January to March.

To bring bed occupancy down to the recommended minimum safe limit of 92%, the NHS in England this winter will need to continue using 5,000 escalation beds opened at the peak of the winter crisis last year and will need an additional 5,000 general and acute beds.

Hospitals in busy areas have the greatest need – with London requiring as many as 900 extra beds this winter. Regional figures are included in the briefing papers attached.
Predictions for the winter: Pressure on emergency care
Without extra resources, the BMA believes approximately 238,000 patients will spend more than four hours waiting to be admitted to hospital, 12,000 higher than the record from the previous winter; if conditions deteriorate more dramatically, a staggering 305,000 could endure long waits on trolleys. The percentage of patients seen, admitted or discharged within four hours of visiting an emergency department will reach record lows, with compliance falling to somewhere between 84.3 per cent and 82.5 per cent, down from the previous low of 85 per cent. The Government target is 95%.
We have called on the government to address these endemic resourcing issues.

Motion BY NORTH WEST RCC. That this conference rejects the precept behind policies such as ‘Procedures of Low Clinical Value’ as currently deployed by commissioners. This conference believes that such policies serve no purpose other than to ration demand for popular surgical interventions, and sit in direct conflict with Good Medical Practice.

It asks the BMA to confirm that such policies need not be recognized or executed by clinicians in the course of their direct clinical or supportive professional practice and that it will support members who may have been sanctioned by doing so.

CC responded jointly with GPC to NHS England’s consultation on procedures of low clinical value and evidences based interventions. In that response we clearly underlined our position, setting out that:
As established in our consultation response, the BMA is open to the concept of a set of national criteria for treatment provision, with the goal of eliminating the post-code lottery and ensuring equitable access to care for all patients.

However, we continue to have serious misgivings regarding the EBI proposals and what they could mean for both patients and doctors.

The impact of the proposed reforms on primary to secondary care referrals remains a major concern. The ability to refer patients to a specialist for an opinion on their care is crucial to GPs, in respect not only of their own medicolegal and GMC duties, but also the right of a patient to receive a second opinion when it is in their best interest. Despite its importance, this issue appears to have been overlooked in both the consultation and the overall proposals, which primarily focus on referral to treatment, rather than referral for clinical opinion.

The option to seek a specialist opinion is incredibly important for both patients and doctors, therefore, it is essential that it remains open regardless of new criteria for the specific interventions. NHS England should provide assurances that this form of referral will remain available following any implementation of the proposals, as well as issue guidance to CCGs and those managing IFR or prior approval processes.
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:

i. The BMA opposes any further privatisation of services through the introduction of ACOs.

ii. 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.

iii. The Health Secretary issues a directive to ACOs to engage front line clinicians, including consultants and GPs, in designing patient-focussed care.

iv. The BMA oppose the introduction of ACOs unless legally ring-fenced from privatisation.

The BMA is supportive of the principle of integrating health and social care services, and we have called for greater integration and collaboration between different parts of the health service and social care for several years. This includes our longstanding opposition to the internal market within the NHS in England and to the Health and Social Care Act 2012, which limits co-operation between NHS providers and commissioners.

However, we do not believe that NHS England’s current proposals for a new ACO contract are a viable means of delivering integrated care for patients in the context of a procurement framework that requires such contracts to be put out to competitive tender. We have several concerns regarding ACOs, including the lack of clarity and accountability surrounding their development thus far, the risk of privatisation they present, whether the Government will provide the level of NHS funding and investment required for them to work, and how they will ensure services are based on a foundation of strong primary care.

We believe that integration can be achieved within existing contractual and organisational frameworks, but existing barriers must be addressed. We have consistently raised concerns about the fragmentation of NHS services and have opposed the current purchaser provider split and competition framework, which undermine collaboration. If these issues were remedied, it is possible that a less formal system of collaboration, without widespread contractual change, could be developed to enable meaningful change.

The BMA has produced a briefing for members on what BMA members can do and where to access further guidance and support.

This conference

i. acknowledges the value to patients of drawing high quality non-medical graduates into the NHS,

ii. believes that training of Physician’s Associates must not reduce the training available to junior doctors.

iii. asks the BMA to work closely with the relevant Royal Colleges, educational institutions and regulatory bodies to ensure that Physicians Associates and similar roles support doctors.

Shared with ARM

The president and chair of professional standards sub-committee from the faculty of Physician Associates at the Royal College of Physicians has attended the Executive subcommittee of CC meeting to discuss this issue.

We are also liaising closely with SASC and JDC in respect of their position regarding Physician’s Associates.

This conference recognises the success of the junior doctors committee Less Than Full Time Forum and asks that a similar initiative be considered for Less Than Full Time Consultants.

Funding for the consultants LTFT forum has been considered and agreed by the Association. In discussion with the wider Association we have agreed to include membership from SAS and Medical Academic doctors who face many of the same LTFT issues which consultants need support in dealing with.
Motion BY SCOTTISH consultants committee. This conference regrets the failure of the Scottish Government to act meaningfully to address the consultant vacancy crisis in Scottish hospitals and calls upon the Scottish Government to return to valuing its doctors.

The vacancy rate among hospital consultants in Scotland is twice as high as official figures show, an analysis by doctors' leaders has found.

While official NHS workforce figures record an already high vacancy rate of 6.8%, data obtained by the BMA's Scottish consultants committee under a freedom of information request to the country's health boards showed an actual rate of 13.9%.

The anomaly is explained by the exclusion of certain types of vacancies from official figures, said the committee. Vacancies that have not been filled through a recruitment process or have not yet been cleared for recruitment can be removed temporarily from published figures.

The freedom of information request to the health boards showed 173.9 vacant posts at the end of September that were not under active recruitment and not included in official statistics. Most of these are likely to be hard posts to fill, where attempts to recruit have not been successful.

In addition, the official figures do not fully reflect the reliance on locum doctors to cover vacant consultant posts. Although this provides a temporary fix, it is not a sustainable solution, and the committee wants these posts to be included in the data on vacancies to improve workforce planning. In total, the committee said that 375 full time vacancies are not being recorded in the official figures, representing enough doctors to staff a large hospital.

The committee chair, Simon Barker, said, 'Our members often tell us that the published consultant vacancy figures don't reflect the reality of the huge challenges of working on the front line of Scotland's NHS. The new data from our freedom of information [request] suggests they are absolutely right to feel that way.'

He said that the extent of consultant vacancies is putting doctors under pressure. 'We risk burnout and stretching people beyond their limits. Inevitably, this leads to more people leaving the profession early and the high standard of care for patients that we all strive for not being achieved.'

Motion BY CONFERENCE AGENDA COMMITTEE. That this conference believes that most errors in medical practice ultimately are due to failures in the complex systems of healthcare itself and therefore calls for:

i. government to stop blaming doctors for error resulting from system failures

ii. government to support the no blame culture required to ensure that all errors are raised to allow systems to be changed to improve safety for patients.

iii. establishment of anonymous reporting systems for concerns about patient safety

iv. appointment of Freedom to Speak Up Guardians as recommended in the Francis Report.

i, ii) Through its submissions and oral evidence to the Williams rapid review of gross negligence manslaughter (GNM) and the GMC’s independent review of GNM and culpable homicide, along with its submission to the Health Select Committee’s evidence session on patient safety in relation to GNM and professional regulation, the BMA has made clear its views on the impact of system pressures and the need for an open and learning culture. The BMA’s support for a learning culture and the ending of the current blame culture in the health service form a key part of the BMA’s Caring Supportive Collaborative project.

iii) A number of reporting systems exist within the health service which have been added to through the development of the GMC’s Regional Liaison Service to include acting on anonymous information provided by doctors to investigate concerns.

iv) Freedom to Speak Up Guardians have been appointed since their introduction in 2016, with more than 500 now in place. The BMA supported activities at local level in Speak Up Month in October 2018 to raise awareness of the guardians. In its policy report on bullying and harassment it also highlighted the potentially valuable role they can play, and guidance on how they should be appointed and the support they need to be effective in post.
54  H1100  Motion BY NORTHERN IRELAND consultants committee. That this conference believes that the BMA must take a bigger role in patient safety and provide leadership in this vital area as a champion of patient safety.

The BMA has a steady stream of work in 2018/19 which draws attention to the increasingly severe pressure that the NHS is under. In addition to monthly analysis of NHS England data to highlight pressures, the health policy team has published several sets of projections indicating likely levels of demand during this coming winter and calling for action from the Government to address the strains placed on the NHS.

More recently, the BMA highlighted the bed crisis in the NHS, calling for 5,000 more beds for the winter of 2018/19 in England, as well as a long-term bed strategy in order to again achieve an 85% occupancy figure in England.

The analysis was picked up by a large number of media outlets including the Telegraph, Guardian, Independent, Daily Express, Press Association, as well as online regional publications such as Devon Live, ITV, Sky News, across all heart regional radio stations, LBC radio, Talk Radio, BBC South West, BBC Radio Devon, Lincs FM, Birmingham Mail, the York Press and the Yorkshire Post.

The BMA has been clear in its calls to government that the current environment doctors work in is not safe and that adequate resources are needed for the NHS to cope with rising demand. This was presented in our submissions to government ahead of the 2018 UK budget and our response to NHS England’s consultation on their long-term plan.

The BMA contributed to securing an additional £20 billion for the NHS in England (a funding uplift of 3.4%), which is a step forward, but falls short of the 4% real terms funding uplift independent bodies have identified as the basic increase necessary to meet the core needs of patients. We are now calling on the government to invest further resources into the NHS and to ensure the funding uplift is applied not just to NHS England’s budget, but the overall health budget, including areas such as public health, education and training and capital investment.

56  H1128  Motion BY CONFERENCE AGENDA COMMITTEE. That this conference notes that recent high profile cases highlight that doctors can be held personally responsible for system failures and face multiple jeopardy in terms of legal proceedings and

i. insists that individual doctors must not be held accountable for systems failures carried as a reference

ii. believes there must be a genuine ‘no blame culture’ carried

iii. insists that when there are systems failures, legal proceedings should not be considered against doctors carried as a reference

iv. calls on Council to demand creation of an urgent task and finish group with the, BMA, the Academy of the Royal Colleges, the Department of Health and the GMC to consider the future of professional regulation. Carried as a reference

The case of Dr Bawa-Garba sent shockwaves through the medical profession, raising questions about support for doctors working in a system under pressure, the actions of the GMC and the prosecution of healthcare professionals under the criminal offence of gross negligence manslaughter. Following the Bawa-Garba decision the consultants committee introduced guidance for consultant doctors working in a system under pressure which outlined their rights, duties and obligations to themselves, their colleagues, and their patients when working a system under severe pressure.

The Association more widely has produced a wide range of resources to support members, and created an internal working group to lead on our range of work in this area: https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/the-case-of-dr-bawa-garba
Motion BY MERSEY RCC. That this conference notes a trend of increasing requirements for evidence to be available for electronically driven appraisals. The production of such evidence consumes vast amounts of time, that may be better used for patient care. This conference:

i. Demands that the GMC produces objective evidence that appraisal and revalidation have resulted in improvements in clinical practice sufficient to justify the expense, time pressure, stress and loss of practising doctors that it causes.

ii. If there is insufficient evidence of significant improvement in clinical practice then the process of revalidation should be re-evaluated with a view to it being discontinued.

The BMA supports the principle of revalidation and contributed to the Pearson review of revalidation. We see the Pearson review action plan as an opportunity to reduce the burden that revalidation imposes on doctors. In particular, we want to see implementation of the recommendation from Sir Keith Pearson’s review that local organisations should not use revalidation as a lever to achieve objectives beyond the GMC’s revalidation requirements. We also agree with Sir Keith that doctors should be able to challenge decisions they feel are unfair.

We will continue to press the GMC and other bodies about the actions needed to relieve the unnecessary burden that revalidation can sometimes place on doctors, in order to ensure the process delivers for patients, doctors and the NHS.

Motion BY MERSEY RCC. This conference is concerned by the burden of mandatory training and requests that the BMA enters into negotiations with the relevant Departments of Health to define the requirements and frequency of mandatory training.

Shared with ARM – the Association continues pan branch of practice negotiations with key stakeholder around this issue.

Motion BY EASTERN RCC. That this conference believes that the CQC should review all whistleblowing reports within a trust as part of its review of that trust. All such reports should be signed off by the CQC as being reviewed and that adequate action has been taken by the trust to mitigate the issue that was highlighted.

iii. Carried as a reference

We undertook an FOI of the CQC where we asked them for the data CQC holds on whistleblowing activity linked to NHS hospitals and trusts. For example, CQC’s Provider Information Collection for NHS Trusts includes the question – ‘How many incidences of whistleblowing have you recorded in the last 12 months?’ While CQC may receive whistleblowing contacts directly, this information request focuses on the number of whistleblowing incidences that providers have reported or made known to CQC. In addition, we asked if CQC has provided any analysis of this data or categorised any themes relating to this data please do include this.

Unfortunately, there are so many caveats with the data provided to CQC by trusts that it is very much doubt it’s of any use to us. We are taking stock I respect of next steps.

Motion BY LONDON SOUTH RCC. This conference calls upon the BMA to lobby for the Doctors’ London Weighting Allowance to be updated and held in line with London house prices.

Repeatedly raised in negotiations and also passed to ARM as pan-Branch of practice, with JDs & SASC.

Motion BY LEWISHAM AND GREENWICH LNC. This conference notes the importance of workable job plans, and notes that in the 2017 BMA National Consultant Survey 40% of consultants felt their workload had a negative effect on patient care, with 60% reporting low morale. A local Trust survey has shown that 40% of consultants dread job planning and find it combative with high rates of bullying during such meetings. Conference asks that:

i. Local surveys are conducted widely to find out how common bullying of consultants is during job planning

ii. Trusts with a high rate of bullying are advised to suspend job planning for the safety of their consultant body

iii. Such Trusts should not recommence job planning until training has been put in place for those leading job plan meetings, and that this should be run with support from the BMA.

Last year the consultants committee carried out a national survey of consultants regarding their experiences of bullying during the e-job planning process.

Those survey questions have been distributed to LNC chairs for them to use locally.
Motion BY EASTERN RCC. This conference believes that all NHS Trusts should be mandated to run annual Local CEA rounds and award all of the agreed funding for those awards so as to reward consultants for the excellent work they do.

Schedule 30, 2003 TCS

Motion BY NORTH WEST RCC. That this conference calls on the BMA to lobby the Department of Health to ensure that, with respect to any new mental health legislation in England and Wales:

i. the Appeals and Tribunals are robust, and protects patients’ rights;

ii. clinicians involved in Appeals and Tribunals have adequate time and resources to meet the requirements of the process;

iii. adequate funding is provided in primary and secondary care for implementation.

Shared with ARM
CC has welcomed moves to review and modernise mental health legislation in a broad sense. We welcome this review and with it the recognition of the importance of improving the overall patient experience in relation to mental health legislation and the subsequent care they receive.

The review rightly addresses concerns over discrimination and fairness within the current system for those at greater risk, such as people from certain ethnic backgrounds who are unfairly disadvantaged. Indeed, discrimination of this kind has no place within our modern health service and as such, all efforts must be taken to eradicate this and ensure safeguards are in place to avoid this in the future.

Changes to mental health legislation must ensure that any restriction to fundamental rights is both proportionate and necessary with respect to the care that an individual requires. This is particularly relevant in the case of community treatment orders (CTOs). While we welcome progress in acknowledging patients’ wishes and preferences and proposals for greater limitations of CTOs, there is a need for further review of their use given that current evidence does not substantiate their viability. As well as a significant legislative overhaul, there is a clear need for investment in mental health to ensure effective patient care, with a focus on treatment rather than security. Meaningful change can only endure if underpinned by properly staffed and fully resourced services.

We will ensure that the conditions in this resolution are a part of our ongoing position in respect of the development of the review.

Motion BY CONFERENCE AGENDA COMMITTEE. That this conference:

i. notes the increasingly complex and less rewarding nature of NHS consultant pensions

ii. notes that the pensions committee no longer meets

iii. asks that the pensions committee should be reconstituted immediately

iv. believes that the BMA must urgently establish an independent and appropriately staffed unit to advise members on the tax implications of pensions contributions, separate from the BMAS approved financial advisors

v. believes that the BMA should produce and frequently promote additional basic pension guidance and circulate it as a member benefit.

Pensions committee finally reconstituted. Pension information being updated, circulated, Pension Calculator in development.

Motion BY CONFERENCE AGENDA COMMITTEE. That this conference:

i. asks member relations to check at least annually the membership of regional consultants committees, LNC forums and LNCs and to provide this information to the officers of the relevant committees

ii. believes that the BMA should re-introduce annual Service Level Agreements (SLAs), for LNCs, RLNCs and RCCs to agree and sign up to, specifying the support that the BMA will provide. Such SLAs should include the six-monthly review of the members of each committee

iii. believes that members of committees such as RLNCs, RCCs and LNCs should be asked on joining the committee to agree that their contact details may be disclosed to the officers of the committee who may use those details to contact them only in the pursuance of their BMA responsibilities

Service Level Agreements are in the process of being finalised with the BMA’s member relations directorate.
112  H1019  Motion  BY NORTH WEST RCC. That this conference wishes to congratulate HMG on the speed of their Brexit negotiations so far, and wonders if they might pass on any tips to the BMA, Department of Health and NHS Employers.

No action taken.

126  H1000  Motion  BY OXFORD RCC. That this conference asks the BMA to demand that the government should urgently review pension tax and contribution arrangements which actively discourage long NHS service among senior doctors and are driving skilled doctors into working in the private sector when they are desperately needed in the NHS.

Ongoing. The consultants committee has run an England wide survey of the impact which pension tax arrangements are having on consultants and their retirement intentions. Letters have been written to the Chancellor and Secretary of State for health both calling for annual and lifetime allowance tax limits to be removed and for the employer pension contributions to be recycled to consultants leaving the scheme.

We have also published the results of our pension survey in the national press.

127  H1054  Motion  BY LONDON SOUTH RCC. This conference encourages those responsible for work force planning to consider the implications of maternity/paternity leave in planning recruitment, particularly to small specialities.

This issue will be delegated to the consultants committee LTFT forum to take forward.

128  H1090  Motion  BY NORTHERN IRELAND consultants committee. 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.

The Board of Science hosted a symposium in May 2018 with the following objectives:

- To discuss the opportunities for the health and veterinary sectors to combat AMR, how barriers might be overcome and identify collaborative solutions that can be implemented after the symposium
- To inform the current development of the UK’s next AMR Strategy

Participants included representatives from across the health, medicines, veterinary and farming sectors. There were also representatives from a wide range of BMA branch of practice committees, specialty committees and council committees in the devolved nations.
Motion BY YORKSHIRE RCC. That this conference deplores the lack of action by the government to provide assurance to non-UK doctors post-Brexit which may result into serious health care disasters due to potential exodus of EU doctors.

We call upon the Health Secretary to assess the serious impact on NHS and announce that EU workforce should be allowed to continue working and supporting NHS.

Since the EU referendum, the BMA has extensively explored the impact of Brexit on health services across the UK and Europe. We have produced a series of briefing papers which have highlighted the many ways in which the UK’s membership of the EU has benefited patients, the health workforce and health services, as well as the risks of leaving the EU without a deal in place.

At our annual representative meeting in June 2018 the BMA voted on a motion which declared our opposition to Brexit and called for the public to have a final say on Brexit in a second referendum, now more is known about its wide-ranging effects.

There is far too much uncertainty around the implications of Brexit for patients, doctors and health services.

Any form of Brexit could have wide ranging, and damaging consequences for health services across the UK and Europe, including on workforce and immigration, Northern Ireland, access to medicines, reciprocal health care, professional qualifications and patient safety, access to medical radioisotopes, medical research and rare diseases.

The BMA is calling for the public to have a final, informed say on the Brexit deal.

Motion BY CONFERENCE AGENDA COMMITTEE. In the wake of the GMC’s actions regarding the erasure of a senior paediatric trainee from the Medical Register, there has been an unprecedented loss of confidence in the GMC by the medical profession. Carried

In particular, in light of an apparent discrepancy between a review by the Professional Standards Authority and the statements of the GMC about its decision-making process in this matter, this conference asks the BMA to clarify with the GMC on what basis and what steps they took in making the decision to appeal the MPTS decision. Carried

If adequate explanation and appropriate and necessary apology from the GMC are not forthcoming, then the BMA must demand the resignation of the chair and chief executive of the GMC and consider whether the GMC is fit for purpose. Carried as a reference

Shared with ARM.

The GMC is aware of the no confidence motion and has met with BMA representatives in several fora including attendance at the BMA’s GMC Working Party meeting where it heard directly from members. A meeting has been arranged in the new year between the BMA’s chair of council and the GMC’s CEO to address the specific demand for an apology. We have written to the past and current Minister of State for Health requesting a meeting with the chair of RB to discuss professional regulatory issues, including the Bawa-Garba case, and are awaiting a response.

Motion BY NORTH EAST LONDON RCC. In January 2018 the Turkish Medical Association (TMA) issued a statement denouncing war as a threat to public health, with specific reference to the war in Syria. Following this members of the TMA received several threats of physical violence and death. Subsequently the Ankara Chief Public Prosecutor’s Office issued detention warrants for 11 members of the TMA council. This conference

i. Calls for the Turkish Government to stop hostile actions against the Turkish Medical Association and respect the rights of all Turkish doctors to practice medicine impartially in accordance with their core professional obligations.

ii. Urges the BMA to advocate for the full respect of Turkey’s humanitarian and human rights obligations, including the right to health, freedom of association and expression.

The BMA, via the chair of the medical ethics committee and the Treasurer of the BMA have written to the Turkish president Recep Tayyip Erdoğan.
Appendix II

Standing orders

1. The UK consultants conference

The BMA consultants committee (CC) shall convene each year a conference of representatives of consultants, specialists and Senior Hospital Medical Staff. The conference shall be held on a date to be determined by the CC. The conference shall be known as the UK consultants conference.

CC may convene one or more extra conferences at dates to be determined by the CC and conference agenda committee. Such a conference shall be known as a ‘special conference’ and shall usually be called on matters of policy requiring expedient decisions of the representatives of consultants, specialists and senior hospital medical staff.

2. Members of conference

The conference shall be composed of voting and non-voting consultant representatives.

Voting members:
- One consultant representative elected by each NHS Medical Staff Committee or equivalent in the United Kingdom or, where a medical staff committee is not active, the relevant local negotiating committee.
- All voting members of the consultants committee.
- The chair of the committee for medical managers and the CC Specialty Leads.
- 3 consultants elected by the Medical Women’s Federation.
- The chair and deputy chair of the consultants conference (from the previous year’s conference election).

Non-voting members:
- All non-voting members of the consultants committee if not otherwise specified below.
- 1 non-voting consultant representative from each organisation that represents doctors from minority groups; the organisations to be those on the list published by the BMA equality and diversity committee.
- 2 General Practitioners appointed by the general practitioners committee of the BMA.
- 2 junior doctors appointed by the junior doctors committee of the BMA.
- 2 SAS doctors appointed by the SAS committee of the BMA.
- 2 consultants appointed by the British International Doctors Association.
- 1 consultant representative of the Academy of Medical Royal Colleges.

In the event of there being spare places available, these will be allocated on a regional basis to any consultant who wishes to attend.
3. Appointment of deputies
i. Deputies may be appointed for each representative. They may attend the conference and act as a representative should the appointed representative be unable to attend.
ii. The responsibility for appointing deputies shall lie either with the body that appointed the representatives or, in the case of regional and national members of the CC, with the relevant regional or national committee. A regional or national committee may, if it wishes, delegate to the CC the responsibility of finding a deputy, who may be appointed from outside the region or nation.
iii. Deputies for those members of the CC elected by the Representative Body shall be appointed by the CC for the representatives from England and by the relevant national consultants committee for the representatives from Scotland, Wales and Northern Ireland.

4. Interpretation of ‘representatives’
Wherever in these standing orders the words ‘representative’ or ‘representatives’ are used they shall mean representatives appointed under standing order 2 and shall include the Deputy so appointed under Standing Order 3 for any representative who is absent.

5. Eligibility of representatives
All voting representatives shall at the time of their election be medical practitioners who are or who have within the preceding six months been under contract as a consultant as defined from time to time within the Articles and Bye Laws of the BMA/Standing Orders of the CC.

6. Tenure of office of representatives
The representatives elected to act at the annual conference shall continue to hold office until the commencement of the succeeding annual conference, unless the CC is notified to the contrary by the committee or subcommittee concerned.

7. Composition of the agenda
a. Motions, amendments and riders for the conference agenda may be submitted by medical staff committees (or LNCs if no MSC), the regional and national consultants committees and the CC, its subcommittees and the specialty leads.

b. Subject to the next following subsection, there shall not be included in the agenda any motion which has not been received by the secretary of the CC by a date to be determined annually by the CC. Any amendment or rider (submitted by a committee or subcommittee) to any items on the agenda must be notified to the secretary of the CC by 12 noon on the Friday of the week preceding the week in which the conference takes place.

c. There may be included in the agenda such other motions, amendments or riders (or composite motions, amendments, or riders as the case may be) which have been set down for consideration by the ARM of the BMA, as may be recommended by the conference agenda committee or joint agenda committee to facilitate debate on matters pertaining to the business of conference. There may be included in the agenda ‘topical motions’ on events that have occurred since the deadline for motions and before the start of the final meeting of the conference agenda committee before conference. It shall be the decision of the agenda committee whether such motions submitted are ‘topical’ and pertaining to new business which could not have been foreseen prior to the deadline for submission of motions and should be put to the conference for debate. Time shall be set aside in the second session of conference for debate on topical motions. Any amendments or riders to topical motions must be submitted to the agenda committee by 11.00am on the day of conference.

iii. Emergency motions on events that have occurred since the final meeting of the agenda committee may be submitted to the conference agenda committee. It shall be the decision of the agenda committee whether such motions submitted are ‘emergencies’ and should, therefore, be put to the conference for debate. Amendments to emergency motions will only be acceptable if designed to obtain minor textual clarification of the motion.

d. No motion to rescind any resolution of a previous conference shall be in order unless it is passed by a two thirds majority of those members of conference present and eligible to vote. The Chair of Conference shall indicate at the beginning of the debate on those motions which he considers would constitute a reversal of Conference policy and which would accordingly require a two thirds majority.

e. In addition to the motions prioritised by the conference agenda committee, representatives will be invited to indicate motions (other than those already scheduled to be discussed) which they would
like to see given preference for debate during the meeting. Representatives will be invited to indicate up to three items on a form which should be completed and returned on the morning of conference. The THREE most popular items selected will then be prioritised for debate under the ‘Chosen motions’ section of the agenda.

8. 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 order 10 (Order of Business), 11 (Time limit of speeches), 14(h) (Motions for adjournment or that the vote be taken), 14(i) (Motions that the conference proceed to next Business), 22 (Suspension of standing orders), and 23 (withdrawal of Strangers).

b. Motions relating to votes of thanks, messages of congratulations or of condolence.

c. Composite motions replacing two or more motions already on the agenda and agreed by consultants’ conference agenda committee mentioned in standing order 7(a).

9. Motions not dealt with
Should the conference be concluded without all the Agenda having been considered, and motions (except those prefixed by the agenda committee with an ‘A’ or ‘AR’ under SO 18c(iii) and (iv)) not considered shall be referred back to the sponsoring constituency. If the sponsoring constituency wishes such a motion to be pursued, it shall be entitled to submit a written memorandum for the consideration of the CC. Any motions prefixed by the agenda committee with an ‘A’ or ‘AR’ not considered at the close of conference shall not require to be referred back to the sponsoring constituency but shall stand as policy of conference.

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

b. Prior to the beginning of debate, representatives will receive the standing orders of the conference and a notification of any amendments. In the event that any representative wishes to raise an objection to the standing orders or any amendment thereof, he/she shall submit his/her request in writing, indicating his/her reasons to the agenda committee prior to 5pm the evening before the commencement of the conference. The chair shall have discretion to allow the member concerned to address the conference for not longer than two minutes and shall thereafter ascertain the wishes of the conference.

11. Speeches
a. Time limit of speeches:
   i. A member of the conference proposing a motion shall be allowed to speak for three minutes.
   ii. The speech introducing the report of the CC by the chair (or deputy) of the CC shall be limited to 10 minutes.
   iii. During debate of ‘P’ motions as defined under SO 17(c)(ii) and other open microphone sessions speeches shall be limited to one minute.
   iv. All other speeches on a motion under debate both for and against, shall be limited to two minutes.
   v. The conference may at any time reduce the time to be allowed to speakers and in exceptional circumstances a speaker may be granted an extension of time as conference permits.

b. Notification of an intention to speak in any debate (with the exception of open microphone sessions) shall usually be by the filling out of a ‘speaker slip’ to be handed in to the agenda committee before the commencement of debate. Members must indicate on which debate they wish to speak and whether they are ‘for’ or ‘against’ or if they are proposing the motion. Under exceptional circumstances and only with the permission of the chair may members speak during a debate having not filled out a speaker slip.

12. Voting
Only ‘voting members’ of the conference as defined in SO2 shall be entitled to vote at the conclusion of debates and in elections.
13. Mode of voting
Voting shall be by show of hands, voting cards or such electronic methods as may be approved by the conference agenda committee from time to time; unless a formal division is demanded by 20 members of the conference, signified by their rising in their places, in which case the names and votes of the members present shall be recorded. In the event of an equality of votes, the chair shall have a casting vote to be used at his discretion.

14. Rules of debate
a. A member will stand whenever possible to speak and shall address the chair.
b. Debates on all motions, amendments and riders shall proceed as follows:
   a. The proposer of the motion
   b. Speakers on the motion (either for or against, generally to be taken alternately)
   c. The chair of CC (or their deputy) and/or chief officers to reply to the debate
d. The proposer in reply to the debate
e. Voting
f. A member shall not speak more than once on any motion, amendment or rider, but the mover may reply at the end of debate, and in his reply shall strictly confine himself to answering previous speakers and shall not introduce any new matter into the debate.
g. ‘P’ motions as defined under SO 17(c)(ii) shall normally be debated as ‘open microphone’ sessions without the use of speaker slips other than for the proposer of the motion.
h. No amendment to any motion, amendment or rider, save those put forward by the conference agenda committee to facilitate debate under SO 7(c) shall be considered unless a copy of the same with the names of the proposer and seconder and their constituencies has been handed in writing to the Chair, before the commencement of the session in which the motion is due to be moved, except at the discretion of the Chair. Such late amendments will only be acceptable if designed to obtain minor textual clarification of the motion, amendment or rider. Amendments which substantially change the meaning of the original motion will not be accepted.
i. Whenever an amendment to an original motion has been moved and seconded, no subsequent amendment shall be moved until the first amendment has been disposed of, but notice of any number of amendments may be given.
j. If an amendment be carried, the amendment or motion, as amended, shall take the place of the original motion, and shall become the question upon which any further amendment may be moved.
k. If it be proposed and seconded that the conference do now adjourn or that the debate be adjourned, or that the vote be taken, such motion shall immediately be put to the vote without discussion, provided always that the chair shall have the power to decline to put to the conference the motion that the vote be taken. If a motion that the vote be taken is carried by a two-thirds majority, the chair of committee or other duly authorised spokesman of the committee, shall be permitted to respond and the mover of the original motion shall have a right of reply before the vote.
l. If it be proposed and seconded that the conference move to next business without further debate or vote, the chair shall have power to decline to put such a motion to the conference. If the motion is accepted by the chair the proposer of the preceding motion, amendment or rider shall have the right to reply to the relevant debate and the proposal to move to next business before the motion to move to next business is put to the conference (without prejudice to the right to reply to new matter if the original debate is ultimately resumed). A two-thirds majority of those present and voting shall be required to carry a proposal that the conference move to next business.
m. In the event that any member objects to a motion having an ‘A’ or ‘AR’ designation, the ‘A’ or ‘AR’ shall be removed from the motion and the motion will not be debated or passed as policy (unless the motion becomes a chosen motion).

15. Election of chair and deputy chair
a. At each conference a chair and deputy chair shall be elected who shall hold office from the termination of that conference until the termination of the next following Conference. All voting members of the conference shall be eligible for nomination.
b. Nominations for chair must be in writing and delivered to the Returning Officer on the day of the conference.
c. Nominations for deputy chair must be in writing and delivered to the Returning Officer on the day of the conference.
16. All resolutions passed by the conference shall lapse as policy after 5 years unless reaffirmed by conference. The agenda committee shall recommend in a motion to conference those resolutions to be reaffirmed for a further 5 years and conference shall vote on that motion. Amendments may be put to that motion to exclude or include individual resolutions.

17. Conference agenda committee
a. The agenda committee shall consist of:
   – The chair and deputy chair of the conference
   – The chair and deputy chairs of the CC
   – 4 members elected by the Conference
   – 2 members elected by the CC
   – 1 member of the JMCC not elected through another route

b. Nominations for the agenda committee for next year’s conference must be handed in on the prescribed form before or on the day of the conference, the voting, if any, taking place during the afternoon session. Any voting member of the conference may be nominated for the agenda committee. In the event that there is a vacancy for one or both of the seats elected to by CC, these vacancies should be filled by the unsuccessful candidate/s who received the next highest number of votes from the election held at that year’s conference.

c. The duties of the agenda committee shall be:
   i. to group items covering substantially the same topic(s) with a bracket, and mark with an asterisk that item which it recommends for debate. If the committee considers that no motion, amendment or rider in the group adequately covers the ground, the committee shall have power to draft a composite motion, amendment or rider. The committee or subcommittees submitting the motions so grouped shall be informed of the decision of the agenda committee, and if anyone raises objection in writing prior to the day of the conference, the matter shall fall to be decided by the conference. The mover of an agenda committee composite motion shall be the constituency whose motion is first in the bracket immediately below the agenda committee’s motion;
   ii. to identify the most important topics in the agenda, and select for priority in debate an appropriate number of motions or amendments on those topics which it deems of outstanding importance. Such motions or amendments shall be printed in heavy type and be given the prefix ‘P’;
   iii. to prefix with a letter ‘A’ those motions which it considers to be reaffirmation of existing policy or which are regarded by the chair of the CC as being non-controversial, self-evident or already under action or consideration, ‘A’ motions will not be voted on separately but will be presented in an appendix at the end of the agenda and automatically become policy of the conference;
   iv. to prefix with the letters ‘AR’ any motions relating to new matters which the chair of the CC is prepared to accept for further consideration without debate as a reference.
   v. to make recommendations to the conference as to the order of the agenda, and the conduct of the business of the conference;
   vi. to consider, and if thought fit, to make recommendations under standing order 7(c).
   vii. to consider those resolutions which are due to lapse as policy and to recommend to conference which of them should continue to be policy. In making their decision the agenda committee shall consider whether the resolution has been superseded by events or by new policy or is out of date.
   viii. to shade grey motions which it considers should not be prioritised for debate. Such motions shall be listed at the end of any relevant timed section of the agenda but not usually debated. These motions are however eligible to be chosen as per SO 7(e).

18. Joint agenda committee
The two representatives of the conference agenda committee to be appointed to the joint agenda committee in accordance with By-Law 53(1) of the By-Laws of the BMA shall normally be the chair of conference and the chair of the CC.

19. Visitors to CC
Conference may propose conference representatives to CC to take up office immediately after conference until the following conference. Any consultant member of Conference may stand subject to the rule that they shall not have previously sat as an ordinary member of CC or as a previous visitor via any other visitor scheme. The number of such conference representatives and their method of appointment shall be determined annually by the CC and notified to members of conference.
20. Returning officer and method of election
The Secretary of the BMA or a deputy shall act as Returning Officer in connection with all elections. All elections by conference shall be by the Single Transferable Vote method.

21. Chair’s decision
Any question arising in relation to the conduct of the conference, which is not covered by these Standing Orders, or relates to the interpretation of the same, shall be determined by the chair, whose decision will be final.

22. Suspension of standing orders
Any one or more of the standing orders may be suspended by the conference provided that two thirds of those present and voting shall so decide.

23. Withdrawal of strangers
It shall be competent at any time for a member of the conference to move that persons who are not members be requested to withdraw, but it shall rest on the discretion of the chair to submit or not to submit such motion to the conference.

24. Press
Representatives of the Press shall be admitted to the conference only on the understanding that they will not report any matters which the conference decides should be regarded as private.

25. Quorum
No business shall be transacted at any conference unless there be present at least one third of the number of representatives appointed to attend such conference.

26. Minutes
Minutes shall be taken of the proceedings of the conference and the chair shall be empowered to approve and confirm such Minutes.