

ARM6



Annual Representative Meeting 2020

**Report of action
taken on 2019
ARM resolutions**

15 September 2020 (virtual conference)

#ARM2020

ARM agenda No.	Resolutions	Accountable team/committee	Stakeholder committee
	MEDICAL STUDENTS		
12	<p>That this meeting recognises that medical student support services, especially in relation to mental health, can be involved in both fitness to practice and academic progression processes. We therefore call for the BMA to lobby relevant bodies to: -</p> <ul style="list-style-type: none"> i) establish clear separation between student support and academic progression services; ii) be transparent about how medical student support services data is used and the limits of confidentiality; iii) provide examples of best practice solutions of confidential student support services; iv) ensure student support services are fully confidential. (AS A REFERENCE) <p>The Medical Students Committee have begun some scoping work with reps to find out more about the state of student support services at different schools and whether there are any examples of good practice.</p>	Public Health and Healthcare/MSC	<p>MSC, SMSC, WMSC, NIMSC</p> <p>PHMC, SPHMC, WPHMC, NIPHMC</p>
13	<p>That this meeting believes that Looked After Children wanting to apply to medicine have equal value to the profession as other applicants and: -</p> <ul style="list-style-type: none"> i) calls that children from care should not be discouraged from applying due to their personal background or lack of family support; ii) calls that children from care should receive additional support and information from universities during the application/interview process if requested; iii) calls that children from care should be allocated a contact from the university responsible for all students from care once a student at the university; iv) calls that children from care should be provided help in finding summer time accommodation for students with no out-of-term time base; v) the BMA should lobby each medical school to produce a 'looked after children' policy to increase participation by people who were looked after children. 	MSC	MSC, SMSC, WMSC, NIMSC



	<p>The MSC and BMA engagement and communications have led on a wider widening participation campaign detailing the experiences of some medics, and included the story of a doctor who was in care. The story is available online.</p> <p>The MSC has developed links with key external stakeholders that lead on issues around supporting young people in care. These have included the Fostering Network, Carers Trust and Propel. Our discussions have involved identifying the barriers for young people in care and young carers pursuing medical careers, as well as the limited outreach programmes that specifically encourage and support access to medicine.</p> <p>We plan to take forward work with the Medical Schools Council to ensure that the experiences of this group of prospective students feeds into contextual admissions criteria. We also plan to continue highlighting the experiences of doctors and medical students who have come from backgrounds in care, or are carers to others.</p>		
NATIONAL HEALTH SERVICE			
15	<p>That this meeting affirms its belief in a publicly funded and provided NHS and calls on the BMA to: -</p> <ul style="list-style-type: none"> i) lobby relevant decision-makers to ensure the NHS is protected from future trade agreements which would threaten this status; ii) work with like-minded stakeholders to resist the privatisation of the NHS; iii) oppose the use or sale of NHS patient information for commercial purposes; iv) insist on an open national register of private contracts with full transparency of accounts, staff qualifications and quality of service. <p>The BMA has been vocal in opposing privatisation in the NHS and calling for greater transparency on the current role of private providers, publishing reports on these issues in 2018 and 2019. A further report on the role of the private sector in the NHS is due to be published in early 2020 (see report on motion 16 below).</p> <p>As part of this, the BMA has strongly opposed the inclusion of the NHS in any future trade agreements. This position has been made clear in our lobbying on</p>	Public Health and Healthcare	PHMC, SPHMC, WPHMC, NIPHMC

	<p>Brexit, as well as in in our recent ‘No-Deal’ paper. We have continued to articulate this position throughout the pre-election period and are scoping potential future work on the wider issue.</p> <p>The BMA has lobbied (including in it’s 2019 Manifesto for Health) for measures to protect the NHS as a publicly funded, owned and provided service in its engagement with NHS England’s recent proposals for new legislation to replace key sections of the Health and Social Care Act 2012. We have called for any legislation which replaces Section 75 of the Act to make clear that publicly funded, owned and provided NHS services should be the preferred provider when commissioning decisions are made. The BMA has also called for wasteful competition rules to be scrapped in its Caring, supportive, collaborative project.</p>		
16	<p>That this meeting is concerned about multiple reports of problems with private providers of NHS services and demands: -</p> <ul style="list-style-type: none"> i) rigorous evaluation of outcomes compared with NHS services; ii) that contracts must enable the provision of integrated, multidisciplinary care; iii) private providers undertaking NHS contract work are required to treat a representative population case mix rather than excluding all but the lowest risk patients; iv) that contracts should be withdrawn from private providers which fail to provide services of the required standard; v) private providers which fail to provide services of the required standard are not eligible to bid for future NHS work. <p>A report on privatisation and the interface between public and private sectors is currently being developed for publication in early 2020. The report will explore some of the key issues relating to the role of the private sector in the NHS, including destabilisation of services and value for money.</p>	Public Health and Healthcare	PHMC, SPHMC, WPHMC, NIPHMC
17	<p>That this meeting, in respect of access to NHS services, the BMA should negotiate with NHS bodies to ensure: -</p> <ul style="list-style-type: none"> i) parity of access is equitable, clear and non-discriminatory for all patients; 	Public Health and Healthcare	PHMC

	<p>ii) decision-making is based on clinical assessment of need and potential for benefit to the individual patient; iii) services which alleviate pain, promote mobility and improve quality of life will remain within the NHS; iv) commissioning decisions will include equity impact assessment, and public and clinical consultation.</p> <p>Research into the current extent of disparities in patient access to care, the ‘post-code lottery’, and the rationing of certain treatments and interventions is planned for late 2019 and early 2020. This will look specifically at NHS England’s attempts to introduce national commissioning criteria for certain treatments, under its EBI (evidence based interventions) programme. This work will continue to emphasise the importance of proper consultation and the role of impact assessments.</p>		
18	<p>That this meeting, in respect of the NHS Long Term Plan: -</p> <p>i) believes that many of the ambitions of the Plan will be largely unachievable because of underfunding of the NHS; ii) asks the BMA to highlight to government and the public that the reforms and structural changes proposed are not in the interest of the NHS; iii) believes launching the Plan without an adequate workforce strategy will precipitate a greater crisis.</p> <p>The BMA continues to lobby the Government and NHS England on the progress of the Long Term Plan – including highlighting the need for additional funding and an adequate workforce strategy. Recent activity includes:</p> <ul style="list-style-type: none"> - Writing a letter to the Chancellor of the Exchequer in September 2019 ahead of the 2019 spending round to highlight the urgent need for additional funding to be announced in key areas such as education and training, public health and capital investment. The BMA reiterated these funding asks in its Manifesto for Health launched ahead of the 2019 election. - The BMA has engaged with NHS England on proposals – originally set out in the Long Term Plan – to make changes to the Health and Social Care Act 2012. As part of this we’ve argued that any structural change must promote the NHS as 	Public Health and Healthcare	PHMC

	<p>the preferred provider of services and must protect the independent contractor status of GPs.</p> <ul style="list-style-type: none"> - The BMA has engaged with NHS England and NHS Improvement on the NHS People Plan. The chair of council and chair of UK consultants committee met with Prerana Issar (NHS chief people officer) and staff and elected members have attended various events and working groups to input into the development of the full plan. <p>Our work on system transformation is also continuing, with an explicit focus on the need for, and importance of, clinical engagement in STPs and ICSs. In November we published ‘Getting your voice heard’, a guide to influencing and engaging with changes to local health systems designed for grassroots BMA members and regional structures.</p> <p>The BMA is also working to support the development of Primary Care Networks across England. In October 2019 we launched a survey of all PCN Clinical Directors to assess how the development of PCNs is progressing on the ground. We will be publishing the results of the survey ahead of the national Clinical Directors conference on 8th February.</p>		
<p>19</p>	<p>That, in respect of the NHS Long Term Plan, this meeting: -</p> <ul style="list-style-type: none"> i) does not support the imposition of funding cuts through efficiency savings; ii) does not support the shift of care from hospitals into the community without concomitant increase in resources; iii) believes that the NHS should be a system to provide healthcare according to clinical need; iv) opposes the NHS Long Term Plan as a plan for a market-driven healthcare system. <p>The BMA continues to lobby the Government and NHS England on the progress of the Long Term Plan. This includes our work on NHS England’s proposed legislative changes – where we have campaigned strongly for the removal of existing competition rules, including Section 75 of the Health and Social Care Act. The BMA’s Caring Supportive Collaborative project work has focused on this issue too, and the need for a fundamental move away from competition within the NHS.</p>	<p>Public Health and Healthcare</p>	<p>PHMC</p>

	<p>We have also been clear in our 2019 Manifesto for Health, and in our earlier spending review submission, that NHS funding must be increased if system transformation is to be delivered successfully. This specifically stressed the need for proper funding to be directed to primary and community care, to support any shift in care away from hospitals.</p>		
20	<p>That this meeting believes that performance targets within the NHS: -</p> <ul style="list-style-type: none"> i) must be evidence-based and must not be driven purely by political agendas; ii) must not attract financial sanctions for non-achievement; iii) should not include the measurement of productivity. <p>The BMA continues to lobby for evidence-based, clinically focused performance targets in the NHS. We are monitoring proposals from NHS England to change current targets (for A&E waiting times, elective treatment waiting times and for cancer diagnosis), some of which are currently being piloted in specific areas. The pilots for these new clinical standards are still ongoing. A public consultation is expected to be scheduled for after the conclusion of these pilots. The BMA will scrutinise the outcome of the pilots to inform our response to any such consultation.</p>	Public Health and Healthcare	PHMC, SPHMC, WPHMC, NIPHMC
WORKFORCE			
28	<p>That this meeting is seriously concerned about the extent of bullying and harassment in the NHS and: -</p> <ul style="list-style-type: none"> i) condemns bullying and salutes those who stand up to it; ii) congratulates the BMA on the stance adopted and the work undertaken thus far; iii) welcomes the Sturrock review and calls for the recommendations of that report to be implemented across the wider NHS; iv) calls for the annual reporting by all NHS bodies of bullying and harassment cases and their outcomes. <p>The BMA has continued to promote the recommendations published in November 2018, presenting at NHS Employer and HEE events. In presentations and updated materials the recommendations have been edited to incorporate more clearly the call in final limb iv).</p>	Professionalism and Guidance	All BoP national councils

	<p>The BMA continues to participate in the anti-bullying alliance in the NHS which is administered by RCSEd and the National Guardian’s Office, taking part in webinars and will be participating in the alliance’s latest conference in February 2019 in Northern Ireland.</p> <p>Bullying and harassment and, in particular the work of Civility Saves Lives, also featured in the BMA’s culture conference held in Belfast in December 2019. John Sturrock QC had also agreed to speak at that event but unfortunately had to pull out at short notice. He sent a supportive message to the BMA and the conference.</p>		
29	<p>That this meeting is concerned that increasing workload and staff shortages are resulting in doctors of all grades experiencing stress and burnout and: -</p> <ul style="list-style-type: none"> i) demands that future working patterns of doctors are sustainable; ii) demands that pastoral support be made available to all NHS staff; iii) demands that mentoring be made available to all NHS staff; iv) calls for annual reporting of staff wellbeing, morale and burnout by all NHS bodies. <p>In October 2019, we published a BMA mental wellbeing charter which calls for employers to offer mentoring, pastoral support and/or coaching to staff. It also calls for wellbeing of staff to be monitored and regularly reported to the board. Several trusts have already signed up to these standards. In the BMA’s Manifesto for Health we have called for the incoming government to ensure the charter is implemented in full. It is worth noting that the GMC’s Caring for Doctors Caring for Patients review references the BMA’s research into doctors’ and medical students mental health as well as calling for the implementation of our fatigue and facilities charter.</p> <p>Our Manifesto for Health also called for safe staffing legislation, including accountability for local / national commissioners <i>and</i> ministers for the provision of safe staffing levels in all NHS settings, and formal reporting and escalation mechanisms so doctors can have their concerns about low staffing levels recorded and publicly published. Through the BMA’s safe staffing project, sponsored by the deputy chair of council, we will publish a research report on</p>	Public Health and Healthcare	PHMC, SPHMC, WPHMC, NIPHMC

	<p>the personal impact of unsafe staffing on NHS staff and patients and host a stakeholder engagement event in early 2020. We will be working collaboratively with the RCN and the RCP early in the new year to establish a safe staffing coalition along with other unions, patient representatives and local and national policy making bodies.</p>		
30	<p>That this meeting welcomes the increasing role of non-medical members of the clinical workforce, with the following provisos: -</p> <ul style="list-style-type: none"> i) they must be fully trained for the role by a national certified body, preferably linked to a royal college; ii) they must belong to a regulatory body; iii) appropriate indemnity must be agreed with the employing body; iv) they must be subject to an annual appraisal in the role leading to revalidation; AS A REFERENCE v) they must be seen to be part of a multidisciplinary team; vi) they must have a title which makes it clear that they are not medically qualified. <p>We continue to work with HEE and the GMC with regard to the career framework and regulation for the medical associate professions. A discussion on MAPs was held at November council and we have established a 'new clinical roles' reference group. We will be holding an internal roundtable discussion on new clinical roles which will cover the issues from this resolution.</p>	Public Health and Healthcare	PHMC, SPHMC, WPHMC, NIPHMC
31	<p>That this meeting recognises the need for mechanisms to allow doctors to raise and resolve concerns affecting their health and welfare and calls for: -</p> <ul style="list-style-type: none"> i) exception reporting to be made available for all grades of doctors; ii) negotiating of contractual safeguards to allow senior hospital doctors the ability to withdraw from long term second on-call in appropriate circumstances. <p>(i) The provision of exception reporting for all grades of doctors would necessarily require contractual change. It would therefore be for the branch of practice committees and their negotiating teams to determine whether they believe exception reporting processes would represent the most effective forms of safeguarding for those grades of doctor, or</p>	Pay and Contracts	All BoP national councils

	<p>whether they believe other contractual provisions would provide sufficient equivalent protections. The possibility of extending exception reporting is being considered by SASC UK as part of forthcoming contract negotiations;</p> <p>(ii) The impact of onerous working patterns on ageing consultants is an issue that is raised frequently, particularly the increasingly deleterious effect on nights on call on subsequent performance as doctors get older. The difficulty is that there is only so much that we can allow for through contractual mechanisms – legal advice has indicated that provisions tied to age would be discriminatory and therefore illegal. The only way to contractually legislate for this would be through a provision which effectively increased employer obligations for providing Occupational Health (OH) services and responding to their recommendations. The aim would be to ensure that where a doctor is struggling with on-call commitments, to the extent that it is impacting upon their health, that they would visit the OH service, which would in turn recommend changes to the individual’s job plan to accommodate their needs. This was something we had taken steps to secure in negotiations over the consultant contract before they stalled and will continue to take forward in negotiations over the SAS contracts.</p> <p>In general, efforts to produce or update retention "asks" for both consultants and GPs are underway (planned publications expected in March / April 2020 in time for conferences). Consideration will be given to updating the SAS Charter along similar lines too. These charters and strategies will sit alongside the Fatigue and Facilities and Mental Wellbeing charters. This work will inform the overarching aims and principles of the BMA-wide safe staffing project, and will be included in the project updates, but conducted across policy teams and committees as normal.</p>		
	<p>AFC</p>		
<p>32</p>	<p>That this meeting calls upon the Department of Health, Health Education England, the GMC, Royal Colleges, the BMA and other stakeholders to work together to improve the professional and pastoral support offered to overseas doctors, particularly those that are recruited via online or other “virtual”</p>	<p>Professionalism and Guidance</p>	<p>All BoP national councils</p>

	<p>facilities, to ensure that they are properly equipped to adjust to the high pressure environment in an unfamiliar country and fully enabled to fulfil the expectation of working within the NHS.</p> <p>In October 2019 the International and Immigration team launched guidance providing a high-level overview of the sequence of steps international students and doctors will need to take to study or work as a doctor in the UK, such as applying for training, getting GMC registration, a visa and a job offer.</p> <p>We developed individual routes for:</p> <ul style="list-style-type: none"> ▪ international medical students who wish to study at a UK medical school ▪ international medical graduates (non-EEA) who intend to come and work in the UK and ▪ EEA (European Economic Area) doctors coming to work in the UK. <p>This resource was produced following discussions with the GMC, the UK Foundation Programme Office and NHS England.</p> <p>Recently, we have contributed to the development of an Employer Toolkit designed by NHS Employers, where we included signposts to BMA resources on promoting health and wellbeing.</p> <p>The Equality, Inclusion and Culture team has launched a ‘Differential Attainment’ working group – the group plans to refresh the BMA’s principles on ensuring fairness in clinical training and recognises that a supportive learning environment can improve the achievement of all doctors, including international medical graduates.</p>		
35	<p>That this meeting condemns the gagging of the BMA Armed Forces representatives serving as reservists and calls upon the MoD to urgently review the policy of preventing a reservist expressing any opinion on government matters.</p> <p>A legal case is being pursued and an update will follow in due course.</p>	Legal Department	
36	<p>That this meeting notes that a majority of senior doctors and dentists in the Armed Forces have stated</p>	Member Relations	

	<p>an intention to leave the Services due to the disproportionate impact that taxation rules on Annual Allowance have on Armed Forces doctors and calls upon the BMA to lobby both MoD and Treasury to take urgent action to prevent this outflow.</p> <p>The chair of Council wrote to the Chancellor on behalf of the AFC in December pointing out that it was unacceptable that this differential treatment continues: a situation in which military doctors must pay a tax which their civilian colleagues can avoid or have paid for them is a clear breach of the Armed Forces Covenant.</p> <p>The BMA has briefed stakeholders including MPs about the breach of the Armed Forces Covenant and the BMA continues to make the case for further pensions reform with considerable contribution from the AFC.</p>		
PENSIONS			
38	<p>That this meeting: -</p> <p>i) notes that restrictions on annual and lifetime allowances in the NHS pension scheme have had a detrimental effect on retaining doctors in clinical practice;</p> <p>We continue to pursue the removal of the AA in DB schemes and discussions with the Govt will begin again soon in this regard following the elections. We welcomed NHSE and Wales initiatives to pay the scheme pays reduction for 2019/20 incurred by members working in the NHS as well as the recycling policy introduced in Scotland</p> <p>ii) Believes that increasing the NHS pension scheme Employer Contributions Rate to over 20% will inevitably reduce the impact of any increase in NHS funding;</p> <p>For the 2019/20 year the excess over 14.48% was met by Treasury</p> <p>iii) calls on the BMA to actively lobby the Treasury to act decisively to improve the NHS pension scheme;</p> <p>We need to wait on the outcome of the redress proposed by Government further to the Judges and Firefighters case.</p> <p>iv) demands that all NHS workers should have a choice to pension only part of their earnings in the NHS pension scheme;</p>	Member relations	

	<p>We anticipate the introduction of a decile facility in 2020 enabling members to choose what to pension between 10% and 90% in addition to full contributions</p> <p>v) demands that NHS workers should not be subject to annualisation of their earnings for NHS pension scheme contribution rate purposes;</p> <p>This matter continues to be looked at to determine the best means of challenging it. The Member survey undertaken was not supportive of our case.</p> <p>vi) demands that, in a Career Average Revalued Earnings (CARE) scheme, all NHS workers should contribute the same net rate to the NHS pension scheme.</p> <p>As above this is being considered as how best to pursue.</p>		
39	<p>That this meeting acknowledges the unfairness of calculating pension contributions on the basis of full time equivalent earnings for doctors who work LTFT and that they should instead be based on actual earnings. We call on the government to calculate the loss of earnings to affected individuals and recompense them in full.</p> <p>This is as per vi) above.</p>	Member relations	
40	<p>That this meeting demands that NHSE and Government stop prevaricating and take action to: -</p> <p>i) terminate, or at least sanction, the contract with Capita due to its catastrophic failings in dealing with GP pension contributions;</p> <p>ii) declare a tax amnesty for doctors facing excessive tax bills due to Capita failing to forward their pension contributions for several years and then the backdated contributions are found to exceed the annual or lifetime allowances;</p> <p>iii) investigate and, where necessary, compensate doctors who have become ill as a result of Capita's failings in handling their pension contributions;</p> <p>iv) compensate doctors who have not been able to retire due to Capita's inability to manage their pension contributions.</p> <p>We continue to have regular meetings with PCSE, NHSE and NHSBSA to work towards better administration of the scheme for GPs. Compensation requests are considered by NHSE on a case by case basis.</p>	Member relations	
MEDICINE AND GOVERNMENT			
41	<p>That this meeting welcomes the UK government's agreement to scrap the annual cap on the number of tier 2 visas, but believes there are still too many barriers to the recruitment of international</p>	Professionalism and Guidance	All BoP national councils

	<p>healthcare professionals. This meeting calls on the BMA to: -</p> <ul style="list-style-type: none"> i) lobby the government to significantly reduce the £30 000 salary threshold to reflect NHS pay scales; ii) lobby the government for priority status for visas to be established for health care staff at all grades; <p>AS A REFERENCE</p> <ul style="list-style-type: none"> iii) lobby the government for the abolition of the Immigration Health Surcharge; iv) join with other unions and professional organisations to campaign for changes to the tier 2 visa system. <p>In November 2019, we argued for the reduction of the threshold in our response to the MAC (Migration Advisory Committee) call for evidence. In addition, we asked that the salary threshold and any future system must accommodate doctors working less than full time.</p> <p>We have attended engagement events coordinated by the Department of Health, and Social Care on the future immigration system. We have put forward our policy asks, including calling for an exemption to the health surcharge for all healthcare professionals. We'll continue to engage with government and put forward our policy asks next year.</p> <p>We have supported a number of individual doctors who had to stop working in the NHS due to problems with their visas. We successfully lobbied the Home Office to reverse their original decisions so that the doctors could resume their roles in the NHS. We fed back these doctors' experiences through the engagement events.</p> <p>In response to our work in this area and more broadly on Tier 2, we have been invited to inform the development of a specialist team of case workers at the Home Office. This team will process visa applications specifically for doctors wishing to work in the NHS.</p>		
42	<p>That this meeting notes that in a pilot to check eligibility for free NHS Care only 1/180 people were deemed ineligible and: -</p> <ul style="list-style-type: none"> i) this meeting believes that it is not cost effective to monitor eligibility for NHS Care; 	Public Health and Healthcare	All BoP national councils

	<p>ii) this meeting calls for the policy of charging migrants for NHS care to be abandoned and for the NHS to be free for all at the point of delivery;</p> <p>iii) that this meeting believes that the overseas visitors charging regulations of 2011 threaten the founding principles of the NHS and that the regulations should be scrapped. AS A REFERENCE</p> <p>The BMA continues to be an active voice in opposition to the current overseas charging regime, building on the debate at ARM in 2019 as well as previous BMA research and lobbying on this issue. In line with this, we have raised our concerns regarding, and opposition to, the reported use by some NHS trusts of credit check firms to support the identification of chargeable patients. We are also planning more substantial research into the cost effectiveness of the existing regime, to be published in 2020.</p>		
43	<p>That this meeting is frustrated with the misinformation that has been provided by politicians, leading to untold uncertainty over the last three years. This meeting demands that politicians who wilfully misinform should be punished appropriately using the Recall of MPs Act 2015. AS A REFERENCE</p> <p>We noted in our briefing to the ARM when this motion was debated that the Act cannot be used in the way suggested.</p> <p>We brief MPs on relevant issues and correct them where possible if they have misrepresented our position.</p>	Professionalism and Guidance	All BoP national councils
MEDICAL ACADEMIC STAFF			
53	<p>That this meeting notes with concern the decrease in academic doctor numbers and asks for any workforce strategy to consider the positive contribution of academic medicine to the UK.</p> <p>The full NHS People Plan is due to be published in the first quarter of 2020 and the interim plan made mention of the contribution of academics to the development of the workforce.</p> <p>The BMA has attended multiple working groups and engagement events on a range of topics relevant to the medical and wider workforce.</p>	Public Health and Healthcare	MASC

	The BMA will continue to influence what we understand will be an iterative approach to implementation in the coming years.		
	MEDICAL ETHICS		
57	<p>That this meeting notes the recent decision by the Royal College of Physicians to adopt a neutral position on assisted dying after surveying the views of its members, and: -</p> <ul style="list-style-type: none"> i) supports patient autonomy and good quality end of life care for all patients; ii) recognises that not all patient suffering can be alleviated; iii) calls on the BMA to carry out a poll of its members to ascertain their views on whether the BMA should adopt a neutral position with respect to a change in the law on assisted dying. <p>Council will be receiving a paper on the final proposals for the survey at the January meeting for approval to proceed and sign-off.</p>	Professionalism and Guidance/MEC	All BoP national councils
58	<p>That this meeting condemns the fact that women in Northern Ireland are currently being discriminated against in their inability to access safe and legal abortions in Northern Ireland. This meeting: -</p> <ul style="list-style-type: none"> i) notes with alarm that in 2016/2017 only 13 abortions were performed in Northern Irish hospitals compared to 861 abortions for Northern Irish women and girls in hospitals on mainland UK in 2017; ii) calls on the UK government to repeal sections 58 and 59 of the 1861 Offences Against the Person Act; iii) calls for the repeal of section 25 of the Criminal Justice Act (Northern Ireland) 1945. <p>At the end of July 2019, the Northern Ireland (Executive Formation etc) Act 2019 was enacted which repealed sections 58 and 59 of the 1861 Offences Against the Person Act in Northern Ireland. In short, this decriminalises abortion up to the point at which a fetus 'is capable of being born alive'.</p> <p>Private Members Bills (PMB) are anticipated to repeal these sections in England and Wales too, after the general election. The BMA will brief in support of any future amendments or PMBs to repeal these sections.</p>	Professionalism and Guidance/MEC	MEC

	<p>Section 25 of the Criminal Justice Act (Northern Ireland) 1945 remains in place. New exceptions to the crime outlined by section 25 are currently being consulted on by the Northern Ireland Office (NIO) – exceptions that would permit abortion on the grounds of serious fetal abnormality, and to preserve the woman’s life or prevent grave permanent injury.</p> <p>This is part of a wider consultation on a new legal framework for abortion in Northern Ireland. A new framework must be in place by 31 March 2020. The BMA ethics team are working with BMA NI on responding to the consultation.</p>		
	FORENSIC AND SECURE ENVIRONMENTS		
62	<p>That this meeting believed 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's 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 meeting: -</p> <ul style="list-style-type: none"> 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. <p>We have supported this position since 2007 and worked closely with the Royal College of Pathologists at the time to lobby for this. We also fed these views into the independent review of the Human Tissue Act in 2013, which included this as one of its recommendations. The Government accepted this recommendation but time was not made available to make the necessary legislative changes. We will continue to lobby for Parliamentary time to be made available and public affairs will identify whether any</p>	Professionalism and Guidance	FSEC

	<p>MPs in the private members' ballot may have an interest in this issue.</p> <p>Despite these efforts, it is likely to be some time before legislative change can be achieved and so we are investigating how the current procedures can be improved to maximise the possibility of consent being obtained under the current system. We have asked the Human Tissue Authority to consider this issue and to include it on the agenda for its next stakeholder engagement meeting. We will continue to engage with other organisations to try to achieve this. Further discussions with relevant stakeholders are planned.</p>		
63	<p>That this meeting believes that painful control & restraint methods should be outlawed for use in secure children's homes.</p> <p>We have written to Charlie Taylor, Chair of the Youth Justice Board, who is chairing an inquiry into the use of pain-inducing restraint on children and young people, to highlight the BMA's policy position, and offering to meet to discuss in more detail. It is not clear, however, when or how this inquiry will be concluded in light of the 2019 General Election. We are also engaging with other external stakeholders – such as the Howard League for Penal Reform – to explore other options for action. This policy will also be reflected in the revised BMA guidance on restraint and control, which is to be developed.</p>	Professionalism and Guidance/MEC	MEC
INTERNATIONAL			
65	<p>That this meeting fully endorses the BMA's continued membership of the World Medical Association for the opportunity it provides to support and influence the development of global health policy.</p> <p>As a member of the WMA, the BMA can promote our policies and share the views and experiences of UK doctors while learning from colleagues in other nations.</p> <p>Following the recent WMA General Assembly 2019, the BMA secured the following successes:</p> <ul style="list-style-type: none"> - the BMA led on an emergency statement on Climate emergency which was supported unanimously at the General Assembly. We called for the WMA and its constituent members to commit to advocate to protect the health of 	Professionalism and Guidance/International Committee	IC

	<p>citizens across the globe in relation to climate change.</p> <ul style="list-style-type: none"> - Our policy proposal on the medical role in solitary confinement of children and young people was unanimously accepted and adopted as formal WMA policy. This built on our existing policy work opposing the solitary confinement of children and young people (developed by the Medical Ethics Committee). - Our proposed revision of the WMA’s policy statement on antimicrobial resistance (AMR), drafted in line with BMA policy, was unanimously accepted at the General Assembly. Tackling AMR requires concerted action and cooperation at an individual, national and international level. WMA revised policy is therefore an important mechanism to address this significant global health problem. - The BMA led on a WMA statement on Promoting healthcare information for all. While there is agreement on the importance of universal healthcare, it is equally vital that there is equitable and accessible healthcare information for all patients, which will affect outcomes through empowering patients to optimise their health and make informed decisions about their treatments and to prevent illness. Our proposal was unanimously accepted at the General Assembly and adopted as formal WMA policy. - Our role in leading on the final revision of the Declaration of Madrid on professionally-led regulation of medicine gave the BMA the platform to highlight the UK perspective and the need to take account of the broader context to regulatory approaches, which was recognised by other national medical associations. This was unanimously accepted at the General Assembly. 		
	WALES		
68	That this meeting notes with dismay that Welsh Government has stated that it supports GPs on the one hand but demonstrates contempt for them on the other in announcing that GP indemnity is to be funded from the GMS contract, and calls upon the BMA to:-	BMA Cymru Wales	

	<p>i) campaign for provision and funding of indemnity in line with that provided in secondary care; AS A REFERENCE</p> <p>68 (i) We support the existence of the of the state-backed Welsh General Practice Indemnity scheme (GMPI) for future liabilities, given the escalating indemnity costs for GPs in recent years. Whilst the scheme is funded in a different manner to secondary care indemnity under the Wales Risk Pool, it was considered that securing the existence of the scheme was a priority and the GPC Wales committee has acted to ensure that the financial effects on Welsh GPs have not been unduly detrimental..</p> <p>GPC Wales were discontent with the unilateral decision by Welsh Government to announce that GMPI was to be funded via a reduction in global sum despite ongoing contract negotiations. This resulted in the global sum per weighted patient payment value reducing to £86.75. However, following conclusion of negotiations we were able to secure additional investment into the Welsh GMS contract resulting in a global sum value of £91.19 per weighted patient, backdated to April 2019. As well as compensating for the indemnity monies, this figure exceeds the 2018/19 value of £89.63 per weighted patient. Looking forward, we are prepared to work with Welsh Government regarding the successful introduction of the existing liabilities scheme pending negotiations with medical defence organisations.</p> <p>ii) campaign for formal health economic assessment of the costs of health board managed practices and the value of GP Partnerships.</p> <p>(ii) GPC Wales has already undertaken some Freedom of Information Requests on the cost of directly managed practices in two Health Boards which suggests that spending in those practices while being directly managed significantly exceeded their GMS budget allocation. For instance, once managed practice in Betsi Cadwaladr reported a deficit of £599k for 2017-</p>		
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	<p>18. It is known that these practices often do not offer the same range of enhanced services as traditional contractor practices.</p> <p>The results of this exercise have been used in briefings with Assembly Members and Welsh Government. Anecdotally, we believe it is recognised by Health Boards that the managed practice model is more expensive to operate than the traditional contractor model. Building on these initial findings, we would support a formal health economic analysis of directly managed practice.</p>		
NORTHERN IRELAND			
71	<p>That this meeting warns that attaching criminal sanctions to the professional duty of candour for individual doctors in Northern Ireland is out of step with patient safety developments elsewhere in the UK and Ireland and calls on the department of health in Northern Ireland to: -</p> <ul style="list-style-type: none"> i) create the conditions for openness and transparency by providing protections for doctors, such as the Open Disclosure provisions in the Republic of Ireland to enable doctors to raise concerns and protect patients; ii) acknowledge best practice in patient safety and raising concerns from other health jurisdictions and urgently adopt these in Northern Ireland; iii) commit to the development of a culture where learning not blaming is a priority, lessons are learnt and disseminated across the healthcare system. <p>The publication of the report into the inquiry into hyponatraemia-related deaths (IHRD) in 2018 contained a number of recommendations one of which was the introduction of an individual duty of candour with criminal sanctions, which we are opposed to. This continues to be a priority for NIC and a number of actions have taken place: We submitted a detailed evidence based paper to the IHRD programme; NIC invited the leads of the workstreams to a meeting with members to discuss the duty of candour; Henrietta Hughes</p>	BMA NI	

	<p>the National Guardian presented to a joint divisional meeting; the UKC chair hosted a successful conference on patient safety in Northern Ireland on 4 December – ‘Better Culture, Better Care: Creating Trust, Learning and Accountability within Health and Social Care’, which focused on the concepts of a just culture and looking at creating an environment that is conducive to this; a conference report was drafted and circulated to a range of stakeholders; a roundtable with professional bodies and trade unions was held to garner a consensus on the individual duty of candour with criminal sanctions; a workshop for primary care, postponed due to COIVID is now being reorganized to ensure the voice of primary care is heard; and relationships are being maintained with the key IHRD officials as well as key stakeholders such as chief executives of Trusts, the GMC and others.</p>		
<p>72</p>	<p>That this meeting is dismayed at the ongoing lack of a functioning devolved government in Northern Ireland and is concerned that this is having a negative impact on the delivery of health and social care. We call on politicians to urgently re-form the devolved Northern Ireland Executive and to take the key decisions that are needed to protect the health and social care needs of the population in Northern Ireland.</p> <p>The NI Assembly was restored on 10 January 2020 and we have benefited from our continued political relationships which we had maintained over the Assembly suspension. Consequently, we have existing relationships with various MLAs who were appointed to key roles, in particular the Health Minister Robin Swann and the 9 MLAs appointed to the health committee. On 20th Feb 2020 we gave evidence to the health committee on the workforce strategy and transformation. NIC chair has regular meetings with the Minister by phone and a range of topics discussed: COVID, PPE, the regional rate, for consultants and SAS doctors and banding for JDs during COVID and death in service as well as</p>	<p>BMA NI</p>	

	overarching transformation and reconfiguration issues.		
73	<p>That this meeting 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, at least to the level of that in the rest of the UK, in order to address this.</p> <p>This motion originated from NICC and was subsequently passed at UKCC in 2019, before being sent to the UKPHMC and subsequently to ARM 19. We are working with Dr Dearbhail Lewis from the NICC, to take this forward as the new Protect Life Strategy 2 has recognised the need to tackle this, given direct link with transgenerational trauma and suicide in communities exposed to conflict. The Minister recently announced the appointment of a mental health champion in Northern Ireland and this is a welcome development. This also links in with work across the BMA on funding for mental health services.</p>	BMA NI	
	PROFESSIONAL REGULATION, APPRAISAL AND THE GMC		
74	<p>That this meeting asks the BMA to call on the relevant bodies to review within twelve months the impact on doctors of the involvement in an NHS or other complaints procedure, in particular with regard to: -</p> <ul style="list-style-type: none"> i) impact on the health of doctors; ii) impact on patient care; iii) the part played in complaints by unrealistic expectations and how this can be addressed; iv) BMA council working with BMA patient representatives to review and propose a fair and streamlined complaints procedure; v) raising awareness of the pressures on the NHS and realistic expectation of the service and its staff. <p>Creating a just and learning culture to benefit staff and patients is a key part of the Caring, Supportive, Collaborative project. We have explored our role as a trade union in a just and learning culture with our employment advisers and industrial relations officers. Two member relations staff will be attending just</p>	Professionalism and Guidance	All BoP national councils

	<p>culture training (at Northumbria University) and piloting the new approach with a local trust.</p> <p>We wrote to Prerana Issar, the NHS People Officer, on 27 November, highlighting this call for a review and asking whether the NHS is going to consider taking this forward.</p> <p>We will be engaging with the BMA's patient liaison group at their meeting in January to discuss this motion.</p>		
75	<p>That this meeting instructs council to obtain legal opinion clarifying the legal, GMC and contractual position of a doctor refusing to work knowing that they cannot guarantee patient safety due to system failure such as (but not limited to) significant clinical understaffing, IT failure, lack of support staff and to clarify the legal and GMC position if a doctor does work in these circumstances.</p> <p>A legal opinion has been provided by David Lock QC. He advised that doctors would both act in breach of their contracts of employment and expose themselves to the possibility of regulatory action by the GMC if they were to refuse to go on shift because they were concerned that, by doing so, they would expose themselves to an unacceptable risk of criminal or regulatory proceedings.</p>	Professionalism and Guidance	All BoP national councils
76	<p>That this meeting is concerned by the increasing numbers of doctors that are suffering from burnout and demands that HM Government: -</p> <ul style="list-style-type: none"> i) reduces the bureaucratic burden of assessments during training; ii) reduces the bureaucracy created by appraisal and revalidation; iii) reduces the CQC inspection system which is causing stress to medical and other healthcare staff; iv) recognises that constant inspection does not produce improvement unless funding, staffing and appropriate resources are also improved. <p>Through our regular engagement with the national training authorities, the GMC and CQC we continue to call for the reduction in inappropriate regulatory and educational burdens. For example, these themes continue to be addressed in our work on enhancing junior doctors working lives, our Caring Supporting</p>	Professionalism and Guidance	All BoP national councils

	Collaborative reports and recommendation, and our ongoing safe staffing project.		
77	<p>That this meeting believes the GMC suffers from a top-down institutional lack of insight and demands that the BMA works to ensure that the GMC is reorganised with independent senior medical leaders overseeing its reorganisation.</p> <p>This resolution will be raised with the CEO and Chair of the GMC by the Chair of Council and Chair of the GMC Working Party when they meet in late December. Opportunities will also be taken to further the aim of this resolution when the structure and make-up of regulatory boards are reconsidered - as set out in the government’s response to its consultation on ‘promoting professionalism, reforming regulation’.</p>	Professionalism and Guidance/GMC Working Party	All BoP national councils
SCIENCE, HEALTH AND SOCIETY			
80	<p>That this meeting directs the BMA to act upon the IPCC report; to declare a Climate Emergency, to plan, campaign and cooperate to deliver carbon neutrality by 2030.</p> <p>The BMA is working with key domestic and international partners to progress this resolution.</p> <p>We worked with the International and Immigration department in proposing an emergency World Medical Association (WMA) resolution, which declared a climate emergency and urged governments to work to deliver carbon neutrality by 2030. This was passed unanimously by the WMA General Assembly at its October meeting in Tbilisi. In Spring 2020 we are joint-hosting an event on achieving ‘net-zero’ for the benefit of health with the UK Health Alliance on Climate Change.</p> <p>Alongside this we are developing a programme of work that focuses on the climate footprint of the NHS.</p>	Public Health and Healthcare	International
81	That this meeting recognises the detrimental effect social media has had on the lives of some young people in society, and the vulnerability that they experience when they feel isolated from the community that surrounds them. We ask the BMA to lobby the UK government to: -	Public Health and Healthcare	PHMC

	<p>i) implement binding standards compelling social media networks to prevent the active promotion of self-harm and suicide as a means to deal with mental health issues;</p> <p>ii) mandate social media networks to implement mental health safeguards for any self-harm-related content visible to at-risk individuals, such as children and adolescents. These may include verification that the user is 16 or over, and promotion of child and adolescent mental health charities;</p> <p>iii) prosecute media corporations who are found to spread false news surrounding the suicide of a person. AS A REFERENCE</p> <p>The previous government consulted on its Online Harms White Paper last year. We had planned to lobby, with reference to this policy, on any draft legislation or further consultations that arose from the White Paper. However all major parties committed to improving online safety and tackling online harms in some form, with a specific focus on children and young people. There are therefore opportunities to influence on this issue across the political spectrum going forward.</p>		
82	<p>That this meeting condemns the practice of breast ironing. This meeting calls on the BMA to investigate the prevalence of breast ironing in the UK and to work with appropriate authorities to develop a policy to protect girls from this harmful practice.</p> <p>The condemnation from the representative body of breast ironing will feed into and inform the BMA’s work on child safeguarding and child health. From enquiries made with the key stakeholders in this field – NSPCC, RCPCH, etc – the national female genital mutilation (FGM) centre has produced guidance on breast flattening (http://nationalfgmcentre.org.uk/breast-flattening/) and there are currently no plans amongst stakeholders to develop further guidance. We will continue to monitor for any developments and we will look for other appropriate opportunities to raise the issue with government and other relevant bodies.</p>	Public Health and Healthcare	PHMC MEC
83	<p>That this meeting recognises the recent WHO announcement of anti-vaxxers being one of the top threats to global human health in 2019, alongside</p>	Public Health and Healthcare	PHMC

	<p>Ebola, HIV and humanitarian crises. We urge the BMA to lobby the UK government to: -</p> <ul style="list-style-type: none"> i) implement binding standards compelling social media corporations to actively prevent the dispersal of false or misleading information on the effects of vaccinations; ii) bring legal obligations upon social media corporations enforcing that any anti-vaccine content must display its sources of evidence and of funding; <p>AS A REFERENCE</p> <ul style="list-style-type: none"> iii) provide funds to enable vaccine providers (GPs and outreach services) to annually offer any missed childhood vaccines to children, who have not had them previously, up to the age of 16. <p>The Government’s recent prevention Green Paper committed to the introduction of a new vaccination strategy for England. We discussed the government’s plans for the strategy with civil servants in October and plan to formally respond when a consultation is launched in 2020.</p> <p>We are also developing a set of key policy asks that set out the action that is needed to improve vaccination coverage rates across the UK. This will include action to tackle misinformation online and how to adequately resource and deliver vaccination catch-up programmes.</p> <p>The interim Vaccinations and Immunisations Strategy has been published by NHS England. Ongoing negotiations with NHS England and NHS Improvement will focus on incentives to support improvements in coverage.</p>		
PUBLIC HEALTH MEDICINE			
85	<p>That this meeting is seriously concerned by the increased number of homeless people living and sleeping outdoors across the UK and recognises the deleterious effects of homelessness on physical and mental health. We call on: -</p> <ul style="list-style-type: none"> i) medical schools to ensure that the healthcare needs of this population are included in their curriculum; ii) NHS bodies to explore integrated models of healthcare for this population such as the pathway team; 	Public Health and Healthcare	PHMC PLG

	<p>iii) NHS bodies to provide NHS clinical staff with local guidelines including admission and discharge procedures for patients from this population; iv) UK governments to commit additional resources to support the primary medical care of these vulnerable people; v) UK governments to ensure that no person completing a prison sentence is released to conditions of homelessness.</p> <p>The BMA Patient Liaison Group is hosting a multi-stakeholder symposium in February 2020 which will explore the intersection between public health, health services and housing. Commitments from all political parties on this issue provides a good basis for the BMA to lobby on this issue across the political spectrum in the coming months.</p>		
86	<p>That this meeting believes that everyone has the right to a decent, affordable home and: - i) welcomes the 2019 Shelter report “Building for our future: A vision for social housing”; ii) calls on all political parties to include a commitment to implement the Shelter report recommendations in their next election manifestos.</p> <p>This is primarily a declaratory statement from the RB, affirming its support for the 2019 Shelter report and the inclusion of its recommendations in future election manifestos. However, this will also feed into our work on homelessness more generally (see above).</p>	Public Health and Healthcare	PHMC
87	<p>That this meeting is extremely concerned about the growing presentation of knife crime in emergency departments across the UK. We therefore call on the BMA to: - i) support the work of national charities and projects that aim to tackle this as a public health issue and acknowledges the role healthcare professionals have in tackling this issue alongside other government initiatives; ii) ensure medical students are aware of the social impacts of knife crime on the individual and community via integration of a session into the medical school curriculum from e.g. charities / local projects that tackle this issue.</p> <p>The Board of Science plans to host a discussion event to explore this topic in 2020. The aim is to open a</p>	Public Health and Healthcare	PHMC

	<p>dialogue with stakeholders in the charity and health sectors that have expertise and experience in taking a public health approach to knife crime and serious youth violence, and to identify next steps for policy development.</p>		
COMMUNITY AND MENTAL HEALTH			
89	<p>That this meeting calls upon the Department of Health and Social Care to commit to: -</p> <ul style="list-style-type: none"> 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. <p>We are planning to publish a policy paper in January 2020 to take forward our new asks on mental health funding and the need to achieve parity of resource, access, and outcome for mental and physical health. It will also cover access standards, out of area placements, the workforce and prevention.</p> <p>The paper will be published alongside a new briefing on the mental health workforce, which measures progress against commitments made by NHS England, Health Education England and others, as well as a survey of the mental health workforce.</p>	Public Health and Healthcare	PHMC
90	<p>That this meeting reaffirms the fact that elderly people deserve access to high quality health and social care, and demands that:-</p> <ul style="list-style-type: none"> i) care homes are nationalised in order to achieve and maintain a national standard of residential and nursing home care; ii) care home staff are subject to NHS appraisal processes and terms and conditions of service; iii) home-based social care should be provided by NHS organisations; iv) there should be an increase in the provision of residential and nursing home beds, so that hospital patients in need of supported accommodation are not faced with long delays for supported living. <p>The BMA is currently developing a policy project on social care to take forward the aims of this motion.</p>	Public Health and Healthcare	PHMC

	<p>Scoping work on this has begun, with a report expected to be published in 2020.</p> <p>Alongside this, the BMA has consistently highlighted the pressures facing social care and the impact this has on the NHS, lobbying for urgent investment to ensure that people can access the social care support they need. For example, we made the case for investment in social care in our September 2019 letter to the Chancellor of the Exchequer ahead of the Spending Round.</p>		
OCCUPATIONAL HEALTH			
95	<p>That this meeting: -</p> <ul style="list-style-type: none"> i) notes with regret that the UK is the only major European country that does not have a legal requirement for the mandatory provision of occupational health services (other than for 0.1% of the working population); ii) deplores the 2016 All-Party Parliamentary report findings that 87% of UK workers have no access to an occupational physician and consequently are denied access to the specialist medical expertise required for the prevention of further harm to their health and on the work adjustments required to allow them to continue to work; iii) calls on government to introduce a statutory requirement for the provision of high quality occupational health services for all working people in the UK, either through the NHS or as an obligation on employers. <p>The committee is undertaking a review of EU workplace health and safety legislation and how this will be preserved (and potentially expanded upon) post the UK's exit from the EU.</p> <p>The committee are also developing a comparative review of occupational health provision across several countries benchmarked against the UK, we hope to derive from this a best practice policy document that will be used to lobby for an improved occupational health pathway that would be integrated across the NHS with input from the DWP.</p>	OMC	OMC
96	<p>That this meeting expects equal treatment for mental and physical ill health for medical students and doctors to reduce stigma for people taking sick leave due to mental ill health, and calls on the BMA to</p>	Public Health and Healthcare	PHMC

	<p>produce best practice guidelines for universities and employers.</p> <p>In October 2019, we published a BMA mental wellbeing charter which calls for employers tackle the mental health stigma by encouraging conversations about mental health and normalising and encouraging help-seeking behaviour. It also calls on employers to implement effective policies and practices around sickness absence and outlines the steps employers should take to ensure a smooth return to work. We are approaching trusts to ask them to sign-up to the charter.</p>		
CLINICAL AND PRESCRIBING			
98	<p>That this meeting, noting the policy of the BMA is to support free NHS prescriptions, demands a review of prescription charges in England and asks for: -</p> <ul style="list-style-type: none"> i) a review of FP92A (Application for Prescription Charge Exemption Form) as it is out of date; ii) the extension of conditions eligible for medical exemption; iii) a cap on the maximum charge to each individual patient in one year. <p>It remains BMA policy to support free NHS prescription charges and this resolution has now been explicitly taken into the work plan of the GPC clinical and prescribing group to pursue.</p> <p>The Group has repeatedly called for the removal abolishment of prescription charges in England - as they have already been abolished in Northern Ireland, Scotland and Wales.</p> <p>The Group has also called for a full review of prescription charges in England including a review of the FP92A form.</p>	GPC	GPC
99	<p>That medicines supply shortages are becoming more frequent and the BMA should: -</p> <ul style="list-style-type: none"> i) monitor these shortages; AS A REFERENCE ii) challenge the lack of NHS action to address the problem; iii) raise public awareness of the issue. <p>We now receive regular updates from the Department of Health and Social Care supply team on current supply issues, which are subsequently shared</p>	Public Health and Healthcare	PHMC

	<p>with Local Medical Committees and practices. This helps to monitor shortages.</p> <p>We have been working with GPC to highlight concerns about medicines shortages including through media work and lobbying NHS England and the Department of Health and Social Care. We will continue to argue the need for urgent solutions and raise public awareness about the impact shortages are having on the workforce.</p>		
DOCTORS PAY AND CONTRACTS			
100	<p>That this meeting: -</p> <ul style="list-style-type: none"> i) believes that future discussions on doctors’ pay should be informed by earnings data for other comparable jobs in the modern economy; ii) has no confidence in the Review Body on Doctors’ and Dentists’ Remuneration (DDRB); iii) calls on the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) to be replaced by a transparent, fair and independent system of reviewing doctors’ pay; iv) calls on the BMA to ballot members of the Association for industrial action if the next pay award is deemed not acceptable. <p>i) We have included comparisons on growth in earnings of employees in other comparable occupations, which demonstrate that doctors have seen the biggest fall in median real gross hourly earnings in all recent submissions we are intending to do so again this year.</p> <p>ii) iii) The BMA has been clear for the past several years that we feel the process has let our members down by not recognising the value of doctors working in the NHS. We have repeatedly lobbied for the DDRB to restore its independence and return to its original purpose of defending the profession against arbitrary action from Governments, as well as a revision of its terms of reference to ensure it focuses purely on pay uplifts for all doctors.</p> <p>iv) Following the pay uplift announcement in England, Wales and Scotland (the pay uplift for 2019-20 has yet to be announced in Northern Ireland) the BMA BoP committees and national councils have undertaken an extensive consultation process regarding the pay announcements and next steps. Based on this and evidence from our members the</p>	Pay and Contracts	All BoP, National Councils

	BMA decided that even though the pay uplifts are still not sufficient in addressing the real terms pay cuts that doctors have experienced, they are a first step in bringing doctors uplifts more in line with the wider economy. On that basis there was no need to ballot members on industrial action.		
	BMA STRUCTURE AND FUNCTION		
106c	<p>That this meeting: -</p> <ul style="list-style-type: none"> i) believes the current BMA in-house complaints procedure is not fit for purpose; ii) believes that BMA members with valid complaints are actively discouraged from raising a concern due to the current complaint system; iii) believes that sexism and harassment are not seriously addressed by the BMA; iv) welcomes the announcement of an independent external investigation into recent complaints of sexism and harassment within the BMA, as long as the investigator has the confidence of the complainants; iv) expects the findings of the external investigation into complaints of sexism and harassment within the BMA to be published in a timely manner and any recommendations to improve the complaints procedure to be implemented. <p>i) & ii) The recommendations of an external review of the BMA resolution process, commissioned in 2018 and conducted by Orla Tierney, were approved by BMA Council in July 2019. These were aimed at reinforcing the impartiality and independence of the process and included the introduction of an independent support line for members and staff who wished to raise concerns about member behaviour and external investigations of formal complaints. These were implemented in September 2019. A further recommendation, of having cases heard by panel members who are not involved in the political structures of the BMA was implemented in late 2019- grassroots members were recruited to the pool of approved panel members and are now hearing cases.</p> <p>iii), iv) & v) Daphne Romney QC was commissioned to conduct an independent review of sexism and sexual harassment within the BMA. Her report was published in October 2019 (and is available on the</p>	Corporate development	

	<p>BMA website). Her recommendations, accepted by Council in November 2019, included several points on the resolution process, which echoed and added to those of the earlier review. The BMA has committed to the report recommendations and set up a Romney Review Implementation Group (now called the Inclusion and Culture Group), which is Chaired by Elisa Nardi, BMA non-executive director, to have oversight of the report recommendation implementation.</p> <p>As well as the significant changes that had already been made to the process for handling, investigating and hearing complaints about member conduct, the Romney report called for a guide to the resolution process for members and staff to be produced. This was completed and made available in December 2019.</p>		
108	<p>To best achieve our aims for the National Health Service, medical students, doctors, physician associates and other Medical Associate Professionals (MAPs), this meeting resolves that the BMA should work with organisations representing physicians associates, other MAPs and students of these professions in staff and/or student joint committees.</p> <p>We are planning to set up regular meetings with the MAPs representative groups once we have our 'new clinical roles' reference group up and running and have held our internal new clinical roles round table discussion in early 2020.</p>	Public Health and Healthcare	PHMC
	STAFF, ASSOCIATE SPECIALISTS AND SPECIALITY DOCTORS		
111	<p>That this meeting, regarding the holiday entitlement of SAS doctors: -</p> <ul style="list-style-type: none"> i) welcomes the NHSE recommendation that these doctors should receive an extra 2 days paid holiday per year and congratulates those trusts which have implemented this; ii) instructs BMA to negotiate the inclusion of the recommended extra 2 days holiday into the national terms and conditions of service to ensure all SAS doctors will benefit; iii) requests BMA to ensure that all NHS Trusts and private companies providing services to the NHS, as a minimum give their doctors their annual leave entitlement in full. AS A REFERENCE 	Pay and Contracts/SASC	SASC

	<p>The BMA has entered into initial discussions prior to formal negotiations on the Specialty Doctor and Associate Specialist contracts. SASC UK have already indicated that securing additional leave will be an aim for negotiators. However, as with all negotiations, this aim will need to be considered in relation to SASC's other competing priorities.</p> <p>Regarding (iii), this is clearly a position that the BMA supports and will continue to do so through the Association's employment advice service and the work of its Industrial Relations Officers.</p>		
<p>112</p>	<p>That this meeting congratulates the BMA on agreeing the SAS charter in all four nations. We call upon the BMA to: -</p> <ul style="list-style-type: none"> i) work with management to implement the charter using the toolkit; ii) provide evidence of this implementation; iii) ensure that the SAS LNC representative where present, is involved in the implementation and monitoring of the charter. <p>The BMA and NHS Employers have published SAS Charter resources to help employers and SAS doctors work together to assess their organisation's progress towards implementing the SAS Charter.</p> <p>The SASC UK committee agreed at the 4 December meeting to develop a template survey to SAS doctors on implementation of the Charter. The survey would be intended for IROs/regional chairs to administer and monitor.</p> <p>Several members have already circulated a survey to the SAS doctors in their region, which have been received positively and findings of these have been used in meetings with medical directors to build the case for further implementation of the Charter. This has in some cases led to tangible progress, with some SAS doctors sitting on employment panels and acting as appraisers to consultants.</p> <p>The BMA also plans for some SAS Charter requirements, such as appropriate access to resources to enable SAS doctors to do their jobs effectively and efficiently, to form part of the negotiations for the Specialty Doctor and Associate Specialist contracts.</p>	<p>SASC</p>	<p>SASC</p>

<p>113</p>	<p>That this meeting calls on the BMA to consider promoting a CEA system for SAS doctors as part of a modernised reward and recognition regime for this hardworking and often very innovative cohort of the senior medical workforce.</p> <p>The BMA has entered into initial discussions prior to formal negotiations on the Specialty Doctor and Associate Specialist contracts. NHS Employers have already indicated a willingness to consider the negotiation of an excellence scheme for SAS doctors, however the benefits and costs of such a scheme will need to be considered in relation to the SAS Committee’s other priorities, including an increase in basic pay and contractual safeguards. It is worth noting that such a scheme previously existed, in the form of Optional Points – however, during the negotiations of 2008, SASC UK were of the view that the funding for such a scheme would be better used by increasing basic pay. If they were to seek a new excellence scheme, this would likely be funded from within the envelope for basic pay, just as the funding for the various consultant awards schemes was originally taken from the basic pay of consultants. Again, this is a matter for SASC and its negotiators to consider.</p>	<p>Pay and Contracts/SASC</p>	<p>SASC</p>
<p>JUNIOR DOCTORS</p>			
<p>115</p>	<p>That this meeting: -</p> <ul style="list-style-type: none"> i) notes that trainees who move between different deaneries face problems in continuity of benefits like maternity allowances and childcare vouchers; ii) recommends that the NHS England as single employer for trainees would be a solution. AS A REFERENCE <p>We are aware of the contractual issues caused by the rotational nature of junior doctor training which, along with inter-deanery transfers, can impede a trainees access to benefits due to eligibility often being tied to length of service.</p> <p>To counter this, we have continually advocated for trainees to be employed under lead employer contracts and amend national contracts to prevent trainees from losing contractual entitlements from moving to another NHS employer.</p>	<p>Pay and Contracts/JDC</p>	<p>JDC</p>

<p>116</p>	<p>That this meeting recognises that practical barriers can discourage doctors from exception reporting and calls for electronic reporting systems: -</p> <ul style="list-style-type: none"> i) which are compatible across all platforms; ii) which are accessible outside the workplace; iii) which are free to use; iv) which are demonstrated as part of induction programmes; v) whose login details are provided at, or prior to, induction. <p>Following the outcome of the 2018 Review we have made a number of improvements to the process and outcomes of exception reporting.</p> <p>Despite these improvements, we are aware that trainees continue to experience a range of difficulties with both the availability and operationality of exception reporting platforms. Not all of these issues can be addressed through contractual amendments. However, we are seeking to address these issues through; directly engaging with exception reporting software providers, involvement on NHSI’s exception reporting working group, and through revising and improving existing guidance.</p> <p>A fully functioning exception reporting system for all secondary care settings is recommended in the BMA’s 2018 Medical rota gaps in England report. Medical rota gaps in England report. This also talks about the benefits of appropriate formal inductions, including receiving timely log-in details. It also contains an example of a rota management system, which should ideally include exception reporting functionality. Further rota management systems are being trialled around England, and providers should be supported by commissioners and, where additional resourcing is required, ministers to enable full scale implementation of such workload management and admin-reducing technology.</p>	<p>Pay and Contracts/JDC</p>	<p>JDC</p>
<p>117</p>	<p>That this meeting recognises the negative impact on junior doctor wellbeing when timely annual leave requests are not accommodated by employers and deplores that junior doctors are expected to find their own cover. We therefore call upon the BMA to lobby for contractual change on this basis.</p>	<p>Pay and Contracts/JDC</p>	<p>JDC</p>

	<p>We are aware of a wide range of issues surrounding junior doctors’ annual leave, including the ones in this motion.</p> <p>In England, as part of the 2018 review of the 2016 TCS, a working group have been established to look into issues surrounding leave as part of the JNC(J), which is where we will take these concerns. This issue was also addressed in the BMA’s 2018 <u>Medical rota gaps in England</u> report. Timely leave requests that are not accommodated is a clear sign that staff are under pressure, and most likely means that rota gaps exist and staffing is either at risk of being unsafe or is already unsafe. The BMA’s <u>Manifesto for Health</u> call for safe staffing legislation includes making local / national commissioners and ministers accountable for ensuring providers can recruit and retain sufficient numbers of staff. This will ensure safe care and preserve staff wellbeing so that they can do their very best for patients.</p> <p>In Northern Ireland, this issue will be discussed with the DoH NI and other key stakeholders at the newly established Improving Junior Doctors and Dentists Working Lives group.</p> <p>In Scotland, in July 2019 it was agreed with government and employers on fixed leave – from 1 Aug 2020, juniors will be given 6 weeks’ notice of any period of fixed leave in rotas. In 2018 there was also agreement about leave for “life events” – that employers recognise the importance of leave for weddings etc and will normally allow leave for these; where possible the leave request should be at least 6 weeks in advance. There are no other discussions surrounding leave currently.</p> <p>In Wales, forthcoming discussions in social partnership with Welsh Government and NHS Wales employers about the future of the junior contract in Wales will provide an opportunity for discussion on this topic.</p>		
<p>118</p>	<p>That this meeting recognises the disparity in travel expenses policies between different deaneries, lead employers and local education training boards and we ask that the BMA lobby relevant bodies to create a simpler and fairer standardised expenses policy for all junior doctors.</p>	<p>Pay and Contracts/JDC</p>	<p>JDC</p>

	<p>We are currently engaging with Health Education England who are developing a national framework for relocation expenses and excess mileage. This framework seeks to standardise these benefits across the whole of England for all trainees, but with some room for variation to recognise regional particularities.</p> <p>HEE intend on implementing this framework in April 2020.</p>		
FINANCES OF THE ASSOCIATION			
120	<p>That the annual report of the directors, treasurer's report and financial statements for the year ended 31 December 2018 as published on the website be approved.</p> <p>DONE</p>	Treasurer / Finance	
121	<p>That the subscriptions outlined in document ARM1B (appendix iv) be approved from 1 October 2019.</p> <p>121 – No increase in subscriptions from 1st October 2019</p>	Treasurer / Finance / Membership & Professional Records	
123	<p>That this meeting notes the BMJ editorial of 30th March, and preceding news item from 23rd March 2019, on travel claims for spouses by BMA Chief Officers. We ask that the BMA: -</p> <p>i) commissions a fully independent enquiry into this practice;</p> <p>ii) ensures that in the future no such claims are permitted unless they are extraordinary and have prior approval of the Finance Committee.</p> <p>123 – i) completed, I believe the review was sent to Council and any questions where asked to be sent in via email, I have not seen any</p> <p>ii) Agreed</p>	Council secretariat	
TRAINING AND EDUCATION			
125	<p>That this meeting acknowledges the traumatic impact that clinical events encountered in their training and working environment, such as patient loss of life or patient life-threatening events, can have on junior doctors. This meeting recognizes that this trauma can have lasting negative consequences on trainee wellbeing. It calls upon the BMA to:-</p> <p>i) lobby education bodies and employers to train all doctors in how to undertake an effective debrief;</p>	Public Health and Healthcare	PHMC

	<p>ii) lobby education providers to include information on the importance of debriefing after a traumatic event in all postgraduate teaching programmes;</p> <p>iii) lobby education bodies to promote the use of debriefs to all involved in training junior doctors;</p> <p>iv) acknowledge that debriefs should take place contemporaneously after the traumatic event but must not require junior doctors to extend their working hours or use approved leave in order to receive a debrief; AS A REFERENCE</p> <p>v) work with the UK Resuscitation Council and other life support course designers to ensure that all life support courses have a mandatory debrief built into the end of the scenario training.</p> <p>In October 2019, we published a BMA mental wellbeing charter which calls for employers to provide timely post-incident support and train doctors on how to undertake an effective debrief. The importance of 'hot'/immediate debriefs is also highlighted in the BMA report health and wellbeing at work.</p> <p>The BMA's safe staffing project is considering the personal impact of caring for patients in a system under pressure. Not having enough staff makes it even harder for doctors to find the space that they need to decompress emotionally after traumatic experiences with their patients. Without this, doctors and other NHS staff are at much higher risk of ill-health and or leaving their profession altogether. Treating the NHS' workforce as its number one asset is vital to ensuring patients get the best quality care possible.</p>		
126	<p>That this meeting believes that the RCGP updated curriculum has failed to make the case for a 4 year training program. We call upon the BMA to lobby relevant bodies to:-</p> <p>i) maintain the current 3 year training length;</p> <p>ii) overhaul training to be based entirely in general practice with short integrated secondary care placements designed to directly address trainees learning needs;</p> <p>iii) adequately incorporate training in management and business skills to better equip trainees as future leaders and practice partners.</p> <p>i. We have been in discussions with NHS England and HEE at a senior level on this issue, who have</p>	Professionalism and Guidance/GPC	GPC

	<p>confirmed there is no desire to change from the three-year training length in the face of current pressures in primary care.</p> <p>ii. Commensurate with i), we have been able to confirm that the structure of GP training will be altered to 12 months in acute settings, and 24 months in primary care settings. This will sit alongside an increase in training numbers to support acute settings while also increasing the GP workforce. The structure is unclear at this stage; however, it seems likely that the rotation structure will remain as 6 months for acute specialties.</p> <p>iii. The RCGP curriculum has not been updated following BMA feedback last year that would have managed this from the college level. However, we continue to lobby HEE and NHS England to ensure that this training is provided part of the non-curriculum training package for GP trainees</p>		
<p>127</p>	<p>That this meeting calls for recognition of SAS doctors from Employers, Deaneries and the GMC by:-</p> <p>i) creating career pathways for SAS doctors including an option of returning to training if so desired, and with full recognition of previous experience and seniority;</p> <p>ii) safeguarding the opportunity and time for training within service for SAS doctors, in line with that afforded to doctors in training, to ensure continued excellence in delivery of patient care;</p> <p>iii) recognising those pathways and banishing the use of pseudonyms such as ‘others’.</p> <p>i. This work is underway, with the discussions having taken place with the GMC and HEE. This is also likely to be a feature of the Associate Specialist grade negotiations with NHS Employers that will begin in the New Year. Given the complexity and time required for all these strands of work, it is likely this will take some time to complete.</p> <p>ii. We are actively working with NHS Employers and HEE to meaningfully implement the SAS charter, to allow SAS doctors to access development time and materials. This will also be advanced through contractual negotiations referred to under i).</p> <p>iii. Since 2017, we have been actively changing attitudes in the GMC, HEE and others to prevent the</p>	<p>Professionalism and Guidance/SASC</p>	<p>SASC</p>

	<p>use of this language and terminology through direct interventions with individuals, and changing official references to refer to SAS doctors in a positive way, rather than the negative use of 'others' and by defining SAS doctors by what they are not.</p>		
	<p>HEALTH INFORMATION MANAGEMENT AND INFORMATION TECHNOLOGY</p>		
129	<p>That this meeting welcomes the Secretary of State's announcements on stopping out of date technology, but believes that: -</p> <ul style="list-style-type: none"> i) arbitrary dates to stop any technology without ensuring clinically safe and appropriate alternatives are in place put patients at risk; ii) relevant stakeholders including NHS England, NHS Digital, individual Trusts, and frontline clinicians should collate the advantages and disadvantages of all methods of communication currently in use within the NHS (including reliability, data security and cost), to identify areas of best practice; iii) where personal phones are required, expenses are claimable and the security of personal details should be GDPR compliant. <p>The BMA has established formal lines of communication and collaboration with NHSX's senior leadership and clinical staff. The organisation was formed in July 2019 and 'has been created to give staff and citizens the technology they need'. The BMA hosted three events on healthcare technology innovation across October and November 2019, which enabled senior elected members from across the UK to discuss the BMA's strategy and high-level principles for new technologies, whilst hearing from and debating with international experts.</p> <p>The BMA Board of Science will host an event in early April 2020 bringing together everyday doctors and patients that have benefitted from innovative technology in their everyday lives. This will include a specific focus on the ethical development of tech and prioritising innovations that reduce health inequalities. Key stakeholders, such as NHSX, will be invited to hear and learn from these NHS staff and patients.</p>	Public Health and Healthcare	PHMC
130	<p>That this meeting is appalled that the government requires the Department of Work and Pensions to develop a new digital system for the administration of "health related benefits" which would gather</p>	Public Health and Healthcare/ Professionalism and Guidance	PHMC

	<p>relevant data from general practice records by automated routine requests which would destroy the essential doctor/patient relationship of confidentiality and asks the BMA to demand that the government abandon this project.</p> <p>We are aware of the DWP’s proposals to develop a new digital system, and the BMA continues to liaise with the department at the DWP GP forum meetings. Any such system being developed would have to have the necessary consent from the patient to release medical records to the DWP.</p>		
RETIRED MEMBERS			
132	<p>That this meeting calls on the General Medical Council to change its retiral, revalidation and re-entry processes in order to retain senior members of the profession to contribute to clinical services, teaching and research.</p> <p>This resolution was raised with the GMC during our GMC Working Party meeting in November. Unfortunately, no commitment was received to review the current procedures. Further work will take place to explore in more detail the views of the Retired Members Committee, with a decision on how best to take this forward being taken by both the Retired Members Committee and the GMC Working Party.</p>	Professionalism and Guidance/GMC Working Party	RMC
CONSULTANTS			
135	<p>That this meeting demands that the CEA system should be restored to its original form as its current form discourages consultants from pursuit of excellence.</p> <p>AS A REFERENCE</p> <p>The 2018 CEA agreement was brought into effect as a result of lengthy and complex legal action and the subsequent settlement reached with the Department of Health & Social Care and NHS Employers. The 2018 agreement settled provisions for two stages: the first, for a period from April 2018 to April 2021, and the second, from April 2021 onwards.</p> <p>It remains the intention of all parties that there will be a new nationally-agreed performance pay scheme negotiated prior to 2021 and introduced by April of that year. The negotiations over how this successor scheme will look will be informed by the spirit of this</p>	Pay and Contracts/CC	CC

	<p>motion. It is however worth noting that BMA engagement events and surveys have continued to indicate that not all consultant members favoured the CEA scheme as it was previously designed, with only around half believing that it represented an effective means of recognising and rewarding outstanding consultant contributions. As such, we will seek to negotiate a scheme that commands the confidence of a majority of our consultant members.</p>		
CHOSEN MOTION (Workforce)			
204	<p>i) That this meeting believes that wholly owned subsidiaries undermine the terms and conditions of health workers and lead to a two tier workforce. ii) This meeting calls on the BMA to oppose wholly owned subsidiaries and to call for existing wholly owned subsidiaries to be abolished and all workers to be brought back into NHS terms and conditions.</p> <p>The BMA has publicly opposed a number of trusts' attempts to transfer staff contracts to wholly owned subsidiaries. A webpage is currently being drafted to clarify the BMA's position and provide information to members – this will be published in early 2020.</p>	Public Health and Healthcare	PHMC
CHOSEN MOTION (Medicine and Government)			
257	<p>That this meeting: - i) is horrified that the Home Office is attempting to embed immigration officers as part of an "enhanced checking service" into NHS trusts and local authorities; ii) calls on the BMA to demand that this practice is stopped.</p> <p>The BMA is currently planning further research into the cost effectiveness of the existing overseas charging regime (see response to motion 42 above). This will include a specific focus on the use and cost of the Home Office "enhanced checking service" within NHS Trusts.</p>	Public Health and Healthcare	PHMC
CHOSEN MOTION (Medical Ethics)			
273	<p>That this meeting insists that women accessing lawful abortion services and the staff providing those services: - i) should not be subject to intimidation; ii) should be provided with protestor free buffer zones outside abortion clinics.</p>	Professionalism and Guidance	MEC

	<p>The BMA continues to monitor developments in this area and lobby for buffer zones outside abortion services.</p> <p>Most recently, on the 7 October 2019, the BMA co-signed a <u>letter to the Home Secretary</u> asking her to look again at the possibility of introducing national buffer zones. The letter was also signed by the Faculty of Sexual and Reproductive Healthcare (FSRH), Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG), amongst others. Shortly after this, the general election was called.</p>		
282	CHOSEN MOTION (International)		
	<p>That this meeting calls on the UK government to exert pressure on the Brunei government to reverse its decision to administer cruel, inhuman and degrading punishments, including public flogging of women who have had abortions and death by stoning for homosexuals, as part of its extension of Sharia Law within its criminal justice system.</p> <p>We have been researching this issue and are liaising with the comms team. We will be writing to the UK Government with a view to getting them to exert appropriate pressure. It is worth noting though that although capital punishment has been on the statute books in Brunei, it has not been used since 1957.</p>	Professionalism and Guidance	International
	CHOSEN MOTION (General practice)		
396	<p>This meeting calls on the BMA to work with relevant organisations to ensure all CCGs and Health Boards in the UK can guarantee provision of a hoist, with appropriately trained staff, and appropriate examination couch in at least one practice within their groups, enabling timely and accessible examinations of patients with disabilities.</p> <p>The EIC policy team has been working with the healthcare policy team to explore the logistical and financial considerations around this proposal. We have also been in touch with relevant third sector organisations who have previously raised this issue in relation to specific health conditions. We are now exploring options to bring together the relevant organisations at a stakeholder meeting in early 2020 to work through practicalities.</p>	Professionalism and Guidance	

CHOSEN MOTION (BMA Structure and Function)			
454	<p>That this meeting believes that in instances where the BMA advocates for members with protected characteristics, the lived experience of members possessing those characteristics is of fundamental importance to the discussions. It therefore calls for the BMA to create a fair and transparent process for the appointment of liberation officers from within the committee of each branch of practice.</p> <p>The BMA has developed a process for the appointment of equality champions (liberation officers) to committees. The process has been reviewed and approved by the BMA board of directors and will be shared with all committees for implementation shortly. The roles will be elected on an annual basis to ensure fairness and transparency. The champions will:</p> <ul style="list-style-type: none"> • Asct as a point of contact and advocacy for branch of practice-specific or pan-BMA equality issues. • To ensure that equality considerations are fed into all discussions and items on branch of practice committees. • To champion the BMA’s commitment to equality, diversity and inclusion. 	<p>Corporate development / Council secretariat</p>	
EMERGENCY MOTIONS			
EM1	<p>That this meeting condemns the conditions being reported from within immigration detention centres in the USA, and the reopening of former internment Camp Fort Sill and: -</p> <p>i) calls on the UK government to urgently condemn these conditions publicly;</p> <p>ii) calls for the UK government to lobby through diplomatic channels for the closing of these immigration detention centres;</p> <p>iii) calls for a boycott of US goods by the UK public until dehumanising treatment of people in these centres comes to an end;</p> <p>iv) calls for consultation with relevant organisations about proper definition of these detainment centres.</p> <p>Following discussion with the proposer of the motion, we have written to Physicians for Human Rights US and the American Medical Association to explore the best methods of making these issues known. We have also written to the International Rescue Committee as it has taken a strong public position criticising the US immigration detention</p>	<p>Professionalism and Guidance</p>	

	centres. We will continue to make representations to the UK Government on this issue once purdah is lifted. We are seeking to identify US companies directly involved in the immigration infrastructure in order to press for targeted sanctions.		
EM2	<p>i) That this meeting joins with the Sudan Doctors Union UK branch and the Sudanese Doctors Union of Ireland in condemning attacks by masked security men on doctors in Sudan;</p> <p>ii) This meeting extends solidarity to health workers in Sudan;</p> <p>iii) This meeting condemns the killing of civilians;</p> <p>iv) This meeting calls on the BMA to insist that the UK Government stop selling weapons to dictatorships such as Saudi Arabia as these weapons can then be used in the killing of civilians;</p> <p>v) This meeting calls on the BMA to make a public statement expressing our condemnation and to communicate this to the Sudanese Government.</p> <p>EM 2 – <u>all parts</u> taken AS A REFERENCE</p> <p>The BMA has <u>written</u> to the Sudanese Ambassador, and the Home Office to express concerns about attacks on Sudanese physicians and health facilities.</p>	Professionalism and Guidance	International
EM3	<p>That this meeting: -</p> <p>i) is appalled to hear of an attack on doctors in Kolkata who were trying to provide care to patients earlier this month;</p> <p>ii) expresses solidarity with our health care colleagues in India and the Indian Medical Association in their fight for better working conditions;</p> <p>iii) asks the association to work with World Medical Association to develop a charter to ensure safety of health care workers across the world.</p> <p>EM3 – <u>all parts</u> taken AS A REFERENCE</p> <p>The Ethics Secretariat is monitoring the situation in India.</p>	Professionalism and Guidance	MEC
EM4	<p>That this meeting: -</p> <p>i) condemns the arrest, imprisonment and sentencing of council members of the Turkish Medical Association on 3 May 2019, for speaking out against the ‘irreparable physical, psychological, social and environmental damages’ caused by war;</p> <p>ii) believes that national medical associations, their representatives, and the wider medical profession</p>	Professionalism and Guidance	International

	<p>must be free to speak out against all actions affecting health without fear of intimidation or retaliation, and that any adverse consequences following such statements are a gross violation of international human rights, particularly rights to freedom of expression and opinion;</p> <p>iii) 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;</p> <p>iv) urges the BMA to continue to demand that Turkey fulfil its obligations under international humanitarian and human rights treaties, including by protecting the right to freedom of association and expression;</p> <p>v) requires the BMA to continue to lobby such that those regimes that threaten the rights of health professionals are challenged and made accountable.</p> <p>EM4 – <u>all parts</u> taken AS A REFERENCE</p> <p>The BMA has <u>written</u> a series of letters to the Home Office, the Turkish Ambassador and relevant Turkish officials to condemn the continued persecution of doctors in Turkey.</p>		
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