

ARM6



Annual Representative Meeting 2021

Report of action taken on 2020 ARM resolutions

13-14 September 2021 (virtual conference)

ARM2021

Build back together:
supporting our members, supporting our NHS

#ARM2021

ARM agenda No.	Resolutions	Accountable policy function
PM 1	<p>That this meeting notes the backlog of planned care resulting from the Covid-19 emergency and the likely effect on NHS waiting lists, and calls on the BMA to:-</p> <ul style="list-style-type: none"> i) work with governments to develop a public information campaign on the likely timescale for the NHS to return to normal routine services; ii) demand adequate funding for the NHS to increase its capacity to address the backlog of planned care; iii) seek the return of public funds paid to the for-profit private sector to retain capacity which was under-used during the pandemic; <p>i) The second and third waves of the COVID-19 pandemic have meant that it has been difficult so far for the NHS to return to normal routine services. In October 2020, NHS England and NHS Improvement, and Public Health England jointly launched the ‘Help Us, Help You’ campaign which seeks to address the barriers that are deterring patients from accessing NHS services. However, this was followed by the second wave. As the UK started to emerge from the second wave, the BMA launched <u>Rest, recover, restore: Getting UK health services back on track</u> in March 2021. The report called for all UK governments and system leaders to have an honest conversation with the public about the need for a realistic approach to restoring non-COVID-19 care, and support for systems to tackle the backlog, alongside ensuring the health, safety and wellbeing of the workforce remain a top priority; additional resourcing to help tackle the backlog is provided; and measures to expand system capacity and retain doctors are taken. As cases start to again fall following the third wave, we will now again be looking very closely at how the NHS can best be supported to reopen routine care, including looking at what public messaging is needed – as well as calling out initiatives that prioritise clearing the backlog over the health, safety and wellbeing of the workforce.</p> <p>ii) We regularly calculate the size of the non-COVID-19 care backlog and estimate the cost of addressing it. These stats and analysis were used in our <u>submission</u> to the 2020 Spending Review where it was highlighted that tackling the backlog of non-COVID-19 care at that time could cost at least £4.9bn to work through. Although the spending review confirmed an increase to core NHS funding and COVID-19 funding, commitments for funding the backlog of planned care fell short of what was needed. We will continue to lobby government for sufficient funding to address the backlog. For example, we wrote to the Chancellor ahead of the Spring Budget highlighting the current potential size and cost of the backlog of elective care and the</p>	Public health and healthcare

	<p>need for long term investment and resources to address this. In publishing our July 2021 <u>Medical staffing in England</u> report, we have also now estimated the size of the medical workforce deficit in England and the approximately £8 billion needed just to expand medical school places alone. This does not include the cost of expanding the medical educator workforce and the required teaching estate commensurately too.</p> <p>The BMA is using publicly available data, FOI requests and member surveys to build up evidence of the extent and impact of underuse of independent sector resources during the initial phase of the pandemic. The BMA also submitted <u>evidence</u> to the Public Accounts Committee inquiry on Government procurement and contracts for PPE, raising concerns about the fact that we still do not know to what extent private hospitals were used in the initial months of the pandemic, making it difficult to determine value for money. We will continue to push for an inquiry to further uncover what has happened and we are monitoring the new set of contracts that replace the original block contracts.</p>	
PM 2	<p>That this meeting believes that the global pandemic has demonstrated the need for a well-resourced national health protection function, to meet current and future communicable disease threats. This meeting, therefore, calls for:-</p> <ul style="list-style-type: none"> i) a government review of the fitness for purpose of the UK's current health protection systems; ii) Public Health England to be reconstituted as a fully independent arm's length NHS "Special Health Authority," integrated with the wider NHS and able to hold government to account on matters of Public Health; iii) the establishment of a national public health "infection" service as part of PHE; professionally-led and in charge of strategy, operations, education and training, with an appropriate budget and regional offices; iv) all consultants in Public Health to be employed on contracts equivalent to those of NHS Consultants, with adequate guarantees of freedom to make professional advice public; v) all consultants in Public Health to be employed on contracts equivalent to those of NHS Consultants, with adequate guarantees of freedom to make professional advice public. <p>This motion was drafted prior to the announcement regarding the abolition of Public Health England and the subsequent creation of the UK Health Security Agency and Office for Health Promotion. Action on this resolution is therefore being taken forward as part of wider engagement on the future structure of public health services (in England).</p> <p>The BMA has been a vocal critic of the timing and manner in which the abolition of PHE was announced and we have publicly stated that there remain significant worries about the ability of the new institute</p>	Public health and healthcare

	<p>to speak truth to power and about the lack of public health expertise among its leadership.</p> <p>The BMA's views on these changes were set out in our <u>response to a government consultation</u> on the future of the public health system. The BMA continues to actively engage on the contractual arrangements for staff in the new organisations.</p> <p>We have also fed into a number of stakeholder roundtables run by PHE and the DHSC to better understand the views of public health professionals.</p>	
PM 3	<p>That this meeting insists that there must be a public enquiry into the UK Governments' management of the COVID-19 pandemic in order to be better prepared for and to be able to follow best practice during any future overwhelming health crisis. As a minimum it should cover in its remit:-</p> <ul style="list-style-type: none"> i) the mismanagement of care homes; ii) the purchase, delivery, quality control and guidelines for PPE; iii) the testing strategy; iv) health & care staff wellbeing; v) the timing of interventions and the timing of the easing of restrictions. <p>The BMA has consistently called publicly for a full public inquiry into the pandemic. The Government has now confirmed that a public inquiry will begin in Spring 2022.</p> <p>The BMA has committed to a comprehensive programme of research and engagement ahead of this, to set out views of the medical profession, define the key lessons that must be learnt and influence the terms of the official UK inquiry. Following our public announcement of our intention to conduct this work, we are currently engaging with UK BoP committees, devolved nation council chairs and UK council ahead of commencing this work. To date the BMA has also submitted evidence to several parliamentary inquiries on various aspects of the government's handling of the pandemic.</p>	Public health and healthcare / Public Affairs
PM 4	<p>That this meeting affirms the rights of transgender and nonbinary individuals to access healthcare and live their lives with dignity, including having their identity respected and calls upon the government to:-</p> <ul style="list-style-type: none"> i) allow transgender and nonbinary individuals to gain legal recognition of their gender by witnessed, sworn statement; ii) ensure that under 18s are able to access healthcare in line with existing principles of consent established by UK Case Law and guidelines published by the public bodies which set the standards for healthcare; iii) enable trans people to receive healthcare in settings appropriate to their gender identity; iv) ensure trans healthcare workers are able to access 	Professional policy and activities

	<p>facilities appropriate to the gender they identify as; v) ensure trans people are able to access gendered spaces in line with the gender they identify as.</p> <p>We have a new project plan that sets out the work on this motion in a phased approach. Phase 1 will be a series of actions and activities focused on following thematic areas, to build and evidence base for action:</p> <ul style="list-style-type: none"> – Supporting trans and non-binary members in education training and the workplace – Improved education/CPD and awareness for medical professionals to support their trans and non-binary patients – Regulation, legislation and guidance – Commissioning reform – Ongoing engagement with trans and non-binary communities <p>We responded to the Women and Equality Committee inquiry on reforming the GRA/trans equality in November 2020. This followed with the Chair of MEC providing oral evidence to the Women and Equality Committee in May 2021.</p> <p>We will publish updated guidance for doctors to improve support for Trans and non-binary patients in Autumn 2021. A draft guidance document went to MEC in March 2021 and has been discussed with GPC. The guidance will now be divided into general guidance on best practice for doctors engaging with Trans and non-binary patients and separate GP guidance related to specifics on care-pathways.</p> <p>The MEC also considered, and continues to follow, the Bell vs Tavistock and Portman judicial review and any potential implications in relation to case law and Gillick competency.</p> <p>The EIC team have created a trans working group in member relations to develop FAQs to advise member relations colleagues on how to advice doctors and employers about key issues that arise for trans doctors e.g. in changes to GMC registration.</p>	
PM 5	<p>That this meeting believes the Covid-19 pandemic and the Black Lives Matter movement has demonstrated the importance of addressing health inequalities and racism in the UK. This conference calls for:-</p> <ul style="list-style-type: none"> i) increased funding for public health to tackle ethnic, geographic and gender inequalities in the UK; ii) greatly improved recording and analysis of ethnicity in the NHS; iii) specific action based on culturally sensitive research to address the health, social and educational problems caused to Black, Asian and minority ethnic schoolchildren and make recommendations to reduce these inequalities; iv) all NHS trust and organisation boards should reflect the ethnic 	Professional policy and activities

	<p>make-up of the workforce of the organisation which they manage;</p> <p>We have continued our lobbying of government to push for these asks. In particular:</p> <ul style="list-style-type: none">- In the BMA's <u>representation</u> to the Government's recent spending review we called for increases in the public health grant- Responding to the Commission on Race and Ethnic Disparities inquiry in November 2020- Making public statements in response to the publication of the report by the government on progress against the PHE review in October 2020 and An Avoidable Crisis (the Lawrence Review) into the disproportionate impact of COVID-19 on Black Asian and Minority Ethnic Communities. <p>In addition, Chair of Council now sits on the board of the Race and Health Observatory and has attended roundtables hosted by PHE and NHSEI on racial inequalities in health (the public and workforce). Chair of Council met with Kemi Badenoch (Equalities Minister) in December 2020 and discussed the progress against the COVID-19 ethnic health inequalities report.</p> <p>We contributed to the development of the Medical Workplace Race Equality Standard (MWRES) indicators. The report was published in July 2021.</p> <p>We have also held events across the BMA to improve the ethnic diversity of leadership in the NHS e.g. the Race and Health Panel by the Healthcare Leadership Academy and the Diversity in Medical Leadership event held by the Committee of Medical Managers.</p> <p>In April 2021 we launched our research into progression of doctors from ethnic minority backgrounds. Due to be published in April 2022, this research will provide a framework for how to remove the barriers that prevent certain ethnic groups from progressing into senior leadership roles.</p> <p>In July 2021 we responded to the government's Race Report by publishing a full critique, <u>A missed opportunity</u>. Providing an analysis of the report and highlighting the missed opportunities to improve racial inequalities for doctors in practice and training by the government's failure to acknowledge structural inequality. We have follow-up meetings scheduled with the Minister of Equalities, Kemi Badenoch to support a key recommendation to tackle the ethnicity pay gap. We also hosted a meeting with stakeholder ethnic minority medical organisations to discuss the report and agreed a joint public call for action.</p> <p>In July 2021 the Chair of Council met with the GMC and sent letters to push for the GMC to evaluate its fitness to practice processes in light of the finding of racial discrimination by the employment</p>	
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	<p>tribunal in the case of Dr Omer Karim.</p> <p>We have representatives on the following groups:</p> <ul style="list-style-type: none"> – GPC on the CQCs working groups to address disparities in inspections of GP practices that are run by ethnic minority doctors – The RCOG’s Race task force – GMC’s BME Doctors Forum – UK-Reach study into COVID-19 and ethnic minority doctors working group 	
PM 6	<p>That this meeting commends the commitment and flexibility shown by doctors and healthcare staff in very difficult circumstances during the COVID-19 pandemic. They have worked outside their specialties, worked additional hours, and worked at increased risk to their health. This meeting mandates Council and the Branch of Practice Committees to pursue policies to:-</p> <ul style="list-style-type: none"> i) ensure that temporary changes to job plans, working patterns and deployments cease with a return to pre- COVID-19 contractual requirements and job plans; ii) ensure that all doctors are adequately remunerated for additional work done during the COVID-19 pandemic; iii) ensure that no long term changes to job plans or contracts can be imposed without proper negotiations with local, Branch of Practice or national negotiating committees; iv) ensure that an additional reward is made to all healthcare staff to reflect the personal sacrifices and increase in risk to health made during this pandemic. <p>i) During the first wave the BMA issued two joint statements with NHS Employers: one for consultants, SAS and consultant academics, and one for junior doctors. Both statements made clear that any changes to job plans, work plans and arrangements will be temporary and will only be in place for as long as it is necessary. To ensure this, the BMA and NHS Employers will together conduct monthly reviews to monitor the use and operation of these emergency arrangements. Following each monthly review, the BMA and NHS Employers will confirm their positions as to whether emergency arrangements should continue to apply. Indeed, the BMA withdrew from both statements when it was deemed appropriate. Following the withdrawal from the joint statements, we subsequently issued unilateral statements which made clear the BMA’s position and how any requests from Employers should be managed. Our member relations team also supported individuals in having these conversations on the ground and making clear that any local agreements were temporary and did not constitute a permanent change to contracts.</p> <p>ii) At the beginning of the pandemic we approached NHS Employers and DHSC to reach a national agreement on how additional work</p>	National negotiations and representation

	<p>undertaken during the COVID-19 pandemic should be remunerated. Unfortunately, DHSC told us they were not mandated to reach such an agreement and therefore everything should be deferred to local determination as for AfC staff.</p> <p>Our member relations team has supported members and LNCs in reaching such agreements and challenging trusts when they have been unwilling to do so. CC and SASC have also produced guidance about how additional work should be remunerated. JDC also reached an agreement with NHS Employers that rotas that exceeded the 1:2 weekend limit should be remunerated and pay should be backdated.</p> <p>iii) The BMA has collective bargaining rights for doctors and parties cannot unilaterally change national contracts. Non-NHS Foundation Trusts are under a legal obligation to employ on the nationally agreed TCS. They can still agree different employment terms locally via the LNC but the TCS acts as an irreducible minimum which any locally agreed terms must not fall below. Job plans can only change through the job plan review process and with the agreement of the doctors. Doctors can request BMA advice on how to manage those meetings.</p> <p>iv) Our submission of evidence to the DDRB for this pay round included extensive evidence on the sacrifices doctors have made during the pandemic and asked for this to be recognised, including for those on long-term pay deals. While the DDRB’s recommendation of 3% falls far short of the level we think appropriate for recognising and rewarding doctors for their response to the pandemic, the report did acknowledge their exceptional contribution throughout, as well as the significant personal and professional toll it has taken. Most disappointing has been the Government’s refusal to make any additional financial offer to those groups of doctors subject to multiple year pay deals, in spite of the DDRB’s explicit statements encouraging them to do so. This means that the efforts of those doctors in responding to this unprecedented crisis will go unrewarded, as these pay deals were entered into either before the pandemic began or expressly excluded any increase tied to the COVID-19 pandemic response. We continue to lobby the Government to address this egregious oversight and are in the process of taking soundings from members about further steps. We have also made these arguments to the armed forces pay review body, and have communicated to both the Chancellor and Ministry of Defence that it is unacceptable that the Government’s initial pay announcement did not include a pay rise for armed forces doctors.</p>	
PM 7	On July 6th a Health Minister in the Commons announced a public consultation on the continuation of home use of mifepristone with remote consultation support for abortion, which had been agreed as	Professional policy and activities

	<p>a temporary measure in response to the COVID pandemic. This house urges the BMA to support continuation of these remote services post pandemic which are in line with best global practice and benefit women, particularly those at risk of domestic violence.</p> <p>We have informed the Department of Health and Social Care (DHSC) and Royal College of Obstetricians and Gynaecologists (RCOG) of this new policy and have responded to three consultations on remote EMA (early medical abortion) outlining our position:</p> <ul style="list-style-type: none"> – English consultation <u>Open consultation Home use of both pills for early medical abortion up to 10 weeks gestation</u> (closed 26 February 2021) – Scottish consultation <u>Early medical abortion at home: consultation</u> (closed 5 January 2021) – Welsh consultation <u>Termination of pregnancy arrangements in Wales</u> (closed 23 February 2021) <p>We have updated the BMA’s main publication on abortion to include the new policy – <u>The law and ethics of abortion: BMA views</u>. The BMA was a signatory to a joint letter, with a range of other health bodies and charities, calling on the English, Welsh and Scottish Governments to make the provision of remote services permanent. We will monitor the outcome of the three consultations and continue to explore opportunities to promote this position in all four nations.</p>	
PM 8	<p>That this meeting notes the possibility of an upcoming trade deal between the United States (US) and the United Kingdom (UK) and the threat it could pose to drug pricing and supply in the UK. This meeting therefore calls upon the BMA to lobby the relevant bodies to ensure such a trade deal:-</p> <ul style="list-style-type: none"> i) does not result in a rise in UK drug prices; ii) does not weaken the ability of the NHS and related bodies to negotiate drug pricing with US companies; iii) does not adversely affect the safety and regulation of drugs and medical technologies distributed in the UK. <p>The BMA has lobbied on these points as part of our ongoing work concerning the impact of future trade agreements on the UK’s healthcare system and public health.</p> <p>This has included parliamentary lobbying on the Trade Bill and the Medicines and Medical Devices Bill. The Medicines and Medical Devices Bill has now been granted Royal Assent – while a number of BMA suggested amendments were not incorporated, the Bill was amended by the government to allow greater scrutiny of future regulations.</p> <p>We have also made representations on these points to the Minister</p>	Professional policy and activities / Public health and healthcare

	for International Trade, Ranil Jayawardena, directly, and through the BMA's involvement with the Department for International Trade's Trade Union Advisory Group.	
PM 9	<p>The use of digital consulting has been essential during the pandemic for reducing the risk of infection in GP surgeries and in hospitals but there is a danger that those who have been arguing for a greater use of technology will change services in a way that impacts negatively on those most in need of care. We call on the Board of Science to examine the evidence base on the use of digital consulting and when this can be appropriately used.</p> <p>Following consultation with the Board of Science and internal discussion, a short paper was drafted which outlined 1) whether any research on this exists or is underway 2) what the scope and scale of the research would be 3) what conditions any external organisation would need to meet in a tendering process to carry out this research. This paper was discussed with the Board at their meeting on 6 May 2021 who provided feedback about the complexity of research in this area, and broad scope of the topic. We are therefore currently considering how to best approach further research in this area, focussed on the risks and benefits of remote consultation.</p> <p>Given that the large-scale move towards digital consulting has only occurred during the COVID-19 pandemic, evidence on its impact will take some time to emerge.</p>	Public health and healthcare
PM 10	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) believes the pause in appraisal and revalidation has not resulted in any detriment to patient safety or standards of care; ii) calls on GMC to publish guidance stating that revalidation and appraisal to be meaningful and robust would require a minimum of 1.5 sessions in a job plan; (AS A REFERENCE) iii) demands a reduction in the GMC regulation imposed by annual appraisal and five yearly revalidation to encourage experienced clinicians to retire later. iv) demands a proper independent audit of the processes of appraisal and revalidation to examine any alleged benefits and detrimental effects. <p>This policy predated publication of the revised version of Appraisal 2020, developed by NHSEI and supported by the BMA, GMC and AoMRC. This approach to appraisal significantly reduces the bureaucratic and time-consuming preparation for appraisal, though the BMA is monitoring its implementation and has called on NHS Employers and the GMC to do all they can to ensure it is fully rolled out across the NHS.</p> <p>The BMA also has a seat on the group (led by the AoMRC) formally evaluating Appraisal 2020. The GMC is also separately evaluating</p>	Professional policy and activities / National negotiations and representation

	<p>Appraisal 2020. As significant changes have been made to appraisal since ARM 2020, an independent audit of the past approach is not being prioritised while the AoMRC and GMC evaluations are ongoing.</p>	
<p>PM 11</p>	<p>That this meeting acknowledges the significant work of UK doctors and medical students in fighting the COVID-19 pandemic and that this work was performed on a background of sustained real-terms pay erosion for doctors in the UK. We call on the BMA to:-</p> <ul style="list-style-type: none"> i) survey members as to their opinions of the pay recommendations suggested by the DDRB in their 48th report (2020); ii) survey members as to what actions they believe the BMA should take next, in regard to tackling this real-terms pay erosion, including the option of industrial action; iii) to demand significant above inflation pay rise to compensate for a decade of freezes and sub-inflation pay rises; iv) to formulate an action plan in case doctors are not offered a fair pay settlement; v) withdraw from the DDRB before the end of 2020. vi) include different forms of industrial action in the survey and ask the council to formally ballot members if the survey suggests majority support. <p>At its meeting in November 2020, Council decided by a vote of over 2/3 to defer (v) of the motion because a number of committee and DN representatives said that to not submit evidence would result in them not being best able to lobby on pay increases for doctors.</p> <p>Survey questions on aspects of pay have been included in the tracker survey which has gone out regularly throughout the COVID-19 pandemic. A particular survey on pay has been organised by the Communications and Policy Directorate and the results will inform a pay campaign which is planned to run over the Spring with a view to culminating in the summer when a decision on pay uplifts is expected. Once the uplifts have been announced, BoPs and DNs will decide how best to engage with members on the question of pay and potential IA.</p> <p>In March it was announced that the Government was proposing a 1% uplift (excluding multi-year deals). Considerable media coverage was given and there appears to be relatively strong public support for a higher increase. Additionally, there appears to be some support for IA if the increase is 1% or very low.</p> <p>Council considered this at its meeting in March 2021.</p> <p>UPDATE - New survey results were available in June regarding views on possible pay uplift outcomes and on IA. Generally, the results indicated that there was some support for some forms of IA for</p>	<p>National negotiations and representation</p>

	<p>uplifts of below 2%, some for between 2-3% and then only minority support for action for 3%+. The uplift was 3% but was not applied for groups on multi-year deals. However, both the SAS and Junior contract deals delivered 3% uplifts to the overall contract package (not necessarily 3% pay uplifts for all).</p> <p>Further surveys on the announcement and possible forms of action are currently in the field for consultants and will be for juniors shortly. Webinars and lobbying continue.</p> <p>Decisions on DDRB evidence will need to be taken shortly after the ARM.</p>	
PM 12	<p>That this meeting is concerned about the possible adverse impact that Covid 19 will have on the mental health of healthcare workers and carers:-</p> <ul style="list-style-type: none"> i) with the potential for colleagues to experience anxiety, grief, unresolved anger, depression, moral injury and even PTSD as a result of their experiences; ii) and insists that Governments and NHS departments must without delay make resources widely and rapidly available for all health workers and carers who need mental health support. <p>– In May 2020 we outlined a series of <u>recommendations</u> around staff mental health & wellbeing during and after COVID.</p> <p>– Throughout the last year we have continued to monitor members’ health and wellbeing via our regular COVID-19 tracker survey and its follow-on Viewpoint survey and have used the finding to draw attention to ongoing mental ill-health within the workforce.</p> <p>– Through our work with the Social Partnership Forum and the NHSE/I-led Professional Bodies Echo group, we continue to push for improvements around the health & wellbeing services available to NHS staff. This includes the Health and Wellbeing Taskforce’s recovery from COVID-19 programme.</p> <p>– We are currently feeding into the NHS Health & Wellbeing framework and we will be aiming to ensure this takes a greater focus on individual wellbeing and reflects our mental wellbeing charter.</p> <p>– The NHS People Plan mandated the introduction of wellbeing guardians and we’ll be monitoring local people plans to ensure that this and other wellbeing commitments are translated from the national plan to a local level.</p> <p>– In March 2021, we published the report <u>Rest, Recover, Restore: Getting UK health services back on track</u>. In this report, we set out a series of recommendations to UK Governments to ensure that services resume safely for both staff and patients, including recommendations for the improving the wellbeing of the healthcare workforce.</p> <p>– We launched a survey in March 2021 to understand the extent of moral distress and moral injury within the membership. Moral</p>	Public health and healthcare

	<p>distress occurs when doctors are forced to make decisions that go against their deeply held professional and moral commitments. If prolonged, moral distress can lead to moral injury, leading to longer term emotional and psychological sequelae. In June 2021, we published <u>a briefing and survey summary</u> on moral distress in doctors. We found that moral distress has been compounded by the COVID-19 pandemic and that not being able to provide sufficient quality of care can have a negative impact on healthcare staff's mental health. We also included recommendations for reducing moral distress going forward.</p> <ul style="list-style-type: none"> – In June 2021 we signed up to a position statement as part of OneVoice, a coalition of unions and professional bodies, which argued that the health and wellbeing of NHS staff must be treated with the same level of importance as that of patients. – The Occupational Health Medicine Committee are in the process (July 2021) of publishing a position statement on the workplace stressors within the NHS that cause poor mental health amongst the NHS workforce, and what should be done to relieve such stressors. 	
43	<p>That this meeting is appalled by the brutal death of George Floyd caused by a US police officer. This meeting stands in solidarity with the Black Lives Matter movement.</p> <p>In addition to the information above for PM5, there is ongoing work to raise awareness of and address the wider structural factors that lead to race discrimination. Some examples include:</p> <ul style="list-style-type: none"> – Working with MSC to integrate the BMA's Charter for medical schools to prevent and address racial harassment into their new Inclusive Schools guidance. – Updating our COVID-19 guidance monitoring our tracker survey for notable differences for people from ethnic minority backgrounds. – Chaand Nagpaul participated in a Channel 4 documentary called 'Is Covid racist' setting out the urgency of addressing the disproportionate impact of the virus. – Most recently asking for guidance on and rollout of the COVID-19 vaccine to be resourced sufficiently to be culturally sensitive. <p>We have also pushed for all our policy work to be looked at with consideration for the intersection of different protected characteristics. For example, the menopause webinar in November 2020 addressed differences in menopause for ethnic minority women, and our everyday sexism survey which analysed the differences by ethnicity.</p> <p>We plan to complete an everyday racism survey before the end of 2021 which will give a greater evidence base of the impact of racism on doctors in their working and training lives.</p>	Professional policy and activities

<p>CM 71</p>	<p>That this meeting, in response to COVID 19, demands that government:-</p> <ul style="list-style-type: none"> i) ensure that workers are not under pressure to attend work either for financial or workforce reasons while they are unwell or self-isolating and at risk of inadvertently passing on the disease; ii) provide the equivalent of day- one statutory sick pay to those on zero hours contracts; iii) allow the NHS to requisition private health care facilities to accommodate effective COVID-19 treatment and quarantine provision if needed; iv) ensure workers are paid in full while they are unwell or self-isolating. <p>BMA guidance, and government guidance, has been clear about not attending work if unwell or isolating. We have lobbied extensively to ensure that health and care staff, along with the NHS, are protected and prioritised during the pandemic.</p> <p>The BMA published a standard template ‘zero hours’ contract for GPs to use while engaging during the pandemic, which replicates the model salaried GP contract for sickness provision.</p> <p>Agreements with NHS Employers and NHSEI have meant that self-isolation and sickness due to COVID-19 have counted as special leave (paid at full pay for the duration) and do not impact any other sickness provision. For GPs, the BMA has advised that the same should apply, however NHSEI has refused to enable this through additional funding which has been provided to hospitals.</p> <p>We have not made a definite call about requisitioning the private sector during the COVID-19 pandemic. However, where NHS services are coming under immense pressure and are at risk of being overwhelmed, we want to see appropriate agreements in place with the independent sector to secure additional capacity and support. As such, we have urged the Government (e.g. in meetings with Stephen Powis) to make effective use of the private sector where this is justified, ensuring that this is done efficiently and safely, and the NHS receives value for money.</p> <p>In our November 2020 paper on how to exit lockdown sustainably, and our March 2021 paper on health inequalities, we have called for more financial support for those who need to self-isolate, or who have COVID or ‘Long-COVID’ and for whom it would be financially unsustainable.</p> <p>We are aware that DHSC intends to make changes to the arrangements around COVID-related sickness absences, but we have not had a clear indication of when that might be. We have continued to apply pressure to DHSC and Employers for the provisions to remain intact and, so far, we have been successful. Our</p>	<p>National negotiations and representation / Public health and healthcare</p>
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	<p>position remains that those who have risked their lives to support the NHS cannot be penalised or find themselves financially worse off because they contracted COVID-19, meaning that they should not feel pressured – financially or otherwise – to return to work when it is not appropriate for them to do so.</p>	
CM 100	<p>That this meeting notes that GP locums can be deemed not to be eligible for the full life assurance cover provided through an NHS Pension Scheme membership, should their death occur on a day when they are not scheduled to be working, and:-</p> <ul style="list-style-type: none"> i) welcomes the temporary NHS Scotland Coronavirus Life Assurance Scheme (Scotland), noting that it will not exclude GP locums simply because they do not meet the definition of being active members of an NHS Pension Scheme at the time of their death; ii) welcomes the fact that the temporary NHS Scotland Coronavirus Life Assurance Scheme (Scotland) will provide the beneficiaries of all eligible relevant persons with benefits comparable to those with access to the full death in service cover provided through an NHS Pension Scheme; iii) deplores the fact that GP locums working for the NHS in England, Wales and Northern Ireland do not have access to a scheme similar to the temporary NHS Scotland Coronavirus Life Assurance Scheme (Scotland); iv) deplores the fact that no permanent solution has been implemented in any part of the UK to address the possibility of GP locums continuing to actively contribute to an NHS Pension Scheme but being deemed not to be in pensionable employment at the time of their death; v) demands that all governments in the UK take permanent action to ensure that GP locums are no longer subject to reduced death in service. <p>Due to significant BMA lobbying of DHSC and HMT (calling for doctors to receive death in service benefits and to remove the stipulation that you must be a member of the scheme for a minimum of two years for all the benefits), the Government announced a compensation scheme in England and Wales. The scheme pays a lump sum of £60,000 to the dependants of those frontline healthcare workers who died having contracted the Coronavirus. The BMA welcomed the announcement but is concerned that it comes nowhere near compensating families for the lifetime income their loved one may have earned if they had not died prematurely. We are, therefore, continuing to push the Government on this matter.</p>	<p>National negotiations and representation / Pensions team</p>
CM 142	<p>That this meeting is concerned that a further peak of COVID- 19 infection may occur at the same time as the Brexit transition period ends and that:-</p> <ul style="list-style-type: none"> i) a departure from the single market and customs union will seriously threaten supply chains particularly in pharmaceuticals, 	<p>Public health and healthcare</p>

	<p>medical devices and protective equipment and the NHS staffing shortage will be greatly exacerbated unless the problems of EU citizens' rights have been effectively resolved;</p> <p>ii) a departure from EU procurement arrangements and from Euratom could result in severe shortages of medical products and nuclear isotopes;</p> <p>iii) the government has failed to make arrangements to replace the work previously done by UK membership of The European Medicines Agency;</p> <p>iv) medical research, including into COVID-19 and the production of appropriate vaccines, requires international collaboration, which will be severely damaged by the absence of the necessary structures;</p> <p>v) It therefore insists that the government take all necessary steps to avoid a no deal departure from the institutions of the European Union.</p> <p>In November 2020, alongside colleagues in Public Affairs we sent a letter to the Prime Minister, highlighting the threat a no deal Brexit would pose to the health service.</p> <p>In tandem with this we attended several meetings organised by DHSC where stakeholders were informed of contingency measures in the event of queues at the border. This included plans for the re-routing of supplies away from Dover, air freight for medical nuclear isotopes and an effective 1-year grandfathering in of medicines licensed by the EMA in order to avoid a cliff edge scenario.</p> <p>Subsequent to the EU-UK trade agreement being signed we will continue to work in this area to ensure longer-term issues such as future medical supplies, medical research funding and the mutual recognition of qualifications are addressed.</p> <p>The MASC Executive has had a detailed discussion of the potential impact of Brexit on medical research funding. Members agreed that it was too early to tell at this stage, particularly with the impact of the COVID-19 pandemic on research funding, and resolved to keep the situation under review and to return to the issue in the 2021-22 session.</p> <p>As noted in our July 2021 <u>Medical staffing in England</u> report, international recruitment, for both patient facing and academic / research roles, also remains an important aspect of medical supply in the UK both now and in the future.</p>	
CM 201	<p>That this meeting is dismayed at university inaction regarding the depression and suicide epidemics which permeate our profession and calls upon the BMA to:-</p> <p>i) lobby all medical schools to provide all students with a tutor with a purely pastoral role for the duration of their degree. Formal suicide awareness and mental awareness training should be</p>	Public health and healthcare (Now with PPA)

	<p>mandatory for these tutors;</p> <p>ii) identify medical schools at which wellbeing and professionalism staff do not operate in separate departments, and lobby these departments to separate;</p> <p>iii) lobby all medical schools produce annual reports on their actions to improve mental wellbeing provision for medical students;</p> <p>iv) conduct a national survey of wellbeing interventions medical schools have put in place and how complaints from medical students about wellbeing support services are handled.</p> <p>A workshop was held at the June 2021 MSC which looked in more detail at the current problems with medical student support services and the approaches that could be taken to rectify them. The next steps, including our approach to lobbying for change with key stakeholders, will be determined during the 2021/22 session.</p>	
EM 1	<p>That this meeting notes that in the past few weeks, we have seen alarming rises in the rates of new COVID-19 infections to a higher level than when we went into lockdown, albeit in a younger population with a lower risk of admission to ITU and subsequent death.</p> <p>In order to prevent the need for further national lockdowns, with all of the adverse impacts that this may have on the education of our younger generation, the economy, older adults in care, mental health and social isolation, this meeting calls on governments to pursue a policy of near-elimination of SARS-COV-2.</p> <p>We have repeatedly highlighted the need for a more sustainable approach to managing COVID-19 and a more cautious approach to easing restrictions, particularly in England.</p> <p>In our November 2020 paper on exiting the second lockdown, we laid out a comprehensive set of recommendations that we believed would better equip the UK to move sustainably away from a cycle of lockdowns. However, with restrictions relaxed and the spread of new variants the UK experienced another large wave of COVID-19 infection and disease, putting the NHS and healthcare workers under huge pressure.</p> <p>In February 2021, prior to the Government setting out its 'roadmap' for exiting the third national lockdown we published a new <u>briefing setting out measures to support near-elimination of COVID-19 from the UK</u> – highlighting the need for a cautious approach to prevent further waves of infection and protect NHS capacity. Following on from this we have continued to make high-profile interventions in the national debate about the easing of lockdown restrictions, urging a more cautious approach. This has included securing a delay in the 'final step' of lockdown easing in England from 19 June 2021</p>	Public health and healthcare

	to 21 July 2021.	
EM 2	<p>That this meeting notes the 48th report from the DDRB on Doctors' and Dentists' Remuneration and is deeply concerned that by offering Junior Doctors and GP Principals a lower pay settlement than other staff groups, during a time of an unprecedented international pandemic, these recommendations will lead to a reduction in Junior Doctor and GP Principal morale.</p> <p>We call on the BMA to:-</p> <ul style="list-style-type: none"> i) lobby the Secretary of State for Health & Social Care to include recommendations on pay for Junior Doctors and GP Principals in the remit for the 49th report from the DDRB; ii) lobby the Secretary of State for Health & Social Care to specifically ask the DDRB to consider a pay settlement in 21/22 above any previously agreed multi-year settlement, in recognition of the services performed during the ongoing COVID-19 pandemic; iii) return to submitting full and detailed reports as part of the evidence gathering round of the DDRB process. <p>(Note this motion was passed as a reference)</p> <p><i>This resolution seeks to continue using the DDRB process whereas PM11 calls for the opposite (that we withdraw from the DDRB) which is why this was taken as a reference. It should be noted though, that iii) in particular is starkly against resolution PM11.</i></p> <p>The BMA submitted evidence to the DDRB, applying the spirit of this motion by calling on the DDRB and Government to award an additional uplift in recognition of the COVID-19 pandemic efforts of those groups currently in multi-year pay settlements.</p> <p>The DDRB did state (of those in multi-year deals): <i>“We would stress that recognising their contribution during this period, as well as responding to the impact of the pandemic on them personally and on recruitment, retention and motivation, is as important as it is for other groups. Recognising the contribution they have made to the pandemic response is extremely important, and we would urge ministers to consider this”.</i></p> <p>However, the government rejected this and therefore did not include those in a multi-year pay deal, in any COVID-recognition element of the pay uplift.</p> <p>We subsequently wrote to the Secretary of State asking for a review of this decision. JDC and GPCE, along with SASC, are considering how to progress this issue further in anticipation of a response from the Secretary of State.</p>	National negotiations and representation

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