2023/2024

Your Local BMA Consultation Findings

Meeting name & meeting date	BMA Council 24 January 2024
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Purpose	For council to receive and note the findings of the Your local BMA consultation on new local structures and the resulting changes to the proposals approved by council in May 2023. NOTE: The paper below has been updated for wider circulation and reflects and reports on what members said in both consultation meetings and via the consultation survey. The consultation ran over a period from ARM 2023 until 2 January 2024.
Recommendation/questions to answer/decision to be made	RECOMMENDATION: That council receives the findings of the Your local BMA consultation and the resulting changes to the outline proposals which were approved by council in May 2023.
Identified risk(s) and mitigation actions	Risk: The proposed changes are not brought to ARM 2024 for approval in breach of policy. Risk: The proposed changes are implemented in a disjointed way with poor governance. The consultation findings refine the original proposals for new local structures approved by Council in May 2023 which followed policy passed at ARM 2022. The relevant articles and bye-law changes will be brought to March council for approval by Organisation Committee so they can be submitted to ARM 2024. Meanwhile model constitutions for the governance of the proposed new structures will be produced for approval.

	A staff implementation group involving key staff across BMA directorates is being established to operationalise the proposed changes should they be approved at ARM 2024.
Resource implications (incl impact on finance)	Staff time in council secretariat. A business case for the operationalisation of the refined proposals will be produced with the help of the staff implementation group.
Legal and Equality and Diversity implications	As noted in the report. Further work on these areas will be considered as part of the changes to article and bye-laws, governance of the new local structures and their operationalisation.
Affecting the BMA – **England** – **Scotland** – **Wales** – **NI** – **UK**	Pan BMA
Attachments	Your Local BMA findings

Introduction

We received 175 individual responses to the survey; hundreds more participated in consultation meetings at Regional Councils, Divisions, Regional FREE groups, LNCs and other meetings to give verbal responses; and we have received written collective responses from Regional Councils, Divisions, the Devolved Nations and most Branches of Practice.

> **There is overall support for removing Divisions and moving to a workplace-first approach.**
>
> **We have made substantial amendments in several areas as a result of the feedback.**

This paper sets out first a summary of the major changes proposed as a result of the consultation, followed by analysis of the results of consultation. Comments are presented selected but unedited, as illustrations of the data and have been expressed by members who participated in the consultation. Some responses gave wider or more general feedback.

In the course of the consultation a major question has been raised regarding allocation of ARM seats. In consultation with Regional Councils, Alex Freeman pointed out that divisional allocation would lead to far more single-seat constituencies, possibly more than the current divisional seat allocation. This is contrary to the recommendations of Romney for multi-member constituencies which allow electoral constraints to ensure diversity. There are a number of options to resolve this problem, which will be considered by Organisation Committee and brought back to Council for discussion.

Summary of Major Changes resulting from the consultation

Retaining pan-professional Working: Combines (Working Title)

Many in active divisions valued the pan-professional elements of their division. In consultation meetings, members contributed reports of their divisions campaigning to maintain local services (maternity or emergency departments) and of educational meetings about, for example, health impacts of poor housing, which cuts across public health, General Practice and secondary care.

Other respondents expressed that their divisions were dominated by retired members and had no relationship to their issues at work. The vast majority want their local BMA unit to represent them at work. Although participation in divisions is low and views of cross-BoP working is mixed even amongst those with active divisions, the significant number who raised this as a concern does require a solution.

Proposal: Meetings in which members from multiple branches of practice can meet (Combine) will be enshrined in the constitutions of the new workplace divisions. Initially our suggestion is that this is set at a minimum of 2 meetings per year, with at least one having an educational or campaigning focus.

General Practice

Among those who were generally accepting of the proposals for GP units there was no pan-UK dominant view on the most appropriate geography, with suggestions including: county level, ICB level, Health Trust/Board level, LMC level, place level, PCN level (generally thought too small), and trust catchment area level. In some Devolved Nations, there is more consensus.

Proposal: GP Divisions in each nation will be based on the geography of one of: (1) local NHS structures such as Integrated Care Systems, Health Boards or Trusts; (2) Local Medical Committees or (3) Counties. This will be determined by the GPC in each nation.

Salaried and other sessional GPs working for APMS contractors also described how they might want to work with GPs outside their local area also employed by the APMS holder to respond to employment disputes.

Proposal: GPs working for APMS providers can belong to both their local GP workplace division and a national division for each APMS provider.

Primary Care

Both GPs and other primary care doctors expressed that they felt GP divisions should not include other primary care. Those working in e.g. sexual health or outreach services considered themselves closer to either secondary care or argued for national branches for charities and third sector organisations.

Proposal: Doctors working in primary care beyond General Practice can join the most appropriate workplace division for them: a local secondary care or GP division; a national division for their employer, or the regional public health division.

Public Health

Respondents working in OHID and UKHSA expressed that they had functioning LNCs in these employers and would prefer a national unit for all doctors working in these areas. Public Health Registrars may also have a Lead Employer, for which the Lead Employer solution described under “secondary care” applies.

Proposal: Alongside regional and Devolved Nation Public Health divisions for those working in local authorities, Integrated Care Systems, Consultancy and other work, doctors working for UKHSA and OHID will each have a division.

Armed Forces

Civilian Medical Practitioners have suggested that their issues are often hyper-specific and that having easy access to each other, and to BMA support would assist them. **Many Armed Forces doctors reported they primarily needed to work with other BMA members in their NHS workplace, and that regional groupings would spread their expertise too thinly. They also described how some regions would contain many Armed Forces members and others far fewer.**

Proposal: Civilian Medical Practitioners will have a national division. Serving and Reserve members of the Armed Forces will have a national division. Both groups will also have the ability to join the local GP or secondary care unit and combines.

Members classified as ‘Other’

Several members classed as ‘other’ reported that there would be too few of them, with too disparate interests, to work on a regional basis. It was suggested they could self-allocate to whichever unit fitted them best.

Proposal: Members classed as ‘other’ will be able to self-allocate to the most appropriate workplace division.

Isle of Man

The consultation paper did not include any proposals for the Isle of Man. Thankfully, we received several responses that explained the specific concerns of members there. Due to the unique legal circumstances of the Isle of Man, the BMA division there will continue to reflect the Isle of Man Medical Society.

Name: Divisions

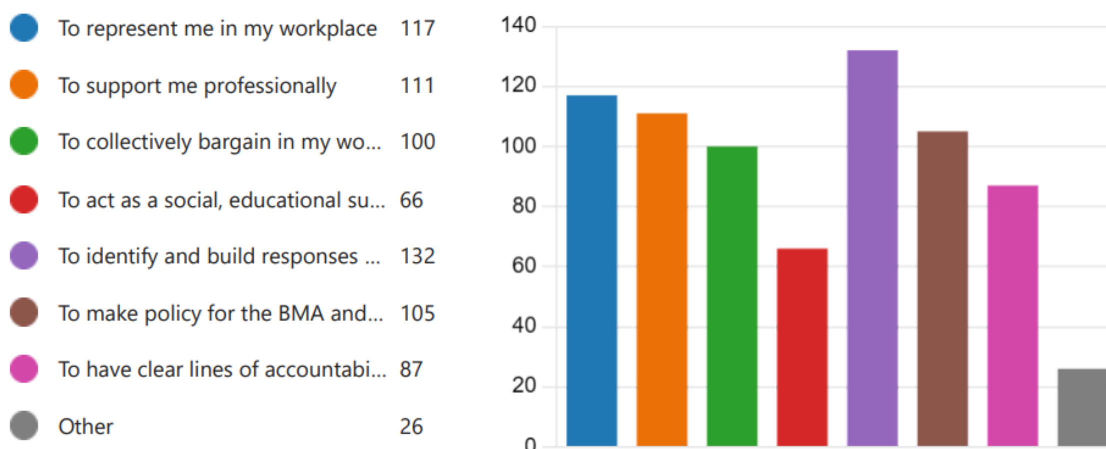
Some respondents told us they liked the names of their divisions, or that "division" was a good word the local unit. Keeping the name "division" for the local units adequately differentiates from Branches of Practice.

Proposal: Keep the title "Divisions" for the new units

General Comments

Members had a number of operational concerns about any new system, relating to funding, staffing, support, and information to members. All of these concerns are valid, important and are being considered with relevant staff across the organisation. An implementation group has been established involving key staff across BMA directorates.

What do members want from their local BMA?



Members were asked which of Council's eight aims for local units they wanted their local BMA to achieve. We did not include the need for units to be welcoming and free from discrimination. Almost every individual respondent agreed with at least one of the aims, and there is substantial consensus on the proposals Council made. The exception was that a substantial minority saw no need for the social functions of local divisions.

In general, the free text responses are encompassed by the eight aims agreed by Council. The few that did not described pan-professional meetings as a priority; a lack of need for a local BMA; or a desire for their local BMA division to tackle issues covered by national negotiations and branches of practice.

BMA

What do those in active divisions value?

No value

Many, even in active divisions, do not see much value, do not attend, or see the divisions as "self-selecting". Ten people specifically responded that their active division has *no value* to them.

Consultation respondents did not consent for widespread sharing of comments. Broadly, these respondents told us that their divisions:

- Did not serve them or did not connect to their workplace issues
- Were outdated or confusing
- Were "talking shops"
- Were "self-selecting"
- Were difficult or impossible to attend for reasons of geography, timing, or lack of advert

ARM

Some in active divisions highlight their role in ARM, but this was seen differently by those who described themselves as being in positions of leadership in their divisions than by other members. When asked the question about what they valued in their division, many respondents either only mentioned ARM or explicitly explained this was the only role of the division.

Consultation respondents did not consent for widespread sharing of comments. Broadly, these respondents told us that their divisions:

- Submitted high quality motions to ARM
- Considered and discussed the agenda of ARM
- Only served to submit motions and send representatives, in some cases nearly every division attendee goes to ARM

Sending policy and representatives to ARM is a responsibility Council has already determined will be distributed through the new system, and therefore this link and function will be maintained.

Pan-Professional Working

Many respondents from active divisions valued cross-BoP working:

Consultation respondents did not consent for widespread sharing of comments. Broadly, these respondents told us that their divisions:

- Attracted "all" branches of practice and generations
- Discussed local issues, including those at the interface of primary and secondary care
- Had social interaction

Those who valued pan-professional working raised this in all sections of the consultation. Whilst currently, the practical utility of divisional cross- branch of practice work is heavily limited by their lack of activity and low turn-out, this is clearly valued by those in active divisions. For example, only

BMA

21 divisions met for the recent divisional referendum, some were inquorate (fewer than five attendees) and the total number of votes was 135.

Pan-professional meetings were not a key feature in the consultation paper. Pan-professional meetings are incorporated into the amended proposals as combines (see summary).

It is notable that only members from active divisions raised concerns about pan-BoP working: no members from inactive or dormant divisions raised or requested this.

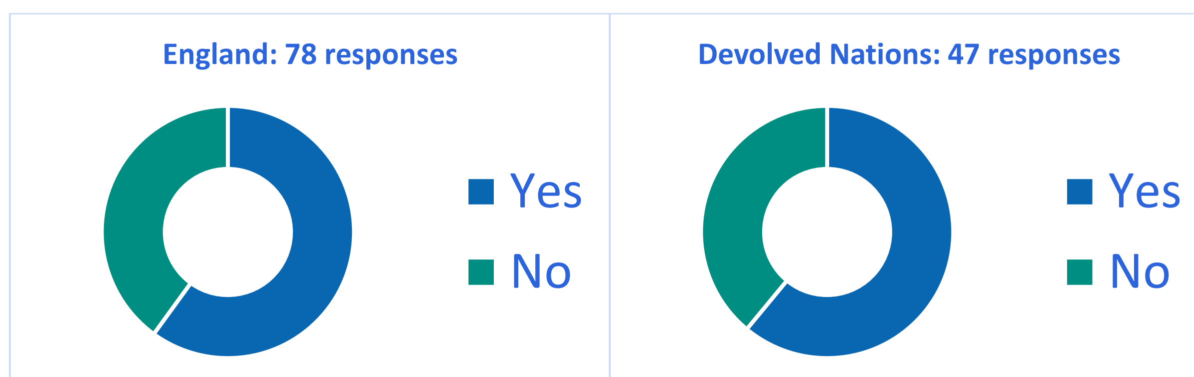
Political "Safety Net"

A few openly identified Divisions as a "safety net" of political power in the BMA which is beyond the politics and reach of the Branches of Practice or "splinter groups".

Consultation respondents did not consent for widespread sharing of comments. Responses on this are covered by above description.

General Practice

The proposals for "primary care" had majority support:



Many respondents including the GPCs discussed the BMA relationship with LMCs. Comments raised included the importance of maintaining good links and not duplicating work, but some individuals expressed that many groups of GPs (registrars, non-contract-holders) are not well represented by the LMCs which don't do "trade union work" and "focus on patient care".

Among those who were generally accepting of the proposals there was no dominant view on the most appropriate geography, with suggestions including: county level, ICB level, Health Trust/Board level, LMC level, place level, PCN level (generally thought too small), and trust catchment area level. In some Devolved Nations, there is more consensus.

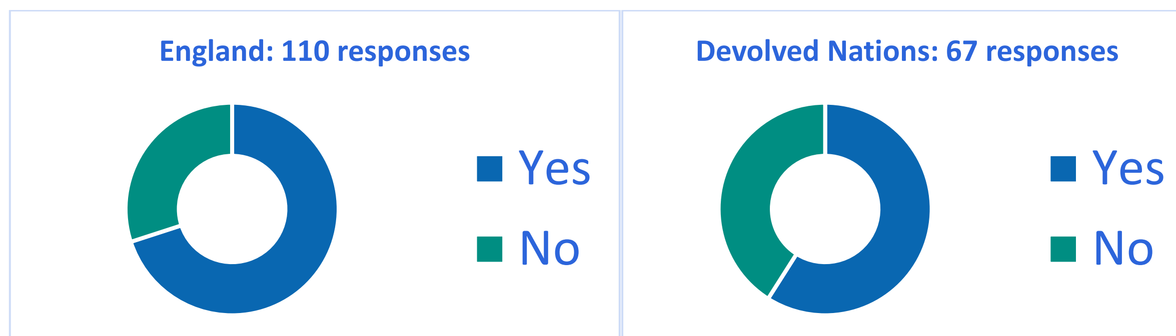
When considering geography, several respondents asked us to consider that registrars and sessionals often work in several locations and too small a geography would make it difficult for them to join in.

In Scotland, most felt LMC boundaries should be the geographical basis for the GP unit. In Wales and NI, there were differing views on whether to use LMC or Health Board/Trust boundaries. In England, many expressed discontent with using local NHS structures (e.g. ICS) as a geographical basis for a new work focused division, as these frequently change. Others believed that changing to meet the local NHS structures would assist when interacting with commissioning, secondary care structures and local politics. There is no reason that our structures cannot change in response to NHS reorganisation, if GP committees choose to use NHS Structures as their geographical base.

As described in the summary, the proposal is that GP Committees in each nation will be able to choose the geography appropriate for them for work focused divisions.

Secondary Care

The proposals for secondary care were widely welcomed.



The outstanding issues of clarification are:

LNC Clarity

Many respondents did not see how the new units would fit with existing Local Negotiating Committees (LNC). The new constitutions will be clear that all workplace division members can continue to elect their negotiations team as they do now. The new division will not replace the LNC – all members will be in a workplace division and only a small number on the LNC, as is the case now. This relationship could be described as similar to a county and its Council. The inter-relations between the all-member division and the negotiating committee will be secured by the standing orders of the two bodies.

Lead Employers

Consultation responses raised the issue of junior doctors employed by Lead Employers needing representation in both their host and Lead Employer settings. Junior doctors with a Lead Employer will have access to two divisions, one for host (with all other doctors working in e.g. Bolton NHS Foundation Trust) and one for Lead Employer (with all other doctors employed by e.g. Mersey and West Lancashire Teaching Hospitals NHS Trust Lead Employer).

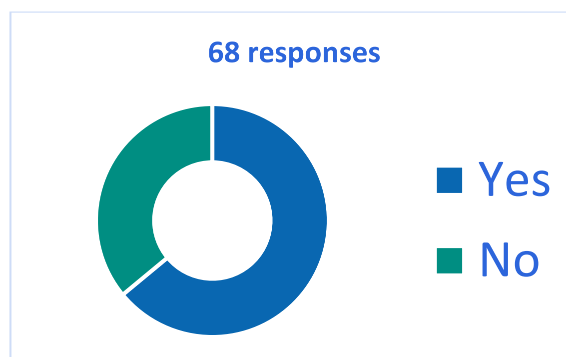
Other Portfolio Groups

Responses from individuals and the committees of those working in academia, the Armed Forces, General Practice, and other groups raised the issue that they wish to have access to the secondary care division where they work, given that they sometimes primarily interact with the BMA in a secondary care setting. Doctors will be able to belong to two division though they will need to identify a primary division for election and policy-making purposes.

Academia and Students

In medical academia the proposals were also well received. Current and former students described how proposals for regional units would help them to achieve supra-medical school organising, for example around shared placements, that has previously been impossible. The proposal for combined regional division with academics is also supported by students who want closer links on issues of importance to them both.

Medical Academics believe it would be difficult to populate a separate local structure at this time, citing the difficulty gaining two representatives per institution for COMAR (the academic BMA conference). Currently, MASC believe that "LNCs are the most important local organisation for academics" and want to maintain their primary links in secondary care or General Practice workplaces. Constitutions of GP and secondary care divisions will ensure representation for academics in clinical workplaces.



Retired Members

Many retired members responded to the consultation to say that working members benefitted from their experience, expertise and time. However, both in early responses about their divisions and in the specific questions about structures for retired members, working doctors taking part in the consultation expressed that they found that retired members were overrepresented in their local structures and that this affected the ability of doctors in work to achieve their strategic aims. This was a source of friction.

Working and retired doctors alike highlighted the social functions of local BMA structures for retired members. Some retired respondents expressed that they would prefer to socialise with former colleagues than with those they live near. This was especially the case at regional and national borders and where transport links are less conducive to attending meetings.

Consultation respondents did not consent for widespread sharing of comments. Broadly, these respondents told us that their divisions:

- Benefitted from their experience and expertise as retired members
- Were dominated by retired members, and that working members were less able to deal with their issues because of this imbalance

Some retired members told us, regarding the regional structure plans:

- That regional structures for retired members could improve accountability for the branch of practice and fulfil the needs of retired members
- That the geography would be "too vast" in some regions to allow face-to-face meetings

The geography of face-to-face meetings for retired doctors will have to be given thought by those taking representative or organisational roles in the regions or devolved nations, given the large areas required to maintain unit activity. The vital social and political functions can be retained in the new unit model, and the addition of combines/joints will mean that retired members can contribute experience whilst allowing working members to have separate space.