UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif — *International non-profit organisation*

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REPORT UEMS NMA – United Kingdom
UEMS Council meeting 7/8 October 2022

Name of the National Medical Association	British Medical Association	
Legal Status	Trade union & professional association	
Website	www.bma.org.uk	
Head of delegation	Name: Dr John Firth Email: JohnFirth@nhs.net Phone: 0044 7711 937 039	
Other Members of the Delegation	Name: Email: Phone:	Name: Robert Delis Email: rdelis@bma.org.uk Phone: 0032 496 43 91 33
	Name: Email: Phone:	Name: Email: Phone:
CME status in your Country (mandatory/voluntary?)	Mandatory, though the requirements are vague and are part of Annual appraisal by the employer and Revalidation	
Please specify if sanctions could apply in case of breach	Unclear due to vagueness and problems associated with the pandemic	
CME accreditation body	No CPD (As CME is called in the UK) accreditation body, as anybody can offer to accredit if it meets their standards	
Is there a separate "CME credits recognition body" for individual doctors?	Each Royal College or Faculty has their own mechanism for recognising CPD activity.	
Number of delegates to UEMS Bodies	83 Delegates to UEMS Sections and Boards (largely consisting of 2 delegates per body)	
National Registry of Specialists and website	*General Medical Council*	
Do NMA members participate in EACCME national review? If Yes, how many events have been reviewed in 2018?	No	
Please list events/topics/developments that you consider the most important for medical specialists in your country	• Health and care bill • Elective recovery • DDRB / Pay award • Specialists and specialty doctors • Pensions • Covid-19	

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	• Brexit
Comments	**Health and care bill** The UK Government's Health and Care Act has come into force, with its various changes to the health system in England now being implemented. The Act has given ICSs (Integrated Care Systems) a statutory basis, following their informal development over recent years. As a result, the 42 ICSs are now the core local unit of the NHS in England, holding power over commissioning and funding decisions within their footprint. The BMA is monitoring their progress closely. The Act has also reformed competition rules in England with a new system – the Provider Selection Regime – due to go live this autumn, which is expected to reduce the number of competitive tendering process. The Act has also granted the health secretary additional authority over the health service, though this has yet to be utilised openly. The BMA opposed the Bill, on the basis that it was the wrong bill at the wrong time and remains sceptical of much of the final Act. However, BMA lobbying did help secure some key concessions, including around private providers sitting on ICS boards. Much of our lobbying around aspects of the Act is continuing, namely on clinical representations within ICSs. **Elective recovery** The most recent NHS England performance statistics reveal record A&E waits and the largest ever number of people waiting for treatment. These statistics highlight the enormous pressure that the health service is still having to endure. Covid-19 cases hitting the highest level on record last week in England and resulting hospitalisations placing further demand on services and with almost 200,000 NHS staff absent due to Covid-19 in just one week. The Government said it would prioritise the recovery of the NHS in its Elective Recovery Plan in February and that it would eliminate 2 year waits for surgery by this July – yet there are still over 23,000 people waiting over 24 months for treatment. Furthermore, the target that no one will wait more than 18 months by April 2023 seems equally unrealistic given that there are more than 6 million people currently waiting, record high A&E waits, and Covid-19 infections directly impacting on normal NHS services. There is no confidence among the medical profession in the Government's ability to tackle the backlog. In a BMA survey published this week, only 1% of doctors had confidence in

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	the Government's plan to reduce the waiting lists for elective care, investigations, and procedures. The BMA issued an immediate response to the announcement of the plan, stressing that without urgent and tangible action on workforce any strategy, policies, or targets would fail to deliver elective recovery. We believe it is essential that steps are taken immediately to help keep existing staff within the NHS, if elective services are going to recover effectively. This should include prioritising staff wellbeing and pay and conditions, ensuring all services have proper rest facilities, and reforming punitive pension rules. Aspects of the plan are potentially positive and address key points from our reports Rest, Recover, Restore and Weathering the Storm. This includes the focus on staff wellbeing, the honest appraisal of the challenge facing the NHS, and the intention to allow patients to track the status of their referrals and waiting times. The BMA consultants committee has been attending the NHS England elective care taskforce working group and continuing to influence communications from NHS E around elective recovery, including getting recognition of the need to tackle pensions taxation and retire and return in order to retain consultants to support the delivery of the elective recovery plan. **DDRB/Pay award** The Government announced a pay award of 4.5% in 2022/23 for NHS consultants in England. This award is far below the rate of inflation and for consultants is likely to deliver nearly a 6% real terms pay cut (against OBR's current 22/23 inflation forecast). The award does not apply to Clinical Excellence Awards (CEAs). This means that consultants with a CEA will experience an even bigger real terms pay cut. The BMA's UK Consultants Committee (UKCC) is running a campaign – Fairness for the Frontline – calling on the Government to recognise and remedy significant multiyear real erosion of NHS consultant salaries in England, as well as reform the DDRB and agree reforms to the unfair pension taxation system. **Specialists and specialty doctors – pay erosion** This year the government announced that it would award SAS doctors in England on the old 2008 contracts a 4.5% uplift as recommended by the DDRB, and doctors on the newly negotiated 2021 contracts would remain subject to the multi-year pay deal, with no uplift above this. SAS doctors on the new contracts in Wales and Northern Ireland have also

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	received a lower pay uplift than those on the old 2008 contracts. This has meant that for a second year in a row, those on the new contracts have received a lower pay uplift than their counterparts on the 2008 contracts as the government has refused to take into account the most significant cost-of-living crisis in a generation when considering their pay uplift, something the BMA has condemned. Consequently, the BMA has expressed its strong disappointment that this will make the new contracts unattractive and is proceeding with forms of action to express our discontent. Most recently, the SAS committee published a rate card which sets out recommended minimum rates for extra-contractual work. We are also exploring other steps and the BMA as a whole has expressed its opposition to the paltry pay uplifts for this year. Transfer numbers onto the new SAS doctor contracts remain lower than predicted in England and we expect this trend will continue given the disparity in pay uplifts. **Pensions** In the NHS, we still face a pensions taxation system that is not only unfair but one that leaves doctors will little option but to retire early or reduce the work they do for the NHS. The spiralling rate of inflation has made a bad situation worse, and unless urgent action is taken by the Government, there will be an unprecedented loss of senior staff across the NHS this financial year. . The BMA has found that Thousands of senior hospital doctors could face losing tens of thousands of pounds in pension benefits if they work beyond 60. This is due to a failure by the Government to fix failings in the way in which the NHS pension scheme rules and pension taxation interact. The pension modeller tool allows doctors aged 59 and over and in the NHS 1995 pension scheme, to explore the impact on their pension if they continue to work full time and delay their retirement. In essence for those most experienced and senior doctors on the 1995 scheme – which the majority are – if they continue to work after they reach 60, they face losing over £100,000 in pension benefit over the course of their retirement even if they delay retiring by just a year. The Government's recent announcement which said they would implement permanent retirement flexibilities and 'encourage' NHS Trusts to offer recycling of employer pension contributions, do not go far enough and long-term fixes are needed to retain doctors in the NHS.

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	The BMA pensions committee are clear that in the long term, the solution to the pension taxation crisis is a tax unregistered scheme for those impacted by pension taxation in the NHS. The Government implemented a reformed pension scheme for the judiciary, in response to similar issues with recruitment and retention to those found within the NHS. There are early indications that this has already started to reverse the recruitment and retention difficulties in the judiciary. However, if the Government failed to act until the NHS reached crisis point before taking such an action, it would be too late to rectify the situation as senior doctors will have been left with little option but to retire and it will be incredibly difficult to persuade them to return to the NHS with a change in policy. The BMA is therefore strongly advocating for the introduction of a similar tax unregistered defined benefit pension scheme across the UK for those affected in the NHS, to mitigate the current punitive pension taxation system, would ensure that the scheme remains sustainable. The BMA recognises that introducing a tax unregistered scheme will take time and in particular with rapidly rising inflation, there is a real urgency to take action now to prevent an exodus of senior staff. The BMA are therefore also strongly advocating for short term mitigations such as: <u>Amend the Finance Act</u> Annual Allowance is a threshold which restricts the amount of pension savings a member is allowed each year before tax charges apply. The Annual Allowance limit is only supposed to apply to pension growth above inflation. However, in the rapidly moving inflation environment, anomalies within the Finance Act (Section 235) means that this is not the case as two different values of Consumer Price Index (CPI) inflation are applied. The issue arises that the pension opening value is calculated based on CPI from September of the preceding year whereas revaluation of pensions is based on CPI from September of the current tax year. This has a significant impact given the current high rates of inflation and results in large additional tax charges for members affected. Simply, amending Section 235 of the Finance Act to ensure that the pension opening value is aligned with this year's CPI (not CPI from September last year), will solve this problem and ensure that he inflationary uplift of benefits is aligned with inflation in the same year. <u>Mandate the use of recycling policies in NHS trusts</u> The BMA continues to advocate for trusts to offer an alternative reward policy to those staff adversely impacted by pension taxation. In essence, this means paying the employer's pensions contributions as additional salary rather than directly into the scheme. This essentially

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helps maintain their "total reward package". Whilst recognising the initial cost pressure caused by this measure for trusts, the BMA would highlight the clear benefits of this approach in retaining staff and allowing them to take on extra contractual duties that, without such a policy, would likely see them incurring taxation charges to their pension that would in effect cost them more than they would earn for this extra work.

Covid-19

COVID-19 continues to be a key priority for the BMA. This is especially important as we move into the winter period where infections and hospitalisations are expected to rise, made worse by a simultaneous flu season, being known in the media as the 'twindemic'.

Lessons learnt

Ahead of the independent public inquiries, the BMA conducted one of the largest, most detailed analyses of doctors' views and experiences of the pandemic. We have now published series of five reports that reveal the experiences of those working in the medical profession during the pandemic. The contents of these reports will be used to feed into the public inquiry.
As the UK Covid Inquiry commences, the BMA is working to ensure the voice of the medical profession is heard, and that there is recognition that the profession was failed. We aim to secure clear recommendations to address the failings, ensure lessons are learnt and support future preparedness.

Long COVID

Long COVID is an area of increasing priority for the BMA, with the latest monthly ONS data reporting approximately 2 million people in the UK suffering with long COVID. In August, the BMA published a report *Addressing the health challenges of long COVID* which sets out our key recommendations to government to improve the diagnosis, care, treatment and support of people with long COVID, including doctors.

The BMA is concerned about the lack of support for doctors and other healthcare workers and we continue to call for long COVID to be recognised as an occupational disease and for a compensation scheme for healthcare workers to be established.

We have published a member support web page for doctors with long COVID – this outlines the work taking place across the organisation and

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	externally and signposts members with long COVID to support and assistance. We continue explore ways to better support doctors suffering with long COVID. Protections for healthcare workers Appropriate protections in healthcare settings continues to be a key focus of the BMA's lobbying work, including adequate PPE (Personal Protective Equipment) for healthcare workers. We have repeatedly called for clearer national IPC (infection prevention control) guidance, that adequately recognises that aerosol transmission is a key driver of infection. The BMA has called directly on providers to ensure that they are meeting their legal duties under UK health and safety law, particularly around conducting risk assessments. At the BMA's ARM (Annual Representative Meeting) 2022 held in June, several motions passed relating to protecting healthcare workers so this area is likely to remain a key focus of the BMA, particularly in the coming months. Wider public health protections At a time when infections and hospitalisations are rising, the BMA has been clear that the Government must make every effort to ensure the booster vaccine programme is successful in helping keep infection rates low and reduce the numbers requiring hospital care this winter. The BMA has called on the government to ensure it delivers on the COVID-19 booster and flu vaccination programmes, ensuring communities and areas where vaccine uptake is low are targeted. There must be clear public health messaging to encourage people to get their booster. **Brexit** Professional qualifications As of 1 January 2021, the UK is no longer bound by the EU Mutual Recognition of Professional Qualifications (MRPQ) Directive which means that UK professionals will need to seek recognition for their professional qualifications from the appropriate regulator in the EU/EEA states under third country rules, except Ireland, Spain and Switzerland.

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	The UK has unilaterally decided to continue recognising EU/EEA qualifications for a period of two years post-transition. Recently, the UK General Medical Council (GMC) advised that this 2-year standstill on EU/EEA qualifications has been extended until the end of 2023. In addition, the GMC is currently looking into its post-Brexit routes to registration to ensure that EU/EEA doctors can continue to register with the GMC in a timely and streamlined way once the standstill rules end, and they will be developing this work over the next 12-18 months. Consequently, doctors who meet the national requirements for training across specialities in EU/EEA states are currently eligible to have their qualifications recognised in the UK by the GMC under the EU Professional Qualifications Directive (as per Annex V of the PQD as it stands on 31 December 2020). Any future changes to Annex V will not be recognised by the GMC. GMC regulations on specialist/GP registration Currently, the GMC is working with the UK Government to amend existing legislation to support a more flexible and accessible registration framework. This is expected to enable many more specialists and GPs to gain registration and work at a senior level in the NHS. This requires amendment to the Postgraduate Medical Education and Training Order (PMET), which is expected to broaden the evidence the GMC will accept, and which will enable doctors to demonstrate their knowledge, skills and experience thus increasing the numbers of overseas qualified doctors who can work at a senior level in the NHS. PMET Order governs how the GMC recognises specialist applications and currently, international doctors who seek specialist registration need to go through a very long-winded and bureaucratic process called the Certificate of Eligibility for Specialist Registration (CESR) process which is enshrined in legislation. Around 1,000 doctors use this route to obtain specialist or GP registration each year. Around half that number are successful on first application, rising to over 90% on review following feedback from us on the original application. The legislation will be amended to remove reference to Certificate of Completion of Training (CCT) equivalence and replace it with the standard that is used for general registration. Future applicants for specialist or GP registration will be expected to demonstrate that they have the 'knowledge, skills and experience' that the GMC expects for entry to the specialist register in the relevant specialty or to the GP register. These changes are expected to introduce a more equitable and inclusive approach to demonstrating that the

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	standard has been met and doctors will be able to use the full range of evidence from their existing practice to demonstrate eligibility. The aforementioned recognition of EU/EEA qualifications is expected to be removed from the Medical Act in early 2024 and without reform, doctors with EU/EEA specialist and GP qualifications will have to apply through the CESR/Certificate of Eligibility for GP Registration (CEGPR) pathway. The legislation is expected to be laid in parliament in October 2022 and to come into force in October/November 2023.