

BMA REVIEW

A Review into BMA Employment Related Services to support Black, Asian and Minority Ethnic Members

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Old Square Chambers

1. Context

1.1

The BMA is a representative body that any doctor registered with the UK General Medical Council is eligible to join. One of its key functions is to represent all doctors who practice medicine in the UK, whether or not they subscribe to the BMA. The BMA describes itself as a democratic and open organisation.

1.2

A note on language.

The term "minority ethnic" is used in the UK when referring to groups of people from a variety of races, nationalities, and ethnicities. In the UK it is used to cover all ethnic groups except white British. It is preferred by some to the expression "ethnic minority" because not leading with the word "ethnic" recognises and emphasises the fact that everyone, including white British people have an ethnicity. It is a term which is considered problematic by many to whom it is applied, not least, because it may imply to the unsophisticated or incurious that all minority ethnic groups and their experiences are homogenous.

1.3

The term is used in this report because it is used in the terms of reference document provided to me. At the time this Review was commissioned it reflected current usage within the BMA.

1.4

I also use the term 'race' in this report. When it is used, it is intended to reflect definition of 'race' in section 6 of the Equality Act 2010 and therefore to include: colour, nationality, and ethnic or racial origins.

1.5

I acknowledge and embrace the rich and very varied experiences of all those who participated in this Review. This Review did not engage with people from all minority ethnic backgrounds (that would not have been possible or proportionate). It does seek to respect and represent faithfully the views of those it did engage with; to identify themes or common experiences which affect minority ethnic doctors; and to provide specificity where it may aid understanding of the experiences and perspectives that are shared.

2. Terms of Reference

The terms of reference for this review were agreed on 28 March 2022. They are set out in summary in this section.

3. Purpose

3.1

The overall purpose of my appointment was to provide a confidential and legally privileged Review into BMA services to support Black, Asian, and Minority ethnic (minority ethnic)

members. I was commissioned to establish the extent to which minority ethnic members are receiving quality services and support by the BMA on a range of matters. If necessary, I was asked to make recommendations for any changes needed to address issues in the quality of services and support.

3.2 Specifically, the purpose and desired outcome of this Review is to recommend actions with the aim of:

- Ensuring that minority ethnic members are receiving the highest quality of service and support from the BMA on employment-related issues whilst respecting the resources of BMA members and utilising these in a financially sustainable way.
- Promoting the interests of the medical profession
- Improving recruitment and retention of members
- Reducing the risk of damage to the reputation resulting from unsatisfactory or perceived poor support or service to minority ethnic members
- Optimising processes for communication with members and more widely about BMA member support on employment-related issues
- Establishing an ongoing system of monitoring minority ethnic member recruitment and retention.

4. Operational Scope of the Review

4.1 In furtherance of the Review Purpose as the investigator I was expected to:

4.1.1 Undertake a comprehensive audit and review of the Association's implementation of the 2019 Member Service Support Review (MSSR) recommendations as they relate to minority ethnic members.

4.1.2 Review the current escalation, appeal, and review process, including roles and responsibilities of the BMA Cases Committee and its operation.

4.1.3 Identify relevant learning from members' and non-members' experience within the BMA during the relevant timeframes, namely, those who have left membership in the last 5 years and concerns

about First Point of Contact (FPC) will be considered within the last 3yrs.

- 4.1.4 Understand the needs, wants and expectations of minority ethnic and International Medical Graduates (IMG) doctors, both current and non-members, on matters related to their employment as doctors and other relevant matters.
- 4.1.5 Map the member journeys from first contact with the BMA through to conclusion of a case to identify the touchpoints and associated interactions for members accessing BMA support.
- 4.1.6 Review the user perceptions and experience of the services provided compared to global data such as established performance measures.
- 4.1.7 Make specific recommendations to address BMA services support to minority ethnic members.
- 4.1.8 Recommend ways to actively seek member feedback at every stage of support the BMA offers from the entry point at FPC to legal support. The feedback process will be integral to the BMA's listening and learning culture.

5. Scope of the Review

5.1 The terms of reference stated that this Independent Review will seek to:

- 5.1.1 Consider the experiences of minority ethnic members involvement and their interactions with the BMA.
- 5.1.2 Be open to confidential feedback from all BMA members and staff on the matters within its purview.
- 5.1.3 Consider and identify ways to improve recruitment and retention of members.
- 5.1.4 Consider and identify unsatisfactory or perceived poor support or services from the BMA to minority ethnic members.
- 5.1.5 Identify optimal processes for communication within the BMA and our minority ethnic members.
- 5.1.6 Establish an ongoing system of monitoring minority ethnic members recruitment and retention and consider whether any amendments

are required through the appropriate processes set out in the BMA's Articles and Byelaws.

5.2. Geographical Scope

The Review considered the employment-related support and services provided to members in England, Wales, Northern Ireland and Scotland.

5.3 Out of Scope

The Review is not an investigation of any broader legal services that are procured, be this corporate advice, debt recovery or general legal compliance advice. Any activity that may be associated with the subject matter but has no direct relevance to the purpose of this Review is out of scope.

6. Limitations on Liability

- 6.1 This report is provided based on information provided by the BMA and contributors to the Review. I have relied on those parties and participants to fairly represent the information provided to me and to notify me of any factual errors, inaccuracies, or material omissions of fact.

7. Approach

- 7.1 The author reviewed the MSSR report and appendices. The author conducted a series of remote interviews with:
- minority ethnic members of the BMA,
 - other members of the BMA
 - BMA employees
 - Key internal stakeholders
 - non members of the BMA

over the course of approximately six months. The author has read written material submitted by interviewees. Where appropriate consents were provided, the author considered case papers relating to individual members.

8. SUMMARY

- 8.1 The minority ethnic doctors who contributed to this Review are not an indivisible group. Their backgrounds, life and career histories are rich and varied. They were, however, all united in their view that the BMA could and should do more and that they and others 'deserved better.'
- 8.2 Contributing doctors expressed feelings of frustration, disappointment, betrayal and gratitude in describing their interactions with the BMA and its employment-related member services.
- 8.3 When members reach out for help they may be vulnerable. They need to be listened to, supported and where possible reassured. They need and expect high quality professional advice delivered in a timely and appropriate way. Very many members receive that but it is important to acknowledge that some members do not. The BMA is still finding its way in that regard.
- 8.4 Levels of trust and confidence in the BMA amongst its minority ethnic membership are low. They do not believe that its interests are aligned with the BMA's interests. This means that a single poor experience is likely to be shared among informal networks and can overshadow and negate weeks, months or even years of constructive, supportive engagement.

MSSR

- 8.5 The BMA has implemented some but not all of the recommendations of the MSSR that might be expected to impact on minority ethnic members. Whilst overarching recommendations such as to make the BMA more representative of its members and to engage with dissatisfied members to understand their challenges and be more responsive to the issues facing them might themselves be considered vague and indirect, efforts have been made to engage with them.
- 8.6 In general, recommendations which would have led to significant changes in the way that the BMA's employment-related support services operated have not been made. Thus the use of experienced first point of contact call handlers to triage all incoming calls was not adopted nor was the use of employment advisors to identify strategic and important cases at first contact. Whilst process improvements have been made it is not clear that they are sufficiently far-reaching to breakdown the somewhat siloed ways of working in this part of the BMA. Members are best served when an organisation is working in an open and collaborative way.

- 8.7 The BMA has modified a recommendation that a barrister's opinion should be obtained in all discrimination and whistleblowing cases before they are referred to external solicitors. The measure implemented requires a barrister's opinion only if a negative merits assessment is given by one of the BMA's legal services providers. That is a reasonable and proportionate modification which is appropriate in circumstances where the BMA has re-visited its legal services provision and broadened it to ensure that the current providers have expertise in these areas. Whilst this measure has been well received in some quarters, it is questionable whether it is a good use of BMA resources to require a barrister's opinion in every case. Providers had a discretion to seek authority for counsel's opinion before these new arrangements were put in place. Resources directed towards identifying cases in which strategic issues can be explored might ultimately be of greater benefit to the BMA's minority ethnic members.
- 8.8 Recommendations which sought to bring some necessary oversight into the case management process and the activities of legal services providers have also been put in place.
- 8.9 There do not appear to have been any systematic attempts to assess the impact of the measures that have put in place nor has any timeline for a review of these recommendations and their relevance been established.
- 8.10 The BMA is hindered in its efforts to conduct meaningful impact assessments by the poor quality and coverage of its ethnicity data.
- 8.11 Many of those who contributed to this Review offered the view that whilst litigation is sometimes necessary, it is rarely the answer and never the end to a workplace dispute. Most spoke of the emotional, financial and professional toll that workplace issues can take on doctors who are already working hard and under pressure. It is surely incumbent on their representatives to find ways of easing their burdens. That must include promoting 'just culture' in the workplace, alternative dispute resolution, challenging poor management and holding NHS employers to account on issues of race and ethnicity, bullying, harassment and victimisation. The BMA has the resources and the influence to do this work. Its black and minority ethnic doctors are asking whether it has the vision and whether it has the will. The challenge for the BMA's leadership is not just to place equality and fairness at the heart of the BMA's agenda but to keep it there.
- 8.12 This report sets out recommendations derived from interactions with the various contributors which it is hoped might improve the

understanding of the employment-related support services offering, including its limitations, augment its quality and effectiveness and positively impact the experiences of minority ethnic doctors as they engage with those services and with the BMA more widely.

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Detailed Findings and Analysis

Undertake a comprehensive audit and review of the Association’s implementation of the 2019 Member Service Support Review (MSSR) recommendations as they relate to minority ethnic members.

Summary of MSSR

Introduction

9. The MSSR was an independent review of the BMA’s employment support services, commissioned by UK Council. Its aim was to help the BMA identify opportunities to make the services it offered to all members better. One of its points of focus was to ensure that BMA members received the highest quality of service and support on employment-related issues. Three specialist external providers were appointed to undertake the review. They drew on their experience

in the fields of employment law, operational performance, and communications to analyse the employment-related support offered to individuals by the BMA and its contracted suppliers. They also looked at comparable and competitor organisations to understand how the BMA's services compare.

MSSR Findings

10. In one sense, *all* of the findings and recommendations of the MSSR relate to the minority ethnic members of the BMA but this Review focuses on those findings and recommendations which might be expected to have a particular impact on minority ethnic members.
11. The MSSR found that complex cases (by which it meant discrimination and whistleblowing cases) and strategically important cases were not being identified by the employment support services or were being identified too late. It considered that the judgment deployed in the assessment of the prospects of success for complex cases at trial, was inadequate. It found that as a consequence, it was disproportionately difficult for complex cases to pass the merits threshold for legal support. It found that this was in conflict with BMA values.
12. A key finding of the MSSR was that International Medical Graduates (IMGs) and minority ethnic members were less satisfied by the service they received from the BMA than their white or UK trained counterparts. BMA members from all backgrounds expressed dissatisfaction with regards to the timeliness, completeness, consistency, and quality of the support services they received.
13. The reviewers concluded that the BMA internally is not representative of its membership. It noted a particular problem with ethnic diversity at First Point of Contact (FPC) and Employment Adviser ("EA") level, and with both ethnic and gender diversity level at UK Council. They considered that the lack of minority ethnic representation within the BMA meant that the organisation was not very close to its members.
14. The MSSR reviewers identified a number of key areas for improvement. These included the BMA's response to strategic cases of interest which the reviewers stated had been inconsistent and slower than its competitors. In some cases BMA responses had been inconsistent with its values, particularly in relation to "*Challenging*" *unafraid to challenge effectively on behalf of all doctors* and "*Leading*" *an influential leader in supporting the profession and improving the health of our nation* but also possibly in relation to "*Committed*" *committed to all doctors, placing them at the heart of every decision the BMA makes*, "*Reliable*" *doctors' first point of call*

because the BMA are trusted and dependable and "Expert" an indispensable source of credible information, guidance and support throughout doctors' professional lives.

15. The reviewers made a number of recommendations which were adopted by UK Council in September 2021. It was recognised that some of the MSSR recommendations would require a review of BMA structures, roles, and responsibilities, supporting technology and governance structures over a longer time span. An implementation programme was devised to implement the short- and medium-term recommendations of the review and a task and finish group was established to co-ordinate implementation of the MSSR recommendations across the BMA in a coherent way.
16. High level recommendations that specifically related to minority ethnic members included a recommendation that the BMA engage with members from minorities in order to understand and be more responsive to issues facing them, and that BMA representatives and employees act consistently with BMA values.
17. There were also recommendations that related to the BMA's approach to and processes for managing cases raised by its minority ethnic members and complex cases (which were defined as those involving allegations of discrimination or whistle-blowing detriment or dismissal). These recommendations and the extent to which they have been implemented, are considered below. Thereafter, this report reviews the implementation of the more granular recommendations of the MSSR in respect of operational matters.

Make the BMA More Representative of Its Membership

18. In order to fulfil this objective, the BMA must have an accurate picture of its membership. Who are they? At what stage of their careers and professional development are they? What are their aspirations?
19. The MSSR noted that *"the BMA gathers considerable amounts of data about its membership, but this data is difficult to access, and it is difficult or impossible to relate datasets to each other."*
20. The BMA's Corporate Equality, Diversity, and Inclusion ("EDI") team has the task of carrying out equality monitoring of the BMA membership as part of its remit. The BMA monitors by sex, ethnicity, religion and belief and disability. Monitoring efforts are focussed on membership, participation in BMA development

programmes and committee membership. There are some 243 committees comprised of some 3000 elected members.

21. Equality monitoring is not mandatory across the organisation, in part, because there are not systems in place to carry out monitoring effectively. The existing CRM system cannot produce the reports needed.
22. I have been provided with BMA membership data as at January 2023 collated by 'ethnicity,' sex, disability and religion or belief. In every category except sex, the proportion of 'prefer not to say' and 'unknowns' is greater than the proportion of members who report holding a particular characteristic.
23. The high level of non-disclosure means that BMA membership data remains unreliable as regards race (and probably also for other protected characteristics such as disability and religion and belief).
24. Anecdotally, suspicion of the uses to which information provided will be put, and a lack of engagement with and trust in the BMA provide part of the explanation for members being unwilling to entrust the organisation with these important pieces of sensitive personal data.
25. The BMA's corporate EDI strategy for 2022-2025 states that the organisation will continue to improve the collection and analysis of EDI data and evidence so that it can acknowledge the needs of its members and the impact of its work on them.
26. The limited categories available for self-description reduce the quality of the ethnicity data collected. This inhibits a more intelligent and nuanced approach to representation being taken by the BMA. The data collected is of limited value in exploring and addressing disparities within the broader 'ethnic minority' identity.
27. The BMA's ethnicity data is not of sufficient quality or adequate coverage to enable the BMA to understand who its members are and address the challenges they face in their places of work and study. BMA employee contributors to this Review from across the UK stated that their EDI data on members was "really, really poor" and apologised that they were unable to provide me with even the most basic data sets.
28. The BMA's systems do not enable the data available to be analysed with reference to multiple protected characteristics. This inhibits understanding of the complexity of the lived experience of *all* BMA members and makes it more difficult to understand the impact of overlapping protected characteristics on minority ethnic members.

It makes it more difficult to think holistically and intelligently about diversity and inclusion.

29. Whilst changes which may make access to and interrogation of data easier, such as the introduction of a new CRM system, are in progress, the BMA is still not in a position to provide an accurate profile of its membership by race. This is a significant organisational failing across England, Wales, Scotland, and Northern Ireland.
30. The failure to act urgently to effectively address these known deficiencies is taken by some of the contributors to this Review as evidence of a lack of interest in meaningfully addressing issues of equality, diversity, and inclusion. Robust data is a necessary precursor of effective, targeted action.
31. As a result of the limitations of the BMA's data gathering exercises it is not in a position to engage with this recommendation in a way which is nuanced and evidence-based. This means that the impact of its efforts is likely to be reduced.
32. That said, since the MSSR the BMA has engaged in activities as part of its efforts to widen its representation and deliver its EDI commitment.

Widen Representation: Elected Members

33. The BMA's corporate EDI team works with elected members and representative structures of the organisation as well as BMA staff. Its aim is to ensure that all BMA activities and meetings are inclusive. Activities include free and bespoke training for elected members.
34. The BMA leadership programmes are CPD- accredited courses delivered by an external facilitator and are open to all BMA committee members. The foundation level course focuses on personal awareness, effective committee meetings and leadership and team dynamics. The advanced programme focuses on change leadership, resolving conflict and facilitating collaborative decision-making. Committee members can also participate in culture and inclusion courses.
35. New committee members can be supported by a mentor allocated under a committee mentoring programme. The rolling programme runs for a twelve-month cycle.
36. UK Council is the principal executive committee of the trades union and sets the strategic direction of the BMA in line with policy

decided by the Annual Representative Meeting ("ARM"). There are five seats reserved for ethnic minority members on UK Council. There are also reserved seats on the junior doctors committee. Other branch of practice committees, such as the general practitioners' committee, can allocate seats to representatives from other bodies such as the Medical Women's Federation and the British Indian Doctors' Association, in order to increase diversity and inclusion.

37. There does not appear to be any systematic monitoring in place to assess whether these measures have an impact on improving representation and increasing diversity over time.
38. An initiative which derived from the ARM encourages an individual who is already an elected member of BMA committee to become a 'Committee Equality Champion.' The idea is that the individual will be a point of contact for members and will ensure that issues of equality are brought into the committee's work and thinking. The Champion's brief is not to focus specifically on race or ethnicity. It embraces the full spectrum of equality issues. It is not mandatory that a committee have an Equality Champion. At the time of writing 15 committees had adopted the role. The corporate EDI team are working with BMA staff who work with committees to help them understand and promote this new role.
39. The staff and associate specialist and specialty doctors committee and the medical students committee appear to have greater levels of diversity and to have acquired a higher profile within the organisation and externally. That appears to be a consequence of the activities and efforts of committee members rather than as a result of a conscious effort by the organisation to raise the profile of these committees.
40. A Committee Member Code of Conduct was introduced in 2017 together with processes to monitor member conduct and to resolve complaints. It was reported by some BMA staff contributors to have had a positive impact on member behaviour. Some contributors considered that these measures might assist the BMA in broadening and retain its elected membership by introducing an element of accountability in respect of conduct and providing a more inclusive working environment.
41. Contributors asserted that the structures of the BMA are complicated and can be difficult for individual members to navigate without assistance or patronage. Recognising this, a number of initiatives have been established which seek to reach out to non-elected members and provide them with an insight into the way the

BMA works and to highlight opportunities to become involved. Members of the corporate EDI team speak to various Committees about the barriers to joining them and how those barriers might be overcome. The BMA operates a Committee Visitors Scheme which allows any member to visit a committee meeting to gain an understanding of the work of the committee and the role of a committee member.

42. The BMA operates an activist scheme which is designed to identify potential talent within the BMA by seeking to engage with members who attend its events.
43. Information providers in Wales highlighted the challenge of seeking out diversity from across its minority ethnic communities. They estimated that of their 7.7% membership 15.6% identified as minority ethnic with 40% of members not disclosing ethnicity information. They noted that most minority ethnic members on Welsh committees, staff groups and LNCs were from a particular ethnic background. Locally employed doctors who are predominantly female and minority ethnic were really under-represented in their structures.
44. In Scotland the information provider noted that grassroots member involvement was broadly the same irrespective of ethnicity with most members only becoming involved with the BMA when they had a problem.
45. The corporate EDI team's remit also includes delivering initiatives to under-represented and minority groups through a range of vehicles such as networks, fora, and elected equalities representatives on committees.
46. Contributors to this Review have pointed to the National Forum for Racial and Ethnic Equality ("FREE") and its regional fora as a positive attempt to widen minority ethnic participation within the BMA. Membership of FREE is open to those members who identify as black, Asian, or ethnic minority.
47. The national FREE was created in response to calls from BMA members for greater support for doctors and medical students from black, Asian and minority ethnic backgrounds.
48. It has terms of reference which indicate that it seeks to:
 - explore and highlight relevant issues and experiences faced by black, Asian and minority ethnic doctors and medical students in their places of work and study

- act as a consultative forum by contributing to the BMA's policy work for members and the wider medical workforce to ensure that black, Asian and minority ethnic perspective is included
 - Act as representatives and advocates for the BMA's work on improving race equality in medicine
 - Review and provide guidance on BMA products and services (such as employment advice) that support black Asian and minority ethnic members
 - Influence and support external stakeholders to improve support for minority ethnic and IMG doctors and students
 - Raise the profile of the contribution of black, Asian and minority ethnic doctors to the NHS and the BMA
 - Support the BMA's efforts to build ethnic diversity in its membership and elected structures
 - Help to connect and network with grassroots members, bringing their lived experiences, knowledge, and diverse ideas to the forum and to the wider BMA.
49. BMA national FREE is made up of two representatives from each of the UK branch of practice committees, two representatives from UK council, one representative from each of the devolved nations and the co-chairs of all the regional fora. Its make-up was designed to make sure the BMA hears from its members across all its parts about the issues that face them in their places of work and study. The national FREE committee elects two people to Council for a two-year term.
50. Perhaps because of the elected member component of its membership, contributors to this Review considered that the national FREE had thus far been less successful in introducing new and diverse voices into the BMA. A number of contributors expressed the view that this was another vehicle occupied by the 'usual suspects' with a pre-defined and largely self-serving agenda.
51. The national forum is supported by regional fora. The regional groups were envisioned as a space where minority ethnic BMA members can network and support each other, raise issues, and influence BMA's national policies and campaigns. Each of the devolved nations except Northern Ireland has a regional FREE. There are twenty regional co-chairs. In order to be eligible to be a co-chair, the doctor must not be a member of a national committee. At the moment regional fora are managed and supported by the BMA's Regional Co-Ordinators. The regional fora are widely regarded as having been more successful in drawing 'new actors' into engagement with the BMA, building local networks and establishing local mentoring programmes.

52. Information providers in Scotland stated that BMA Scotland was working hard to increase the number of minority ethnic doctors on its committees by working with FREE Scotland. It was also working with NHS Scotland's Ethnic Minorities Forum on a number of areas. BMA Scotland was also trialling posting on Facebook groups not run by the BMA but where the BMA has external contacts, in an effort to engage with UK minority ethnic doctors.
53. Beyond the ability of the national FREE to elect two members to Council, regional and national FREE have no formal mechanisms to influence the policy decisions made by the ARM or to directly impact the work of the BMA. It is not a committee established by standing order.
54. There is no obligation to consult with it on matters which might be of interest to it. These arrangements limit the utility of the fora in the eyes of some contributors. It also fuels their scepticism about the existence of a genuine desire to understand the needs and experiences of minority ethnic doctors.
55. The BMA is in the process of finalising a 'Diverse Stakeholder plan' which is intended to achieve strategic and mutually beneficial engagement with a number of organisations who represent diverse groups of doctors. A number of the organisations identified in the plan represent minority ethnic doctors. The plan outlines a number of engagement activities that might be undertaken and indicates a willingness to commit BMA resources to that engagement (in accordance with due process) where appropriate. Representatives of minority ethnic doctors' groups continue to express a willingness to work collaboratively with the BMA. It is to be hoped that the action plan is finalised so that activity for the benefit of those doctors can begin in earnest.

Widening Representation: Employees

56. This Review considers the representativeness of the BMA with reference to its employees as well as its membership. BMA HR are responsible and accountable for EDI related matters for BMA staff. A range of EDI activities have been undertaken since MSSR. The HR team have promoted EDI training which has included valuing difference, active bystander, and anti-bullying training. New recruitment software enables information which might identify a candidate's protected characteristics to be removed so that they do not adversely influence selection decisions. There is a minority ethnic staff network.
57. This Review notes that as an organisation the BMA has a stable staff group with relatively low levels of staff turnover. This limits

opportunities for increasing diversity in recruitment. It is also accepted that the ethnic populations in different geographic regions is a relevant consideration when the organisation is considering the representativeness of its workforce. That said, this Review is not aware of any targeted programmes directed at under-represented groups that have been considered or developed in respect of minority ethnic prospective employees in employment-related support services or elsewhere. This is a missed opportunity.

58. Whilst it is acknowledged that FPC advisors are not employed by the BMA but by a third-party, there is an opportunity to seek greater ethnic diversity in respect of those engaged on this work. It does not appear that this opportunity has been explored with the third-party provider or at all.
59. As well as recruitment it is also necessary to consider the development and retention of minority ethnic employees. Information providers working in Member Relations in an advisory capacity pointed to the limited opportunities for professional development and a relatively ad hoc system of allocating them. For some, this was a source of frustration and dissatisfaction.
60. Identifying development opportunities and ensuring that there are transparently advertised, and a proportionate but fair recruitment exercise is undertaken to fill them, is important. Providing meaningful feedback to unsuccessful candidates is a valuable exercise. It assists the candidate in addressing learning points and skills gaps and is a concrete indication that the organisation is prepared to invest time in helping them to progress. Building a pipeline of minority ethnic talent across the organisation is critical if the BMA is to reach a truly representative reality.

Impact and Accountability

61. It is unclear what specific impact assessment activities have been undertaken by the BMA to determine the effectiveness of the interventions it is undertaking. Given the deficiencies in its reporting and monitoring systems the reliability of any reported outcomes must also be questioned in any event.
62. Whilst there has undoubtedly been significant activity on EDI in the wake of MSSR much of it has been generic EDI activity (which is of course valuable and to be welcomed). With the exception of FREE, it has not been targeted on race. It has also not been launched from a secure foundation of a knowledge and understanding of who the BMA's minority ethnic members are – Who is joining? Who is leaving? Who is progressing and why? This means it is difficult to

identify an evidence-base which might inform or support specific interventions and improve their effectiveness.

63. Whilst it might be possible to acknowledge anecdotal evidence that the BMA has made itself more representative of its membership, it is not possible to empirically demonstrate that or how it has been achieved.
64. It is also not clear who is accountable for delivering this recommendation or how success in delivering it is to be defined.
65. Whilst the organisation appears to be moving beyond a "one and done" mindset it has not yet clearly articulated what success looks like.

Engage With Dissatisfied Members and Non-Members in order to understand their challenges

66. It is right to note that there is not a UK engagement function. This means that to some extent each nation operates its own member engagement processes. There is no vehicle for sharing information about engagement activities across the nations and therefore no opportunity to consider whether strategies being deployed in one nation might work well in another.
67. As yet no nation has devised a robust system for measuring the value that flows from member engagement.
68. There are a number of general observations that can be made.

Member Dissatisfaction

69. The BMA is dependent upon a member to express their dissatisfaction to it before it can engage with them to understand their challenges. Member satisfaction is gauged at a number of points in the employment-related support services journey: following contact with FPC advisors, during engagement with employment and senior advisors, and at the conclusion of a case. The member is also able to use a designated complaints process to express their dissatisfaction.

FPC

70. FPC close between 3,500 and 4,000 cases per month. *All* members who engage with an FPC advisor receive a satisfaction survey which they are asked to complete. Following MSSR the sending out of the

member satisfaction survey has been automated to reduce the possibility of advisors 'cherry-picking' respondents. The response rate is poor. For example, in 2022, 20,000 surveys were sent out but only 650 responses were received. Those members who do respond to the survey indicate high levels of satisfaction with their call.

71. The results of the 2021 Member Relations automated satisfaction surveys across the UK showed similar satisfaction levels across the categories of ethnicity available. Of the survey respondents, 88% unknown, 87.8% minority ethnic, 86.4% prefer not to say and 86.8% were satisfied with the service received.
72. The shortcomings of the ethnicity categories are obvious and represent a missed opportunity to gather more layered and meaningful data to inform the organisation's services and thinking.
73. In England, FPC have introduced a follow up call to the member a month after the original call in which the member is asked if the advice they received resolved their queries. It was reported that these calls are producing good satisfaction results albeit that they are lower than those reported on the first calls. There is no disparity by ethnicity in terms of these satisfaction levels. The follow up calls provide the BMA with an opportunity to have further contact with a member and to consider escalating the matter to a local employment advisor. It is not clear whether data from these follow up call is separately collected and analysed by race, ethnicity, or other protected characteristics.
74. Information providers working within the Member Relations team considered that these process developments had improved the member experience, including the minority ethnic member experience. The number of complaints raised per case opened, has decreased over time and that trend is continuing.
75. It appears that no action is taken to follow up respondents who express dissatisfaction with the services they have received. The survey does not seek information on the reasons for dissatisfaction nor is there any thematic review of reasons that are provided. An information provider from Northern Ireland reported contacting respondents to the automated survey who had expressed dissatisfaction to discuss their concerns, but they that they were generally reluctant to engage.
76. Following MSSR the retention work of the FPC team has been expanded. That work includes seeking to speak to members who are cancelling their membership and trying to understand why they

have taken the decision to end their membership. Reasons provided by members are included in a Members Relations monitoring report. Where those relate to the involvement of any member of the team, they are investigated by the FPC Service Delivery Leads.

77. Information providers from the Member Relations Department stressed that these were very rare occurrences. In the event that such complaints are upheld attempts are made to provide the member with appropriate redress and reassurances that learning points will be taken from the experience and used to try and improve the offering going forward. The outcomes of these complaints are not monitored by protected characteristic of the member or the FPC advisor or local advisor. It was suggested that the sample sizes and the unreliability of membership data made monitoring inappropriate.
78. BMA Scotland is conducting an analysis of exit interviews with minority ethnic members to understand why, according to anecdotal evidence, they are leaving in higher numbers than other groups.

Advisor

79. Employment cases referred to a local advisor or senior advisor can run over a period of time. This means that there is periodic contact between the member and advisor, sometimes over a number of months or even years. A member who is dissatisfied as a result of contact with an advisor has the opportunity to escalate their concern to the advisor's line manager at any time.
80. If the concern is not framed as a complaint, then it is handled informally and there does not appear to be a mechanism for recording that in a way which is visible across the Member Relations team and more widely. Accordingly, that information is not captured or analysed with reference to race.
81. Information providers who worked as advisors and those who managed them reported instances of member dissatisfaction that were addressed by engagement with the member by telephone, email, or video platform and in some instances by allocating an alternative advisor.
Advisors have considerable discretion as to the way in which they engage with dissatisfied members.
82. Information providers in Northern Ireland expressed a desire to conduct spot check calls after a case has concluded to receive member feedback. It was felt this would be more useful than the automated survey results they received. They reported that they did not receive complaints from dissatisfied members.

83. Again, it is not known whether there is any formal collection and analysis of satisfaction data by race at the conclusion of an employment case.
84. This Review has not had sight of satisfaction rates from members who have engaged specifically with employment advisors and senior employment advisors. It is not known whether this information is collected by the organisation nor whether it is analysed with reference to the race of the member and/or the advisor.

Complaints Process

85. There is a formal complaints process. There are a number of routes by which members might be funnelled into that process. There is currently insufficient data to conduct meaningful analysis of the members' complaining, the nature of the complaints and their outcomes by race.

In Summary

86. Existing engagement with dissatisfied members, irrespective of their race, is superficial with no meaningful attempts to understand their concerns or challenges. A prevailing view expressed to the Review by some members of the UK Member Relations Department was that members would be dissatisfied because they disliked the advice that they had received. Members who had used the services were more likely to frame their dissatisfaction in terms of the tone of the advice given, and a lack of empathy or understanding rather than the nature of the advice given. Responsiveness remained a commonly cited complaint.
87. The lack of reliable data about the volume of work carried out by advisors and senior advisors with minority ethnic members and how long cases are taking to resolve, is unsatisfactory. The lack of visibility across the organisation of the outcomes of such cases is also unsatisfactory. The fact that there is no avenue for external validation of Member Relations reports and analysis is also problematic whether or not there is evidence of race disparity in outcomes. Transparency builds confidence amongst *all* members and provides reassurance to those minority ethnic members who have reservations about their engagements with the BMA, and to staff providing employment-related support services.
88. The BMA has sought to implement this recommendation. The absence of reliable membership data on race has prevented the organisation from maximising the potential benefits and learning opportunities from such engagement.

Non-Member

89. The BMA has not devised any mechanisms specifically to engage with dissatisfied minority ethnic non-members.

Engage With Members from minorities in order to be more responsive to issues facing them

90. §§47-52, set out the efforts of the BMA to engage with minority ethnic members in newly established fora in order to be more responsive to their needs.
91. In addition to those efforts, members of the BMA's leadership team have made themselves accessible to minority ethnic members and to a range of different organisations such as the British Somali Medical Association, Melanin Medics, Muslim Doctors Association, Nigerian Doctors in the UK in an effort to inform the BMA's responses to issues facing minority ethnic doctors inside the BMA and in their workplaces and beyond. Engagement activities have included relationship building, attending meetings and conferences, and seeking opportunities for collaboration and joint working.
92. Seeking out opportunities for engagement with communities of minority ethnic doctors is to be commended. Participation of senior leaders in such activities is important because they embody and reinforce the BMA's commitment to tackling race discrimination and inequality. However, to be most effective, such engagement ought to be taking place within the framework of a clearly stated and agreed external engagement strategy with identified and measurable goals. In an ideal world such a strategy would be firmly and demonstrably evidence based. It is to be hoped that the 'Diverse Stakeholder' plan referred to at §55 above when finalised achieves some of these objectives.
93. Whilst it is imperative that the BMA seeks out a wider range of communities of minority ethnic doctors, it remains vital that existing relationships are nurtured and strengthened. The BMA should not take for granted the support of any minority ethnic group.
94. Whichever community groups the BMA engages with, whether via its senior leaders or otherwise, it remains crucial that such engagement is conducted transparently in accordance with the BMA's processes. The existence of 'back channels' and alternative routes to influence undermines the integrity of those processes and member and staff confidence in them. If those processes are not fit for purpose, then, they should be called out and changed. It is important that engagement with minority ethnic members and

groups is both visible and transparent so that those engaging can be held to account for their actions and their failures to act.

The BMA's approach to managing cases raised by its minority ethnic members

95. The heading pre-supposes that the BMA is able to identify who its minority ethnic members are. This Review has already commented on the fact that the race and ethnicity data held by the BMA is incomplete and unreliable. This means that the BMA cannot with certainty identify cases which are raised by its minority ethnic members.
96. At FPC, advisors will not know the race of the member that they speak to unless it is disclosed by the member or is ascertainable by the name or the accent of the member. Local advisors may know the race of a member they are supporting if it is disclosed to them by the member, recorded in the case paperwork or they meet the member in person or virtually.
97. There is no evidence that the race of the member has any direct bearing on the way in which the cases of minority ethnic members are managed. The case management process is the same.

The Case Management Process

98. The MSSR made recommendations in respect of the case management process generally. These are set out below. Implementation of these general recommendations ought to positively impact on the experience of all BMA members using its employment-related services, including minority ethnic members, and so I consider these briefly below.
99. The FPC team is, as the name suggests, a member's first formal point of contact with the BMA employment-related services. That contact can occur via telephone, email, or webchat. FPC advisors are employed by a third-party provider, Kura. There are approximately 40 FPC employment advisors and 30 information or membership advisors who operate on a hybrid basis, working from home and from a contact centre in Glasgow. Approximately 17 managers oversee the advisors. They are overseen by an Operations Manager and an Account Director. A BMA employee is responsible for managing the contract between the BMA and the third-party provider. Their primary interface is with the Operations Manager.

Align the Case Categories used by the BMA with those used by Third Parties

Make it possible for each case to be classified as belonging to Multiple Categories

Give members an expectation of how long they will spend on hold when calling FPC

FPC Confirmation of the issue being reported by the member before providing a solution

Confirmation of member details by the FPC advisor later in the call

100. The recommendation in respect of alignment of case categories and the ability to categorise cases in multiple categories have been implemented although there remain instances of incorrectly or incompletely categorised cases.
The recommendation relating to the anticipated duration of the call has been addressed by an indication given in the recorded message at the beginning of the call.
101. The recommendations concerning the content of the call have been addressed by changes to the training provided to the FPC advisors by their employer, Kura. The initial induction training programme for FPC advisors includes sessions which touch on personalisation, data capture and evidence. In addition, the structure of the call has been altered so that an identified bare minima of security information data is gathered at the outset of the call with further information gathered organically during the course of the call. Call handlers are also encouraged to listen actively and to probe for information that may be relevant, but which the member may not volunteer.

FPC Quality Assurance

102. The BMA seek to assure the quality of calls by an audit of cases. Every advisor will have at least three of their cases audited by a team manager each month. The audit process is guided by a questionnaire which seeks to ensure that data is captured and recorded appropriately and that any communications to the member are of an acceptable standard.
103. A percentage of audited cases is then sent to six managers in the BMA at Delivery Manager level for further review. These audit outcomes are fed back to team managers on a monthly basis so that learning points can be shared with the FPC advisor teams. They are also fed into a monthly status meeting with the service provider

and the Director of Member Relations, providing a further opportunity for any issues to be picked up.

104. In addition, between two and four times a year 'listening in' exercises are conducted with the FPC team which allow reviewers to listen in on member calls and hear how advisors deal with members directly.
105. The processes in place result in the auditing of the service being carried out predominantly by supervisors and managers who work in the service. I understand that these managers have now received unconscious bias training.
106. There is still limited external scrutiny of this work which accounts for the opening and closing of the vast majority of cases brought to the BMA.

Use Experienced First Point of Contact (FPC) call -handlers to triage all incoming calls.

107. This recommendation has not been implemented. The Member Relations Department did not consider this change to be an effective use of the more experienced FPC advisor resource. Instead, a decision was made to focus on improving the training and guidance provided to new and existing FPC advisors and to provide clarity around the referral process.
108. Part of the efforts to upskill FPC advisors have included training sessions in which they have had the opportunity to have direct conversations with members, including IMG members. One of the aims of such training sessions is to encourage FPC advisors to place themselves 'in the shoes of the member' to gain a better understanding of what the member wanted and needed from the service.
109. It is unclear how the Member Relations Team intends to review the effectiveness of the alternative course it has decided to adopt. The customer satisfaction surveys which it currently deploys to gauge member satisfaction will not provide any data directly relevant to this element.

Change the BMA Referral Form

110. The BMA's internal referral form made it difficult to categorise a case at the point of referral in a way which aligned with the

categories used by legal services providers. It was also not possible to place a case in a number of categories.

111. Changes made to the internal referral form have removed these obstacles and now include prompts in a section dealing with evidence in respect of discrimination and whistleblowing. It is hoped that as a result, complex cases can be identified at an earlier stage and more relevant information can be obtained to refer and assess them appropriately.
112. There are no specific measures designed to assess the effectiveness of this process improvement against the desired outcomes which relate to Improved reporting and improved case management other than to review as part of regular case reviews with advisors.

Re-word the Merits Assessment Decision Letter

113. Changes have been made to the legal services provider's negative merits assessment outcome letter in an effort to improve its structure and tone. The MSSR recommendation was intended to reduce the number of member complaints arising from the merits assessment letters generally. The quality assurance measures in place will not enable any analysis of the impact of this change on minority ethnic members.

Increase Bias Awareness and Empathy Through Training

114. Consideration has been given to bias awareness and empathy training for all staff who provide employment-related support. The purpose of that training was identified as being to eliminate structural and individual discrimination and bias, and to improve internal diversity data.
115. The effectiveness of bias awareness training is contested. However, research conducted on behalf of the Equality and Human Rights Commission ("EHRC") suggests that the aim of training which is most often achieved is awareness raising. It suggested that increasing the sophistication of such training, for example, by delivering an interactive workshop, increased both the participants' awareness of their own implicit biases and concern about wider discrimination, and that this awareness would continue to increase over time.
116. Bias awareness training, and specifically unconscious bias awareness training can be effective for reducing implicit bias but is unlikely to eliminate it. It is not generally designed to reduce explicit bias and training with that aim has had mixed results. There

is only limited evidence for the effectiveness of such training in promoting behaviour change.

117. New FPC employment advisors receive some training on 'empathy' in their induction programme. It is not clear whether FPC advisors have access to online diversity and inclusion training modules which includes content on bias awareness from their employers. They do not currently have access to learning modules on bias awareness and empathy produced by BMA HR.
118. FPC team leaders have received a session of unconscious bias awareness training from their employer, Kura. This Review is not in a position to comment on the content and delivery methods used by the Third Party nor on its effectiveness in reducing bias towards specific groups.
119. The BMA HR team are responsible for the BMA's EDI policies and procedures and for developing and facilitating learning and development programmes for BMA staff. BMA employment advisors, senior employment advisors and other BMA employees providing employment-related support have access to online equality, diversity and inclusion training modules which incorporate unconscious bias awareness training. They are required to complete and pass diversity and inclusion training periodically.
120. A number of BMA advisors commented that this felt like a "*compliance tick box exercise*" rather than a meaningful attempt to provide effective equality, diversity, and inclusion training.
121. There was an EDI week for advisors at the BMA for the first time in 2022 which contributors to this Review generally welcomed.
122. This recommendation has been implemented in part. Of course, one must encourage the provision of some training to FPC advisors rather than no training at all. However, a single session of unconscious bias training will not have a material impact on the organisational culture of the team or on the future practice of those who receive it. It is not clear what steps the BMA takes to assure itself of the quality of the training provided by the third-party provider nor of the steps taken to ensure that the training delivered is aligned with the content and approach of BMA HR.
123. Perhaps more fundamentally, the idea that this training of itself could eliminate structural and individual discrimination and bias must be challenged. Such training can, at best, serve to raise awareness of individual and organisational biases and of the need for empathy. In isolation such training cannot lead to long term

change at an organisational level. Change at that level requires intelligent and direct targeting of the structures, policies and procedures that inhibit equal, diverse, and inclusive workplaces and organisational cultures. It follows that awareness and empathy training must be treated as one part of a comprehensive strategy for achieving organisation-wide change.

Identify Strategic and Important Cases at First Contact with Employment Advisors

124. In light of a pattern of discrimination and whistleblowing issues being missed or discounted on the basis that the employer's narrative was taken at face value, the MSSR recommended that a process was put in place to identify these and other strategic and important cases at an early stage. The MSSR dubbed these cases 'Complex Cases.' The recommendation was that there was an immediate triage of Complex Cases by an experienced employment advisor to an experienced advisor.
125. The BMA has not specifically implemented this recommendation. It has taken the view that other process changes it has made are a more effective means of achieving the identified aim of ensuring that complex cases are not missed. The process changes implemented, and their effectiveness are considered further below.

Contract with Third Party Suppliers to share performance data

126. The MSSR recommended that service level agreements with external LSPs and employment service providers should contain a requirement that performance information, including information about complaints and information concerning the protected characteristics of members, be supplied to the BMA for BMA internal monitoring purposes. It was considered that the sharing of this information would enable the BMA to learn from the complaints made about its employment-related support services and to gain further insight into the makeup of its membership.
127. In 2020 two new providers were appointed by the BMA to commence work with the BMA in January 2021, with a third provider appointed in 2022 to start work in 2023. Each of the current LSP contracts contains a requirement to share the specified data with the BMA. The data obtained is used to assist the BMA in its quality assurance and equality monitoring processes. This recommendation has therefore been implemented.

Increase the volume of cases Processed by the Cases Committee

128. The MSSR invited the BMA to consider adding to the routes by which cases could be referred to the Cases Committee. At the time of the MSSR, only the BMA's Director of Legal Services was able to refer cases to the Committee.
129. The MSSR had noted that the Cases Committee's purpose was to decide when and on what basis external legal representation should be provided for cases falling outside the BMA's contractual arrangements with its LSP or outside the Legal Director's financial upper limit of £40,000 excluding VAT. At the time the MSSR reported, all cases which had been referred to the Committee by the Legal Director had been supported. The MSSR took the view that, having regard to its stated purpose, the Cases Committee was working well.
130. Whilst the terms of reference for the Cases Committee are in the process of being reviewed, the stated purpose of the Committee has not changed and is not expected to materially change. Accordingly, this recommendation has not been implemented.
131. It is proposed that the power of referral to the Committee be extended to other members of the Legal Department under the supervision of the Director of Legal Services.
132. It is proposed that a standing committee of the BMA, a Chief Officer or Council are effectively required to sponsor any case which is said to fall into the 'Exceptional Cases' category i.e., a case where even though the merits criterion is not met, it is of such political and representational importance that it is appropriate for the BMA to consider whether to provide support. They do so by submitting a written case.
133. These proposals have not yet been agreed. They do not materially alter the process of referral to the Committee or the routes for such referral. In practice, all requests for external legal representation are brought to the Legal Director from whatever source they emanate. They are always referred to the Cases Committee for determination. At the date of this Review, the Committee had yet to decline a request for support.
134. In addition, the BMA has committed to undertaking periodic reviews of how effectively the Cases Committee is functioning.

Create an Independent Monitoring Body to monitor the status and progress of employment-related support, including the progress of complex cases

135. This recommendation has been implemented. It was made to address a concern that there was a lack of transparency in the scrutiny of case management by the Member Relations Department. At the time of MSSR, the Member Relations Department effectively conducted an audit of its own work. The only other feedback the BMA gathered about its case management was derived from complaints it received via its sole LSP.
136. The BMA Board approved a proposal to create a body called an Independent Monitoring Body ("IMB"). It meets quarterly and is attended by the Directors of Member Relations and Legal Services together with representatives from each of the three LSPs. The body receives a report from the Member Relations Director and data in relation to call-handling which includes information about the volume and nature of cases, the number of complaints and satisfaction levels. The Legal Director provides an overview report on high spend cases to the IMB. They can also report on cases presenting potential reputational risk to the organisation. The LSPs have an opportunity to report on the cases which they hold and to raise any issues or concerns.
137. The IMB can initiate actions but has no mandated authority. The IMB has now captured twelve months of data. It is not yet clear how and to what extent that data will be used to inform decision-making around case management processes. Nonetheless, the introduction of the IMB appears to have introduced a degree of transparency and represents a point at which useful data can be collated and considered.

The Implementation of Recommendations Concerning Complex Cases

138. The BMA defines complex cases as those involving allegations of discrimination or whistleblowing detriment or dismissal.

Obtain a Barrister's Opinion for All Strategic and Important Cases

139. The MSSR recommendation was that where a 'Complex Case' was identified, a barrister's opinion should be obtained before the case was referred to external solicitors. The recommendation was made in part to address the phenomenon whereby discrimination and whistleblowing cases were disproportionately likely to fail the BMA merits assessment operated by its legal services provider.

140. The BMA has implemented a variation of this recommendation by altering the point at which a barrister's opinion is obtained. Rather than that opinion being obtained before the external legal services provider ("LSP") has advised, counsel's opinion is obtained at the point when there has been a preliminary merits assessment which indicates that the case has less than 51% prospects of success.
141. Under arrangements put in place since the MSSR, the allocated employment or senior employment advisor will advise on Complex cases and seek to resolve matters informally if they can.
142. If they consider that the case may give rise to a legal claim and the member wishes to have advice on the merits of that potential claim, the advisor will complete a referral form for legal advice. The contents of the form are approved by the member before the advisor submits the referral to their line manager for approval.
143. Once the manager has approved the referral for advice the advisor will prepare a file of relevant documents to be sent to the LSP who will provide a preliminary merits assessment. The preliminary merits advice is shared with the member.
144. Since January 2021, if the case is a complex case and the preliminary advice is that the proposed claim does not have a better than 50% prospect of success, the member is entitled to seek counsel's opinion. The member has the opportunity to provide further information and evidence before they attend a conference with counsel. Following that conference, counsel will finalise their advice.
145. The process put in place ensures that members have the reassurance of a second external opinion in the event that their claim receives a negative preliminary assessment outcome.
146. If the final merits assessment is positive, then the case is passed to the LSP to litigate in the normal way. If the final merits assessment remains negative, then the member is informed that the claim does not meet the threshold for support. They are advised that this does not mean that the claim will fail, simply that there is not, at that time, sufficient cogent evidence to satisfy an employment tribunal that the claim is well-founded.
147. The structure of the BMA's agreements with its LSPs means that there is an incentive for providers to reject cases referred to them rather than to accept them. This makes it all the more important to ensure that there is a rigorous process to select LSPs, and that the

outcomes of the merits assessment processes are subject to monitoring, review and, from time to time, audit.

148. In March 2021, the BMA commissioned a qualitative desktop review of merits assessments made by its LSPs from an employment silk. That review did not identify any material anomalies and concluded that the level of advice provided was “generally good, diligent and detailed, providing invaluable and much needed support in the highly complex area of employment law.”
149. As noted above there is now quarterly reporting of the LSP outcome figures and other quality assurance measures have been put in place. It is important that these measures continue.

Review of the current escalation, appeal, and review process, including roles and responsibilities of the BMA Cases Committee and its operation

150. This part of the Review is focused on understanding BMA decisions to refuse to provide support to members whose cases do not meet the merits assessment threshold of 51% or better prospects of success.

Escalation Process *Generally*

151. Members seeking legal advice in non-complex cases that have not been resolved at FPC will be referred to a local employment advisor. The advisor has discretion to seek authority to refer a potential claim to an LSP for legal advice. The member may also request that a referral for legal advice is made.
152. Information provided to this Review supports a finding that there is no reluctance to make a referral to LSPs. Rather, advisors welcome the opportunity of a second pair of eyes on the problem. A February 2023 Member Relations report to the Legal Review Body indicates that in 2021 and 2022 approximately one in every thirty-eight cases taken up by employment advisors was referred to LSPs for a merits assessment.
153. LSPs expressed a concern that some advisors use the escalation process as a way of protecting their relationship with the members. Escalating a matter to an LSP, even when it was obvious that there was no tenable legal claim, enabled the advisor to avoid being the person who delivered bad news. There was also a concern that some advisors were not managing members’ expectations in an appropriate way. Basic information to members such as that there is a statutory cap on unfair dismissal claims or that a member has a

duty to mitigate their loss in the event of a dismissal was not being consistently communicated. This contributed to members dissatisfaction with the advice and services they were provided with.

154. The quality of the referral form and the information provided by the advisor varies. At one end of the spectrum, LSPs described receiving material which is chaotic and disorganised, at the other end of the spectrum material is well organised and appropriately signposted This is the case whether they are standard case, or special case, referrals. It is because there is no standard guidance, and the forms are filled in by individual advisors who all have their own ways of working.
155. Having said that, the consensus amongst the information provider LSPs is that the quality of the referrals that are escalated to them by BMA advisors is generally significantly better than those from other trade unions.
156. The referral form is provided to the LSPs by the BMA. It tries to encourage uniformity in terms of the details it seeks. Each of the LSPs have had conversations with the BMA about developing the referral form in order to improve its functionality. A poorly prepared referral form may mean a case is rejected at initial assessment because of a lack of relevant information. Equally, a deluge of information may make it difficult to properly identify relevant causes of action. All LSPs observed that the introduction of an effective document management system would make the referral and escalation process more efficient and reduce the delays which so often frustrate and antagonise members.
157. The LSPs provide an initial assessment on the papers. The LSP receives case papers and a referral form, but they do not have any interaction with the member. LSP information providers indicated that they considered the benefit of this to be that a solicitor will not be influenced by how they think an individual is going to appear on the witness stand, in making their assessment.
158. There is currently no formal mechanism in the arrangements between the BMA and the LSPs which allows the LSP to go back to the referrer to seek relevant information before providing an initial merits assessment or in advance of a review meeting. LSPs and advisors rely on goodwill and common sense and will pick up the phone or email to seek the information they require in a timely way. If this option is not available the case will receive an initial rejection. This means that a final decision on the merits is delayed

and can be a considerable source of frustration to the member and the LSP.

159. LSPs have a discretion to seek a meeting with the member if they consider it necessary. The LSPs indicated that they rarely rejected a case solely on the papers.

Standard Cases

Review

160. If the initial assessment is negative the preliminary advice is shared with the member who has an opportunity to provide further information, evidence, and clarification of their case in response to areas of weakness or difficulty identified by the LSP. A review meeting then takes place.
161. LSPs, members and advisors all agreed that the preliminary assessment and the prompt for further information it provides, is a useful tool and opportunity. Because the request is placed within the context of the legal issues in the case, members gain a better understanding of the legal framework and the evidence required to prove their case. This can provide clarity and facilitate better engagement and responsiveness as between member, advisor and LSP.
162. LSPs may wish to obtain counsel's opinion in a standard case. If, for example, the case gives rise to a difficult point of law, may be impacted by an ongoing appeal, or may amount to a test case then providers may wish to seek authority from the BMA to instruct counsel. That authority is generally granted.
163. Final advice on the merits of the claim is provided by the LSP in writing after the review meeting. Each LSP has its own outcome document. Members and LSPs agree that sensitive and clear communication is key in delivering assessment outcomes.
164. Employment advisors who contributed to this Review stated that they would generally advise the member that the merits advice did not mean that their case was bound to fail at tribunal, simply that the BMA was not able to support the case. They would advise the member that it was open to them to seek alternative advice and/or fund their claim themselves. Some advisors would also signpost the member to other potential sources of representation. Advisors would make clear that they remained willing and available to assist with seeking a resolution of the employment-related dispute outside of the employment tribunal process.

165. Advisors indicated that this is the process that was followed in standard cases irrespective of the nature of the complaint and/or the ethnicity of the member. Minority ethnic members who participated in this Review did not suggest that the escalation process presents an unfair barrier to access to advice or support
166. Anecdotal evidence from contributors to this Review indicate that the escalation process in respect of standard cases is working well. Although the available monitoring data is limited, there is no indication of a race disparity in the escalation of standard cases brought by minority ethnic members.

Appeal

167. Where a member is dissatisfied with the final merits assessment decision, or the service provided by the LSP they are able to make a complaint via the LSP's complaints procedures. If a complaint is upheld by the LSP it is open to that provider to re-visit its merits assessment or to instruct counsel to do so. If the merits assessment changes as a result, so that the merits threshold is met, the member would be entitled to receive legal support from the BMA.
168. LSPs reported fewer anticipated appeals against negative merits assessments and no successful complaints to date.

Complex Cases

169. The general findings made at §§151-159 are equally applicable to complex cases.

Escalation

170. In relation to the escalation of complex cases LSPs and members noted the continuing difficulty with cases being escalated which have been proceeding through internal grievance and other hearings sometimes for many months. These cases tend to be escalated at a later stage. This can present challenges in terms of complying with the merits assessment process for these special cases within the applicable time limits for tribunal claims meaning that protective claims may have to be lodged.

Quality of Referrals

171. An LSP commented that they were surprised at the number of referrals they received from minority ethnic doctors. The cases referred were not necessarily race cases. Many of them were claims about unlawful deductions from wages, many were claims were from members who were not in consultant grades. It led them to question how effective BMA representatives were at identifying potential race claims.

172. LSP information providers remarked on what they perceived as a “tiptoeing” around issues of race at the initial referral stage. This was in respect of both cases where race may have been a reason for the treatment complained of and where it was very unlikely to have been the reason for that treatment. The issue was summarised as, “no one has asked what is an obvious question given the facts or the situation.” They conjectured that this might be because the member did not bring the issue to the advisor as an issue of race, because the advisor is too busy, because the advisor does not have a relationship with the member that enables questions around race to be asked, or a combination of these reasons. Whatever the cause, this diffidence can mean that a lot of time is taken, and a lot of work is done on a case without getting to the main issue.
173. Advisors indicated that members often did not identify their issue as a discrimination claim. There appeared to be a degree of diffidence and/or uncertainty with even experienced advisors as to the wisdom or appropriateness of having conversations with members about whether they had considered whether the reason for the treatment they were complaining of, was their race. Advisors noted the difficulty of, and sensitivity required for such conversations. They also spoke of “*not wanting to put words into the members’ mouths.*”
174. This reluctance on the part of some advisors to discuss and interrogate issues of race before matters are escalated to LSPs can also contribute to delays in resolving workplace issues.
175. A hesitancy around open and honest discussions about race on the part of advisors can also adversely impact the advisor’s ability to provide relevant information and manage member expectations. Information about the tribunal process, the approach to compensation in discrimination and whistle-blowing cases is often useful to members as they make their decisions about how they wish to proceed. That information of course needs to be delivered appropriately so that it is not construed as an attempt to dissuade a member from pursuing a claim.
176. Advisors noted that members were more willing to bring forward whistleblowing concerns and to identify protected disclosures as the reason for unfair treatment they received. Some advisors and LSPs considered that minority ethnic members used whistleblowing claims as proxies for discrimination claims because some doctors considered it to be more acceptable to make an allegation of whistleblowing detriment than to make an allegation of discrimination.

177. Many minority ethnic members expressed irritation and frustration that they did not receive an indication of what compensation they might receive were their claim to succeed nor how compensation would be calculated, until some way into the process.
178. Delays are exacerbated by inadequate information on the referral form. LSPs gave examples of referral forms failing to identify the alleged disclosures in whistle-blowing cases or failing to identify the relevant protected characteristic in a discrimination case. Failing to briefly indicate whether and how a member's narrative is challenged by an employer on the referral form was identified as a factor which impacted the quality of initial assessments in complex cases. Also cited by LSPs was a failure to ask the causation questions which are relevant to a merits assessment e.g., why do you say that this happened because of your race? Or why do you say that this happened because you made disclosures?
179. As with standard cases, the LSP provides an initial merits assessment as described above. If that assessment is negative the LSP **must** instruct counsel to provide an opinion on the merits. The current procedure requires the LSPs to offer the member a choice of three counsel. In race cases, where possible, at least one of the three will share a protected characteristic with the member. A preliminary merits opinion is then shared with the member.
180. Thus far, LSPs note that most minority ethnic members either seek and accept guidance from them as to which counsel to instruct or opt for the most experienced barrister on the list irrespective of ethnicity.
181. A review meeting with the member, the advisor, LSP and counsel then takes place at which the member has an opportunity to clarify information provided, provide further information and ask questions. Thereafter, counsel may provide a written final opinion on the merits or a note confirming the initial assessment.
182. If in the review meeting with counsel a different, alternative cause of action is identified as having merit, a new referral may be required. If the final assessment is that the case does not meet the threshold, the case will be closed by the LSP.
183. There are some practical difficulties thrown up by the special case procedure. Some LSP information providers pointed out that the Employment law Bar has its own issues with diversity so that identifying an appropriately diverse shortlist of counsel may take some time and on occasion, not be possible. Some LSPs and some

members viewed *the requirement* of a diverse shortlist as tokenistic. Minority ethnic members expressed the view that they were more concerned that their barrister was appropriately qualified and an expert practitioner in the field than that s/he shared their race and ethnicity. What they valued was an understanding of the issues around race discrimination and/or whistleblowing and an ability to empathise with their predicament.

184. Some members wish to instruct counsel of their choice, who may not be considered appropriately qualified or experienced by the LSP generating conflict and distrust. Some members will lobby elected members in order to achieve the outcome they desire. If the LSP acquiesces they may be left with a legal opinion which they do not consider credible and are reluctant to rely on. The member does not benefit because ultimately it is the solicitor's merits assessment, albeit informed by advice from counsel, that determines whether or not the BMA will support a claim. Managing these conflicts takes time and costs money.
185. Managing member's expectations whilst counsel's opinion is obtained was identified as a challenge by advisors and LSPs. Waiting for that advice was identified as a challenge and frustration by members. Whilst that advice was awaited members often contacted the LSP for advice or to update them on developments in their case in the erroneous belief that the LSP was now responsible for their case. Typically, members seeking advice on litigating these kinds of disputes are under significant stress and require considerable support which they look to the LSP to provide.
186. The provision of this support is not within the LSPs remit and cannot comfortably be accommodated within the commercial constraints of their contracts with the BMA. Equally, having escalated the case because the advisor and the member have agreed that it is necessary to consider a legal resolution, advisors may feel that there is little further support that they can provide. Furthermore, they will be working on other cases where their engagement and attention is actively required. Advisors also point out that some members are dismissive of what they can offer once a referral has been made, preferring to engage with lawyers rather than with them.
187. The inability of LSPs to respond to this member need can damage the relationship with the member and lead to member dissatisfaction and mistrust of both the LSP and the BMA. The inability of advisors to respond to this need can have an equally corrosive effect on the relationships between local advisors, the BMA, and the member.

188. The relationships which work most effectively are tri partite. The member continues to engage with the local advisor and issues relating to advice or strategy can be referred on to the LSP as appropriate. The LSP can re-direct member queries outside these parameters to the local advisor where necessary. LSPs state that advisors can be particularly useful to prompt a member when they are not getting the information or response that they need. The advisor supports the member and addresses their concerns in a timely manner as well as assisting the LSP in managing member expectations.
189. The nature of the BMA membership is also a source of challenge to LSPs and advisors. BMA members are highly educated, well-resourced, and demanding. As an LSP put it to this Review, "*they expect a Rolls Royce service*" at all times. Those members with means will on occasion offer to pay in order receive a more responsive or comprehensive service. This can place advisors and LSPs in the difficult position of having to explain that that is not possible under their terms of their arrangements with the BMA.
190. There is a risk that the current process disempowers both local advisors and LSPs. Some LSP information providers observed that it can appear as if counsel is being used to assess the advice given by the LSPs. That can in turn undermine the member's confidence in the expertise of the LSP who will be charged with the future conduct of the litigation. It may also feed an unrealistic expectation that, going forward, all decisions in the case will be taken in consultation with counsel.
191. It is questionable what, if any, value the special cases procedure brings beyond the merely performative.
192. The special cases procedure is a visible way of demonstrating that the BMA is supporting members to address concerns around discrimination and whistleblowing in the workplace. The use of external legal advisors and independent counsel might reassure members who believe that the BMA is reluctant to challenge employers on these issues in the tribunals. For such individuals, negative prospects advice might be easier to hear and accept. Generally, rightly, or wrongly, members view the instruction of counsel as evidence that their claims are being taken seriously and appropriately explored.
193. Members who do not trust the BMA's independence or integrity are unlikely to be reassured by a process which involves LSPs contracted to the BMA instructing counsel to provide merits advice.

If the objective of the procedure is to placate elected members who wish to ensure that the BMA is seen to be doing something to support a particular sub-set of members or address a particular set of issues, it may serve a purpose.

194. It was suggested to this Review that the procedure reduces the amount of time staff members spend engaging with elected members on casework and that saving ought to be factored into the costs/benefit analysis.
195. However, the special cases procedure does not improve the organisation's ability to identify discrimination and whistle-blowing cases. It does not, of itself, improve the quality of the advice and support minority ethnic members receive when seeking to pursue cases of discrimination and/or whistleblowing and it does not improve their outcomes.
196. The quality of the advice available to members can be controlled by the stipulations contained in BMA's contracts and service level agreements with LSPs. Reputable LSPs would seek advice and/or a second opinion from counsel in difficult cases in any event.
197. By February 2023, approximately 130 cases had been dealt with under the special case procedure since its introduction. The average costs per case was £2,600. Of those cases only one resulted in counsel arriving at a positive merits assessment. Seven cases where counsel was provided with further information at the review meeting resulted in a revised positive merits assessment.
198. The cases whose merits are assessed through the special cases procedure cost the BMA more than those whose merits are assessed through the standard case procedure. Whether that additional spend provides value for money or compensatory alternative benefits is ultimately a political question for the BMA to decide.

Appeal

199. As per §167 above the member is able to utilise the LSP's internal complaints procedure if they consider the case has not been handled appropriately. They are also able to raise a complaint via the Corporate complaints procedure.

Cases Committee

200. A member whose case has failed either of the merits assessment processes described above, may seek to bring their case before the Cases Committee for consideration.

201. The Cases Committee is chaired by the BMA Treasurer and consists of the Chair of the Representative Body, a Director, BMA Chief Executive and Policy Director. The Committee has a power to co-opt and, if a referral affects a branch of practice or the work of another BMA committee, the relevant committee chair or their nominee will normally be asked to attend in an advisory capacity to represent the committee's interests.
202. Referrals to the Cases Committee are currently made only by the Legal Director. There are proposals to amend the terms of reference to enable a member of the Legal Department to make a referral to the Committee under the Director's supervision. The Legal Director is responsible for coordinating and managing the Committee and for the provision of legal advice to the Committee. It is open to the Director to procure advice from counsel if they consider it appropriate to do so. The Legal Director is also responsible for implementing the decisions of the Committee and for the management of legal costs in the event that external legal representation is granted.
203. There is currently no requirement that any referral to the Committee be in writing. Any referral must be minuted and the minutes circulated to the Chair of the Committee in a timely manner.
204. According to the Cases Committee's terms of reference, consideration of a case where the merits criterion is not met should be confined to "exceptional cases" where the case is "of such a political and representational important nature" that it is appropriate for the BMA to consider it. Such cases must be supported by a branch of practice committee or the political board of the BMA. The terms of reference do not identify any other criteria to be considered or applied in deciding whether to grant support or not.
205. The Cases Committee is not established as the body to consider appeals against decisions that the merits threshold is not met. It should only decide to support such cases as the exception rather than the rule and only where the political and representational importance of the case justifies it.
206. The BMA may wish to consider whether an appeals body specifically to hear appeals against decisions that its merits threshold has not been met, is appropriate or necessary given the procedures that it currently has in place and the evidence that it has collated as to how robustly and effectively those procedures are working.

207. The terms of reference of the Cases Committee mean that an individual member's case that has failed the merits threshold must be championed by a branch of practice committee or an elected member in order for it to be brought to the attention of the Legal Director. In practice it is rare for such cases to be considered by the Cases Committee.
208. The majority of elected members on the Cases Committee means that it is vulnerable to political lobbying. Accordingly, is not a body which is best placed to make difficult and potentially unpopular decisions. It is notable that the Cases Committee has not yet declined to support any case brought before it.

Governance and Transparency

209. There is currently no requirement that minutes of the Cases Committee are circulated other than to the Chair. There are no parameters for the decision-making of the Committee beyond those contained in the terms of reference and set out above. There is no requirement for the Committee's reasons to be recorded in writing. The Committee is under no obligation to report to the Board or any other body on its work or on the progress and outcomes of cases that it decides to support.
210. The current Cases Committee terms of reference are insufficient to ensure appropriate oversight and accountability.
211. Information providers to this Review have stated that members who have not engaged with the process for seeking legal advice and support, or whose cases have failed the merits assessment, but are connected to influential political figures in the BMA or who are in a position to lobby such individuals, are able to secure consideration of their cases. Their cases are drawn to the attention of the Legal Director by elected members or by staff on behalf of elected members. Merits assessments and/or additional work including counsel's opinion may then be authorised by the Legal Director. Whilst these cases may not be supported for full representation, some members receive a benefit which is not available to others by reason of their personal connections and networks.
212. Contributors to this Review within the Legal Department have suggested that this view is founded on the memory of how BMA processes were operated in the past. The use of LSPs and the outsourcing of the merits advice process was designed, in part, to address and assuage this concern. Nonetheless the perception persists amongst members and BMA staff.

213. Information providers have also described instances of external lawyers contacting the Legal Director with details of cases which have been rejected in the merits assessment process or which they consider to be of interest to the BMA. Again, work on these cases may be authorised to re-visit the merits assessment outside of BMA process.
214. Some information providers considered that having alternative routes by which members could seek support for their cases did not need to be discouraged because it gave doctors reassurance that all avenues have been explored. Such routes were described as "*a safety valve.*" In my view this remains problematic. It undermines confidence in the organisation's processes and is contrary to the principles of transparency and equality of opportunity. These decisions are not recorded or monitored and may give rise to indirectly discriminatory patterns of behaviour which cannot be justified. If a case is raised which does not fall within the Cases Committee terms of reference it should be sent on to the local advisor or regional employment relations development manager for consideration for referral to an LSP. All such cases should be recorded and reported on in an appropriate way. If there are exceptional reasons why a case cannot be dealt with through the BMA's normal processes, they too should be recorded.
215. Reinforcement of the appropriate channels by all in the organisation, however senior, is important in order to build confidence in those channels and those who work in them. It enables the BMA to give effect to proper EDI monitoring and reporting of critical decisions so that it has reliable evidence as to how its procedures are working and whether they are effective in eliminating discrimination and inequalities of opportunity.

Alternative Support Mechanisms

216. Information providers across the nations reported a reluctance to take up counselling and well-being services offered by the BMA. Many doctor contributors spoke of feeling that they needed to cope on their own. They spoke of feelings of shame, shock and helplessness.
217. Advisors routinely discussed the benefits of welfare and counselling services with doctors in complex or long-running disputes. They pointed out that services were often available to support family members as well. Many minority ethnic doctors were reported to be resistant to the idea that such alternative support mechanisms were necessary or of benefit.

218. Employer occupational health services were often regarded with suspicion.
219. However, informal networks, mentoring and coaching by minority ethnic doctors have valuable roles to play when doctors are in distress or difficulty. Regional FREE fora were also highlighted as a useful source of information and support.
220. The difficulty with defining alternative support mechanisms for members whose cases have failed the merits assessment is that by the time members have reached this stage many are wedded to the idea that the solution of their employment-related difficulties must involve litigation. This is, in part, a consequence of the way in which the BMA promotes the benefits of its employment support services. Some of its messaging appears to suggest that the measure of success for BMA's employment-related support services is whether or not a member is supported in a claim in employment tribunal. In some ways then, it is no wonder that some members consider a refusal to support a tribunal claim as evidence of a failure on the part of the BMA. They feel let down because the BMA is refusing to provide them with the assistance they believe they need to resolve their employment-related issues or to vindicate their position.
221. By the time a member has reached this point they are likely to be highly stressed, distressed, perhaps suffering from physical and/or mental ill health. They are not interested in well-being services, buddying schemes, or opportunities to be mentored. They want to prove that they are right, that they have been wronged, they want their day in court.
222. In the longer term what is required is a renewal of focus on the idea that workplace disputes should be addressed and resolved at the lowest possible level and that systemic issues such as discrimination and punishing whistle-blowers need to be addressed by the BMA in a strategic and collective way. Individual doctors cannot and should not be expected to bear the brunt of struggles to challenge systemic issues. It is not sustainable or fair. Neither the individuals nor the NHS can afford the price they pay.
223. The BMA may wish to explore putting together a programme of bespoke tailored support it can offer to doctors who have been embroiled in long running and difficult disputes. The programme might involve working with a range of professionals: occupational health services, psychologists, education and skills advisors, coaches, who can provide bespoke tailored assistance to rehabilitate a doctor, enable them to reflect on their experiences and their

practice in a safe space and return to and thrive in a workplace or place of study.

Understanding and defining the BMA's Role in Supporting Members Undergoing GMC Investigations and concurrent employment-related complaints

Terms and Conditions of Membership

224. The BMA terms and conditions of membership state explicitly that the BMA does not support members in matters concerned with conduct, including professional conduct or clinical performance. They specifically state that in such matters, support and representation is provided by the medical defence organisations ("MDO"). That message is not stated with the same degree of clarity elsewhere.

Website Content

225. The BMA website advises doctors to contact their MDOs straight away if they are notified that they are subject to action or investigation by the General Medical Council ("GMC"). It identifies the MDOs as the ones who can offer advice and legal support if appropriate. For those doctors who are not members of an MDO the website states that they should contact the BMA's employment advisor service. It identifies employment advisors as the group who can offer expert employment advice and support on matters related to personal conduct. It does not provide any examples of what conduct might be considered personal rather than professional conduct.
226. The website content does not explicitly set out what, if anything, members can expect from the BMA should they be embroiled in GMC investigations or proceedings at the same time as employment-related issues with their employer. An opportunity to manage members' expectations so that are not disappointed when the BMA is unable to provide the member with assistance, is wasted.
227. A section on the website which is explicit on the demarcation between the work of the BMA and the MDOs is needed. It should reflect the areas excluded from representation and support which are contained in the terms and conditions of membership. This would be a significant step in providing clarity and removing confusion. Setting out what members can and cannot expect of BMA employment advisors in the context of concurrent regulatory proceedings, perhaps in an FAQ section, would also be helpful.

228. Members who contributed to this Review reported ignorance of the nature and extent of support they can expect from the BMA where there was GMC involvement in their cases. There were concerns about poor lines of communication and disjointed liaison between BMA and MDO advisors. As a result, in their contributions to this Review members routinely reported confusion, frustration and disappointment about the BMA's involvement in their cases.
229. Employment advisors reported that they are primarily oriented towards providing support in internal hearings. Time and caseload pressures meant that they tended to be reactive where there was MDO involvement, responding to requests for information and providing pastoral care on an ad hoc basis.
230. Senior employment advisors tended to deal with MHPS investigations and reported working with the MDOs where issues of conduct or capability arise and a referral to the GMC results. Individual workers have devised their own ways of working to try and meet members' needs.
231. There appears to be no standard protocol as to the rules of engagement for BMA employment/senior employment advisors working with MDOs. The parameters of the BMA's role need to be set by the organisation, informed by members' needs but tempered by the realities of limited resources and the need for advisors to operate securely within their areas of knowledge and expertise. This would benefit both members and employment advisors.

Identify relevant learning from members' and non-members' experience within the BMA during the relevant timeframes, namely, those who have left membership in the last 5 years and concerns about First Point of Contact (FPC) will be considered within the last 3yrs.

232. It is important to record that the sources from which member and non-member experience was gathered for the purposes of this Review cannot be considered representative of the BMA's minority ethnic membership overall. This is, in part, because as previously discussed, the BMA does not have an accurate picture of the make up of that membership. It is also because the gathering of data depends on the willingness of a member or representatives of a minority ethnic group to engage with the BMA in the first place. To that extent the participants were self-selecting.
233. There were members who had raised their concerns directly with senior officers in the BMA and had agreed to be interviewed. There were members who were approached but declined to engage with

the Review. There were also members who, having initially declined to engage, changed their minds and members who having engaged and met with me, later asked for their contributions to be withdrawn.

234. It is also fair to say that those members and non members who had engaged solely with FPC are under-represented amongst contributors.
235. This Review could discern no particular pattern in terms of race or ethnicity in the range of those responses. It received information and evidence from students and doctors at various stages of their career working in a range of clinical settings under a range of contractual arrangements. It included doctors from most but not all nations in the UK. Participants were male and female, working full and part-time, religiously observant and secular. Doctors who trained in the UK and overseas shared their experiences. Contributors were from a range of minority ethnic backgrounds with African, Asian, Caribbean, European and mixed heritages, all represented.
236. This Review is aware of a degree of concerted action by individuals and groups to ensure that their perspective emerged. This Review does not consider that this approach invalidates the legitimacy of the feedback provided. Generally, this Review is satisfied that all those that did engage with the Review did so to place on record their lived experience as ethnic minority members and/or doctors seeking to engage with the BMA's employment-related support services. They wished their voices to be heard. Many hoped that their contributions might assist in improving the services offered. However, some contributors considered that the BMA had no real interest in serving their needs as minority ethnic doctors and doubted that there would be meaningful, positive change.

An analysis of a selection of cases brought by members who have felt unhappy or complained.

237. This Review was not conceived of as an opportunity for discontented members or non members to receive a second (or third) opinion on the merits of their legal claims or to determine the validity of decisions made in their cases. Such an exercise is also inappropriate where complaints are ongoing. Instead this Review offers an analysis of the features and themes which emerge from a selection of cases where members have felt unhappy and/or have complained.
238. No contributors suggested that BMA employees or LSPs deliberately set out to provide a poorer service to minority ethnic members. All

contributors, even those that reported negative interactions or who rated the services they received as inadequate in some way, also identified members of BMA staff who had provided them with very good and sometimes excellent levels of support and advice. This suggests an inconsistency in the levels of service provided and a variability in knowledge and skill across the UK and within regions/divisions.

239. Where negative experiences were recounted they were not confined to 'historical' cases or events nor did they appear to be unduly reliant on negative anecdotes from sources antipathetic to the interests of the BMA.

240. A number of themes emerged from this engagement exercise. They can be broadly summarised as:

At FPC

- Communication that does not appear to be aware of and/or sensitive to race and religious issues and the difficulties some individuals might have in raising them
- An eagerness to close cases down
- A disconnect between the call centre and what happens on the ground
- Poor explanations of process and next steps
- Feedback opportunities are too superficial.

Employment Advisor/Senior Employment Advisor

- Difficult to contact
- Lack of responsiveness
- Unreliable – i.e Did not do what they said they would do, e.g. attending meetings or writing a letter within a particular timeframe
- Under-resourced and over-worked
- Did not provide clear information about processes
- Did not give advice or provide a risks/benefits analysis on the options available
- Did not advocate for the doctor
- Shied away from robust challenge
- Were not pro-active
- Too slow/reluctant to escalate matters for legal advice
- Were too close to Trust managers/Colluded with employer
- Too keen to compromise
- Insufficient knowledge and awareness of discrimination issues.

Complaints Handling

- A reluctance to acknowledge that things had gone wrong
- An unwillingness to apologise
- Defensiveness

- Lack of transparency

How Things Might Have Been Done Differently: A member and no-longer member perspective

241. Since this Review cannot be focused on individual cases which are necessarily fact and context specific, this section of the report focuses on suggestions for improvement that are more general in character but which are drawn from the interactions with contributors.
242. Contributors suggested that in terms of the work of advisors there was a need for:
- Earlier action and escalation
 - More robust and timely challenges
 - A more 'hands on' approach
 - A more pro-active approach
 - More human resource so that they carried lower caseloads
 - Better training in active listening and probing but empathetic questioning.
 - Practical advice on things like other avenues for funding litigation, sabbaticals, alternative work
 - More training on how to recognise and talk about discrimination
 - More training on gathering information and evidence in whistle-blowing and discrimination cases and building a case
 - Specific port of call and/or access to dedicated resources when they have queries about how best to support minority ethnic doctors
 - Effect introductions to counselling or other services do not just send a link
 - Support for advisors so that they could do their best work
 - There should be a specific request for feedback when a case is closed which allows some free text/a narrative account rather than the automated tick box satisfaction survey.
243. In terms of LSPs, participants suggested:
- There should be a choice of LSPs.¹
 - They should be able to instruct counsel of their choice.
244. As to the BMA itself participants suggested:
- The BMA should be doing preventive work with employers
 - BMA should challenge and speak up about poor management cultures in the NHS

¹ This comment related to cases begun when there was a monopoly provider of legal services to the BMA. However, it may still be material because under the current process the member is allocated an LSP rather than being able to select from the list of providers.

- Different levels of subscription for different levels of service
- Remove the contractual term that allows withdrawal of support if a member seeks independent legal advice
- Facilitate discussions with members and **listen** to what they have to say
- Acknowledge that under-represented groups are the experts when it comes to their lived experience and the BMA can learn from them
- An independent person within the BMA members can take their concerns to
- BMA should run more test cases
- Be braver in the cases it supports- running cases that don't meet the merits threshold if there is a point of principle or an issue that affects particular groups of members disproportionately
- Push for Trust accountability on their legal spends on suspension, investigations, MHPS proceedings and settlement
- Amplify the voices of those who are unfairly treated by current arrangements
- Don't leave it to individuals to challenge unfairness.

'Never Members'

245. This Review received limited insights from those who had never joined the BMA. The main reasons given for not joining the BMA were;

- Doctor could not see what the BMA had to offer them;
- The BMA was not an organisation that was relevant to them;
- Costs.

246. The reasons given suggest that the BMA's efforts to communicate the benefits of membership to minority ethnic doctors, in particular, remain ineffective. Some representatives of minority ethnic doctors' groups who were already engaging with the BMA stated that they encouraged their members to take up membership of the BMA. Others did not see it as their role to advocate membership. Minority ethnic doctors' groups such as MANSAG, who did advocate membership, did so on the basis that it provided members with an insurance policy if they got into difficulties. Others cited the size of the BMA and its influence with stakeholders such as government, regulator and employers as reasons for joining.

247. Interestingly, in a parallel with non-minority doctors, minority ethnic doctors claimed that the BMA was dominated by GP interests and minority ethnic GPs suggested that hospital doctors and consultants held sway.

248. The cost of membership was stated to be a very real issue for those who work part time, and for locally employed and SAS doctors who

tended to be paid less than other doctors. Membership was not necessarily a priority for these doctors, particularly those with financial commitments which included supporting family members in the UK and overseas.

249. The relevance of the BMA to the lived experience of these 'never member' contributors was repeatedly raised. One doctor said, "*[the BMA] doesn't really understand what is going on for doctors like me.*" Another said, "*IMGs interests are not the BMA's interests.*"
250. The fact that the BMA does not look like a diverse organisation contributed to the sense that it was not for 'people like them.'
251. When one considers the diversity of the profession and the proportion of minority ethnic doctors in the profession the lack of representation and influence of minority ethnic doctors in the BMA calls for explanation and response.
252. The labyrinthine structures of the BMA were also cited as an issue. Doctors stated that they did not understand the BMA structure. They did not know how to get involved or who to approach. They were unlikely to approach people outside of their personal networks for this information. One young doctor commented that the BMA "*seemed like a closed shop – I wasn't clear about how anyone got involved.*"
253. The minority ethnic 'never members' spoken to tended to look for and derive their professional and other support from members of their own communities where they knew and understood the mores. Only when there were barriers to obtaining that support would individual doctors look elsewhere.

The BMA Staff Member Perspective

254. Advisors noted the co-operation, respect and understanding that underpinned the best of their relationships with doctors who were facing difficulties in the workplace. Without exception, BMA employment advisors described the satisfaction of making a difference to a member's situation as the greatest benefit of their role.
255. Advisors who work with minority ethnic members on discrimination and whistleblowing cases all pointed to the levels of stress that the doctors they are working with are facing. They noted that, even before the pandemic, doctors were operating in under-resourced environments which placed significant challenges on their personal and professional resources. Following the crisis caused by Covid-19

pressures on all NHS staff have increased and that has manifested itself in more behavioural issues in the workplace.

256. Advisors noted that they were often dealing with members who were socially isolated or who felt unable to confide their professional difficulties in friends or family members. This placed an additional strain on the advisor/member relationship which it was only possible to navigate well, with clear boundary setting. Advisors spoke of calling a doctor on a Friday afternoon knowing that s/he would not be speaking to anyone until the following Monday when they returned to work.
257. A major challenge for members who seek to bring these complex cases is the legal landscape. This was a challenge which advisors were aware of but were not always able to communicate clearly to members. The legal elements of a valid claim are complicated and the evidence required to support them is often very difficult to obtain. Conveying that without sounding defeatist was a task that some advisors struggled with.
258. Most members are unaware that even with legal representation a Claimant is more likely to lose a whistleblowing or discrimination claim than to win it if they proceed to a full hearing. Many members therefore believe that there is a likelihood of vindication if their case proceeds to a hearing. They are not prepared for the often brutal reality of litigation or the disappointment of compromise and settlement.
259. Further, many doctors do not engage with the fact that when litigation is over they will have to return to a workplace and resume professional practice with colleagues. They may be reluctant to think about what preparations for that might look like or simply be too exhausted to think that far ahead.
260. In many cases advisor and member are locked in a cycle of trying to find evidence from which treatment because of race or some other protected characteristic can be inferred. In whistleblowing cases they will be looking for evidence which might suggest that an employer has taken action because of a protected, qualifying disclosure. Because many discrimination and whistleblowing claims arise out of difficult working relationships there is rarely a clear line of causation. NHS employers have become very astute at arguing that it was not the fact that a doctor raised concerns or made allegations of discrimination that led to action against them, rather it was the way in which those concerns were raised. Too often doctors are simply out-manoeuvred.

261. Advisors also noted that members do not appreciate that the advisors are reliant on them to provide them with baseline information to explore their potential claims and that this has to be done within quite tight time frames. Doctors are generally time poor and can find it difficult to find time to prioritise work on their case.
262. Many members who have expressed dissatisfaction have experienced issues in the workplace over a long period of time which can make effective resolution more difficult.
263. Members may not have identified for themselves what a 'good' outcome will look like. There is often a difference of opinion as to the best approach to achieve a desired outcome. Particularly where issues are longstanding, members are apt to seek a more combative approach whereas advisors are generally keen to emphasise the value of discussion and compromise, turning to adversarial means if other methods fail. This can cause conflict, disagreement and mistrust.
264. Advisors spoke of members not always appreciating that they carried other cases. They frequently referred to members having unrealistic expectations on turn round times and response times. There is resistance to advisors prioritising their work and explaining that they are supporting others.
265. Some described members who would not take advice, which objectively viewed, was good advice and of the frustration and difficulty that working with such members could cause. One summarised the situation in this way, "*a member who is not taking good advice, you can see where it's going to end up and you are trying to pull the member back -then they turn on you and say you are not on their side, they don't trust you, you are having secret side talks with the employer, they don't think you are taking it seriously.*"
266. Advisors have a range of strategies for coping with such situations but all recognised that there were occasions when the relationship with the member broke down and the appropriate thing to do for both the member and the advisor was to bring in a new advisor. Most advisors would have alerted their line managers to difficulties in the relationship before a tipping point was reached. Advisors accepted that there were instances when relationships did not gel for whatever reason. However, they expressed irritation and frustration with members who agitated for a different advisor simply because they disliked the advice that they had been given or wanted a more senior advisor. It was suggested that it is important for managers to explain what they are doing and why.

267. Advisors were also critical of members who had unrealistic expectations as to outcome.
268. Some advisors across England spoke of not feeling valued. This was not a sentiment expressed by Review participants in the devolved nations. Advisors in England described rude and occasionally unacceptable behaviour by members. There was an acknowledgment that some steps had been taken by the Member Relations Department to 'call out' such behaviour but also a feeling that there was still some way to go before this issue was under control.
269. Poor or inappropriate conduct from members was not identified as a concern in the other nations.
270. A number of staff members across the organisation did pose this question, "*Who is looking after us to look after the doctors so that they can look after their patients?*"
271. It was pointed out that in some very long-running cases where members are constantly pulled into employer procedures, the advisor's work was akin to the member having a personal caseworker for the whole of their career.
272. Advisors expressed hurt that some members did not recognise the value of the work that they do or believed that they were being given poor advice or representation based on their race or background. Many pointed to their extremely knowledgeable, specialist colleagues who provided "*fantastic service*" for the price of a BMA subscription. They contrasted those charges with the hourly rate a private solicitors firm or other lawyer might charge.

What Has Led to Successful Results

273. Members and representatives do not necessarily share the same understanding of a "positive outcome." For a doctor who believes that they have been unfairly targeted in the workplace and as a result is subjected to complaints about their conduct or capability having a grievance upheld or obtaining a secondment to another employer or a placement in another department may not feel like "success." Similarly, agreeing a severance package rather than being dismissed may not feel like success.
274. It is therefore important that representatives and members jointly agree at the outset what the objectives in pursuing the case are. They should define what 'success' looks like. They should re-visit those agreed objectives periodically to make sure that they still

make sense and, if they do not, to re-define them. Where this has happened and has been appropriately documented, members are more likely to consider the outcome to be positive.

275. Cases where members have expressed satisfaction with the employment services they have received do not necessarily result in the member 'winning' or getting what they want. The following comment is typical of observations from many advisors who have formed positive working relationships with minority ethnic members and who have had to deliver negative news or outcomes, "*They appreciate what you have done because they have seen the whole process unfold with you.*"
276. Representatives who have the confidence, skills and experience to think outside the box can produce positive outcomes for members. For example, in a case where a doctor alleged discrimination by a work colleague the advisor placed the onus on the employer to take action through appropriate line management to resolve the issue rather than requiring the individual to raise a grievance.
277. A feature of 'successful outcomes' is that they have resulted in the member feeling listened to, heard and supported. Members have received regular contact at times and via means that work for them. They have been clearly advised on their rights and obligations. They have been consulted on next steps before those steps are taken. They have received debriefs after meetings in their cases and had updates on progress or the lack of it.
278. Positive outcomes have depended on the member and advisor being able to establish a relationship of mutual trust and respect. That has included open and honest, sometimes difficult conversations, establishing boundaries and managing expectations of what is and is not possible. Good outcomes generally result from members and advisors working collaboratively. This can be time-consuming while trust is established. Members want to understand the process and the evidence or rationale for a particular action or decision. This means that advisors have to be in a position to articulate these things. If they do not know the answers (and it is impossible to know all the answers all the time) being upfront with the member about that and identifying a credible source to find the answer can be a really valuable element in trust-building.

Understand the needs, wants and expectations of minority ethnic and International Medical Graduates (IMG) doctors, both current and non-members, on matters related to their employment as doctors and other relevant matters.

279. Like all doctors, minority ethnic doctors and IMG doctors want to be able to practice their profession, widen their skills and expertise to fulfil their potential and provide the best patient care that they can.
280. Minority ethnic doctors and IMG doctors told this Review that they wanted to be able to carry out their work in workplaces free from unlawful discrimination and the unfair and punitive treatment of those who raise concerns. They wanted to be valued and respected in the workplace. They wanted to be supported to learn, develop and pursue excellence. Accordingly, they wanted the BMA to work to bring about this state of affairs. Broadly, that means robustly challenging punitive treatment and discrimination in the workplace and in health outcomes and ensuring that discrimination and unfair treatment was an issue for everyone not just the individuals directly affected and damaged by it.
281. Whilst minority ethnic doctors and doctors' groups were broadly aligned in terms of their needs, wants and expectations, there was less agreement on the means of achieving them.
282. Some individuals believed that the BMA was incapable of handling the issues of black and minority ethnic doctors because it did not hear their voices or understand their circumstances and therefore could not properly represent their interests.

FPC

283. At first point of contact, doctors want a convenient port of call which provides clear, expert advice in answer to work-related queries and questions in a timely, accessible way. If the first point of contact advisor is not able to resolve the query then doctors want to be signposted to someone who will be able to help them. They want user-friendly advice and information which is delivered in a non-judgmental way. An immense challenge for those FPC advisors is the scope of the subject matter which they can be called to advise upon. There is currently no specialisation in terms of subject matter or even national jurisdiction.
284. Those minority ethnic and IMG doctors who contact FPC have commented on the tone of the calls suggesting that they are not sufficiently open, patient or empathetic. However, it was noticeable that for some contributors the issue was about whether an ethnic minority or IMG doctor could have confidence that they would receive a good standard of care rather than having actual experience of poor standards or peremptory treatment. This is an

example of anecdotal and sometimes historical anecdotal evidence continuing to frame people's perception of the services offered.

285. Contributors to the Review repeatedly pointed to the lack of diversity amongst FPC call handlers as a concern and as evidence that the BMA was not representative of or able to properly serve all of its members.
286. There was also some suggestion that more probing at the initial contact stage might assist in directing potentially time-sensitive matters to an appropriately skilled employment advisor in a more timely way. Some doctor contributors observed that they did not know the ingredients of a whistle-blowing claim or a race discrimination claim and that they could not always be relied on to flag these issues as concerns on first contact.
287. The majority of the contributors did not have confidence that an FPC advisor could properly explore and signpost a case which involved a number of issues like race and sex discrimination, religion and race or sex, or race and disability discrimination. There was a concern about the quality of advice given to SAS doctors in relation to changing their contractual arrangements. Information providers from LSPs also suggested that links around issues of pay and race were not appropriately explored.

EA/SEA

288. When it came to contact with employment advisors, many members said that there were not always told who would be contacting them. They were also critical of delays before contact was made. Some members felt that it would have been helpful to receive some information on 'what to expect' and 'next steps' once their case had been allocated to an advisor.
289. Members expected a reasonable degree of contact from their advisors even when there were no particular developments on their case. Reaching an agreement about the means and minimum level of contact between advisor and member at the outset of the relationship may be a useful way of setting boundaries and managing expectations.
290. Clear information setting out the available options with their benefits and potential disadvantages was identified as something that doctors wanted to aid them in their decision-making.
291. Generally members wished to have a pre-meeting or discussion with their representatives before they attended a meeting with their employer. If the meeting was in person, members expected their

representatives to arrive at any scheduled meetings in good time to have a brief conversation with them before the meeting started. If the meeting was held remotely, members expected to have an opportunity to speak to the representative before the meeting started.

292. Where members attended a meeting with their representative they had an expectation that the representative would take a note of any salient points of the meeting and would actively participate in the meeting, including by advocating the member's cause.
293. If time-scales were breached by an employer, members expected their representatives to follow up seeking an apology, an explanation, an indication when the task would be done and making clear that breaches of timescales were not acceptable.
294. Members were adamant that their representatives needed to be prepared to challenge their employer and to have difficult conversations with them.
295. It is fair to say that members expected a high degree of professionalism in the services that they were offered. They were not necessarily aware of the distinction between the first point of contact call handlers and the employment and senior employment advisors in their contributions to this Review.

IMG Doctors

296. The BMA's own "Racism in Medicine"² survey reported that, overseas qualified doctors experienced racism more often than doctors trained in the UK. 84% of respondents who qualified overseas said they had experienced racist incidents in their workplace in the last two years, compared to 69% of respondents who trained in the UK.
297. Only 12% of overseas qualified respondents said they had never experienced racism, compared with 31% of UK qualified respondents. Across all types of incidents respondents who had qualified overseas were more likely to experience these incidents than respondents who had qualified in the UK. For example 52% of overseas qualified respondents reported having their clinical ability doubted, compared to 27% of UK qualified respondents. 43% of overseas qualified respondents reported being subject to bullying, compared to 20% of UK qualified respondents.

² "Racism in Medicine" 2021 BMA

298. Respondents who had qualified overseas were twice as likely to think that racism was a barrier to their career progression than those who had qualified in the UK.
299. This context perhaps explains why a number of Review contributors argued that IMG members needed more specific, targeted outreach and welfare support. It was suggested that large numbers of doctors who would benefit from these services are not able to access them via the BMA because they are not in membership.
300. Contributors to the Review argued that programmes of activities that targeted newly arrived IMG doctors and sought to assist them with NHS induction, familiarisation with the NHS culture as well as more practical problems like relevant qualifications, resolving immigration queries, finding accommodation and locating community networks, were sorely needed.
301. Specific mentoring projects and career development advice for IMG doctors or less formally links to existing networks of supportive doctor peers were also identified as gaps in the BMA's offering to already established IMG doctors in the UK. The gap is currently filled by individual doctors who provide this support to their communities. It was noted that regional FREE fora are also slowly beginning to occupy this space in England. The devolved nations rely heavily on the good auspices of their SAS and LEDs to fill this gap. These resources are both finite and voluntary. At the moment there is no provision for organisational resource to be put behind this valuable work.
302. IMG contributors have suggested that employment advisors should have access to a network of IMG doctors who they could speak to if they wanted advice on how best to approach a particular issue. Rules in relation to confidentiality and consent would have to be carefully observed.
303. A significant gap identified in this review is the dearth of information on female, IMG doctors. They are under-represented in BMA membership despite being the doctors most likely to bear the brunt of intersecting discriminatory conduct and practices. They are also under-represented in groups which purport to speak for and on behalf of IMGs so there are few places in which their authentic voices, wants, needs and expectations can be heard. Specific outreach work to engage with these doctors should be considered.
304. Currently some members wrongly believe that they are entitled to receive a service without limits or constraints. They do not appreciate that where the BMA provides employment-related

support services, it does so holistically and subject to conditions. They do not necessarily appreciate that the BMA is not amenable to the doctor adopting a 'pick and mix' approach where s/he sources some advice and representation from the BMA and some from other sources. They consider it unfair that seeking independent legal advice or a second opinion is a ground for withdrawing BMA support.

Member Feedback

Review the user perceptions and experience of the services provided compared to global data such as established performance measures.

305. It is important to note that members who have had a negative experience of a service are unlikely to give objective feedback. Nonetheless, the service provider can gain valuable insights from their reflections on the service received.
306. Interestingly, a majority of service users who contributed to this Review reported positive experiences of working with BMA employment relations staff even in cases where they went on to complain or have causes for concern. The experience of working with service providers was never described as wholly negative.
307. A majority of members who contributed to this Review recognised that advisors were doing their best to provide a good service but faced constraints of time, resources and process which affected their ability to deliver solutions to members' problems. Members attributed the advisors inability (in their view) to deal effectively with discrimination and whistleblowing cases in particular, to a lack of knowledge, understanding, time and experience rather than to hostility to them because of race or ethnicity. Members were also clear that the NHS systems and workplace relationships were ultimately the sources of their difficulties not the BMA's advisors.
308. Where there was real disappointment, anger and frustration was in the work that the BMA was doing to tackle these systemic challenges which members perceived as being largely beyond the ability of individuals to address. One of the most frequent criticisms raised by contributors to this Review was of the spaces that the BMA was not occupying, the issues that it was not taking up and championing. Members spoke of BMA disinterest in their struggles, of the BMA being disinclined to have the difficult conversations and to take the action needed to shift the dial on fair treatment of minority ethnic doctors across the board. Very many doctors (members and non-members) were vocal in asserting that this work

is the work of the BMA and not the work of individual doctors. Pursuing whistleblowing cases or discrimination claims was really a course of last resort which generally ended with careers in disarray, if they were not ended altogether.

309. A summary of the themes that emerged from member interviews is set out above. Generally members did not recognise the value of the services that they received. They did not have a conception of the monetary value of the services provided or of the costs that they would have incurred had they sought and received that advice and representation from private sector firms. Essentially they expected that "*all avenues would be explored*" in seeking to resolve their issue. Costs and proportionality were not central to their thinking.
310. Members had/have a naïve faith in the power of litigation and the courts to solve workplace issues and/or to provide personal and professional vindication. That faith is in part fed by the way that the BMA positions its employment-related support services. The emphasis is not consistently and implacably placed on resolving disputes at the lowest possible level within the shortest possible timeframe.
311. For these reasons there is a disconnect between minority ethnic users' perceptions of the BMA employment related support services and the BMA's established performance measures.
312. This Review has already commented on the limitations of the current performance measures. The insights that they provide on user perception and experience must be treated with extreme caution given the poor response rates and the limited opportunities to provide texture and complexity in automated survey responses or elsewhere. There appears to be no real opportunity for validation of that data outside of the Member Relations Department.
313. Nonetheless on the face of that data the vast majority of members who use the BMA's employment related support services are satisfied with the service they receive. Based on the internally held data there is no statistically significant differential in the reporting of satisfaction by race or ethnicity. However, there are certainly no grounds for complacency. There is a lack of focus, seriousness and rigour in the collection of data that could make a difference to the BMA's member relations offering. There is an obvious opportunity to provide meaningful data to improve the member experience and/or to provide reassurance about the quality of services provided by the employment related support services team, which is being repeatedly ignored.

314. This means that many minority ethnic members continue to feel that they are being done a disservice by those who are employed to support them. As one contributor put it, *"It is a perception and it is really hard to interrogate the feeling behind it."*

Recommendations

315. Make specific recommendations to address BMA services support to minority ethnic members.

For Members

The creation of basic information booklets on: pay and contract disputes, race, whistleblowing, which include practical tips on building a case, dispute resolution etc, which they can be provided with if their case is passed to an employment advisor.

BMA should consider refreshing its workshop/webinar offering to include material on 'working relationships' 'managing conflict in the workplace' 'reflective practice' alongside content specifically directed towards under-represented doctors. It should consult its networks and fora for suggestions on suitable subjects.

Consider piloting phone line/email address where members could seek initial advice specifically on discrimination and whistleblowing matters. If appropriate members would be referred on to an employment advisor.

A resource page for information on non-legal support and advice services for minority ethnic doctors which is kept up to date.

FPC

Work with FPC providers to devise a programme to diversify the FPC advisor workforce. Consider the use of a positive action programme to secure a representative workforce.

Work with FPC providers to ensure training includes unconscious bias awareness training for all new recruits, team leaders and managers. Ensure that the training provided is aligned with that undertaken by BMA staff.

Consider establishing FPC advisors with specialist areas such as Wales, Scotland, Northern Ireland, SAS doctors, Locally employed Doctors.

Develop a training module for FPC advisors in which minority ethnic doctors provide their perspective to the advisors on their experiences and the advice that they need.

Seek qualitative feedback from members who have made an FPC call as part of a periodic audit regime. Collate ethnicity, sex, age, disability status and job grade data. Include that data and feedback in Member Relations reports.

Consider a time limited trial where a small group of advisors seek qualitative feedback from members as above. Review and share the results with EDI.

Employment Advisor

Consider the use of a positive action programme in relation to recruitment for a designated number of advisor roles.

Provide further specific training focused on the elements of discrimination and whistleblowing law. Include specific work on identifying and progressing these claims in the workplace.

Provide training on 'managing difficult conversations' and 'negotiation skills.'

Consider opportunities for skills and career development: mentoring colleagues, conducting a webinar masterclass on a topic of interest to the advisor for the benefit of colleagues.

Consider whether minority ethnic advisors might be willing to buddy/mentor an advisor in one of the devolved nations for a period of time.

Provide advisors with dedicated time for reading and training every month.

Consider an advisor/member template agreement where:

- the agreed objectives for the case are recorded
- means and frequency of contact
- requirement for mutual respect are set out.

A periodic review of open cases (perhaps every six/twelve months), which must include speaking to the member.

A case recording system so the number and nature of cases an advisor is carrying is recorded centrally as well as locally and can be monitored and reported.

IRO/ERDM

Working with advisors to raise issues such as: bullying, disproportionate use of MHPS, recruitment, or pay errors or failure to follow job planning protocols as collective issues. Placing the onus on the employer to ensure that its management is effective and accountable.

Being proactive in challenging dysfunctional Trusts and employers.

Work on pattern spotting within Trusts, regions and nations. Collecting and disseminating information to advisors and to Member Relations in a structured way.

Member Relations

A periodic meeting of the Heads of Member Relations in the four nations to share information, discuss issues that are arising and exchange member engagement strategies.

Generally

Better knowledge-sharing within the BMA

Develop clearer lines of accountability for EDI in Member Relations

Develop clearer lines of responsibility for strategic work with NHS Trust employers. Specify how Member Relations and EIC policy team work together and hold systematic intelligence on Trusts.

Consider and then specify how FREE and Regional FREE will work with the advisors in Member Relations. There should be periodic opportunities for meeting and engagement.

Make member recruitment practices more relevant to under-represented groups by building and improving links between the BMA and under-represented communities. Use multiple channels to reach different audiences.

More outreach activities in the workplace – making local connections

BMA needs to work hard to encourage as many members as possible to self declare their ethnicity.

Use ONS census categories to include a broad range of ethnic identities. Ensure that people can select multiple categories to reflect how they self identify.

Make clear that the data will only be reviewed and reported in aggregate and where there is sufficient representation of each ethnicity to ensure anonymity.

Monitor and evaluate progress in recruiting and retaining minority ethnic members. Collect data on recruitment of minority ethnic candidates into representative roles.

Request ethnicity data at the start of membership and whenever members take part in engagement surveys or other activities.

Explain how providing ethnicity information can help the BMA to meet its EDI strategies and priorities. Report on progress, provide examples of how data has driven changes in practice.

Keep the data in a format which allows for efficient analysis of different outcomes for different ethnicities.

Ensure that the specificity of the data captured is retained on the system.

Consider using member networks to promote engagement and share stories of people from diverse backgrounds who see the importance of sharing their data "*See me, know me, represent me.*"

Establish a programme to increase the representation of minority ethnic members in BMA structures.

Set targets to improve the representation at all levels, including on decision-making bodies regionally and nationally. Consider publishing those targets to drive intentional planning and progress.

Consider offering an anonymous reporting process for members to raise concerns about their experiences when they interact with the BMA.

Work *collaboratively* with other organisations to highlight and challenge practices that adversely impact minority ethnic doctors. The BMA should be using its voice to amplify the voices and campaigns of those who are often not heard.

Training: BMA should consider offering spaces in its legal update training to representatives from other organisations as part of relationship building/strategic partnership. It could also consider offering local rep training on particular topics to representatives from other organisations.

Consider commissioning research in one or two areas of particular interest like female IMGs and part time work or locally employed doctors in the devolved nations and then using the research outcomes to support outreach and recruitment campaigns and to drive future engagement activities.

Consider developing one or two projects under joint working arrangements to address specific concerns such as differential attainment or agencies recruiting doctors from overseas to work in the private sector.

Promote mediation, early resolution and alternative dispute resolution. This means in its interactions and interventions the BMA should emphasise the importance of senior management taking managing conflicts seriously and the value of holistic approaches.

When mistakes are made, acknowledge them and learn from them.

Where a member's feedback has been used to inform the organisation's learning or improve a process make sure that the member knows that their experience will help others.

Find better ways to tell the 'good news stories' that involve members and advisors so that successes can be shared. Selective interventions perhaps once or twice a year providing information to members about progress made, achievements and successes with a focus on minority ethnic doctors.