Experiences and insights of midwives and obstetricians from ethnic minority groups, in relation to equality, diversity and inclusion

Report for Care Quality Commission

Listening to maternity workforce

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1. Introduction to the research
   1. Background

The Care Quality Commission (CQC) commissioned this research in response to evidence of inequities in how people from ethnic minority groups experience maternity care and outcomes in England. The purpose of the research was to explore:

* Experiences of people from ethnic minority groups *working in maternity services*
* Insights that staff have into safety issues and experiences of people from ethnic minority groups *using maternity services*.

This was a small-scale piece of qualitative research, conducted in two phases. First, 10 interviews with midwives from ethnic minority groups working in England (in summer 2023), which fed into CQC’s annual State of Care report[[1]](#footnote-1). Second, 10 interviews with obstetricians from ethnic minority groups (in autumn/winter 2023). The findings from both phases will inform insight and research work with people who use maternity services and with other staff groups, as well as guiding CQC’s future approach to inspection[[2]](#footnote-2).

The research was undertaken by an independent researcher (Lucy Smith).

* 1. Method
     1. Scoping and design

CQC provided an initial draft of the questions and topics to be explored in the interviews. This was developed and refined with the input of the Association of South Asian Midwives (ASAM), the Society of African and Caribbean Midwives (SoAC), and a practising obstetrician and CQC inspector (from an ethnic minority group).

The interview discussion guide had two broad sections, exploring:

Challenges and issues for staff from ethnic minority groups working in maternity services, and awareness and perceptions of work underway to address these.

Safety issues and negative experiences for people from ethnic minority groups using maternity services, and awareness and perceptions of work underway to address these.

* + 1. Recruitment and sample

An invitation to take part in an interview was shared with midwives via midwifery membership associations, ASAM and SoAC. Obstetricians were recruited via CQC networks and regional obstetric leads.

Interviewees received a thank you payment in recognition of their input.

A pragmatic approach was taken to sampling, with the aim being to include maternity staff from a range of ethnic minority groups, in a mix of roles/bands and working in different areas of England. Specific quotas were not set.

Overview of achieved sample

|  |  |  |
| --- | --- | --- |
|  | **Midwives** | **Obstetricians** |
| Ethnic group | Five Black, 4 Asian | Four Black, 6 Asian |
| Band/grade | Mix of bands, student to Band 8 | Mostly trainee ST1-6; some consultants |
| Work setting | Mix of hospital and community | Hospital |
| Gender | All female | All female |
| Age | Good distribution of ages | Mix of ages, majority 25-44 |
| Disability | Two reported a disability | None reported a disability |
| Where trained | All UK educated but some raised outside the UK | Most UK educated - 2 trained outside UK and 3 raised outside UK |
| Location | Most from London and the south east, others the north west and East of England | Good mix of regions |

See [appendix 1](#_Appendix_1._Participant) for a breakdown of participant information.

* + 1. Fieldwork

Interviews with midwives were held during June and July 2023, and with obstetricians, September 2023-January 2024. They took place by Zoom or phone, lasting an hour.

While the discussion guide contained a number of specific questions and prompts around staff’s experiences, insights and awareness of improvement initiatives, in practice the interviews were generally free-flowing, allowing participants to tell their stories and focus on the themes that were most relevant to their experience.

* + 1. Analysis and reporting

Interview notes were entered into an Excel spreadsheet and analysed for common themes within each broad topic area covered in the interviews.

This report summarises the themes emerging from the interviews, illustrating findings with quotes and examples from participants’ experiences (these are anonymous).

* + 1. Note on language

Participants were invited to identify the term or words to be used to describe ethnic group/s during the interview. These included people from ethnic minorities, people/women of colour, Black or brown, people/women from the global majority.

In this report, the term ‘people from ethnic minority groups’ is used, except where a specific ethnic minority group is being referred to. Those using maternity services includes women and birthing people and their partners.

* + 1. Limitations to the research

The research is based on a small sample of maternity staff, in the context of the size of the workforce. However, there was good diversity within the sample in terms of ethnic group, age and band/grade, and a wide variety of experiences.

Participants were self-selecting. Midwives came from within a pool that can be considered to be ‘informed’ or ‘engaged’ with issues affecting midwives from ethnic minority groups, in that they are members of midwifery associations specifically representing midwives from ethnic minority groups.

A handful of the participants were actively engaged in EDI or advocacy roles within their trusts. Some participants had a specific experience they wanted to share, that had driven them to be more determined not to accept the status quo. All had agreed to take part in the research because they were highly motivated to support change in relation to the experiences of staff and people using maternity services.

**Abbreviations**

DoM / Director of Midwifery

EDI / Equality, diversity and inclusion

HCA / Healthcare Assistant

HCP / healthcare professional

HoM / Head of Midwifery

IMG / International medical graduate

PMA / Professional Midwifery Advocate

SAS doctor / Speciality or specialist doctor

1. Introduction to the findings

#### Experiences of staff in maternity services

Maternity staff taking part in this research identified a pervasive backdrop of differential treatment for staff from ethnic minority backgrounds, particularly those educated outside the UK, impacting massively on their experiences of working in maternity services.

Participants described a culture in which it is normalised for people from ethnic minority groups to tolerate discrimination from colleagues and work harder to prove themselves, than their White counterparts.

When staff spoke up about unfairness towards themselves or to people from ethnic minority groups using maternity services, they could find themselves ignored, dismissed, or effectively punished by negative treatment.

This can lead to midwives and doctors from ethnic minority groups feeling excluded, undermined and frustrated.

#### Staff insight into experiences of people using maternity services

Those interviewed had seen people using maternity services being treated with a lack of respect, not listened to and not given choices in their care. Experiences were seen to be significantly worse for those who don’t speak English.

Care was affected by racial stereotypes and lack of cultural awareness among staff, which led to negative experiences and safety issues.

Interviewees recognised that staffing pressures in the NHS made it more difficult for staff to provide good quality care. They noted that many colleagues are providing excellent care to people from ethnic minority groups. Some observed improvements in how their trusts have been addressing issues for staff and people using services from ethnic minority groups, over recent years.

None of this withstanding, there was a clear view that there is a huge amount to be done in terms of tackling inequitable care and workforce experience, and this must be based on more open acknowledgement of the root cause. One of the most common phrases used by interviewees was ‘swept under the carpet’.

“Systemic racism is rife in the NHS. Before we can address any change we need to acknowledge that. We need to accept that racism is a thing. Nobody wants to use the word racism.”

1. Findings: experiences of staff
   1. Challenges and issues for staff from ethnic minority groups working in maternity services
      1. Overview

Interviewees were asked about the challenges and issues they had experienced working in maternity services. There was much in common in terms of midwives and obstetricians’ views. The findings are grouped into the following themes:

* Career progression
* Stereotyping and cultural awareness
* Belonging and inclusion
* Speaking up
  + 1. Career progression

Career progression was one of the key challenges identified by midwives from ethnic minority groups. They reported a range of issues in relation to this area, all broadly feeding into reduced opportunity to develop and progress, compared to White counterparts. Interviewees observed that midwives from ethnic minority groups were less likely to be represented in leadership and managerial roles and noted a pattern of White colleagues being better prepared for, and more likely to secure, promotion.

Obstetricians interviewed did not focus as much on career progression, but some of the same themes came up, particularly around the representation of doctors from ethnic minority groups in senior leadership roles, which was seen to be lacking.

#### Access to training, mentoring and promotion opportunities

* There was a perception of a general lack of support and encouragement for midwives from ethnic minority groups in relation to their development; a sense that they would be left to get on with their job, at Band 5 or 6, rather than actively encouraged to seek out and take up opportunities that could lead to promotion.
* “I can’t even count how many White students I have mentored and they are now senior to me. They are HoMs. What is wrong with me? I have taught them, they have been with me and learned from me. You can imagine that is disillusioning. I feel forgotten.”
* Midwives in the lower bands were often referred to as those ‘on the shop floor’; people in these roles lack time during work to check emails and find out about non mandatory training, and if they miss something, it is not likely to be flagged to them by senior colleagues.
* Mentoring and coaching were seen to be more common for White midwives than those from ethnic minority groups. It was perceived that senior people who are White are more likely to encourage and advocate for other White people because they feel more connected to them - they ‘see their younger selves’ in those colleagues. For obstetricians from outside the UK, more support and mentoring was thought to be needed, not only when they first arrive in the UK, but to support their ongoing development and career progression.
* There was a view that promotion for midwives was based on ‘who you know’, not on merit; ‘who’s friends with who’ – which was seen to be based on shared ethnic background. With White people more likely be in senior roles, junior people who are also White are more likely to be promoted.
* “I don’t see the mentoring and support given to people from ethnic minority backgrounds. You might be going for a job and you just know that somebody else has been mentored for that job – so you know who is going to get it. It puts people off even applying. It’s all about who’s friends with who. The talk on the shop floor – ‘so and so will get the job because they are very pally with so on so on the panel’. Who is friends, who goes out with who for drinks, who is in the same circle. Not about merit and considering who would be good for the job. Cliquey, that is the word. Or nepotism. Based on people having the same cultural background.”
* Participants described midwives from ethnic minority groups being dismissed or discouraged from pursuing promotion, being told that they are ‘not ready’ and having their confidence undermined. This is compounded where they do not see people from ethnic minorities in senior roles, to act as role models as well as advocates.
* “Being in interviews – it was always, ‘you were very close, you just were not quite there’. If you are having this throughout your career, you start to believe it - you think, maybe I am only suitable for a certain role. And when you lose confidence, you don’t perform as well or you stop aspiring.”
* Midwives from outside the UK, without family support networks, may be less able to attend training outside of work hours; and without strong professional networks, less able to tap into support and mentoring opportunities.
* Role models were identified as an important influence on both midwives and obstetricians in terms of their progression:
* “Most of the clinical directors where I work are Caucasian, and it doesn’t represent the consultant workforce. People won’t put themselves forward for leadership roles as they think they won’t get it. Same with clinical excellence awards – I have seen people being less likely to put themselves forward for those. There is a lack of encouragement for doing that. They should handpick people for training, 121s, mentoring, build aspiration into appraisals. If people see the change [more people from ethnic minorities in leadership roles] then it will become more natural to go for them.”
* It was observed that people from ethnic minority groups have to work harder to prove themselves, and this was felt by both midwives and obstetricians:
* “There is this ‘secret midwife’ community on Facebook, I went on and posted on it, ‘I feel like I have to go the extra mile and have to jump through hoops’, and lots of people said, ‘yes me too’. A lot of people don’t have the confidence to speak up about this. It is a culture that is accepted.”
* Some obstetricians at trainee grades talked about tolerating the challenges and issues they experienced as ethnic minority doctors, because they felt these were interlinked with their lower status as junior doctors and would therefore be overcome or at least mitigated once they reached consultant level, like this trainee:
* “If you are not recognised and valued, it affects your confidence. But I just try to overcome it by thinking, [training] it’s just 7 years and then I will be a consultant for 20, 30 years.”

However, not all trainees had the same belief – following a conversation with a consultant (also from an ethnic minority group) in which they discussed the way they had both been treated by some colleagues, this interviewee was so discouraged she planned to leave obstetrics and change to another field:

* “I came home and I was like, there is no hope. Even a consultant feels like this! There is no hope for me. I don’t want to do obstetrics any more.”

**It’s not what you know**

“You see people go for the position who are very qualified for the role but someone [White] will get the job - because they know how to talk the talk [in the interview]. I have seen an instance where a midwife applied for Band 7, it was given to another member of staff who was White and the Black midwife was asked to train that person, showing that they were more than competent. So why didn’t they get the job?

You know that as a person of ethnic minority, if I want to go for this job, I have to work extra hard to prove myself, whereas my White counterpart will just get it. They might not be capable of doing the job, or not willing to go the extra mile to get it - but they have been trained to answer the interview questions really well – someone will tell them, ‘This job is coming out soon, you should apply, this will be the sort of questions’. They are told in advance so they have time to prepare, but when the job post actually comes out, there is only a week to apply. They say ‘no, there is transparency, anyone can apply’, but effectively it’s rigged.”

#### Experiences of the interview process

Some of the midwives spoke about experiences of being interviewed for promotion. In addition to being less likely to apply for promotion, midwives from ethnic minority groups may be disadvantaged in the interview process, because:

* Panels may not include people from ethnic minority groups, which does not set an encouraging and supportive tone. A midwife from an ethnic minority group who does sit on interview panels, as part of a trust initiative, nonetheless did not feel she had an equal voice to White people on the panel.
* Cultural norms may affect interview performance. For example, cultural perceptions around eye contact affected one midwife during an interview, where her lack of eye contact was construed as a sign of poor communication or even rudeness:
* “I have gone to an interview where I was told I didn’t make eye contact with the panel, and they found that to be a problem, a problem with my communication. But traditionally where I come from, making eye contact is showing a lack of respect. So getting this feedback, it throws me, because culturally where I come from, that would be very disrespectful. I was disadvantaged by their lack of understanding of that.”

#### Experiences of students and trainees

Midwives interviewed described disadvantages to students’ progression during their training, including the following:

* Not being given placement allocations that enable them to develop or demonstrate the skills they need to learn and evidence in order to move forward in their training (with others being given priority for placements)
* Being offered shifts that the placement allocator knows they can’t do
* Being given poor marks or failed on assignments
* Having to work harder to get evidence and signatures in their assessment logs.

Students and junior midwives spoke about not feeling able to question what they are being taught, or what they are observing in terms of practice. Staff from ethnic minority groups develop a sense of the need to ‘keep your head down’ – because if they don’t, they might be failed on an assignment, or put into a challenging placement or role.

* “When I started rotation on the post-natal ward – well it’s like a battleground, the vibe is so off. Staff are speaking so disrespectfully to women [from ethnic minority groups]. And they target women who don’t speak English because they know they won’t complain. So I saw this and I raised it. After raising that, the same person who allocates the placements decided I couldn’t move on from first year. I still finish on time overall, but it holds you back. I went back and asked for the signatures and apparently I didn’t have enough things signed off. Other girls [White] have had the same number of signatures and they were progressed. I think if I hadn’t spoken up, I wouldn’t have been treated like this.”

Particularly for students, but continuing for registered midwives, interviewees felt that midwives from ethnic minority groups were disproportionately affected by power dynamics and hierarchies at play within midwifery. Students and junior roles felt that with both senior staff, and HCAs, interactions conveyed a sense of their inferiority - of being told, or made to feel, ‘know your place’.

* “So when you call for a second midwife at second stage, they would come in and take over the room. They treated me… there was a lot that was not being said. They were undermining my capabilities and it was clear, they wanted me to know, they had a poor opinion of my intelligence.”

Obstetric trainees who are from ethnic minority groups and from other countries were reported to be more frequently challenged by midwives around their decision-making and way of doing things, than those from the UK. They had to work harder to gain the trust of midwives and prove themselves capable in the midwives’ eyes, and obstetricians interviewed thought that there should be more sensitivity and support around this:

* “They are not trusted, the midwives are questioning them about their skills. Just trust them, because they were given the job!”
* “I can see it from the midwifery perspective - you have high litigation in maternity and if you are the coordinator, you want to have a doctor you trust. I understand that. But some of the new registrars, they get challenged - and that’s OK, you want challenge - but sometimes it is not done in a very professional manner. So the doctors are left feeling very undermined.”

**‘Once you progress the daggers start coming’**

“When I became a band 7, some of the team stopped talking to me. I would come to work and there would be lots of eye rolling, comments, or just ignoring me. I’d be saying, ‘right, this is what we’re going to do today’, and nobody would listen to me. And that was just because I got that job. [They questioned how I got the job], saying I couldn’t possibly have the knowledge, and someone must have given me the interview answers. And then this group of midwives went above me and raised concerns about patient safety, to say women’s care was being compromised and people were being neglected. This was completely unjustified.

[Eventually] those midwives left the trust, they resigned, so from the trust’s perspective it was like, ‘they have left so we don’t need to do anything’. But nothing stops this happening to another member of staff. Because it was not actively addressed or acknowledged – that they had basically complained and lied about me because they were not happy that I got the job.

I have constantly been in meetings about this and the response is always, ‘oh maybe we should schedule a meeting to see how best we can support you’. This makes it seem like the problem is that I am struggling with my emotions. No, that is not the problem - I don’t need support - I need the issue to be addressed so this does not keep happening to people.

So it’s, I am a good midwife as long as I stay as a band 6. Once you progress, then the daggers start coming. I feel people’s view of me has been tainted by this whole episode. So I constantly have to prove myself, prove I am worthy of the job. I get good feedback on my work, but I still have that feeling.”

* + 1. Stereotyping and cultural awareness

Participants experienced and witnessed use of language and behaviours by colleagues that reflect racial stereotypes and lack of cultural awareness. Examples included the following:

* Questions regarding cultural practices, for example, to a Muslim midwife: ‘Do you eat sheep’s head? Why do [Muslim] women cover themselves? Will you have a forced marriage?’
* Colleagues commenting, ‘Oh, you speak good English’, even to colleagues born in the UK – with the effect of implying, ‘you do not really belong here’.
* Microaggressions[[3]](#footnote-3) in use of language by colleagues, and often a lack of awareness, or claimed lack of awareness, around these. For example, use of the word ‘aggressive’ to characterise Black women (both staff and women using maternity services), and then if called out on this, denying that it is an issue.
* “About a [White] staff member, they will say ‘that person is so passionate’ and when it’s a Black person, it is called aggressive. Even though those two people are saying the same thing.”
* “Sometimes I have finished a night shift and I have staff members come up to me, saying ‘you look very angry this morning’. No, I am just tired. So there are microaggressions as well, I am labelled aggressive.”
* “If I am getting passionate about something – it is called getting heated up, getting aggressive – and as soon as you hear that you are being seen as aggressive, that makes you feel shut down. And as soon as you say ‘racist’ no one wants to talk about it, White people become defensive.”

Microaggressions also took the form of insinuations, such as in the following example:

* “You hear someone muttering, ‘there was a complication, one of the international midwives was involved’. Well, there were probably ten complications today and the other nine of them involved a British midwife. So that is a microaggression.”
* Midwives finding themselves in a position of having to act as educators about race, explaining aspects of culture or religious practices such wearing the hijab; or explaining why certain words constitute a microaggression and are therefore not acceptable.
* “I have heard comments like ‘why do women have to cover up, it doesn’t say that in the Qur’an’. Er, have you read the Qur’an?! I have no respect for these midwives who can’t be bothered to educate themselves about the women they are supposed to be caring for. ‘I have seen women who are gorgeous and they wear the hijab, why is this happening?’ I am seen as the expert, like it’s my job to educate people. They need to educate themselves! There are so many of this kind of comments.”
* Participants acknowledged that at times this behaviour by colleagues reflected genuine ignorance of cultural traditions and practices, and were willing to take on the role of explaining and educating – nonetheless it was frustrating, and tiring, to have to do this; it all contributed to making them feel uncomfortable, out of place, isolated and excluded.
* Some interviewees were frustrated by being expected to act as translators for people using maternity services. While they want to help, this is not part of their job, and made them feel ‘used’ by colleagues.
* “You feel used for translation. I would be pulled here there and everywhere to translate, and it is not part of my job but I feel am doing it for this family - because that is the worst thing for someone, to be in an emergency situation and not know what staff are telling you. So I do it, but it isn’t part of my job.”
* “Sometimes I will say no, I’m busy, use language line [translation service]. It’s not my job. And that is accepted if I am busy, clearly busy like I am there with a catheter in my hand. But then I feel guilty - what if that person has rubbish care, because I wanted to make a point about not being used as a translator?”
  + 1. Belonging and inclusion

As well as colleagues explicitly drawing attention to their difference as described above, interviewees talked about more subtle behaviours contributing towards a sense of exclusion, lack of belonging and not feeling part of the team.

* Interviewees described a ‘cliquey’ culture amongst midwives, a ‘gossipy’ atmosphere and a sense of camaraderie which staff from ethnic minority groups were excluded from:
* “Quite often I was the only person of colour on the ward. I felt that there were times when people wouldn’t say hello to me, would not respond to my request for help, or they would answer me impatiently. A handful of people were kind but not most people that I was consistently working with. They weren’t welcoming me to the team. It was very much a clique system.”
* “I have seen when midwives [from ethnic minority groups] have left and gone to work elsewhere and there has been nothing - but when someone is leaving and they are White, they get a big party.”
* Interviewees talked about not being seen as individuals, such as being referred to by their role instead of their name, or mixed up with other staff from ethnic minorities:
* “The way you are made to feel, it is subtle, it is not like, obvious discrimination. For example, there were two Black trainee doctors and the midwife would call them by each others’ names. She said they look alike. And they don’t look anything like each other. That sort of thing, it makes you feel not valued, you are not important, you are just another member of staff.”
* Exclusion was manifested in terms of work allocation too, with midwives from ethnic minority groups being given more work overall, and more high-risk, more complicated patients, and being told, ‘you can look after your own kind’:
* “The work allocation is not fair. In one shift I have been given four labouring women whilst there has been a White midwife sitting at their desk, drinking tea and not working. You see that ethnic minority staff are on their feet tirelessly doing more work.”
* “If a woman who is Black is coming in and maybe they had a mental health issue, maybe there was something about their behaviour that the staff find difficult - they assigned me to this person. If there was someone with a transmittable disease, it was assigned to me. Always the women with more a complicated pregnancy history were given to the ethnic minority staff.”
* Participants reported not being included in social events, because they are not inclusive (for example, socialising being based around alcohol - colleagues going out and ‘doing shots on a Friday night’ – and religious dietary requirements not being considered).
* There were experiences of conversations stopping or changing when they go into a room:
* “I walk into the staff room, people are talking about sexual things, inappropriate things - they would say to me, ‘Oh cover your ears, you won’t want to hear this’. But they shouldn’t be talking like that anyway, you are at work, it should be respectful, professional. There is this assumption you wouldn’t want to be involved in that conversation. And I wouldn’t. But the effect is you feel like a spare part, feel different, alone. With a team around you who listen to you and hear you – you feel appreciated. Without that, you don’t feel part of the group.”
* In more formal settings too, such as in meetings, one interviewee reported being frequently talked over, not listened to and her ideas not taken forward:
* “Sometimes when I am trying to put things across, I am not heard. I might say something in a meeting and it can be shut down, or the next person interrupts me - which will probably be a White person, because that is who else is in the meeting - and then it moves on and I have said something that has not been addressed. This is very, very common. So then I just keep quiet and just leave it. I stop talking for the rest of the meeting.”
* Lack of inclusion and connection also manifested itself in terms of a sense of a lack of kindness, compassion and supportiveness, both from peers and managers. There were several examples where interviewees felt that basic kindness and consideration was lacking towards them, for example, when returning to work after maternity leave and being placed straight into a more challenging setting, or being denied small accommodations that were granted to White colleagues:
* “My manager would let my colleagues go home early if they needed to, but if I asked for the same, it would always be no.”
* Several midwives noted that midwifery is a small sphere (compared to nursing), and a sense that it is easier for staff to ‘get away with’ perpetuating an exclusionary, ‘cliquey’ culture; that this culture becomes more entrenched within a small group and harder to call out and challenge.
* As well as affecting overall wellbeing, feeling excluded has an effect on the ability to reflect and learn, if staff don’t have peer relationships that enable this.
* “I feel like I can’t be my true self in work, around midwives. I might be somewhere and there are two midwives talking and the conversation stops when I come in. I don’t feel part of it. I feel like, oh my goodness someone speak to me! It’s natural as part of this job, you want to reflect and offload with other midwives, about patient care. So it’s very hard when you don’t feel you have anyone you can do that with.”
* Not feeling able to be themselves at work was a recurrent theme, expressed by both midwives and obstetricians.
* “Back then, I had no role models, no people who look like you, to aspire to, no safe space. Those things were very absent. You just become so invisible. You just go into work and be someone you are not. And yes, that is still there now, very much so.”

In the following example, an obstetrician described how she was excluded both in terms of rapport and opportunities because some staff did not make the effort or felt awkward about saying her name:

**‘Because my name is difficult, they will ask someone else’**

“My name is not easy to pronounce, and there are a lot of staff members who can’t say my name so they will use my job role instead. They will say ‘can you ask [the trainee] if she will do this’. It is not deliberate but it changes your experience. Because my name is difficult, they will speak to someone else instead.

It is just sad, you try to build a relationship and you are always trying to build rapport and build trust, show people they can trust your abilities and judgement. I have learned everybody’s names that I work with, and I would like to feel that effort is reciprocated.

It does affect my opportunities to do things and that is very frustrating. People have someone they will go to because they know their name. I would rather people just ask me, and say, ‘sorry, can you just remind me how to say your name?’”

Without exception interviewees felt that a more diverse workplace helped them to feel a sense of belonging and inclusion and, furthermore, to do their jobs better as a result. But this was not simplistic; obstetricians in particular said that ethnic diversity was only one factor in their experience and it could be difficult to disentangle this from the impact of other differences: gender, seniority, and dynamics between between midwives and doctors, all of which intersect to affect the experience of ethnic minority doctors in the workplace. This is illustrated in the example below.

**‘Where there is more diversity, there is better working together’**

“In a previous hospital where I worked, the midwives were predominantly White British, and it was a very unfriendly work environment, there was a lot of hostility, between midwives and between midwives and doctors - a culture of midwives and doctors against each other. It made working there unpleasant, I would feel very anxious going on to the labour ward, knowing that I am disliked by the midwives before they have even got to know me, because of my job title. It affected communications as I wouldn’t want to go and talk to the midwives if I didn’t have to, I would actively avoid the staff room and the office. In contrast to other hospitals where there is a more diverse mix of people – White, Black, eastern European – where I find there is a lot more understanding and it’s a lot nicer place to work.

When I moved to my current hospital, I was actually surprised when a midwife know my name, because at the previous one the midwives would certainly not bother to get to know our names, you would be just ‘the SHO’. Simple, respectful behaviours like that, it is a way of building relationships and that means a better workplace. Where there is more diversity there is better communication, better working together.”

* + 1. Speaking up

A very common theme in the interviews was around speaking up, whether about patient care, or about how staff themselves had been treated at work, when calling out a colleague’s use of language, or raising a concern more formally. There was a clear view that speaking up was likely to be a negative experience. Midwives and obstetricians spoke about the fear of speaking up, and of weighing up the risks and consequences of doing so – how will this affect how I am treated, how I am seen, how will it affect my health and wellbeing? – with their desire to call out unfair treatment of staff or care of people using maternity services.

* “I am treated differently, because I am brown and because I ask questions. It’s the elephant in the room – the message is ‘you can be here and you can be quiet and get along OK, but if you want to start talking about things – you will feel the consequences.’ In my case I wasn’t given the placement I needed, I was failed and not progressed for speaking up.”
* “When we start talking about race, in British culture it is like a no-go zone. And I don’t want to be followed by a reputation of being that person, who brings up race and makes a fuss. There are not many Black doctors, not many Black consultants. If you are going to raise things, you want to be backed up. So it isn’t just me being seen as, I am always the one calling things out. For me to call it out, it has to be very overt. And mostly racism is not overt, it is microaggressions.”

Experiences of speaking up were characterised by the following:

* Being ignored, not listened to – for example, an email raising a concern not being replied to, or not in a timely manner.
* Being dismissed, disbelieved or questioned – for example, asked, ‘did it really happen like that, or was it just how you perceived it?’
* Excuses being made for the behaviour being reported, for example, being told, ‘be more sympathetic, you don’t know what is going on in that person’s life’.
* Being labelled as a troublemaker, a know-it-all or other character slur.
* Being punished by receiving poor marks, failing assignments, being allocated certain tasks (e.g. placed into high risk rather than low risk environments), not given opportunities.
* Midwives had been accused of lying, their mental health questioned, their suitability to be a midwife questioned and their own traumatic pregnancy or birth experiences used against them (instead of being supported).
* Some interviewees who had been involved in disciplinary or grievance processes reported that individual managers involved in the former had also been involved in the latter, or had later sat on an interview panel; reflecting a lack of impartiality – and sensitivity - towards the candidate.

Participants overwhelmingly felt that when they spoke up, issues were ‘swept under the carpet’, or addressed only superficially, showing a lack of genuine accountability either by individuals or the organisation. There was a sense of ‘closing ranks’ by management and HR, with a defensive position adopted rather than openness to investigating issues and initiating change as a result. For example:

* “If you complain or raise a concern, it’s always, ‘we are sorry that you are having this issue and we are working on it’. If a White colleague complains it is escalated very quickly to highest management. When it’s an ethnic minority person it is swept under the carpet. Like if you complained about unfair workload, or bullying and harassment – they just say, ‘oh we are sorry, let’s investigate it – it might not be racism, it might not be bullying’. I know that where a White colleague has complained about bullying, then members of staff are reprimanded.”

There were instances where issues had been raised and not responded to at all, for example:

* “I raised it kind of quietly with the other registrars and they said ‘oh yeh, [that colleague] is very racist, but nothing gets done if you raise it’. But I did anyway, I raised it with the college tutor and the gynae matron was supposed to call me but she never did. I raised it again and it was just ignored. As trainees we rotate every year, so they just wait for us to go, rather than address it. But then new ones come, and this person is still there, still treating people like that.”

Obstetricians at trainee grades described the challenge inherent in speaking up when the complaint is against a more senior colleague, in terms of the potential negative consequences for career progression:

* “I don’t think there can be a mechanism where we can speak up against more senior people. Our managers control the environment we work in. it could affect our career progression and it might even affect you in the future – we tend to stay in the area we work in, and it might affect your ability to get a consultant post in future – here or elsewhere. They talk to each other, everyone knows each other.”
* “I personally would find it difficult [to call someone out], being a young doctor, talking to someone who may have so much more experience. I would struggle to speak directly to the person.”

One obstetrician described the inability of a White colleague to take on board the existence of racism or her encountering it:

* “It's really hard telling people your experiences [of racism] when they have not experienced it themselves. Like my supervisor – he is a professor, older, White – it’s never happened to him, of course, so it’s almost like, it’s too much too grasp, he doesn’t want to think it could happen. I don’t think he had the mindset to understand that could happen – especially with people he knows. In my trust, I do think it’s getting better, overall - we are quite open about talking about issues where I work. Even so - I would possibly not tell people who don’t look like me [about an experience like that], in case they don’t want to hear it.”

The overall impact of being denied, disbelieved or even punished for reporting racism, for many, is to stop speaking up altogether - or they ‘pick their battles’ and let other things go:

* “Talking to Black midwives, doctors, HCAs - they don’t always want to address issues – they don’t have the confidence. Perhaps in the past they have tried to raise things and have been told, ‘it’s your fault, you are being aggressive, you don’t know what you are talking about’. So, they come in, do what they need to do, and go home. The exposure – if you work in an area where majority of staff are White, and have never dealt with Black people, if you start challenging things – you will be seen as aggressive. So you would just give up.”

If they do give up on speaking up, staff feel conflicted. They may be concerned about patient wellbeing, fear being blamed for not having flagged up a concern about someone’s care, and feel guilt towards their colleagues from ethnic minority groups:

* “When people are raising something [a concern about care] and they are not listened to – they stop bothering. They try their best for that woman and just hope nothing bad happens, and then they get the blame.”
* “You cannot win because you are not going to get a pat on the back from your Caucasian colleagues for calling someone out and them getting disciplined. But if you ignore things then you risk being seen by your ethnic minority colleagues as condoning racism.”

As well as reluctance to speak up being driven by poor experiences of doing so, interviewees highlighted the historical and cultural factors that play a role:

* “There is a serious trust issue – Black maternity staff have difficulty in trusting in authority because history has taught us what happens when you trust in authority.”
* “It goes back to culture and growing up – our parents and grandparents, they came here and worked and they struggled and there is this narrative of being grateful – you don’t say anything, racism is normal, you stay quiet and move on - that has been so ingrained in you.”

#### Speaking up, examples

Some interviewees had a specific experience to share of speaking up. These were extremely intense and impactful experiences, shaping participants’ feelings about their day to day work and their careers in midwifery. In the following two situations, below, the midwives felt they were treated much more harshly than they should have been when an issue arose with their performance. In both examples, these issues were related to the midwives’ own experiences of pregnancy and birth trauma, which their managers were aware of, and both midwives felt they were unsupported and treated with a lack of compassion by their managers. Both raised grievances as a result and felt that these were handled poorly. They were both clear in their belief that in the same circumstances, a White midwife would not have had the same experience.

‘It could have been handled so differently’

[A midwife made an error in practice (non life threatening), and was placed on a supervisory plan].

“There were several instances on my return to work as very triggering of my own traumatic birth which I had at the same unit I worked for. I remember distinctly one episode where I couldn’t move or think at all, one of the senior band 6 midwives spoke with me afterwards, we spoke but I was not in a fit state to speak confidently or advocate for myself, she then said she was going to send an email about my practice to the PDMs [professional development midwives]. She framed it as a support, but not once did she ask me if I was OK or well. The unsaid thing was not that I needed help, but that I was too stupid to do my work. This would not have happened had I been White and I would have been shown sincere compassion. At the end I did not feel genuine support, I felt she was practicing her seniority on me. When she got to know me more, I felt she was surprised at my intellect.

I spoke to [senior colleagues] about what had happened [with the error]. I don’t think they understood – they were not compassionate - they knew I had had a traumatic birth, but they were not supportive [of how that impacted on me at work, in triggering situations]. That is not how you should treat someone who is traumatised. They put me on a supervisory plan.

I saw emails from people [colleagues] saying what I had done and some of them had lied. I put in an informal grievance to refute this. I felt stripped, indignified, horrible. It could have been managed so differently. It was demeaning, insulting, lacking reflection and communication with me. They lied about communication with me. They used my traumatic birth to evidence me as a danger to women. The feedback I got was really harsh. I felt doomed either way whatever I did. I think if I was White none of this would have happened.

I had a meeting with the HoM and I was honest about how I thought that because she was involved in the supervisory plan, she should not have been placed on the grievance – because in that position she was not impartial. The mistakes I made were not life threatening, so I wonder why it went all the way up to the HoM.

The response to my grievance was really tone deaf – it was tick box, not really reflective about what happened and why. During the grievance process I was accused of [something else] which was completely false. She was meant to do an investigation of one thing - why was this coming up? It was really worrying, the poor communication with me and lack of my input.

I am not the only one – I know other midwives of colour have been treated really harshly. I got union representation and they were good, but not good enough - I had to advocate for myself. I was really emotional, hurt, betrayed. My mental health was seriously affected.”

‘How dare they treat me this way?’

[A midwife asked to be moved to a different room, citing personal reasons (previous trauma) that her education facilitator was already aware of. The midwife was pressured to disclose the reasons to a different member of staff, and subject to a lengthy ‘interrogation’.]

“I was crying so much, I couldn’t breathe - they treated me so badly [in that meeting]. They tried to make out like I am a liar. [X] was challenging me, ‘why this, why that’. So I had to go into great detail about how and why being in that particular room was triggering me. For an hour and a half! [Y] was questioning my mental health – ‘are you sure you can do midwifery?’ I said, I was fine until you marched me in here.

So I raised a complaint. Because how dare they treat me this way? I don’t believe they would treat a White person like this. Later on I heard from a colleague – who is White - she wrote me a letter, saying that she had also had a personal situation involving trauma, and had received trauma informed support - so why did they not do that for me?

Raising the complaint – no one told me how to do it, I had no guidance. I was passed around and eventually I sent the email with my account of what happened to about six different people – having to re-live that trauma each time. Eventually someone in HR contacted me. I said that I want to know why they [X, Y] thought it was OK to do that to me. I feel like it is because I was a brown student. So HR was very concerned about that - not about how I was treated badly, not about their use of their power to put me through that meeting - it was obvious to me that HR were just worried about me saying I had been racially discriminated against.

I had to raise this, I had to in order to be true to myself. I believe I have been treated like this because of my religion, my hijab, my colour.

I was discouraged from making it formal. I said fine, it doesn’t need to be formal, I just want to understand why they thought it was OK to treat me like this - I want an explanation.

So she said, let’s set up a meeting with them. But there was no accountability, no apology. The meeting was pointless. It really just added insult to injury. So now I will make it formal. I feel I must pursue this. I have spoken to my union who said it sounds racially motivated – they advised me to build a picture, including the previous incidents. So I wrote to matron and said I will be making it formal. But I have not heard anything since. I don’t know if they [trust] are ignoring it or what. It’s not even been acknowledged, not been given a timeline for their response. I have been told ’I will pass it on’, but not heard anything.

When I speak to other students, they just think this kind of thing is normal and they just put up with it.”

* + 1. Impacts on staff

The impacts of the challenges and issues experienced by maternity staff from ethnic minority groups were felt in terms of wellbeing (stress, anxiety), mental health, confidence, motivation and career options.

* **Wellbeing and mental health**. Speaking up about unfair treatment or care, and being involved in supervisory or grievance processes related to discrimination, were hugely stressful experiences. Interviewees spoke about dreading going into work, and having to take time off sick – or not feeling able to take time off sick:
* “I was constantly stressed and I even had to have my blood pressure medication changed, I was really unwell mentally and physically. But I would still come into work because I didn’t want that to be held against me.”
* Feeling undermined by being accused of poor practice had a major and lasting impact on wellbeing, with interviewees talking about the sense of hurt and betrayal this caused:
* “For me it has had a massive impact. for example if I go in a woman’s record and see one of their names I start to panic – thinking, are they going to be checking my work, looking for mistakes. It upsets me. The emotional toll it has had on me is quite deep.”
* The constant ongoing experience of feeling excluded by peers, made to feel different, and not feeling supported or encouraged by senior colleagues also had the effect of making midwives and obstetricians unhappy, uncomfortable and anxious at work.
* **Confidence**. Feeling excluded and unsupported were also reported to have a significant impact on confidence. This was thought to affect internationally educated staff particularly, but also those who are UK-trained. For example, some talked about midwifery students graduating knowing that they have learned the skills they need, but not having had the support and affirmation to build their self-belief. One described how this made her want to move to a different trust - but others did not have the confidence to do this:
* “When I qualified, I felt I knew a lot - but I didn’t feel confident. Very few people had cared about my training and my learning, the midwives in the hospital were so busy trying to survive the system – having a student in the mix as well was too much for them! For example, there was once, the coordinator came in and she just took over the birth and then she wouldn’t sign my book [even though she had not let me demonstrate that I could do what was needed]. It is an example of the discrimination I experienced. So when I qualified, I didn’t even apply to work there. I was the only one in my cohort that didn’t apply – the others didn’t feel they could survive anywhere else – they felt it was, ‘better the devil you know’.”
* **Motivation and energy**. Interviewees described feeling conflicted, torn between wanting to do the right thing for their patients, to educate and drive change amongst their colleagues, but also to get away from a toxic work environment that had a very negative effect on their own wellbeing.
* For many of those interviewed, this drove a sense of determination, that they would not allow discriminatory treatment and attitudes to destroy their confidence and prospects, and they want to challenge discrimination on behalf of others/future others:
* “I could have applied elsewhere but I want to stay here, I want to be in your face and I will thrive and show you. You have got another think coming. Every time I am treated wrong, I will tell you about it. I feel that I have to do this - otherwise there won’t be change.”
* However they also reflected that this was very much not the experience for many colleagues from ethnic minority groups, who instead were de-motivated and discouraged from fighting for change:
* “I am very vocal – if I see something being done to me or another a colleague that isn’t fair, I feel strong enough and confident enough to speak up, especially in the past few years. But I know that some people will feel fear of being reprimanded, or they think that nothing will be done if they do speak up. For me it’s about having self-determination – I know it might not work but even for the sake of one change, I will keep trying. I have had incidences where I have spoken up and I have to think about making sure my health and wellbeing is not being compromised by doing so – there is a fear that by speaking up, your wellbeing and work will be compromised. I have always weighed up my options very carefully – but in the end I believe you have got to be part of the solution. So I will tend to do it.”
* There was a sense of energy being drained by the effort of either challenging or accommodating discriminatory treatment.
* **Career options and choices**. As well as the impact on progression and promotion, as described earlier, interviews reported that their experiences affected where they want to work. Negative experiences could lead staff to move trusts, or feel stuck due to lack of confidence, or determined to stay in order to challenge organisational culture and drive change. Some interviewees reported that colleagues had left midwifery entirely as a result of discrimination, and that obstetricians from overseas had changed roles or specialisms or even left the UK because they did not feel respected and valued.
  + 1. How experiences differ

Some of those interviewed reflected on a hierarchy of experience for staff from ethnic minority groups according to whether they are British-born or UK-educated. It was thought that being British-born, speaking English as a first language, speaking without a strong accent, and being educated in the UK made life easier than for those who are educated elsewhere, as described by this midwife:

* “I speak English, I was born and raised here. [In my previous trust] there were a lot of nurses from abroad, with a strong Indian accent – they have a lot of knowledge. But they were not progressing, and I know they felt there was racism there.”

Several interviewees felt that the experience and knowledge of internationally trained midwives and doctors was not always respected, echoing the theme discussed earlier around hierarchies and perceptions of inferiority/superiority within maternity services. The NHS continues to be Western-centric in terms of service delivery and education and training:

* “For people from diverse communities - some are homegrown and others from another country – for the latter, they are learning to navigate the system, they might not have the soft skills. They need to understand how the system works, even the lingo. I think that we need more recognition that people from different countries respond to situations differently, based on their experiences, and that doesn’t mean it is wrong just because it is different - we need to look through a broader lens, not just the White lens. The NHS is amazing but it was built by White people for White people. We need to adapt, because now we have a diverse population and workforce.”
* “In maternity we get a lot of trainees from overseas. They definitely find it difficult in terms of being understood and I know that they are experiencing rudeness and incivility from other members of the workforce because their communications aren’t up to what is expected, and rather than seeing an opportunity to help and teach them by being kind and supportive, instead it can be very uncivil towards these trainee colleagues whose English is less good or less clear. I have been told by trainees that they struggle to ask for help, to apply for roles, they have a lack of confidence – they don’t feel they belong.”

In the following examples, a midwife and then an obstetrician reflected on how staff coming from other countries are disadvantaged, in terms of having to learn about British culture, communications styles, health systems and practices, and how they are perceived by colleagues.

**‘Don’t listen to her’**

“If you were trained here you are more savvy. Coming from abroad there is a lot for you to catch up on - the way people speak, you don’t know all the slang, what people eat, there’s so much to learn. It’s totally different. People trained here are at an advantage – even though people trained abroad can be more knowledgeable, for example about detecting things on Black skin. ‘Advantage’ - means progression, confidence, knowing the culture. When you come from abroad your culture is different. If you are from abroad and trained here, you have had three years to pick up all that. If you trained abroad, you need to play catch up.

The way you are perceived - every time I tried to say something I was put down, ‘oh don’t listen to her’. You are seen as so different. Someone might say to me, ‘I don’t think your face fits.’ Yes! This is very much still an issue. Especially in parts of the country where there are not many Black and Asian midwives.”

**‘I felt constantly judged’**

“It’s a different system to [my home country], so there was an initial period of adapting. There was quite a bit of support for that but also quite a lot of judgement. I felt constantly judged – for way I communicated, the way I dealt with patients – I quickly had to adapt and change myself to be accepted. The main resistance was from the midwives. They find it so difficult to accept a non White registrar. They don’t accept our decisions. You are battling to do the right thing for the patient with the midwives against you. You have a way of doing things that you know is right, but you meet with so much resistance.

I learned, slowly, to say things in a way so they don’t feel I am making the decisions, like, I have to manipulate them into thinking that it’s their idea. I have learned to do this but it has been such a fight. You are not just doing your job, you are doing all these extra things, to get yourself accepted and get the midwives to let you do your job. The White registrars are just accepted. They are all coming from same culture, background, the way they speak is the same. Whatever I do, I can’t be friends the same way as them. So it was a battle initially, I felt really judged, I kept thinking - what can I do so they are happier with me? It is a lot of mental burden. It does get easier as they get to know you, but I rotated every year - and had to do it all again.”

* 1. Perceptions of how issues for staff are being addressed
     1. Overview

Interviewees were asked about their views on how the challenges and issues experienced by staff from ethnic minority groups are being addressed, where they work. This section covers staff’s awareness of initiatives to address issues, including Freedom to Speak Up, views on the effectiveness of this work, and what more they think is needed.

* + 1. Awareness of and views on effectiveness of initiatives

#### General awareness

There was variation in the extent to which staff interviewed were aware of any work underway in their trust to address challenges and issues for staff from ethnic minority groups, and the extent to which they thought this work was making a positive difference. Interviewees who were more aware were those in roles with a specific remit around equalities, and they, along with the other interviewees, generally agreed that awareness of any improvement work or initiatives ‘on the shop floor’ was low.

For example, this midwife had worked in her trust for many years but could not identify anything she saw as making a meaningful difference:

* “I don’t know. I don’t know if there is anything. We have lot of EDI things but it feels like a tick-box exercise. It’s not filtering through, on the ground. As the person who I am, someone who has been here for so long - I know what is happening out there, I know what buttons to press to find out what’s going on. But other Black members of staff wouldn’t.”

Those with specific equalities roles described a range of positive initiatives and mechanisms for improvement, including staff networks, approachable senior people with an open door for staff, and training. While some who had been working in their field for longer did emphasise that things have improved, many said that change is recent – nascent - and that there is a lot to do in order to effectively cascade out and engage wider staff:

* “As a Black African woman working in maternity services now, I will tell you, things are *just* starting to change. People like me have gone and said, enough is enough. So things are changing. We are starting to talk about inequalities for midwives.”
* “Covid and Black Lives Matters shone a light on inequalities, the disparities that we knew existed, but that were silent - and now there is light on it. There is progress because we are talking about it. We would not have had this conversation two and a half years ago. But there is a lot of work to do. In some ways I think I see racism more now than before – because we were silent before - but now we are challenging the system, we are calling it out, and that gets a reaction.”

#### Equalities roles

As stated, those who were most knowledgeable about EDI work in their trust were those with equalities as part of their remit. These ranged from a permanent role to roles created as a result of staff proactively pushing for them, and were supported – recognised and funded - to different extents by trusts.

There was a degree of tension around the effectiveness of these roles. Dedicated roles reflect the importance of the task but can only make a difference if they have senior support and are not tokenistic or simply ‘handing over’ responsibility to (sometimes junior) individuals.

One midwife worked over many years to carve out a role where she could promote education and training around cultural competencies and enable the voices of people who use maternity services to be heard. Eventually she was given an ‘official’ role doing this but only on a fixed-term basis – she had to continue to advocate and evidence the need for the role.

* “They need to make my role permanent. It feels like a tick box, created because something has happened, ‘ok we’ll make a 12-month post’. I have been asking, what will happen when I go back to my day-to-day role, who will drive this work? I have been told, ‘well when you leave, at that point it will be everyone’s business’. I just don’t think that is enough and actually my manager agrees and is extending my secondment – I think you need someone to be dedicated to this. If you want change – fund things to create change, and show you’re serious.”

Another described her efforts being only tokenistically supported by the trust, as set out below.

**‘You deal with it’**

“Equality, diversity, inclusion, racism, discrimination - not everyone will recognise that they are issues and often as a marginalised midwife you are the only one to speak up which you must recognise is scary and so hard. I feel as though for management, they don't want to deal with it or do not think it is important in the grand scheme of things. They just are not invested and this is apparent in the conversations you hear on the shop floor - when you speak up, it becomes uncomfortable for others. When you are one of few people speaking out, you become the token person for EDI, for tackling racism and discrimination and you are essentially used by the system. You are expected to complete work in your own time, with little or no support. I strongly believe the staff who are speaking up are invaluable, we are driven and want change to happen but within NHS structures and systems, there is no room for this.”

#### Initiatives

**Freedom To Speak Up**

Interviewees had heard of Freedom to Speak Up (FTSU) champions, but many were vague about the role, who was in the role or how they would access them if they wanted to. It was seen as a positive initiative in principle, but there were questions around whether staff would feel comfortable in approaching the FTSU champion and confident that they would supported by them.

* “FTSU - I have heard of it, I may have seen a poster, but personally couldn’t tell you who it is.”
* “There is a lack of understanding of the role and fear of, who is that person and who are they going to tell about what I said? There is an issue of trust and suspicion, who will this information go to? More people are going to external organisations because they have trust in them and they have independence. If it stays in-house, it will be covered up, and your reputation is at risk.”

**Workplace Race Equality Standards**

No interviewees mentioned Workforce Race Equalities Standards (WRES) spontaneously; when prompted, a few were aware of these but did not think that WRES had any profile with most staff.

* “I know about it of course because of my role and the Trust does speak about it - but not to midwives on the shop floor. The WRES data is discussed in the EDI meeting and Board meetings. But the people it affects are the Band 5s and 6s because a high proportion of those are Black. They have no way of hearing about things like WRES.”
* “WRES is not rolled out in many places as well as it can be. You have a group of people who worked hard and pushed it - we should all be looking at it – but there is lack of awareness on the shop floor. Awareness is with those who created it – it’s staying in that bubble.”

**Staff networks and training**

Some interviewees spoke about staff networks, events and training within their trust, but again acknowledged that while positive in principle they were not necessarily reaching and impacting on all staff, for several reasons:

* Events such as workshops taking place during 9-5, so timing not working for everyone on different shifts.
* Participation being voluntary and therefore more likely to be reaching only those who already have an appetite to learn and change:
* “I know that lots of people don’t always read their emails, and that things that affect the global majority staff – that they need to know – tend to happen during the day 9-5, and some midwives are doing night shift. We need to look at how and when we run workshops and training sessions, to be able to reach everyone. And at the moment attendance at these things is voluntary, and it’s people who are keen for change, people who want to educate themselves – we need to go wider.”

While limited in reach at the moment, nonetheless there were some very positive reflections on the impact and potential impact of work promoting cultural safety, cultural competencies and multicultural inclusion. Examples included:

* Cultural competencies and cultural safety training, focusing on communication and respectfulness when working with people from different cultures; training enabling conversations about bias and systemic racism.
* Active bystander training:
* “We need bystanders – people who are there and if they have seen something happening, they call it out. Of the active members in our group, most are White British people who are passionate about change and challenging things.”
* Public narrative training – which teaches people (staff and people who use services) to tell their story in an impactful way, in settings where this can have an influence i.e. at Board meetings.

These were taking place in a variety of formats – voluntary, drop in events, or mandatory, interprofessional training. One interviewee had created a regular group for staff interested in being part of a change, which was made up largely of White colleagues. Training was seen as an effective way to raise awareness and start conversations, and interviewees involved in this were very enthusiastic about the potential to generate positive change. The existence of groups or networks for staff from ethnic minorities – if promoted effectively so staff are aware of them, and with sufficient senior support – enabled people to feel more confident that discrimination can be challenged:

* “It’s better and more peaceful to work somewhere you know you can voice concerns without backlash.”

**CapitalMidwife Anti Racism Framework**

The CapitalMidwife Anti Racism Framework[[4]](#footnote-4) (London only) was mentioned in positive terms by several midwives interviewed, who were aware of their trust implementing or interested in implementing this guidance/tool. However it was pointed out that take-up has not been consistent across trusts.

#### Leadership

Interviewees did not think that midwives or doctors in more junior roles had a voice in decision making or a role in influencing change; there was little sense of any formal infrastructure in place to enable this. Where interviewees felt they were effecting change through their roles – i.e. those in equalities roles as described above – they were clear that senior buy-in and support was absolutely essential to making this work and having an impact. Several talked about this being driven by a motivated individual at senior level, whether in midwifery or obstetrics.

* “It is led by a Band 7 and a Band 8 and the Director of Midwifery herself is involved. So it’s grassroots but we have a foot in the senior management department via the Director of Midwifery. It’s crucial that we have her wanting to make change, and that senior management are open and want to deal with the challenges and issues.”

However senior leadership buy in and support is not enough; it may be at middle management level where action is being blocked because of reluctance to acknowledge the problem:

* “The denial of that fact that racism exists - when you have White managers who are in high positions in the NHS they haven’t had these experiences, they are coming from a place of privilege, it is hard for them to acknowledge. They will say, well that hasn’t happened to me. That contributes to systemic racism in the NHS. It’s not a priority because White managers are not affected by it.”
  + 1. What is needed

Interviewees were asked for their thoughts on what would need to change in order to improve experiences of staff from ethnic minority groups. Increasing ethnic diversity within the maternity workforce was a common theme, along with more open acknowledgement of the issues and higher priority on taking action to address them.

#### Diversity in the workforce

Ethnic diversity within the workforce, to reflect the population it serves, was agreed by all interviewees to be hugely important to staff and people using maternity services. In relation to the experiences of staff, diversity amongst colleagues – and particularly at senior level - was important for the following reasons:

* Feeling equal and being represented:
* “We are a minority, and a small one, so we are insignificant. [If it is just me having this experience, then] Who am I going to talk to about this? I don’t want to say them and us but if there were more of ‘us’ we would have an equal footing. There is not enough representation.”
* Having role models and advocates for progression:
* “It is necessary for more junior staff to see a pathway through which to rise up in terms of their progression and see that they are not blocked off from that because of the colour of their skin. Senior people of colour are more likely to invest in their younger colleagues. White people in senior positions, it’s not to say they wouldn’t invest in junior people of colour, but – they don’t remind them of themselves. There are so many biases - that people of colour are stupid, that they are a body, a cog in the system rather than a human with complexity. A senior team that is just White is a dangerous one, you need to have different perspectives and experiences and fill the gaps you don’t know are there.”
* “I have done a lot in terms of leadership but still you can’t get away from the fact that our whole exec board is White – I sometimes look at that and feel, I don’t fit it – my face, my [regional] accent. People don’t say it to you, they don’t say ‘you don’t fit’, or ‘this isn’t for you’, but it’s what you see – those faces are White.”
* Ensuring there is awareness of the reality of racism and discrimination:
* “When I have pointed out racism, I have been doubted, questioned, ‘does that really happen?’. That’s very bad and it riles me so much. Whether it’s taken seriously depends on individuals and how they support the workforce and what is on their agenda. I don’t believe that equitable patient care and proper support for staff is on the agenda for many leaders in midwifery. There is no diversity in leadership and they don’t see it as a problem because it doesn’t affect them.”
* Feeling able to speak up and raise concerns:
* “We need a senior person of colour so we can feel safe to raise concerns. In the past if you complain of racism there have been dire consequences. It’s more likely that people will feel they can report things if there are people of colour in senior roles.”

It is important to say that a diverse workforce is not in itself a guarantee of equitable experience for staff. One obstetrician trainee reported that she had received harsh treatment from senior colleagues themselves from ethnic minority groups:

* “She knew she could yell at me and not be challenged. I accepted it, I said, ok I don’t want trouble - and she knew I would do that. I have never challenged it. But that happening in front of everybody, that was awful. And you don’t challenge it outwardly but it puts such a burden on you.”

#### Support and mentoring

Obstetricians felt that support and mentoring would make a huge difference to the experience of staff joining the NHS from other countries. This support would help staff to settle in, get to know how things work and build their confidence. Interviewees thought that it would be most effective if the mentor had a shared background with the mentee, in terms of having also come from another country and therefore having an understanding of what it is like to settle into a new culture and workplace. Some spoke about offering this support to new colleagues on their own initiative, but thought that a formal scheme within trusts would help ensure that people have access to this support, rather than rely informally on colleagues’ goodwill.

* “For doctors coming here, it is a big deal to come to a new country, it is hard. So to feel undermined and resented and unsupported – that is not OK. They need someone to support them and that champion should be from an ethnic minority group too, so that people feel comfortable with them. And that person can speak on their behalf.”

A few said that their trusts do have formal support mechanisms in place such as, for obstetricians, an IMG support team and RCOG regional SAS doctor representatives, and for midwives, PMAs with responsibility for international midwives.

#### Celebration of diversity

Marking of events in different cultures was seen by interviewees as a positive and fun way both to recognise and celebrate diversity in the workforce and to raise awareness amongst staff.

* “[In one trust I worked in] we had a lot of celebration of different cultures. And there was a Diwali party in my current trust. All of the staff members who celebrate it get together and that was fantastic. It makes a huge difference, you feel more included, like the hospital has seen you and recognised you. We do so much for Christmas, we always have the decorations, mince pies and secret Santa, and I love all that but it’s also nice of them to recognise there are other ethnicities and beliefs amongst people working there. It makes me feel more seen and valued.”

#### Openness to acknowledge and address issues

Those interviewed felt there was a need for more education and mandatory training about race and culture, and more opportunities for staff to talk about race in informal ways such as celebratory events, more support and encouragement at senior level for grassroots action, and building trust by acknowledging and addressing issues. But acknowledgement was a key first step and some felt that denial of the problem was acting as a blocker to change.

* “I wish people would talk about it more. In my trust they act like it’s not happening.”
* “What makes a difference is for the managers, for everyone to talk about racism and managers to take this seriously and really be inclusive. Get everyone involved and make sure that people from ethnic minorities – particularly international midwives - are being offered opportunities, training, focus groups, safe spaces. Let’s talk about it. It’s going to be uncomfortable!”
* “The problem is where middle managers refuse to acknowledge the problem. You hear, ‘this person has a chip on their shoulder’ – this is a constant phrase you hear from middle management talking about when staff from ethnic minorities speak up. This phrase is what is said to silence you or stop you talking.”

#### Reframing inequalities as a priority

Several interviewees felt that inequitable experience for people from ethnic minority groups was not a priority for leaders in their trust, and felt there was a need for it to be re-framed to emphasise its importance:

* “[Action on inequalities] should be mandatory. It should be embedded. EDI should be the golden thread, not just a separate item on the agenda. Inequalities lead to unsafe care. It should be part of the safety agenda, it should come under that umbrella.”

1. Findings: insights into care
   1. Challenges and issues for women from ethnic minority groups using maternity services
      1. Overview

Interviewees were asked about their insights into safety issues and negative experiences for people from ethnic minority groups using maternity services. Very similar insights were shared by midwives and obstetricians; a few obstetricians noted that perhaps they were less likely to witness poor care because other staff may be more mindful of how they interact with women from ethnic minority groups, in the presence of a doctor of ethnic minority background.

The findings are grouped into the following themes:

* Language
* Respect and choice
* Stereotypes and cultural awareness
  + 1. Language

There was a strong consensus across interviewees that having poor or no English was associated with worse experiences of care:

* “My summary is, if you are White you will get good care. If you are not White but you speak English, it’s OK, you will get what you need. If you have poor English – it’s going to be the very basic standard.”

This ranged from staff ‘not bothering’ to try and communicate effectively with people who don’t speak English, to actively targeting people for worse treatment. Overall it was seen that not enough importance was placed on ensuring that women are able to understand information:

* “Staff need to be very mindful that you will get people nodding their head but not understanding. And instead of just choosing to accept that, staff need to make sure that they have understood.”

There were a number of issues around the availability and use of translation services, as follows:

* Lack of willingness to use translation services. Despite these being generally available via technology such as Language Line, they are not being used consistently, because it is seen as taking too long, or not worth bothering with, especially in less critical situations (e.g. a routine appointment):
* “We have the interpreters, we have access to them, but no one is picking up the phone to use it. I’m getting very frustrated with our staff - we have the service, why aren’t you picking up the phone? It’s staff being lazy about a change in the system, and it takes longer and more energy to use the interpreter so people are not wanting to do it.”
* “I think overall we do really well – for big conversations (decisions about delivery and interventions) we do always use the translator or language line. But for smaller conversations – if you are just taking blood, putting in a cannula - something we think is ‘small’ and so we don’t bother about translation as it takes an extra 10 minutes. But I think even for that sort of thing, it does affect women, if they are being jabbed with a needle and they don’t know why.”
* Time implications of using translation: a standard 20-minute appointment is not long enough to allow for the extra time required for translation, so even if the translation service is used, a woman may still not get care of the same standard.
* “You try and use that 20 minutes to see a woman that doesn’t speak English - it is not enough, you need longer. We talk about individualised care but it doesn’t feel as if you can make that happen because of how the system is. The result is they don’t understand their care, don’t know if they need more appointments.”
* Technical issues with translation services: translation could not always be accessed quickly enough, and technical issues with equipment or Wi-Fi could affect its use (e.g. the connection dropping).
* Accuracy of translation: interpreters may not understand all of the medical terminology; they may not reflect the wording the doctor or midwife has carefully chosen in a sensitive situation; they may not know the specific dialect of the patient’s language.
* “I could see the facial expression of the patient changing as the interpreter talked and I realised there was a heated conversation between interpreter and the patient - which there really didn’t need to be, based on what I had said.”
* “It’s not just the language, it’s the specific country – the dialect. People are afraid to say, ‘I sort of understand, but that’s not my dialect so I don’t really understand’.”

In addition to the practical barriers around language, it was reported that women who don’t speak English are singled out for worse treatment because staff know that they are less likely to complain. This was ascribed to lack of language skills, lack of knowledge of processes to complain, fear of consequences if they do complain (‘how will they treat me if I go back there?’), and a level of acceptance around services.

* “Those who don’t speak the language are being treated appallingly because the staff know there will be no comeback.”

Digital inclusion was also noted as a barrier for some in accessing services, where language barriers and lack of digital access can combine to disadvantage people further – such as being unaware of, or not able to use a self-referral system.

Systems may not be well set up to communicate with those who don’t have good English; for example, when being given an appointment time, women may not be able to understand information given verbally over the phone, but would be able to get someone to translate a text message for them.

* + 1. Respect and choice

Alongside language barriers, the other major issue that interviewees identified for people using maternity services was around respect. This was seen to underpin many of the differences they observed in how staff interact with women from ethnic minority groups, compared to White women. As described in the previous section on experiences of staff from ethnic minority groups, power dynamics and hierarchies impact on care, with a sense that some staff see themselves in position of power over women, and in particular over women from ethnic minorities. This was manifested in the way that women are spoken to and interacted with, whether they are listened to, trusted and believed, and whether they are given choices in their care.

#### How women are spoken to

‘The way they are spoken to’ was a common phrase when interviewees were asked about the care of women from ethnic minority groups, with ‘dismissive’, ‘disrespectful’, and ‘patronising’ used to describe the tone of interactions. For example:

* Lack of friendliness and rapport, lack of effort being made:
* “I notice subtle things in terms of their [admin team] conversation and rapport with women. E.g. a Caucasian patient has seen a consultant and been told she needs a follow up appointment in so many weeks, so she comes and tells the receptionist, who says Oh yes and they will make the appointment now, the woman goes off happy, it’s booked, that is all fine. Then the next patient, who is from an ethnic minority group, maybe she has poor English but you know, she can communicate. And from the receptionist, it’s, ‘Oh I will send you a letter in the post with an appointment’. Why? Why do it differently?”
* Lack of basic courtesy and politeness:
* “A woman came in with her baby and she was put into a room and I went in just to say, the midwife is coming soon, and to take her some water. This woman was so grateful that someone was speaking to her, acknowledged her, was bringing her water. I wondered, why is she so immensely grateful for the bare minimum? What experiences has she had that she is so grateful for this totally standard treatment from me?”
* Outright rudeness:
* “There was a [member of staff] saying to this woman, time to go home, GO GO GO! The woman was trying to explain, my husband is going to pick us up, but she wasn’t listening. So I am seen as chief translator and negotiator for these women, so the [colleague] goes, ‘OI!’, and beckons me across the ward. ‘Can you tell her this’, absolutely yelling at both of us – it was so unnecessary.”

Where women have a name that is not English and that staff may not know how to pronounce, rather than take the time or make the effort to learn it, staff may simply avoid using the woman’s name. This was seen to communicate a lack of respect and contribute to women feeling less valued and important.

#### Not being listened to

There was a strong theme around women not being listened to when they express or try to express their concerns and views. Language was a key factor in this but interviewees said that even where women can communicate, they are less likely to be listened to than White women.

* “We are still not listening to the women who are most underserved. They are being made to feel inadequate. Especially those not speaking English – it is like, speaking English gives you status and the right to better care. Staff see [people who don’t speak English] as lowly, they dismiss them. This affects care because they are not listening. Women who have come from different systems, the way they respond to us, their healthcare behaviours are very different. If someone doesn’t fit a box – their behaviours don’t tally with what’s the norm – they are labelled as difficult. Staff don’t seem to think we need to listen, to look beyond, dig deeper to find out, how is this person seeing things and what does this person need.”

Examples included the following:

* Communicating symptoms:
* Examples of this included where women were further along in their labour than staff believed, where women had raised concerns about the colour of baby’s skin indicating jaundice, and where women’s efforts to communicate their symptoms were not listened to.
* “She didn’t have good English but I could tell she was saying ‘suddenly, pain, dizzy’, ‘blood pressure’. [My colleague] said to her, ‘I can’t take your blood pressure, it’s not time yet. If I do it and it is not right you can’t go home – you don’t want that, do you?’ The way she was talking to her, it was wrong – she needs care and you are giving her ultimatums. I took the baby away to finish the examination, and when I came back, lots of midwives and doctors were there - it was obvious something had happened, and that colleague hadn’t responded appropriately to the woman trying to communicate how she was feeling, she had tried to shut her down.”
* Communicating preferences:
* “You have cases where women are saying stop, and staff are not stopping. Women of colour come with this backdrop that increases their vulnerability. They are scared and intimidated by the systems. Especially if they don’t know English. Women are not being treated with compassion and respect.”

#### Not being given choice

People from ethnic minority groups, particularly those with language barriers, may not be offered or enabled to make choices to the same extent as White people. This was related to language (not understanding the choices available) and also the issues described above around respect and communication (not being enabled to communicate their views, to ask and have their questions answered). Other factors playing into lack of choice were as follows:

* Cultural perceptions of authority, where people from some ethnic minority groups may be more inclined (or perceived by staff to be more inclined) to accept the advice of health professionals without questioning it.
* Staff not offering choice, because they know they will not be challenged.
* Staff’s perceptions around who is ‘entitled’ to care, and what care:
* “I have heard staff say, ‘If they were in their country, they wouldn’t have an epidural’. There is this sense that women from ethnic minorities should be grateful.”
* “There has been an influx of people from [country] into the area I work, and I have heard midwives saying, ‘our women are struggling too’. The way they talk about them - making them separate, different - there is clearly this sense that ‘they are not OUR women’, because of their language, culture, race.”

Interviewees reported that there were incidents where people had given consent without understanding they had a choice in doing so.

The following two examples show where women were not given choice.

‘Because the consultant said I had to’

“There are a lot of women being coerced, not understanding their choices. I looked after a woman who was booked in for induction – it wasn’t clear to me why she was being induced, so I asked her, and she just said, ‘because the consultant said I had to’. I said, ‘you know you can ask them, speak to them, you have an option, you can decline’ - and she had no idea she had any choice whatsoever.

I was asking the midwives on the ward, I said why was she being induced, and no-one seemed to know. They were like – ‘we’ve started, so we’ll carry on’.

You would not be seeing that happening with a White woman. Staff have this perception that White women are more educated, so they would have read up on things, whereas someone from an ethnic minority background will just take whatever the doctor or midwife tells them. There is a level of respect and trust that people from ethnic minority groups are seen to have towards health professionals. So they are not given choice.”

‘She has to accept the rules’

During Covid restrictions, a woman from an ethnic minority was being induced and tested positive for Covid. Her partner was not allowed to be present.

“She was very, very upset, saying, ‘I just can’t do this without my husband’. I asked is there another member of the family who could come and support you - but the midwife in charge said, no way, absolutely not, no one can come and support this lady - she has to accept the rules. So I said, come on, we have compassionate visiting rules- we need to think about how we support this woman’s mental wellbeing. And every colleague said no, no, that would be putting everyone at risk. I had to go back and tell the lady, sorry, no. And she said, OK then I am going home – I want to stop the induction.

I knew that would not be in her best interest. I said we need to speak to the Director of Midwifery, and I was frank, I said to her if it was a White woman then this would not need to be escalated to you. We all know the evidence, Black and Asian and mixed race women are five times more likely to have poor outcomes. That was a lightbulb moment for our DoM I think, and she said OK I agree. The lady spoke to her sister who came in to support her, and she thanked me so much for speaking up for her. I went to a lot of effort to get that through - I had to, because she had been through so much. And I knew that there had been women previously who had tested positive that had been allowed to have someone with them - White women – so I was determined that this lady should have the same.”

* + 1. Stereotypes and cultural awareness

Stereotypes around Black and Asian women and lack of cultural awareness amongst staff were seen by interviewees to impact significantly on quality of care and help-seeking by women. They said that women were judged according to racial and cultural stereotypes.

**‘Staff have a lot of judgement towards the patients’**

“Staff have a lot of judgement towards the patients. When staff see an Asian name on the list they say, ‘oh she’s going to need a LOT of TLC’. Like, eye rolling. Because culturally, Asian woman are cosseted during pregnancy and that is a cultural thing, but White British staff treat it like a joke. So when you see an Asian name on the list, the staff are expecting, ‘oh she is going to complain so much’. When it’s a Black woman, again there is judgment, ‘they are so stubborn, they are trouble’.

Why are more Asian and Black women dying - it is because staff don’t explain things to them, they don’t provide the understanding that women need, and most midwives can’t do it because they don’t understand where the women are coming from. The feeling of judgement affects whether women will seek help, if they feel like something is not right with their body, their baby – they won’t seek help if they feel like they are going to be judged and ignored and treated without respect.”

#### Microaggressions

The racial stereotype of Black women as ‘aggressive’ was seen to be directed towards women using services as well as towards midwives themselves, as discussed earlier. Interviewees reported this stereotype to be common and not always recognised or acknowledged as problematic by those using it, even when challenged.

The other racially stereotyping term that came up was ‘princess’ (of Asian women), which interviewees thought was viewed as an acceptable term by some colleagues, rather than acknowledged as being a microaggression. One interviewee, from an Asian background, even found herself using it, as it was so common to hear her colleagues doing so:

* “You wonder, has the system turned me? To fit in, you find yourself following the culture.”

Stereotyping can have a real impact on care, as described in this example:

**‘She’s a princess’**

“There is a tradition of 40 days where the woman doesn’t do anything, she focuses on looking after herself, resting and caring for the baby. All the things that women are advised to do! And one of the support workers says to me, ‘oh she is a princess, she isn’t going to do anything for 40 days.’ This really played on me. The woman had had a c-section and she wanted the catheter taken out, so I asked the support worker to do it and she said, ‘I’m not taking it out, she won’t get out of bed anyway’. Because of this perception of the ‘lazy’ woman not doing anything.”

#### Physical

Examples of stereotypes, misconceptions or lack of knowledge about physical characteristics and symptoms, that affect how staff address clinical scenarios for women from ethnic minority groups, included the following:

* Misconceptions around bodies – interviewees reported having heard the following said by colleagues, including senior colleagues:
* ‘You have an African pelvis.’
* ‘Black women have thicker skin, so they are less likely have a tear after delivery.’
* ‘You are African, you are tough – you don’t need pain relief, get on with it.’
* Lack of knowledge or interest in conditions more common to some ethnic minority groups:
* “If I bring up fibroids or sickle cell, those are conditions that affect more ethnic minority women, and I find that people [staff] don’t know as much about them – and those study days are not as well attended as the ones on conditions like diabetes and pre-eclampsia. Is that because they don’t affect White women?”
* Failure to recognise symptoms that look different on Black and brown bodies:
* Jaundice not being recognised because staff have been trained to recognise how it looks on White skin; DVT symptom taught as the calf going red, again only applicable to White skin.
* “The White body is the norm in the textbooks, which means diagnosis is not effective in Black women.”

#### Cultural

There was a strong view that lack of awareness and understanding about different cultural practices leads to judgement and misinterpretation of behaviours, which affect how women are viewed and cared for:

* “When you have a trust that doesn’t have a diverse workforce, I think they are limited in their understanding how to treat or appreciate people from other cultures. It makes it difficult for them to understand, when a patient from an ethnic minority comes in and behaves in a way they see as unacceptable. You have people from backgrounds where women don’t tend to speak for themselves, or perhaps they don’t make eye contact. I have travelled in some African countries, and I do know that not making eye contact does not necessarily mean you are being rude. People don’t always say thank you, but it doesn’t mean they are being disrespectful. But some midwives label these people as rude so when it comes to caring for them, they already have a biased opinion about the person. When a woman complains about something – says something doesn’t feel right to her - I have to listen, because she knows her body. But midwives who are biased towards that cultural group, they say ‘oh she’s just complaining’. We label people, instead of treating them as an individual.”

Examples of lack of awareness of cultural practices, norms or preferences, or where these are not respected, included the following:

* Expressions of pain being misunderstood because they are different to White norms, or judged according to perceptions about how pain is experienced by people from certain ethnic groups:
* “In certain cultures when they labour, they don’t believe in shouting and verbalising and often labour in silence. So that person’s pain may not be taken seriously, and you end up with the baby born in the corridor, even though they were telling you, if only you were listening.”
* “Staff will be going, ‘ugh, that’s so loud, it’s so annoying’, ‘you don’t really need an epidural’. That’s not right - pain is pain, you have to respect that and offer people what they want or need – not what you think they should get.”
* Privacy not being respected for Muslim women who want to have the curtains closed when breastfeeding or during examinations.
* Staff objecting to the Islamic practices of rubbing date oil or honey on baby’s gums, or playing the call to prayer quietly in baby’s ear, claiming these are harmful, or disruptive to others:
* “We have women from all cultures and beliefs – we should be working with, not against those. In Islam we like to have a prayer said into the baby ears. I have heard, ‘why are they shouting at the baby?’ Dabbing the honey on baby’s gums – ‘oh my god they are giving the child solids, we need to get safeguarding in here’.”
* Perceptions of couple relationships in South Asian groups, around husbands being viewed as controlling or unsupportive.
* Presentation of mental health symptoms being different than HCPs are taught to recognise:
* “There is a stigma around mental health in south Asian communities. How women present with mental health needs is different from how we are being taught to recognise it. They will say they have a headache, they feel sick, off their food – it is articulated differently. They won’t understand if you phrase it like, ‘are you feeling low’ - that won’t mean anything to her. Psychosomatic symptoms - that is their cry for help. If those symptoms are investigated and everything is normal, then we need to look deeper. But services and assessment criteria are built on a White model. The questions are not culturally appropriate for people from outside this. And HCPs are trained within this narrow framing.”
  + 1. Impacts on women

Consequences of women not being enabled to understand information or communicate their feelings, needs or questions ranged from not having the information they need about their own or their baby’s health, to very serious physical and emotional trauma with long-lasting effects. Interviewees noted that staff do not necessarily see these effects, once someone is discharged from maternity services, so they may not realise the impact of their actions.

* “You will never know the full impact because you don’t know what happens in the long term – they could be scared of having another baby, they could have mental health problems.”
* “When things don’t go to plan with birth, there will be trauma, there will be wounds, both physical and psychological – and you enter the postnatal ward and no one cares. This is where they need most support, they are most vulnerable.”

#### Short term

Ensuring that women feel listened to and respected builds trust which may be vital for their safety and wellbeing during the birth:

* “When we offer interventions, advice, counsel – if you have not built a bond, a rapport to begin with, you then do not have that foundation there for if things get difficult.”

The following example illustrates how lack of kindness, connection and understanding between staff and patient impacts directly on safety:

**If you don’t treat them the same – then they don’t trust you.**

“There was one woman, I remember her saying that staff would just ignore her on the ward round, but they would be really friendly, smiley, jokey with White women. And she felt really vulnerable, and really prejudiced against. It made her feel scared, because it made her feel like nobody cared about her. And that made her question the advice she was being given, wondering, ‘are they just saying this to get me out of their hair?’ It creates a lack of trust. If you are not nice to people, if you don’t treat them the same – then they don’t trust you. So then when you tell them advice, they won’t take it. I have had a few cases where, someone’s baby is distressed in labour and you are advising a c-section, but they don’t want it – even when you are explaining, ‘if we don’t do this, your baby could die’. So that is very frustrating and you are wondering, is it mistrust, is it cultural, is it something that I don’t know about, like they don’t want to have a scar because when they go back to their country that would be very dangerous for them? So yes, safety is absolutely impacted.”

#### Medium term

Consequences of negative experiences also include the risk that women disengage from services, and do not attend appointments or seek care when they need it:

* “If you are always getting negative responses, professionals not being kind, not being compassionate to you – then of course people will not come for their appointments, they will be fearful. It builds distrust and fear of hospital so people will ignore advice or avoid coming for appointments. People in the community will talk, they discuss their experiences, they will say to each other, ‘I wasn’t listened to’.”
* “Even when it is partly the workload that has contributed to poor experience, they will see it as they got poor care because they weren’t listened to or weren’t valued. They will feel that their ethnicity meant they did not get as good care as the person next door. Some of them then shy away from being in hospital – they just want to leave as soon as they have the baby.”

Poor experiences during labour can affect women’s feelings about, and care access during, subsequent pregnancies:

* “Things being done to you especially in obstetrics where everything is fine one minute and then suddenly you find yourself in an emergency situation, you have no control, and if you have no voice, that adds to the fear. If you don’t understand what’s happening, you might not absorb all the explanation. You might not understand all the terminology. Some words, in different languages, carry different inferences. It can affect women’s experiences and then they don’t have the confidence to ask what happened or they don’t know that they can speak to someone to get a de-brief. So they carry that fear forward to their next labour. And it can affect willingness to access care.”

#### Long term

Interviewees also spoke about the cumulative psychological impact for women, of feeling they have not received equitable care and respect:

* “All these [negative] exposures to the health service, involve a negative impact - we are very much focused on physical harm, but the psychological impact of this is also a form of harm – long term, it accumulates. Being repeatedly made to feel dismissed – that has a long term impact.”
  1. Perceptions of how issues for women are being addressed
     1. Overview

Interviewees were asked about their views on how the challenges and issues experienced by people from ethnic minority groups who use services are being addressed, where they work. This section covers staff’s awareness of initiatives to address issues, which was overall fairly low, and what they think is needed.

* + 1. Awareness of and views on effectiveness of initiatives

#### Overview

There was very little identified by most interviewees in terms of efforts to address the issues being experienced by women from ethnic minorities using maternity services. The discussion tended to echo what was discussed earlier in this report in relation to how workforce issues are being addressed, i.e. initiatives that aim to make it easier for staff to speak up about inequitable treatment of themselves or patients; training for staff in cultural competencies; and more broadly, a cultural shift towards greater openness about the problem and higher priority on addressing it.

#### MVPs

Maternity Voices Partnerships (MVPs) were seen as a valuable mechanism for patient views to be shared in the running and development of services, but it was noted that MVPs are not necessarily representative of the populations being served, so work is need to increase diversity on these groups. One interviewee mentioned a video to encourage people from ethnic minority groups to join the Maternity Voices Partnership.

#### Practical steps

Other examples of efforts to improve care of people from ethnic minority groups included:

* Stickers for the front of patient notes with the phone number for the translation service.
* An email address that staff can use to raise concerns about patient care.
* A campaign to encourage people who use services to come forward and talk about issues and ideas for improvement.
* Community outreach and engagement with women in ethnic minority communities to understand their experiences and concerns.

#### Roles and workstreams

Some interviewees reported that a role such as a specialist midwife was being considered in their trust. However, one interviewee reported that there was a cultural safety champion in the trust but that this person was being blocked from delivering cultural safety training - highlighting that the existence of such roles does not in itself indicate genuine action on inequalities.

* “It’s easier to just put a person at the front and say it’s this person’s role to work on it. But it’s not being backed up by wider support and resources. One person is not enough – this work needs to engage everyone. The trust wants to be able to say we’re doing something, but we are not, not really.”

One interviewee described a specific workstream in their trust which started by looking at outcomes data by ethnic group, and then went out into those communities to explore the issues and feed back to maternity staff on these:

* “We have been doing focus groups within the communities and we have learned so much from that. Some really interesting stuff -the racism they have encountered from healthcare staff, how they are biased towards women who speak English, how people are being ignored on the ward. We got that feedback and fed it back to ward sisters.”

This initiative was conceived and driven by individual staff and in this case, supported by the trust, motivated at least in part by goals in the NHS long term plan and their (former) CCG.

* + 1. What is needed

As with staff experience, a diverse workforce was seen as key to improving care for women from ethnic minority groups, because it would mean the workforce having an improved understanding of cultural needs and expectations and women therefore feeling better understood and cared for:

* “I can say for a fact that women would feel safer if they had staff who look like them. Having a midwife who understands their cultural nuances, that would help them - instead of constantly getting comments like, your food smells funny, no you can’t use the microwave for that, stop being difficult. It makes them feel unsafe – because they feel staff just want to get them out of there, get them home quickly.”

However, as discussed earlier, diversity in the workforce is not an answer by itself:

* “Maybe because our population and staff is so diverse, the assumption is there that you will know about all the cultural things you need to know about it, ‘hey we are so diverse, just be cool, just chill!’ But I think we need to say it – don’t make that assumption.”

Nor is increasing diversity a quick fix; it will take significant time and effort to change recruitment approaches and practices; and to change culture to improve experiences of staff from ethnic minority groups and therefore support retention. Other actions in the following areas were suggested to support change for people using services – all requiring funding and support of leaders and managers.

#### Speaking up

* Channels for staff to feel safe in reporting inequitable care, such as networks and groups, and access to approachable senior people with accountability for responding and taking action.
* Channels for service users to feel safe in reporting their own experiences, such as MVPs that are more representative, and systematically ensuring that women know how to raise concerns (e.g. leaflets in different languages provided at initial appointments).

#### Translation

* Increasing use of translation services, both availability and usage. Language line or equivalent needs to be provided and needs to function well in terms of technology (e.g. having adequate wi-fi) and in practical terms (e.g. accuracy of translation, enough time in appointments). Translation services need to be consistently, routinely used by staff, instead of being seen as optional.
* Further to this, investing in translators to ensure they have sufficient knowledge of the medical terms and language used in maternity care specifically; and, ideally, further training to enable them to act as advocates or support workers, to help people who do not speak English to navigate their care and ensure they get the care they need.
* Routine provision of information in paper and digital form, in different languages, including information that takes into account gaps in knowledge around pregnancy journeys and services amongst people from other countries (covering things like what appointments and scans will take place and what they are for).

#### Cultural awareness

* Increasing staff’s knowledge of cultural practices and traditions, to address misconceptions and misunderstandings. Recognising that it would be challenging to get to a place where all staff are aware of all things, there was a suggestion of a guide or directory that staff could access in order to look up practices and traditions in cultures they are not familiar with.
* Training for staff in cultural safety etc as discussed earlier in the workforce section.
* Going back to initial training of doctors and midwives, revisit curriculums to ensure they take account of how symptoms and conditions may affect and present differently in women from different ethnic groups.

#### Patient engagement

* Outreach and engagement with ethnic minority communities, to better understand the needs and concerns of people using maternity services and how services can be better oriented to these.
* Education to increase understanding and raise awareness with people from ethnic minority communities, particularly those from outside the UK, around their expectations of maternity care. Promote understanding that they do have the right to choice and agency in their care, and encourage them to ask questions and feel confident in doing so.
* “As a woman or girl, you should feel you can seek advice but in some communities you don’t. I don’t see many non-Caucasian people seeking help for the menopause, for example. That is not because they don’t need it, obviously. For us as staff it means we need to be more proactive, ask questions and make women feel like they can bring up issues and seek help.”
* Individualised care from the outset, whereby a woman’s first appointment with the services should include a discussion of what support she will need in terms of language and communication, religious or cultural needs or anything else.

#### Good practice and guidance

* Where there is good practice in trusts, for example those who have used data to identify communities not being well served and taken steps to understand and address the issues, this could be shared and a model/toolkit for other trusts to undertake similar work could be developed.
* Clear and practical guidance for trusts around implementing and embedding change, aligned with national and local ICB priorities.

It is important to note that while this research focused on the experiences of Black and Asian staff and patients, many of the interviewees noted that some of the issues - language barriers, stereotypes and cultural differences - also affect the experiences of White people from different ethnic groups, whether they are from the UK (Gypsy, Roma and Traveller, and Orthodox Jewish communities were mentioned by interviewees) or elsewhere (Eastern European countries came up frequently). Therefore, initiatives and efforts to address these issues should take into account the full range of ethnic diversity amongst the workforce and populations using maternity services.

* + 1. How CQC could gain better insight into experiences of staff and people who use services

Those interviewed felt that there was a need for CQC to get beyond the rhetoric of what trusts may say they are doing to address issues for people from ethnic minority groups (staff and those who use services), because:

* “Any trust you go to will say they have zero tolerance of racism.”

This means interrogating policies, processes and data to understand what they mean ‘on the ground’ for the experiences of staff and patients. For example, it would not be enough to ask whether translation services are available; data should be collected showing the proportion of appointments where translation was requested and used, and feedback sought on the effectiveness of the translation (i.e. was it accurate).

Interviewees felt strongly that CQC inspectors should proactively ensure they talk to people from ethnic minority groups during inspections.

* With staff, they should consider which bands/levels they talk to, with it being seen as essential to gain insights from staff on the shop floor and compare and contrast with what is said by middle managers, and senior leaders. Junior doctors should be included, even if they are ‘only’ on rotation as opposed to being permanent. Speciality doctors, and especially those from abroad, should be invited to share their perspectives. CQC need to choose who they speak to, instead of staff being picked and fronted by trusts, and they need to create a safe and discreet space for conversations with staff (not on the ward), and shadow staff in their work, including on night shifts.
* With people who use services, they should look to talk to people who are from the communities that the trust serves, ensure a safe space for these conversations, and provide translators to enable participation of those who don’t speak English. Where trusts have groups for people from ethnic minorities, CQC should engage with these; some interviewees think CQC could go further and go out into communities to speak with women in spaces where they truly feel comfortable.

CQC should look at trust policies to ensure there are specific policies in place for dealing with staff issues that are related to race (rather than these being covered under general bullying and harassment policies), ditto regarding patient complaints.

CQC should look at the diversity of the workforce – at all levels, including leadership/Boards - and ask what is being done to increase diversity (e.g. targeted recruitment). This needs to be based on data, showing ethnicity of permanent staff, rather than simply ‘looking at faces’ on the ward, which may include bank staff (one midwife had worked in an area where a high proportion of bank staff were people from ethnic minority groups, which she believed to be either because of discrimination in recruitment or because they were treated so poorly they had no desire to become permanent).

To better assess career progression, CQC could look at ethnicity data in relation to retention, training attendance and promotion. Exit interview data may provide insight into reasons for staff from ethnic minority groups leaving (only ‘may’, as staff may not have felt able to be honest).

With regards to raising concerns, disciplinary and grievance processes, data should be collected on the ethnicity of both those making and those investigating complaints and the outcomes of complaints. Trusts could be asked what they are doing to ensure staff and patients from ethnic minority groups have safe and clear channels to give their feedback and are being encouraged and enabled to use these.

Suggested topics and questions for CQC to pose to trusts:

* “CQC could make it a criteria in inspections, that trusts demonstrate how they are creating cultural safety – ask trusts, how do you ensure people are being treated with respect, what work are you doing to dismantle systemic racial discrimination, to make your culture and processes less heteronormative, are your staff aware of issues for trans people as they use the birth system, how inclusive the electronic systems are (categories Mr, Mrs etc).”

Good practice and innovation should also be a focus of inspections:

* “Inspectors should be talking to staff and understanding what positive activities are happening in the trust – are they celebrating things, and if there is good practice, look at why it is good and roll it out. Let’s allow people to be innovative and try things - is that part of the culture in trusts? Are leaders listening to people from the bottom up and trying things out? Are things being assessed via QI projects? Are people at all levels - from students and juniors, internationally recruited staff – enabled to share their ideas?”

# Appendix 1. Participant breakdown

### 1. Role

|  |  |
| --- | --- |
| midwife or student midwife | 9 |
| Obstetrician or trainee | 10 |

### 2. Ethnicity

|  |  |  |
| --- | --- | --- |
| Ethnic group | midwives | Obstetricians |
| Black/African/Caribbean/Black British: African | 4 | 2 |
| Black/African/Caribbean/Black British: caribbean |  | 1 |
| Mixed/multiple ethnic groups: White and Black Caribbean | 1 |  |
| Mixed/multiple ethnic groups: White and Black african |  | 1 |
| Any other mixed or multiple ethnic background | 1 |  |
| Asian/Asian British: Indian |  | 5 |
| Asian/Asian British: Pakistani | 2 |  |
| Asian/Asian British: bangladeshi | 1 |  |
| Any other Asian/Asian British background |  | 1 |

### 3. Age

|  |  |  |
| --- | --- | --- |
| Age | Midwives | obstetricians |
| 18-24 | 0 | 0 |
| 25-34 | 1 | 3 |
| 35-44 | 4 | 5 |
| 45-54 | 2 | 1 |
| 55-64 | 2 | 1 |
| 65+ | 0 | 0 |

### 4. Sex, gender, sexual orientation

|  |  |  |
| --- | --- | --- |
| sex | midwives | obstetricians |
| female | 9 | 10 |
| male | 0 | 0 |
| prefer not to say | 0 | 0 |

|  |  |  |
| --- | --- | --- |
| Gender same as sex assigned at birth | Midwives | obstetricians |
| Yes | 9 | 10 |
| No | 0 | 0 |
| prefer not to say | 0 | 0 |

|  |  |  |
| --- | --- | --- |
| sexual orientation | midwives | obstetricians |
| heterosexual or straight | 9 | 10 |
| gay or lesbian | 0 | 0 |
| BiSexual | 0 | 0 |
| other | 0 | 0 |
| unsure | 0 | 0 |

### 5. Disability

|  |  |  |
| --- | --- | --- |
| Physical or mental health conditions lasting or expected to last 12 months or more | midwives | obstetricians |
| Yes | 2 | 0 |
| no | 7 | 9 |
| prefer not to say | 0 | 1 |

|  |  |  |
| --- | --- | --- |
| Does condition or illness reduce ability to carry out day to day activities | midwives | obstetricians |
| Yes, a little |  |  |
| no, not at all | 2 |  |
| prefer not to say |  | 1 |

|  |  |  |
| --- | --- | --- |
| health conditions or illnesses that affect in the following areas | midwives | obstetricians |
| stamina or breathing or fatigue | 1 |  |

### 6. Band/grade

|  |  |
| --- | --- |
| midwives |  |
| Student | 1 |
| band 5 | 1 |
| band 6 | 2 |
| band 7 | 3 |
| band 8 | 2 |

|  |  |
| --- | --- |
| obstetricians |  |
| st1 | 1 |
| ST2 | 1 |
| ST3 | 1 |
| ST4 | 0 |
| ST5 | 1 |
| ST6 | 2 |
| SAS DOCTOR | 1 |
| consultant | 3 |

### 7. Where trained

|  |  |  |
| --- | --- | --- |
| where trained | midwives | obstetricians |
| UK | 9 | 8 |
| Outside UK | 0 | 2 |

### 8. Region

|  |  |  |
| --- | --- | --- |
| Region/AREA | midwives | obstetricians |
| London | 3 | 1 |
| South east | 3 | 2 |
| EAST of england | 1 | 3 |
| East Midlands | 0 | 1 |
| Yorkshire and Humber | 0 | 1 |
| North west | 1 | 2 |
| Wales[[5]](#footnote-5) | 1 | 0 |

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1. State of Care 2022/23, Care Quality Commission: [Inequalities - Care Quality Commission (cqc.org.uk)](https://www.cqc.org.uk/publications/major-report/state-care/2022-2023/inequalities) [↑](#footnote-ref-1)
2. One of the 10 midwives opted not to have their data used in this report, only in State of Care. [↑](#footnote-ref-2)
3. A microaggression is a brief statement or behaviour that, intentionally or not, communicates a negative message about a non-dominant group (definition supplied by CQC) [↑](#footnote-ref-3)
4. [CapitalMidwife | Health Education England (hee.nhs.uk)](https://www.hee.nhs.uk/our-work/capitalmidwife) [↑](#footnote-ref-4)
5. One participant worked in Wales but drew on recent experiences of working in England for the interview. [↑](#footnote-ref-5)