Inequalities and racism

We remain concerned about the inherent inequalities in access to maternity services, experience and outcomes for women, and the safety risks this presents.

We stressed the ongoing inequity in maternity services in both our Safety, equity and engagement in maternity services report and our 2022/23 State of Care report.

The most recent MBRRACE-UK data, published in January 2024, showed that, compared with women from white ethnic groups, Black women were 2.8 times more likely to die during or up to 6 weeks after pregnancy, and Asian women were 1.7 more times likely to die during the same period. The National Maternity and Perinatal Audit's report on inequalities highlighted further disparities. It showed that compared with women in white ethnic groups:

- South Asian or Black women were more likely to have babies born early or small for gestational age (SGA)
- Stillbirth rates were high for babies born to women from South Asian and Black ethnic groups and for those in the most deprived areas
- South Asian women are also at higher risk of perineal tears and major obstetric haemorrhage.

The inspection programme highlighted that while some trusts are taking action to address issues with inequality, much more needs to be done to ensure maternity services are accessible and meet people's needs at all stages of pregnancy and birth. Everyone deserves safe care and the inherent inequalities faced by some groups are unacceptable.

We found some evidence of how different units were attempting to reduce the impact of inequalities, but this was not consistent across services. Examples of good practice often focused on:

- mental health support
- support for women who were living in poverty
- awareness and inclusion of ethnic and cultural diversity .

For example, one service introduced several initiatives to address barriers face by the community it served. These included establishing an antenatal and postnatal clinic in a hotel housing asylum seekers and creating communication cards for women who did not speak English as a first language. More examples can be found in our improvement resource.

However, without the right data, it is difficult for trusts to evaluate whether initiatives are driving much needed change. In addition, many of the issues we raise in this report meant some services were operating in crisis mode. While day-to-day issues are important, services must not lose sight of the ongoing systemic issues such as the inequalities that we know can have a significant and unacceptable effect on people's care. Reducing inequalities is imperative in saving lives and preventing harm to people with protected characteristics.

Concerningly, we also found some trusts where both staff and people using the service experienced discrimination because of their ethnic background, or issues associated with having English as a second language or that was not their preferred language.

Women's experience of racism

In our 2022/23 State of Care report, we found that care for people using maternity services was affected by racial stereotypes. This has also been reported in The FiveXMore Black Maternity Experience Survey. During our inspection programme, it was concerning to hear about incidents of racism experienced by women. We heard from people who felt staff were neglectful and rude towards them:

> "The problems started when I was moved to the postnatal ward. Staff were racist, rude and couldn't care less. They didn't listen to my concerns as a new mum and were desperate to discharge me even when I told them that my baby had only fed once in 36 hours since birth."

> "One nurse even told me I'm over-reacting after having some concerns over my baby knowing full well, I'm a first time mother, my clothes were all over the floor because I couldn't bend. However, another woman who happened to be White across the room got every help she could get. I feel this was very disheartening because I was there suffering. I believe it was racial abuse. A Black woman on the same ward got the same treatment as me. I felt ignored, neglected and ridiculed."

These examples are supported by our interviews with midwives and obstetricians from ethnic minority groups. Staff identified an issue around a lack of respect for women from ethnic minority backgrounds, with 'dismissive', 'disrespectful', and 'patronising' used to describe the tone of interactions.

Through the interviews, we heard about the safety implications when women were not supported to understand information or communicate their feelings, needs or questions. These 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.

Failing to hear concerns and respond appropriately can have devastating consequences. As a result of one inspection, we issued a Warning Notice where we had concerns that a Black African woman had not been assessed appropriately despite attending triage multiple times. Sadly, this case resulted in a stillbirth. In another case, a review by the Healthcare Safety Investigation Branch (HSIB, now known as the Maternity and Newborn Safety Investigations or MNSI) into the death of a baby raised concerns that the mother's ethnicity affected the care she received. The mother asked for help but was dismissed.

Equity in access to pain relief during labour and after birth has also been identified as an issue nationally. During our inspection programme, our Medicines Optimisation team held a series of focus groups with maternity leaders and frontline staff across 16 trusts. The aim was to help us understand what trusts were doing to ensure that women from ethnic minority backgrounds had equitable access to pain relief.

We asked how trusts audited people's outcomes and experiences of pain and pain relief. Most did not audit this at all, and in those that did undertake epidural audits, ethnicity was not recorded as part of this.

A study published in the Journal of the Association of Anaesthetists looked at disparities in the delivery of anaesthetic care between different ethnic groups. A spinal anaesthetic for caesarean birth means the baby is exposed to the lowest amount of medication and the mother can participate in the baby's birth. However, the study found Caribbean (Black or Black British) women were more likely than British White women to be given general anaesthesia for elective and emergency caesarean births (58% and 10% respectively).

Further research is needed to better understand the underlying causes of these disparities to see whether improvements can made to reduce any inequalities in the different types of pain relief and anaesthesia provided.

A recent MBRRACE-UK study reported that identifying and responding to language needs was insufficient among women from all ethnic groups, highlighting inconsistent provision of independent interpreters. The research also advised that family members and healthcare staff (who are not employed for their language skills or as interpreters) were inappropriately used instead. As outlined in the section of this report on communication, this is not in line with guidance from the National Institute for Health and Care Excellence (NICE), which states that interpreters should be independent.

Access to interpreting services

English as a second language was also a noticeable theme throughout our inspections. We found various examples where interpreting and translation services were available, including BSL (British Sign Language) interpreting services. The use of these services meant women had relevant information in their first language, or preferred form of communication, so they could make informed and safe choices about their pregnancies and births. We also found examples of services that sent duty of candour letters in the woman's first language after an incident, ensuring that all women and birthing people were adequately informed and involved in the reviewing process of serious incidents.

However, we inspected some services where leaders had made an active decision to keep hospital signage in English only, despite the wide range of languages spoken and understood by women accessing the service. Limited access to relevant information can potentially result in harm to women and babies. We found a service where incidents that were recorded were linked to poor outcomes due to lack of interpreting services. One report also described instances of discrimination, where staff made "inappropriate comments" about women who did not speak English as a first language.

NHS services have a statutory obligation under the Equality Act 2010 to have "due regard" to eliminating discrimination and advancing equality, and access to interpreting services is an important way to deliver this. Good quality interpreting services are also vital for services to meet the regulations covering person-centred care and consent to care and treatment. Providing high-quality interpretation and translation services is an important part of ensuring that women receive the right care, with informed consent, and have improved health outcomes. All the services we inspected had arrangements to provide interpreting services. However, we have concerns that they had not always considered specific aspects to meet the women's needs.

Staff experiences of racism in maternity services

There is a need for action to proactively support maternity staff from ethnic minority groups to ensure a diverse workforce that is representative of the community it serves. We visited some services where staff felt they were discriminated against because of their race and ethnic backgrounds. Staff at one service told us they felt that they were treated differently because of the colour of their skin and at another service, described episodes of racism.

In this example, even though episodes of racism had been reported, no action had been taken to address the issues, which suggests a poor culture around responding to concerns. Discrimination against staff in minority ethnic groups was linked to episodes of bullying and harassment. At one inspection, this was reflected in the trust-level Workforce Race Equality Standard (WRES) data.

Again, this was supported by our research into the experiences of midwives and obstetricians from ethnic minority groups. Interviewees described feeling "ignored, dismissed or effectively punished by negative treatment" when they spoke up about unfairness. Participants overwhelmingly felt that when they spoke up, issues were "swept under the carpet" or only addressed superficially, with a lack of genuine accountability and organisations adopting a defensive position.

On inspections, we also heard concerns from staff at one trust that job opportunities were not made transparent or equally accessible to all staff, with those from ethnic minority backgrounds feeling less able to access senior and board level roles. Through our research, we heard about midwives from ethnic minority groups whose confidence was undermined when applying for promotions, which is compounded where they do not see people from ethnic minorities in senior roles:

> "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."

Although examples of such discriminatory behaviour were limited during our inspections, they are completely unacceptable and raise important concerns about the inclusion, dignity, and safety of staff from ethnic minority groups in the workplace. Through interviewing staff in our research, longer-serving staff told us that things had improved over time for staff from ethnic minority groups. But interviewees described a culture in which it is normalised for people from ethnic minority groups to tolerate discrimination from colleagues, such as microaggressions, and not being made to feel like part of the team.

Using demographic data

Research by THIS Institute confirms that people from ethnic minority backgrounds may have distinctive health needs that maternity services do not consistently meet effectively. It is essential that a maternity service understands the needs of its local population to provide everyone with safe and effective care. Demographic data is vital to achieve this. However, there is currently huge variation in the way trusts collect and use demographic data to address health inequalities and access, experiences and outcomes from using their services and evaluate progress in this area. Having a national-level picture, along with guidance that could be tailored at trust level, would allow services to understand the data they have and use the metrics to improve access and outcomes.

Local systems have an important role to play in addressing unwarranted variations in population health. As discussed in our 2022/23 State of Care report, systems must work to reduce inequalities in people's access to care, their experiences and outcomes. As part of our new responsibilities to assess whether integrated care systems (ICSs) are meeting the needs of their local populations, we will be looking at whether different parts of the system are working together to achieve this.

Through our maternity inspection programme, we were pleased to find evidence at trust level that some leaders understood how various protected equality characteristics may affect treatment and outcomes for women and babies. This awareness was translated into monitoring outcomes and taking action on the findings and even, in some cases, commissioning research , to make services more responsive and appropriate for people's needs. (See more information on these initiatives in our improvement resource.)

But we remain concerned about a data gap at trust-level, which could be preventing trusts from making improvements. We have previously highlighted the need for services to use ethnicity data to review safety outcomes for women from ethnic minority groups. However, during the programme we saw this did not always happen.

Some managers collected information about ethnicity and other protected equality characteristics to identify themes and trends related to inequalities when reviewing incidents. But there are opportunities to review data relating to people with protected characteristics throughout the maternity pathway – not just when patient safety incidents happen.

By looking at other areas, such as the effectiveness of national approaches to improving outcomes, services would be able to gain insight that may not be available from incident data and ultimately improve outcomes. Without this demographic data, many services had no way to analyse whether national approaches, such as NHS England's Saving babies' lives requirements, were reaching those most in need of support in their local communities. Applying a blanket approach may not always be effective. The Marmot review recommends that while action should be universal, the scale and intensity should be proportionate to the level of disadvantage, known as 'proportionate universalism'.

As reported by THIS Institute, clinical guidelines and tools used in maternity services are not always sufficiently sensitive to the needs of different groups. To mitigate the risk of discrimination, there may be a need to adapt guidelines and how they are applied. For example, the NHS Race and Health Observatory recently called for new assessments for newborns from ethnic minority backgrounds. It highlighted that the Apgar score – a scoring system to evaluate the health of newborns – was developed based on white European babies, with some guidance referencing that a baby's skin should be "pink all over." Applying this guidance to babies from ethnic minority backgrounds can lead to inaccurate assessments and poorer outcomes.

We saw some evidence of services adapting guidelines and processes in this way, but this was not always the case. One service amended triage guidelines to have a low-risk threshold to invite women with English as a second language into the unit for face-to-face triage, recognising that language barriers can make telephone triage services less effective.

Engaging with local communities

The role of a maternity and neonatal voices partnership (MNVP) is to ensure the voices of women are heard, and to communicate back to staff and stakeholders to plan, review and improve local services. Where these relationships worked especially well, services built a relationship with the MNVP that allowed people to have their voices heard by their trust, to drive meaningful change and co-produce services or resources.

However, we previously highlighted in our Safey, equity and engagement in maternity services report that MNVPs were not always representative of the local community and we are concerned that in some areas, this issue persists. For the partnership to be successful, services must be proactive in gathering feedback from all women who use services. As stated in NHS England guidance, "effective MNVPs will reflect the ethnic diversity of the local population and reach out to seldom heard groups, including those most at risk of experiencing health inequalities, parents with experience of neonatal care, and bereaved families." It is vital that these services are funded appropriately to enable MNVP chairs to reach those most in need of support.

We also found some examples where the relationships between the MNVP and the maternity service were not as strong as they could have been. To enable the work of the MNVP to be meaningful, there needs to be authentic commitment from leaders within maternity services.

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.

- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.