Turning the Tide

The experiences of Black, Asian and Minority Ethnic NHS staff working in maternity services in England during and beyond the Covid-19 pandemic

October 2020

Dedication

This report is dedicated to people from the Black, Asian and Minority Ethnic communities and frontline NHS staff who have lost their lives or have been affected by the Covid-19 pandemic.

Contents

About this document

This is the first time BAME maternity staff have joined together to speak out regarding historic endemic inequalities that we face as healthcare professionals in UK.

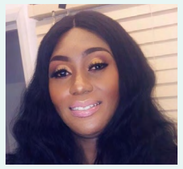
This document began as a discussion about the impact the Covid-19 pandemic was having on Black, Asian and Minority Ethnic (BAME) staff working in NHS maternity services, and on BAME women using NHS maternity services. It initially started in north east London, then expanded across London to include London-based BAME Directors of Midwifery and Heads of Midwifery. It was then decided to open up the discussion to BAME NHS midwifery staff working across England.

While looking at maternity services across England, we discovered that as of May 2020 of the 136 maternity units in England, fewer than ten (7.4%) was led by a director or head from a BAME background, which presents a particular challenge when Black women are five times more likely to die as a result of pregnancy than white women. Women with mixed ethnicity are three times as likely to die as white women and Asian women twice as likely to die. (MBRRACE-UK: Saving Lives, Improving Mothers' Care, November 2019)

This document summarises the discussions resulting from 11 forums with BAME maternity staff from across England, a survey, and bespoke workshops and makes recommendations based on these.

We want to provide much-needed support and to improve services for our BAME maternity staff and service users. We hope this report leads to genuine change in NHS maternity services.

A special thank you to all the BAME maternity staff that participated in the project. Your contributions are much appreciated.



Report author:
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Gloria is the Director of Midwifery at Barts Health NHS Trust, the largest maternity service in the UK and is the Senior Responsible Officer for the East London Local Maternity System, representing three hospital trusts and overseeing over 28,000 births a year.

She leads the BAME Maternity Leaders Covid-19 Response Team and sits on the Chief Nursing Officer National Advisory Group in response to Covid-19 pandemic.

Gloria first trained as a nurse and midwife in Nigeria before relocating to the United Kingdom, where she continued her nursing career after completing her NMC adaptation programme to become registered. She has worked within the NHS and community settings as a Consultant Midwife and Head of Midwifery and has a Bachelor of Midwifery, a MSC Community Public Health Specialist Practitioner and a Doctor of Clinical Practice.

She has a strong passion for change, innovation and transformation of health services. Gloria is the first Black African Head of Midwifery in the UK. She has a passion for change, innovation and transformation of health services.

Gloria has won many national awards for her work in transforming maternity care, and became a Mary Seacole Scholar in 2009, and a Florence Nightingale Research Scholar in 2011. Gloria also chaired the trailblazer group that developed the new midwifery standard and apprenticeship pathway entrance into the midwifery profession.

Executive Summary

This report explores the experiences of Black, Asian and Minority Ethnic (BAME) people working in maternity services in the NHS, during the ongoing Covid-19 pandemic.

It explores their responses to four key lines of enquiry:

- What are the key challenges you have faced as staff from the BAME community during the COVID-19 pandemic period?
- As a member of a BAME community, what do you consider the key socio-cultural factors which have caused BAME groups to be the most affected?
- Reflecting on the pandemic, what aspects of maternity care do we need to improve for BAME women and their families?
- What support do you need to enable you to do your job effectively?

It also summarises detailed discussions around risk assessments and personal protective equipment (PPE).

Evidence suggests that the communities most affected by the pandemic are those from BAME backgrounds. Despite this risk, BAME maternity staff have demonstrated their professionalism by rising to the challenge of providing care in a pandemic, in often challenging and rapidly evolving circumstances, and in some cases, having seen the deaths of valued colleagues, friends and family.

But their experience as employees is mixed, with the Covid-19 pandemic reinforcing that BAME communities continue to face health inequalities, racism and discrimination.

Staff reported:

- They are scared and anxious.
- Too often BAME midwives' concerns are interpreted by management as complaints.
- The particular concerns of BAME pregnant women, as voiced by BAME midwives, have sometimes not been listened to.
- Some managers were seen to be treating BAME staff unfairly in their decision-making, *"White staff members work from home with no underlying health problems while BAME staff are repeatedly questioned about their underlying conditions for the entire duration"*.
- *"I was constantly working on the frontline in acute areas. I was not involved in the decision-making to redeploy me. It was abrupt and I did not have time to put adjustments in place to protect my family and dependents"*.

This report makes a series of recommendations across all levels – to NHS trusts, arm's length bodies and NHS England – to improve the experiences of BAME maternity staff. This in turn will improve the experiences of pregnant women, both BAME and not.

Covid-19 has shone a huge light on health inequalities, both in patients and healthcare workers and has presented an opportunity to learn and make changes. It is now for the NHS to decide how to take this forward.

Introduction

When 2020 began, we did not know that the Covid-19 pandemic would fundamentally change how we worked. We had planned to spend 2020, the year of the nurse and midwife, celebrating our accomplishments. Instead, we have faced a global pandemic and a level of pressure not experienced by the NHS since its inception.

NHS maternity staff have demonstrated their professionalism by rising to the challenge, and have continued to provide excellent care throughout the pandemic despite often challenging and rapidly evolving circumstances, and in some cases, seen the deaths of valued colleagues, friends and family.

Evidence suggests that the communities most affected by the pandemic are those from BAME backgrounds. In the UK, the BAME communities make up 14% of the total population, yet disproportionately account for around a third of those affected by Covid-19. As of June 2020, 64% of healthcare workers who have died of Covid-19 were from BAME backgrounds, while 20% of NHS staff identify as BAME.

"We have not expressed our outrage at what is happening. It is in our hands to do it, as we need to get up and speak about our outrage".

The need to see genuine change has led some of our BAME maternity workforce to begin to reflect on their experiences and think about how they can influence change.

The pandemic has had the effect of magnifying already existing trends. The MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK report (2018) found that among women who were pregnant, the death rate of Black women in the UK was 38 per 100,000, Asian women 13 per 100,000 and White women 7 per 100,000.

In the UK, the BAME communities make up 14% of the total population, yet disproportionately account for around a third of those affected by Covid-19.

The UK Obstetrics Surveillance System published in May 2020 found that of the 400 women admitted to hospital across the UK with severe symptoms of Covid-19 from early March to mid-April, more than 55% were BAME.

Covid-19 has disproportionately impacted BAME communities and highlighted racism and the inequalities facing BAME communities in the UK. Further research is needed to understand why this is, and how it can be resolved.

This report sets out the experiences of BAME maternity staff, and makes recommendations for improvement. Implementing these will benefit the women maternity staff care for, and the UK health system as a whole.

The Covid-19 pandemic response is a prime example of building the road as we walked on it. As new evidence emerged, recommendations changed, much as how this report evolved as we found out more.

Staff have expressed concerns that when the pandemic is over, people will forget the hard work of the NHS and the health inequalities and risks to the BAME communities. We need to make sure the NHS workforce is healthy, resilient, and supported as they continue to care for people during the pandemic and beyond.

Leadership and objectives

We established a BAME senior midwifery leadership organising committee to drive the project forward. They identified five objectives:

- To understand the challenges faced by BAME staff during the Covid-19 pandemic
- To understand what support is required by BAME staff
- To enhance care for BAME women and their families
- To manage misconceptions
- To understand the socio-cultural influences for staff and women

The committee held virtual 11 forums between 18 May – 30 June 2020 for BAME maternity staff across England to talk about their experiences.

They decided to run individual forums according to maternity staff workforce banding. This enabled the team to capture the thoughts, feelings and issues of individual staff groups, and allow them to speak freely and express themselves without fear of seniority or judgement from others in higher or lower bands. Over 334 maternity staff attended including midwives from band 5 – 8, bank and agency midwives, maternity support workers and student midwives.

For each forum, healthcare leaders from the BAME community attended to give words of encouragement, knowledge and support to the attendees.

These were:

Edwin Ndlovu
Director of Operations
East London NHS Foundation Trust

Janet Fyle
Professional Policy Advisor
Royal College of Midwives

Professor Dame Donna Kinnair
Chief Executive and General Secretary
The Royal College of Nursing

Professor Jacqueline Dunkley-Bent
Chief Midwifery Officer
NHS England

Sangeeta Agnihotri
Consultant in Obstetrics & Gynaecology
Clinical Lead for Perinatal Services, Newham University Hospital
Barts Health NHS Trust

Yvonne Coghill
Director, WRES Implementation Team
NHS England

Special thanks go to these leaders for their time, support and encouragement.

In each forum, four key lines of enquiry (KLOEs) were explored:

1. What are the key challenges you have faced during the Covid-19 pandemic period?
2. As a member of a BAME community, what would you consider to be the key socio-cultural factors which have caused BAME groups to be the most affected?
3. Reflecting on the pandemic, what aspects of maternity care do we need to improve for BAME women and their families?
4. What support do you need to enable you to do your job effectively?

This resulted in rich discussions and feedback from staff on challenges faced during the pandemic, and the issues faced by staff and service users.

Those who were unable or did not feel comfortable or confident to speak in an open forum, had the opportunity to contribute confidentially.

> Each forum resulted in rich discussions and feedback from staff on challenges faced during the pandemic, and the issues faced by BAME staff and service users.

For those unable to attend the forums, a survey was developed to gather further insight about individual experiences, challenges and potential solutions from BAME maternity staff. The survey received 132 responses and provides valuable additional insight into the challenges BAME maternity staff face.

The discussions in the forums led to the decision to explore two areas further which were of particular concern to our BAME staff:

- Risk assessments
- Personal protective equipment

Key findings

Some of the participants of this project have reported feeling supported in their workplace. However, our findings resonate with previous reports that BAME communities continue to face health inequalities, racism and discrimination.

KLOE 1: What are the key challenges you have faced as staff from the BAME community during the Covid-19 pandemic period?

Staff reported feeling scared, anxious and worried about our mental health and the wellbeing of others. They were conscious that as healthcare professionals, their ethos is to keep people healthy and well, but the nature of their work means that being around family and friends puts them at risk of exposure.

At the beginning of the Covid-19 pandemic, some BAME staff felt a lack of trust and acknowledgement from their managers that they were vulnerable due to their ethnicity and needed to shield.

"I was made to feel I was being a time waster and I was going off sick for no reason and shielding for no reason."

The constantly changing guidance and advice made it hard for staff to be aware of these changes and to keep on top of information, both at a national and local level. For example, midwives reported not always being told there was an option of staying in temporary accommodation paid for by their employer in order to allow them to continue to work, despite, in some circumstances living in a multigenerational and crowded household, and being at high risk of contracting Covid-19 from pregnant women.

Culturally, some reported finding it difficult to talk about their health concerns and risks as they were fearful of backlash from their family and the wider community.

Some reported not feeling supported at work.

"There was a lack of PPE in the community and increased fear amongst staff as most midwives in our Trust have underlying medical conditions and throughout the pandemic the manager never gave the help we needed."

Some midwives reported feeling scared to visit women at home due to the fear of contracting Covid-19.

Some staff reported a lack of recognition around the psychological impact of Covid-19, including limited awareness of extenuating factors (such as friends or relatives who may be ill or have died) and the negative impact this had on working productively.

Many pregnant and postnatal BAME women were scared or stressed by having to go to their appointments alone and this impacted on staff caring for them.

"The fear was not acknowledged as so many women were anxious. They start to cry in the antenatal clinics and we had to be strong for them but at the same time we had the same fear but you have to pretend everything is fine."

Experiences of students

Midwifery students reported feeling fearful of taking up a placement because of the information they got from the media. They were concerned about the risks of bringing Covid-19 back to their families and reported shortages of PPE.

"It's been challenging psychologically as trying to cope with the degree, being at home and trying to find that motivation, even though we have had online work to do it's still discouraging as you are forced into an environment you're not used to and having to be productive and get assignments done."

"In contrast to the full support we received in clinical placement areas during our redeployment induction, our university has left us in the dark. Emails have been sent and no replies have been received."

Some student midwives felt that the payment scheme (which stopped on 31 July 2020) left them feeling used and discarded.

Experiences of Bank and agency staff

Bank and agency staff play an important role in ensuring maternity units are adequately staffed, covering for the absences of substantive staff. However the nature of bank and agency work makes them more vulnerable, as they move around and don't 'belong' to a particular team, so can miss out on key information. For example, some reported that they don't have access to Trust internal email systems, so don't see information communicated via this (for example the new allocation of a room to Covid-19 patients) and aren't always told when starting their shift. This can leave them at increased risk as they don't know the latest situation.

One participant suggested that agency and bank staff do not support each other. This could be a combination of fear of being seen by the Trust to do so, competitiveness, or simply that it does not occur to them. This needs to change.

KLOE 2: As a member of a BAME community, what do you consider the key socio-cultural factors which have caused BAME groups to be the most affected?

While we are still in the process of reaching a full understanding of Covid-19, there are many factors that make the BAME communities more susceptible to Covid-19 such as fear, stress, housing and accommodation issues and immigration issues (e.g. no recourse to public funds).

Experiences of patients

Maternity staff told us that the Covid-19 pandemic has created fear within communities, meaning many pregnant women were not wanting to attend hospital appointments. One student midwife stated, *"Many people fear going to hospital as they may get the virus"* with another stating *"It's the fear of the unknown."*

Some high-risk women delayed contacting maternity services during the pandemic due to fear, lack of education and the absence of someone they can relate to providing care for them.

There is anxiety among BAME communities around what could happen to them when they go into hospital because of issues of racial discrimination and lack of understanding. Some cited that cultural beliefs within BAME communities are important to individuals, which may result in misinterpretations of BAME pregnant women and staff.

There are also longstanding misconceptions which can lead to inferior care *"The system perceives that Black and brown women have a high threshold for pain."*

Some BAME communities are apprehensive that they will be *"labelled as someone with a disease or at risk of a disease"*, which has the potential to result in delays in seeking medical care or to attend screening or testing appointments.

There are a high number of co-morbidities in BAME communities which could be detrimental to the health of pregnant women during the peak of the pandemic. There is also potential for these to go unidentified, which may place women at an unknown risk.

There is more overcrowding and increased numbers of homes with multiple occupancy within BAME communities compared to those from a non-BAME background. This does not allow self isolation, putting other household members at risk, nor are there risk assessments for different levels of vulnerability.

"With all the concoctions that were going around on WhatsApp and social media about the traditional herbal remedies, there was no dose control so who knows whether the excess taking of them also helped to do some damage?"

"We tend to be quite spiritual and if our pastor says something, that's it, that's the gospel truth and you won't listen to any other scientific evidence that is out there."

"At the beginning of the pandemic social media contributed to the notion that people from a BAME community could not get Covid-19, so, it was not taken very seriously amongst certain groups. A staff member identified that "this played a huge part in the amount of people who weren't social distancing and adhering to the government's guidance."

It has been reported that there is anxiety among BAME communities about what could happen to them when they go into hospital because of issues of racial discrimination led them to delay seeking treatment. News and reports of high mortality and morbidity rates for BAME communities on social media platforms also contributed to this reluctance.

Staff reported not seeing all their patients, as initiatives such as virtual clinics were difficult for some groups to access women (e.g. language barriers, cultural differences and lack of access to technology).

Staff experience

"The system believes Black midwives can withstand anything."

There was recognition from BAME staff that they also need to take responsibility for their own health and wellbeing. They also recognise that as key workers, they need to educate their friends and family. As health professionals, they must ensure that managers organise consistent risk assessments and act according to Trust policy in order to safeguard their wellbeing.

[We need to] *"ask ourselves are we really where most of us need to be? If we were to do a statistical study of how many of us are of a high BMI, how many of us have high blood pressure, how many of us have diabetes, what have we really done to bring our health back to where it should be to take ourselves out of the moderate or high risk group?"*

It was suggested that a lack of assertiveness may have resulted in the inability to address the things that BAME people are concerned about. Some talked about the cultural aspect in that some BAME people want to get things done peacefully and feel they need to remain respectful, which at times has led to inaction.

Student midwives warned of tribalism among BAME staff as the different communities did not support each other at work. They made the point that to effect change, all BAME communities need to start supporting each other to enable a collaborative, strong voice to be heard.

While it was recently reported that the BAME midwives are comparatively well represented, there are issues involving discrimination against BAME midwifery staff. For example, midwives from ethnic minority backgrounds in London are disproportionately more likely to face disciplinary proceedings and dismissal than their white counterparts (Roleloicz and Specer, 2020).

Our maternity staff reported:

- Increased discrimination faced by BAME communities in particular those from an East Asian background due to the origin of Covid-19.
- Some felt they should have been working from home but were not given the opportunity.
- Some reported being unsupported and treated unfairly by non-BAME managers, for example:
  - non-BAME staff members with no underlying health conditions were able to work from home, while BAME staff were repeatedly questioned about their underlying health conditions.
  - Being treated like second-class citizens with non-BAME managers suggesting that they should work on the front line. Some then actually got Covid-19 and were very ill.
  - No local recognition that BAME staff are at higher risk.

A junior midwife had Covid-19 and after being discharged from hospital reported: *"One of the managers called on the premise for finding out how I was and then started to say that my time is up and to come back to work. I felt pressured. I had just got over the worst of it and was still recovering and at that time I didn't feel like it was appropriate."*

A maternity support worker reported: *"We are left alone. When you have worked on a ward for five years, you have seen everything. You see student midwives pass through, with you showing them what to do… and when there's an emergency, it's you that's taking the blood, it's you bringing the emergency trolley; you will be the one doing everything."*

Another maternity support worker said: *"Because you are the support worker, no one knows you, but when it's time to clean rooms you are asked, "Can you clean the room, can you take this lady, can you run downstairs to check this, can you take this blood for me. And no acknowledgement."*

Some maternity support workers found it challenging to get to work safely, by avoiding or limiting use of public transport, as that was their transport option. Some expressed fear to speak out about this and other issues.

Racism

Participants spoke honestly about how they felt institutional and structural racism impacts on BAME people and prevents them from further developing in their careers.

"Racism is not always open and in your face, but who has the power to change how we get jobs, what university you go to and so on that keeps us at a certain level so that we can't advance?"

"I'm sorry to say this, but in my opinion the system of oppression, in particular racism is the causation."

Sadly, 64% staff who responded to the survey said that racism is ongoing and is rife in the UK. They shared that it is experienced in all aspects of life (education, healthcare, police and career development) and is difficult to eradicate.

Some felt that training opportunities for BAME staff were limited, and not well promoted.

"It is not that they are not applying for opportunities but sometimes they only hear about the advertisement a few days before the closing date when your other white colleagues have been made aware of it months in advance."

"The messages about new opportunities should go out at the same time to everybody when you are talking about equality and diversity."

Experiences of bank and agency staff

Some felt that BAME agency and bank midwives were disproportionately allocated to care for Covid-19 positive patients, with one person describing this as *"almost every time."* Some reported cases of when there was only one pregnant woman with Covid-19, yet the agency midwife was required to care for her.

Agency and bank midwives reporting experiencing loneliness and isolation exacerbated by the stress of the pandemic. They also reported having nobody to complain to, or raise issues with, if the need arises. On occasion, when they tried to express their concerns, these can easily be dismissed, particularly because they are unable to access the usual complaints procedures that permanent staff are able to use.

KLOE 3: Reflecting on the pandemic, what aspects of maternity care do we need to improve for BAME women and their families?

Some participants noted that they had witnessed women not seeking early help during the pandemic when needed:

"We have had incredibly sick women with mental health conditions who stayed at home to the point of serious detriment to their own health so that they had to be sectioned under the Mental Health Act. I think it's really important how we communicate messages so that they are really clear in these cases."

Staff raised concerns that the numbers of domestic violence incidences have increased during the pandemic. It was questioned whether maternity services should have changed the overall advice earlier by stating pregnant women should continue to attend hospital and seek medical advice.

Healthcare professionals report sometimes feeling limited by Trust policies and procedures, which means they are often not able to spend time listening to women or are unable to provide continuity of carer and build a relationship from the beginning of the pregnancy.

"We need the resources to individualise our care for all women and I don't think we have that at the moment because we're doing a one size fits all approach and trying to make it fit as well as we can."

Midwives reported feeling women are slipping though the net and this impacts on their job satisfaction. While recognising the need to scale down services, they felt continuity of carer for extremely vulnerable BAME and vulnerable groups should have remained a top priority.

Some participants commented that there are times when pregnant BAME women give feedback about the care provided by BAME midwives, stating that they felt they did not receive the standard of treatment they felt all midwives should be able to provide. This could be due to factors such as cultural differences, or the feeling that midwives are not sharing the benefit of their own experiences.

"It might be someone that looks like her that is not giving her the experience that she feels she deserves or should have."

"We need to be mindful within ourselves as BAME midwives that our behaviours and actions can impact either negatively or positively on a woman's experience."

Understanding BAME patients

Respondents cited the example of medical literature assuming BAME anatomy has to be compared to the standardised (white) norm. This has led to a midwifery and obstetric perspective where they state, for example, that Asian women have a shorter perineum but without defining "shorter than whom". These assumptions are discriminatory, and place BAME women at greater risk. The literature must change to reflect the population and ensure clinicians have the understanding in order to provide high quality care for all.

There have been incidents reported of some non-BAME maternity staff having acted on the mistaken belief that *"Black women have a higher pain threshold than other women"* which has had a negative impact on the experience of Black patients.

Ensuring patients aren't left behind

"When Covid happened, people ran to virtual platforms. But what about the women with language barriers? How many didn't access care because they couldn't get onto these digital platforms? How many didn't have money to top up their phones to get onto the online clinics?"

Some staff raised concerns about delays in screening for sickle cell and thalassaemia and identifying 'at risk' couples and the lack of scans/screening for foetal anomalies, which has the potential to cause women to fall through the net, particularly BAME women who do not speak English.

It was acknowledged virtual clinics don't work for everyone.

"It has been one of our problems as the majority of our Bengali women we care for in an antenatal clinic, when you are doing virtual clinics, it is quite difficult to get hold of them."

KLOE 4: What support do you need to enable you to do your job effectively?

Staff need support and guidance.

"One of the biggest challenges that I am facing is supporting staff with their mental health. I feel so overwhelmed with many of my staff now coming out with mental health issues that have not been disclosed before and that they have been on medication. There is a need for senior management support to deal with this."

"There are non-BAME midwives requesting non-patient face to face contact due to the moderate risk of high BMI over 40 or asthma. They decline to attend homebirths, community clinics, or refuse to have risk assessments. Any advice on dealing with this situation?"

Staff also need to support each other.

"We as Black and Asian midwives, even without others supporting us, should be able to support each other by being vigilant to give support to our colleagues when facing challenges and difficult times."

Some reported having a BAME forum/network is useful to support each other, share their views and collectively influence the organisation.

"Hearing our views and opinions from the shop floor and being a part of the decision-making process at both local and national level."

Staff need good managers.

Having good managers/leaders were seen as essential to enable staff to voice concerns, and staff welcomed having regular one to ones or small group chats with staff, so they can understand them and their concerns.

"I think some managers need to know when to apply policies and procedures and find a balance for being supportive in a way that is using the guidelines." Junior midwife

"It's about role modelling for staff who have the intelligence and confidence to be able to drive the changes you wish to see."

Organisations need to make sure staff are supported and encouraged to share their perspective.

Staff indicated they would appreciate a dedicated Covid support person or team they could go to.

While acknowledging it is difficult during such a pressured time, making sure all all staff have breaks, social support and a fair allocation of workload (which is a problem within the maternity system) is crucial to wellbeing.

There must be more encouragement for BAME leaders and staff to influence policies and care pathways for BAME patients, so that they are developed in partnership, with understanding. BAME staff want to feel that they are listened to and that their opinions and experience are valued.

Exploring experiences of risk assessments and personal protective equipment

Following feedback, we chose to further explore two particular areas of concern:

- Risk assessments
- Personal protective equipment

Risk assessments

A separate workshop was held in June 2020 to explore the views of maternity staff on the updated risk assessment form and the discussion from this, and the survey follows.

Risk assessment process

30 April 2020: NHS Employers released a statement to confirm new guidance on risk assessments has been published to enable understanding of the specific risks staff members face from exposure to Covid-19. It includes actions which employers can take to keep staff safe including staff returning to work for the NHS and existing staff who are potentially more at risk due to race, age, disability or pregnancy. However, a clinical risk assessment tool for BAME patients is also being developed as part of the NHS England plan and further guidance will be provided by the chief medical officer and Public Health England.

28 May 2020: NHS England and NHS Improvement publish an updated risk assessment guidance which provides practical measures to advance the way risk assessments are carried out for BAME people, at risk and other vulnerable staff groups working across the NHS.

19 June 2020: BAME risk assessment forum takes place where over two third of the participants report they are yet to complete their work risk assessment. Forum attendees reviewed six risk assessment templates from NHS Trusts across London and identified multiple differences between each risk assessment template which demonstrated the inconsistency of the guidance and advice being circulated.

24 June 2020: Letter from NHS England and NHS Improvement acknowledging the reporting of staff members not as yet completing their risk assessments and requesting for organisations to publish the following metrics from their staff reviews, until fully compliant:

- Number of staff risk-assessed and percentage of whole workforce.
- Number of Black, Asian and minority ethnic (BAME) staff risk assessments completed, and percentage of total risk assessments completed and of whole workforce.
- Percentage of staff risk-assessed by staff group.
- Additional mitigation over and above the individual risk assessments in settings where infection rates are highest.

In May 2020, the Health and Safety Executive (HSE) produced guidance for NHS organisations on how to enhance their existing risk assessments, particularly for the at-risk and vulnerable groups within their workforce. This included workers returning to work for the NHS, and existing team members who are potentially more at risk due to their ethnicity, age, weight, underlying health conditions, disability, or pregnancy.

"It is accepted that we need to protect and nurture expectant mothers, but concerning ourselves, one comment I heard was that due to the numbers of BAME staff, it was not possible to offer non-patient facing roles as it would cripple the NHS. This made me feel that we were undervalued as a group."

Some Trusts were actively encouraging all staff to have risk assessments, not just BAME staff.

"I think risk assessments should be done for all staff as I do not feel comfortable segregating one staff group from others. As health professionals we all took our oath to care for patients seriously and being in a high- risk group would not deter me from caring for patients."

Staff reported mixed experiences.

"I did have good support from my manager as she would constantly make contact to ask us how we were and how things were going; she made sure we had facemasks, aprons and gloves available."

Less than a quarter (22%) of the survey respondents felt that risk assessments were a good tool to identify people that need additional support. Negative comments on the risk assessment included:

- *"A tick box exercise with no action"*
- *"Vague and unclear"*
- *"Useless"*
- *"A joke"*

And questioning the fairness around the risk assessment process.

On the new revised risk assessment form, BAME staff are no longer identified as low-risk; they are automatically classified "moderate-risk".

"Once you are BAME, you sit in moderate-risk but then it does ask for other risk factors – but does it matter how many other boxes you tick, when it won't make a difference?"

"I found out I was pregnant at the beginning of lockdown and management did not want me to work from home".

"I was made to feel I was being a time waster and I was going off sick for no reason and shielding for no reason".

It was not always clear how the risk assessment forms were being used or who was reviewing them. Many participants found this disconcerting.

Some junior midwives remarked that they were being dismissed by managers when wanting to discuss risks around Covid-19 because, *"I am not identified as high risk not being old, not having diabetes but they don't know they should signpost me to where I can discuss my concerns."*

"I think there should be a scoring system (as there is in a friend's unit but not in my own) to help both individuals and their line managers reach an individualised risk assessment. A clear scoring system will help ensure all staff have equal opportunities as at present in my unit it can vary between departments."

Personal Protective Equipment (PPE)

Public Health England published updated guidance to address concerns raised about the PPE used by healthcare workers during the early stages of the pandemic. This guidance recommended the need for local implementation dependent on local risk assessments.

With the concerns connected with the supply, availability and use of PPE within maternity units having been identified as an important issue during many of the forums, two additional forums were held to discuss PPE specifically.

> **Note:** This is the experience of BAME maternity staff at a point in time. We acknowledge the situation has changed, and in many cases improved, but it is important to understand their experiences.

The initial national shortage of PPE throughout the country meant some hospital staff had to improvise and use alternative materials. For many BAME midwives, the PPE provided was unsuitable as it was ill-fitting, therefore exposing them to greater risk if the patient was found to have Covid-19.

At the time of the forum, half of maternity staff reported that they have never experienced donning (putting on) and doffing (taking off) PPE. From the ones that did, a majority said that they found that in emergencies, it is very chaotic, time consuming and some PPE was not available to hand or they forgot to wear all the necessary pieces. It was an added complication when their focus was on their patient.

Many midwives reported as not yet having had had a mask fit test and those that failed the available test were not given alternative masks, still leaving them at risk.

PPE is usually designed and developed with a conventional white male face in mind. BAME maternity staff, the vast majority of who are female, reported it being difficult to find standard PPE that adequately fit their faces, adding to the potential risk of contracting the virus. The respiratory masks (N95, FFP3, FFP2 or equivalent) in particular have to be tailored to fit individually and this did not happen at first.

Some staff reported being reprimanded unjustifiably due to ill-fitting PPE. Some BAME midwives were reluctant to explain the reason for their difficulty stemming from items of their PPE that did not fit. They did not want to draw attention to their situation.

Many staff members raised the concern that more junior hospital staff, such as midwifery support assistants and agency and bank midwives are often BAME. It was felt they were presumed to be less entitled to the scarce items of PPE, which disproportionately put them at risk of catching Covid-19. Bank staff are dependent on PPE being provided by the hospital where they do their shifts.

When there have been shortages, they reported often being the last to be allocated it and there were occasions when their PPE was incomplete. Agency staff have sometimes been given PPE by their agency, however some depend on the hospital to provide it and face similar issues as above.

Wearing full PPE on the labour ward is a challenge, as wearing it for a long time makes people feel very tired, hot and dehydrated. About 50% of all respondents that facilitated home births said that they did not wear full PPE as per government advice, for a variety of reasons including that it was difficult to wear and did not fit, they felt it was harder to do their jobs while in PPE, or that they could not source appropriate PPE.

The additional challenge of wearing masks when caring for patients was mentioned as adding to communication issues, especially with people with hearing impairments and people that are not fluent in English, who rely on facial expressions to aid understanding.

Recommendations

Self care

- Self-care was a recurrent theme throughout – we need to support BAME maternity staff so they can look after themselves and each other.
- Encourage BAME maternity staff to lift up one another another through mentoring, encouragement, signposting colleagues to job opportunities, and involving other colleagues. Find time to collaborate outside of work and talk about issues regularly, and work together to speak up in a more coordinated and articulate manner.

Support BAME maternity staff to develop and advance

- Establish a National BAME Maternity Network to promote best practice and further research into BAME-related issues in midwifery and maternity matters. This would encompass the entire maternity workforce (doctors, midwives, nurses, maternity support workers and students). This network would provide a sounding board for BAME maternity policy matters and offer reassurance to colleagues that there is hope, potentially, for tangible changes in the system.
- Create a registered BAME maternity mentor programme to encourage and develop staff and share learnings.
- Support Professional Midwifery Advocates (PMA) to play a vital role in guiding and supporting staff.
- Encourage the continued development of junior staff such as maternity support workers and health care assistants who are often in the same role for a long time.

- Hospitals should have strict protocols in place, so that when bank and agency midwives come on shift, they are given all relevant information regarding the services they are working in which must include relevant changes to care pathways as a result of the pandemic.

Show BAME staff that they are supported in the workplace

- Introduce BAME-specific Freedom to Speak Up Guardians, to give BAME staff a safe space to raise concerns
- Appoint a Lead Specialist Midwife for BAME issues for each maternity unit. This midwife would work within a national framework and towards reducing numbers of deaths among BAME women, as evidenced in the MBRRACE reports.
- Increase the numbers of BAME psychologists employed to provide psychological safety training to BAME staff

Ensure BAME staff are represented at all levels

- Encourage professional and regulatory representative bodies such as the Royal College of Nurses, the Royal College of Midwives and the Nursing and Midwifery Council to reflect the proportion of BAME staff in the NHS in their leadership. We recommend a target of at least 30% of representation at executive level to be BAME.

Make sure the voices of BAME patients are heard

- Review the national maternity voices partnership model to ensure that women representative of communities are being meaningfully heard
- Actively seek the views of BAME women, to understand their fears and what is stopping them from accessing services. Questions should be asked in different languages and format, so all women have the opportunity to express their feelings.
- Understand language barriers and different cultures and how this impacts on care. This is a time more than ever when the NHS should educate itself to be sensitive to the different cultures involved in BAME communities.
- Patients from BAME communities should receive targeted information that acknowledges their situations and needs.
- Use technology such as translation services and images to address language difficulties. Health advocates should provide support for reaching out to these communities.
- Women should be reminded that the ‘stay at home’ message does not mean staying away from hospital.

Make sure the needs and cultures of BAME patients are understood

- Ensure all staff are aware of interpreting services for non-English speaking women, to ensure they are not disadvantaged by the effects of a second wave of Covid-19 or any future pandemic.
- Work with churches and religious groups to educate BAME communities on the importance of the need to seek medical attention early.
- Promote self-care such as blood pressure monitoring, diabetes and vitamin D levels checks.
- Raise awareness in BAME communities of what can be harmful to the body such as the use of traditional herbal remedies, where there is little or no scientific evidence that they work. Without dose control, these herbal remedies may be dangerous.
- Bring back continuity of carer teams for BAME women. The teams can build relationships with their patients and educate and inform, lowering morbidity.

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- Reach out to BAME women who have had children and ask them if they can help to support other women from their communities (BAME Women Befriending Volunteer Support Network), building on the examples cited in some Jewish communities, where pregnant women have a strong support network and meet each other and attend appointments with their doulas.
- Provide support and education to women about how to look after themselves and their families, so that they can minimise any risks educate women, especially when they are being discharged to go home. This includes teaching them.
- Understand different cultures to be able to deliver individualised, quality care.
- Explain the challenges that the BAME population faces and do not shy away from these facts.

Support BAME women to receive high quality maternity care

- Develop stratified criteria regarding BAME women's maternity care, using a specific risk assessment tool similar to the staff risk assessment which will identify Covid-19 as an extremely high risk factor among women. This will help to underline that BAME women are high priority for case-loading and continuity of carer pathways.
- Recognise that BAME midwives can be advocates for pregnant BAME women and they should have leadership roles in formulating the policies that affect these women.
- Develop a clear pathway and support for women transferring from delivery suite to postnatal ward while awaiting their Covid-19 test results, who are later told they have tested positive.
- Clearly communicate the risks of Covid-19 to pregnant BAME women
- Implement specific pathways to support midwives to care for pregnant BAME women, as evidenced by MBRRACE reports that indicate higher rates of morbidity and mortality in BAME women.
- Prioritise and focus resources on BAME women where maternal health is an increased risk.
- Support BAME women to navigate a sometimes unfamiliar healthcare system, in order to provide effective maternity care.

Understanding BAME bodies

While not within our power, obstetric and midwifery training curriculums must be revised to include management and anatomy of reproductive structures of BAME women.

Risk assessments

- All healthcare workers, regardless of job role, ought to have a risk assessment completed. This includes substantive and contracted hospital staff, bank and agency staff, maternity support assistants and students.
- Introduce independent assessors for a BAME risk assessment panel to support different outcomes of risk assessment between managers and staff.
- The processing of risk assessments should be treated according to national data protection law and there should be transparency about where they are filed and who they are given to.

Next steps

While Covid-19 has been an extremely challenging time for the NHS, it has also provided an opportunity to shine a spotlight on the experiences of BAME maternity staff.

"Do you honestly think we will get to the stage where we are on a level pegging with our non-BAME colleagues and how long do you think that might take?"

The recommendations made in this report, if implemented, will go a long way to improving the experiences of BAME staff working in NHS maternity services, making sure they are supported by their line managers and by their employers.

A consistent theme throughout was that that the staff who contributed to this report are proud of working for the NHS, enthusiastic about their role in maternity services and motivated to learn and make changes that will benefit all staff. If staff are supported, if they feel equal and are encouraged to develop, they will provide better care – which will result in better outcomes for patients and for management.

As an employer, the NHS needs to make an effort to support and understand BAME staff and BAME patients – their situation, background, culture, language and their bodies.

What we will do	What you can do
1. Continue to advocate for BAME staff working in NHS maternity services	1. Join your organisation's BAME network as a member or ally
2. Ask organisations across the NHS to read this report and tell us what they plan to do in response	2. Review the recommendations in this report and work out what you can do to implement them in your organisation
3. Follow up with individual organisations about our recommendations and progress in implementing them	3. Talk to colleagues and management about this report and its recommendations
4. Hold all levels of the NHS to account to improve the experiences of BAME staff.	4. Consider how BAME staff can be supported and developed in your organisation, and what you will do to support this.

References and further reading

Available at **www.eastlondonhcp.nhs.uk/bamematernity**

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"The discussions were vibrant and thought provoking and was great to be part of an experience where there will be outcomes"

Linda Machakaire

Head of Midwifery at University Hospital Lewisham of Lewisham and Greenwich NHS Trust

"Time for our tone to change by embracing the many skin colours that make up our NHS, and the pitch we use to communicate"

Shahida Trayling

Deputy Chief Nurse North Middlesex University Hospital NHS Trust

"A fabulous opportunity for the midwifery profession to join forces to support BAME staff during and after the Covid pandemic"

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"Giving BAME staff the opportunity to shape and influence the response to the impact of Covid-19 pandemic"

Manjit Roseghini

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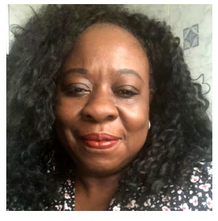
"Sharing best practice and supporting our workforce to enable the best care delivered to our patients"



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Head of Midwifery at Royal Free London NHS Foundation Trust

"A valuable insight into the lived experiences of BAME maternity staff working in the NHS. Thank you for the privilege of honestly sharing your challenges and vulnerabilities in order to effect visible and sustainable change."

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Digital Midwife at Newham University Hospital, Barts Health NHS Trust

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Denise McLeggan

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"I recognise the need for change in the maternity workforce and service provision related to BAME community and I am very excited to be part of this project"

Kate Brintworth

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"Despite the strain, worry and impact Covid-19 is having on midwifery staff from BAME background, their main hope in taking part in the forum was to offer and be part of solid practical solutions to making matters better for the future"

Sharon Elder

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"This provided a much needed platform for BAME staff to discuss their experiences and to explore solutions."

Mercy Ughwujabo

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