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Black maternal health

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Women and Equalities Committee

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Introduction

1. The UK has one of the lowest maternal mortality ratios in the world.[1] There are, however, glaring and persistent disparities in outcomes for women depending on their ethnicity. Maternal mortality for Black women is currently almost four times higher than for White women. Significant disparities also exist for women of Asian and mixed ethnicity.[2] These disparities have existed and been documented for at least 20 years, but only received mainstream attention and Government action since around 2018.[3] Considerable credit for putting the issue on the political and public health agenda goes to campaigners, such as Five X More and Birthrights, who have worked to publicise the issue.

Background

2. Between 2018 and 2020, just over two million women gave birth in the UK.[4] During this period, 229 women died during or up to six weeks after the end of pregnancy, from causes associated with their pregnancy.[5] In 2017, the Government and NHS said they wanted to reduce stillbirths, neonatal and maternal deaths and neonatal brain injuries by 50% by 2025.[6] However, little progress has been made on reducing rates of maternal deaths.[7] Excluding maternal deaths from Covid-19, maternal mortality between the period 2010–2012 and the period 2018–2020 has increased by 3%.[8]

1 World Health Organisation, Maternal mortality ratio (per 100 000 live births), accessed 9 February 2023. The maternal mortality ratio is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period. The most recent data published is for 2017. According to this, the UK has 7 deaths per 100,000 live births. The country with the highest ratio is South Sudan which has almost 1200 deaths per 100,000 live births; the lowest is Poland with 2 deaths per 100,000 live births. The Sustainable Development Goals target is to reduce the global maternal mortality ratio to less than 70 deaths per 100,000 live births by 2030: World Health Organisation, SDG Target 3.1 | Maternal mortality: By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births, accessed 9 February 2023.

2 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 13

3 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17 (November 2019), p vii

4 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 3

5 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 3

6 Department of Health, Safer Maternity Care: The National Maternity Safety Strategy, Progress and Next Steps (November 2017), p 9

7 Health and Social Care Committee, First Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, HC 18, table 2, p 7

8 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), pp 2–3; however the report states that "the increase [in maternal deaths] is only statistically significant for direct deaths" (p 3).

3. Maternal deaths in the UK and Ireland are investigated through the Confidential Enquiry into Maternal Deaths system,[9] currently undertaken by the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) collaboration, led by the National Perinatal Epidemiology Unit (NPEU) at Oxford University. Reports are published on an annual basis, using three years' worth of data.[10]

Disparities in outcomes for ethnic minority mothers

4. Ethnicity data has regularly appeared in the confidential enquiry reports from at least 2000 onwards.[11] All reports since 2000 have shown a greater risk for mothers from ethnic minority backgrounds, compared to White mothers. For example, over the 2000–2002 period, Black African women were almost seven times as likely to die than White women.[12] Since the 2012–2014 period, data has only been given for the larger ethnic groups rather than the sub-groups,[13] but Black women as a group have consistently remained at highest risk. The risks have also been elevated for Asian women and women of mixed ethnicity over most of the period since 2012–2014.

5. MBRRACE-UK's most recent report was published in November 2022 (using data from 2018–2020) and found that:[14]

- Black women were 3.7 times more likely to die than White women, and Asian women were 1.8 times more likely to die than White women[15]
- 1 in 9 of the women who died during or up to a year after pregnancy in the UK were at severe and multiple disadvantage[16]

9 The enquiry system has been running since 1952 for England and Wales; since 1985 a single report has been published for the whole of the UK. Since 2009, it has included maternal deaths in the Republic of Ireland: A M Weindling, The confidential enquiry into maternal and child health (CEMACH), Archives of Disease in Childhood vol 88 (2003), pp 1034–1037

10 MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) is the group appointed by the Healthcare Quality Improvement Partnership to run the national Maternal, Newborn and Infant Clinical Outcome Review Programme: MBRRACE-UK, Information about MBRRACE-UK for Mothers, Parents, Families and Health Service Users, accessed 9 February 2023

11 Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004), p 309. This report (at pp47 and 287) and those for 2003–2005, and 2006–2008 all included the caveat that findings around ethnicity need to be interpreted with caution given ethnicity data from hospitals was incomplete, and in light of the small numbers involved and coding difficulties.

12 Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004), p 309

13 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14, p 25. The report stated that "in the previous reports incidence rates were presented for specific ethnic minority groups in England, however this year we were unable to obtain denominator figures for the specific groups due to restrictions, requirements and charges placed on us by the Health and Social Care Information Centre ….aggregate rates using larger ethnicity groupings are presented…". The use of larger ethnicity groupings has continued for all reports since that date.

14 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022)

15 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p13

16 The main elements of multiple disadvantage were a mental health diagnosis, substance use and domestic abuse: MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p16

- Women living in the most deprived areas continue to have the highest maternal mortality rates[17]
- Cardiac disease remains the largest single cause of indirect maternal deaths,[18] followed by neurological causes (epilepsy and stroke). Thrombosis and thromboembolism (deep vein thrombosis) remains the leading cause of direct maternal death[19] during or up to six weeks after the end of pregnancy[20]
- Improvements in care may have made a difference to the outcome of 38% of women who died.[21]

Our work

6. We undertook this work to scrutinise progress to date. We do not want to read the same tragic statistics for another 20 years. We wanted to review what we know about the causes for maternal health disparities and critically assess the various solutions which have been proposed. However, we were conscious of stakeholder frustrations over much talk and little action. The Health and Social Care Select Committee, the Joint Committee on Human Rights and the Petitions Committee had already conducted work on this issue. Research was also published in 2022 by Five X More, Birthrights and Muslim Women's Network. We therefore decided we could best add value by conducting two oral evidence sessions to understand the current position and bring together existing work. In our first session on 30 March 2022, we heard oral evidence from Professor Marian Knight,[22] Dr Christine Ekechi,[23] Amy Gibbs,[24] and Tinuke Awe.[25] In our second session we heard from Dr Matthew Jolly,[26] the then Minister for Patient Safety and Primary Care, James Morris

17 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p13

18 The World Health Organisation (WHO) defines indirect maternal deaths as those "resulting from previous existing disease or disease that developed during pregnancy and not due to direct obstetric causes but were aggravated by the physiologic effects of pregnancy": World Health Organisation, Maternal deaths, accessed 9 February 2023

19 The WHO defines direct maternal deaths as those "resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above": World Health Organisation, Maternal deaths, accessed 9 February 2023

20 Deaths due to obstetric haemorrhage and pregnancy related sepsis are the next commonest causes of maternal death, followed by suicides. Maternal suicide remains the leading cause of direct deaths occurring within a year after the end of pregnancy: MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 9

21 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 18

22 Professor of Maternal and Child Population Health at the National Perinatal Epidemiology Unit, Oxford. Professor Knight also leads the MBRRACE-UK national confidential enquiries into maternal morbidity and mortality.

23 Consultant Obstetrician and Gynaecologist at Queen Charlotte's & Chelsea Hospital, and co-chair of the Royal College of Obstetricians and Gynaecologists Race Equality Taskforce

24 The then Chief Executive of Birthrights, a charity which "champions respectful care during pregnancy and childbirth by protecting human rights": Birthrights, About Birthrights, accessed 9 February 2023

25 Co-founder and director of Five X More, a "grassroots organisation committed to changing Black women and birthing people's maternal health outcomes in the UK": Five X More, About the campaign, accessed 9 February 2023

26 National Clinical Director for the Maternity Review and Women's Health, NHS England

MP,[27] and William Vineall.[28] We received follow up evidence from Professor Knight[29] and written evidence from Professor Jacqueline Dunkley-Bent, the Chief Midwifery Officer for England.[30]

7. In this report we review what is currently understood about the reasons for disparities in maternal deaths, analyse Government and NHS action to date and existing recommendations for change and consider the ongoing challenges to addressing disparities. This report is titled 'Black maternal health' to acknowledge and address the particularly stark disparity between Black and White women. However, our recommendations are intended to address the ethnic disparities more broadly, as well as the overlapping disparity for women suffering socio-economic deprivation. There is no single quick-fix solution. However, we hope this report and our recommendations can act as an impetus for an effective and coherent cross-Government strategy, that can quickly begin to make sustained progress.

27 The then Minister for Primary Care and Patient Safety
28 Director of NHS Quality, Safety and Investigations at the Department of Health and Social Care
29 Letter to the Chair from Professor Marian Knight, Professor of Maternal and Child Population Health regarding Black maternal health, 31 October 2022
30 Letter to the Chair from the Chief Midwifery Officer in response to letter dated 8 September regarding Black maternal health, 3 November 2022

1 Causes of maternal health disparities

Understanding the causes of ethnic disparities

8. The reasons for ethnic disparities in mortality are not fully understood. Across aggregated ethnic groups, women are dying from the same causes, but Black and Asian women are dying more frequently.[31] We heard that there were many possible reasons for the disparity in the frequency of deaths, including pre-existing conditions and co-morbidities; socio-economic factors including deprivation; and factors impacting on the care that women received, including ignorance, bias, microaggressions and racism. We explore these below.

Pre-existing conditions and co-morbidities

9. Pre-existing conditions are an important factor when considering the reasons for maternal disparities. They cannot, however, be seen in isolation and it is crucial not to attribute disparities to some single, identifiable 'genetic' cause. The NHS Confederation explained that to do so could play into the dangerous narrative of 'race science' theory.[32]

10. 60% of women who died in 2018–20 during, or up to six weeks after the end of, pregnancy had pre-existing medical problems.[33] Dr Christine Ekechi told us that Black women and Asian women with pre-existing conditions are over-represented in that group of deaths. She noted that some conditions in particular, such as diabetes and hypertension, were over-represented in Black and Asian women. However, she pointed out that this did not fully explain the disparities in maternal mortality, and that there was very strong data on the overlap between the socio-economic class and the greater risk of health conditions.[34] Dr Matthew Jolly said there were "certain genetic predispositions to some conditions", including diabetes in the Asian population.[35] He told us about the interaction between genetics, lifestyle and a number of wider social determinants of health. Dr Jolly pointed out that many of these factors were beyond the scope of what maternity services alone could act on, a point echoed by the Chief Midwifery Officer Professor Jacqueline Dunkley-Bent.[36]

31 Q8 [Professor Knight]; Q9 [Tinuke Awe]. See also oral evidence taken before the Health and Social Care Committee on 15 December 2020, HC (2019–2021) 677, Q133 [Professor Knight]

32 Letter from the NHS Confederation relating to black maternal health, 15 September 2022

33 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 16

34 Q11 [Dr Ekechi]. Research published in 2021 (using data from births between 1 April 2015 and 3 March 2018 in England, Scotland and Wales) found that rates of pre-existing diabetes were highest for women from South Asian and Black ethnic groups (1.4% and 1.3% respectively) when compared with women from White ethnic groups (0.6%). Rates of pre-existing hypertension were similar for women from White and Other ethnic groups (0.5%), slightly higher for South Asian women (0.6%) and considerably higher for women from Black ethnic groups (1.9%). Pre-existing diabetes and hypertension rates were lowest for women in the least deprived areas and highest for those in the most deprived areas (0.4% for the least deprived areas vs 0.6% for the most deprived areas for pre-existing hypertension, and 0.6% vs 1% respectively for pre-existing diabetes): K Webster and National Maternity and Perinatal Audit Project Team, Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies: Assessing care using data from births between 1 April 2015 and 31 March 2018 across England, Scotland and Wales (2021), pp 8–9

35 Q52 [Dr Matthew Jolly]

36 Qq52–53 [Dr Matthew Jolly]; Letter to the Chair from the Chief Midwifery Officer in response to letter dated 8 September regarding Black maternal health, 3 November 2022

Socio-economic factors

11. The link between socio-economic factors, including deprivation, and health have been well-documented. The 2010 Marmot review found that "health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health."[37] This link between poor health and deprivation is reflected in maternal health outcomes. MBRRACE-UK's 2022 report confirmed that women living in the most deprived areas continued to have the highest maternal mortality rates and are two and a half times more likely to die than their counterparts living in the least deprived areas.[38] This trend has been evident since at least 2009.[39] There is also an overlap between high socio-economic deprivation and ethnic minority background. The Office for National Statistics noted a higher proportion of babies from Black, Asian and 'Any Other' ethnic groups were born in the most deprived areas, compared with the White ethnic group.[40] The overlap between deprivation and ethnicity has also been acknowledged by the Health and Social Care Committee's Expert Panel,[41] and by NHS England.[42]

12. The then Minister for Patient Safety and Primary Care, James Morris MP (the Minister), acknowledged that social determinants of health were an important factor which would require cross-Government work.[43] William Vineall, Director of NHS Quality, Safety and Investigations at the Department of Health and Social Care, said that looking more broadly than the medical solutions was part of the rationale for setting up the Office for Health Improvement and Disparities.[44] In light of media reports in Autumn 2022 that the Government will no longer publish the awaited health disparities White Paper,[45] we wrote to the then Health Secretary in October 2022 to seek confirmation of the status of the White Paper.[46] We received a response on 28 March 2023 from the Minister for Primary Care and Public Health, which confirmed that the Government will no longer publish the White Paper, instead publishing a Major Conditions Strategy, with an interim report to be published in the summer. The Strategy will "tackle conditions that contribute most to morbidity and mortality across the population in England including, cancers, cardiovascular disease, including stroke and diabetes, chronic respiratory diseases, dementia, mental ill health and musculoskeletal conditions" and seek to address regional disparities in health outcomes.[47]

37 Institute of Health Equity, Fair Society, Healthy Lives: The Marmot Review (February 2010), p 15
38 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 13
39 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 14
40 Office for National Statistics, Births and infant mortality by ethnicity in England and Wales: 2007 to 2019, 26 May 2021, accessed 9 February 2023. This is the latest data available. The article states that: "The Black ethnic group has the highest percentage of live births to mothers who live in the most deprived areas of England for all years, with 82.9% of babies from the Black ethnic group born in the most deprived areas in 2019. The White ethnic group had the lowest percentage of live births occurring in the most deprived areas, with 53.1% of babies from the White ethnic group born in these areas in 2019."
41 Health and Social Care Committee, First Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, HC 18, p 85
42 NHS England, Equity and Equality: Guidance for local maternity systems (September 2021), p 8
43 Q58 [James Morris]
44 Q59 [William Vineall]
45 "Thérèse Coffey scraps promised paper on health inequality", The Guardian, 29 September 2022
46 Letter to the Secretary of State for Health and Social Care on the Health Inequalities White Paper, 12 October 2022
47 Letter from Minister Neil O'Brien on the Government's Health Disparities White Paper, 28 March 2023

Maternity care

13. The need for personalised, respectful and sensitive maternity care for all women (and the failure of some maternity services to provide that care) has been repeatedly highlighted in reports such as the National Maternity Review[48] and the Ockenden review.[49] However, neither report looked specifically at whether there were differences or disparities in the care received according to the mother's ethnicity or other demographic characteristic. The MBRRACE enquiries into maternal mortality have also revealed the need for "complex individualised care and culturally sensitive care" and did look at care differences between White, Asian and Black women.[50] Professor Knight told us that Black women were overrepresented amongst the group of women who failed to receive individualised and culturally sensitive care.[51] For those women who died, MBRRACE assessors found commonalties in the kind of care they received, namely:

- that the women were often viewed as **"not like me"** by medical and care staff; there was a lack of consideration of cultural factors and women's socio-economic background to enable the most appropriate individualised care for a woman, rather than "one size fits all" approach;[52]
- that the vast majority of women who die, across all ethnic groups, have multiple and **complex** problems, and the maternity system was not set up for this; for example, women may have to attend different clinics at different hospitals which were not effectively communicating with each other about the complexities of patients' cases;[53]
- that **microaggressions** were a factor; for example, health professionals sometimes perpetuated racial or ethnic stereotypes, "such as black women having lower pain thresholds",[54] and medical records sometimes inaccurately recorded women's backgrounds, to the detriment of that woman's care.[55]

14. Dr Christine Ekechi, Amy Gibbs, and Tinuke Awe all said that implicit or explicit racism played a role in women's access to treatment and the care they received.[56] Tinuke Awe told us that research by Five X More found that over 42% of women they surveyed reported feeling discriminated against during their maternity care, with one of the most

48 NHS England, National Maternity Review- Better Births: Improving outcomes of maternity services in England (February 2016)

49 An independent review commissioned in 2017 by the then Secretary of State for Health, into maternity services at the Shrewsbury and Telford Hospital NHS Trust and to assess the quality of investigations relating to newborn, infant and maternal harm at the trust. The review was carried out by senior midwife Donna Ockenden. An interim report of 'emerging findings and recommendations' was published in December 2020: Department of Health and Social Care, Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) and a final report was published on 30 March 2022: Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022)

50 Q8 [Professor Knight]

51 Q8 [Professor Knight]

52 Oral evidence taken before the Health and Social Care Committee on 15 December 2020, HC (2019 -2021) 677, Q133 [Professor Knight]

53 Oral evidence taken before the Health and Social Care Committee on 15 December 2020, HC (2019 -2021) 677, Q133 [Professor Knight]

54 Q10 [Professor Knight]; Oral evidence taken before the Health and Social Care Committee on 15 December 2020, HC (2019 -2021) 677, Q133 [Professor Knight]

55 Q10 [Professor Knight]

56 Q2 [Tinuke Awe], Q11 [Dr Christine Ekechi]; Q13 [Amy Gibbs]

common reasons being their race.[57] Amy Gibbs told us that Birthrights had heard about "black and brown women feeling deeply unsafe during their maternity care".[58] She gave examples of racial stereotyping, failure to recognise medical conditions in black and brown babies and their mothers, and a lack of choice and consent around their care options.[59] A report by the Muslim Women's Network said that Black Muslim women (especially Black African women) were most likely to receive poorer standards of care, followed by South Asian Muslim women (particularly Bangladeshi women). The report noted themes including a data and information gap on the needs, experiences and outcomes of minority ethnic women; women not being listened to; and women receiving care which was neglectful, or which lacked dignity and respect.[60]

Training health professionals on disparities

15. The need for health professionals to have training on existing maternal health inequalities, and to challenge prejudices or assumptions based on race, has been a theme of the Birthrights, Five X More and Muslim Women's Network reports and was repeatedly mentioned in evidence we heard.

16. Five X More provided pilot training at Guy's and St Thomas' hospital called *I Am Here To Listen*, alongside badges staff could wear indicating they had received the training. Tinuke Awe described the experience of one woman who reported feeling reassured that her health professional was wearing the badge and was therefore more aware of black women's experiences within maternity services.[61] Dr Ekechi told us that the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG) were committed to training and the Race Equality Taskforce has recently secured funding for an e-learning module.[62]

17. Dr Jolly told us that there was a "growing insight" that there were some areas where the NHS as an organisation could be considered "structurally racist".[63] The examples he gave were that the medical understanding of women's bodies was based around a European white woman's body as the being the default, and that teaching around recognising health conditions in babies was "too white-centric".[64] We put to Dr Jolly the accounts given by Birthrights and others that women had experienced racial stereotyping and direct racism from caregivers. He told us about Health Education England training to improve cultural competence; leadership training to develop cultures of kindness, listening and making sure women are heard; work with Birthrights to develop the iDecide tool[65] and working with Maternity Voice Partnerships to develop a rapid patient feedback system to improve maternity services using targeted interventions.[66] Professor Jacqueline Dunkley-Bent

57 Q28 [Tinuke Awe]
58 Q12 [Amy Gibbs]
59 Q12 [Amy Gibbs]
60 Muslim Women's Network UK, Invisible: Maternity Experiences of Muslim Women from Racialised Minority Communities, July 2022
61 Q25 [Tinuke Awe]
62 Q26 [Dr Ekechi]
63 Q62 [Dr Matthew Jolly]
64 Q62 [Dr Matthew Jolly]
65 iDecide is a decision-making and consent framework, created with women and NHS staff, designed to help women make informed decisions about interventions that may be recommended during labour. It is currently being used by three NHS foundation trusts; Guy's and St Thomas', South Warwickshire, and Birmingham Women and Children's trust: NHS, Welcome to i-Decide, accessed 9 February 2023
66 Q65 [Dr Matthew Jolly]

added that NHS England was working with the NHS Confederation and the Nursing and Midwifery Council to discuss promoting and embedding anti-racism in professional practice.[67]

18. The Minister told us that the meeting of the Maternity Disparities Taskforce on 18 July 2022 would include presentations from Birthrights and the Muslim Women's Network on their reports.[68] However he did not offer specific solutions to the issue of racism or unconscious bias within the workforce on behalf of the Government.

19. **The causes of the appalling disparity in maternal deaths are multiple, complex and still not fully understood. Fixating on any one cause risks over-simplifying the problem and placing blame on the very women who are most at risk. Too many Black women have experienced treatment that falls short of acceptable standards, and we are concerned that the Government and NHS leadership have underestimated the extent to which racism plays a role. The maternity workforce must be properly equipped to understand and recognise the significant disparities that exist, and to use that knowledge to deliver personalised, effective and respectful care. *Health Education England must lead a co-ordinated review involving the National Midwifery Council, General Medical Council, Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, to ensure that both the training curricula and continuing professional development requirements for all maternity staff include evidence-based learning on maternal health disparities, its possible causes, and how to deliver culturally competent, personalised and evidence-led care.***

67 Letter to the Chair from the Chief Midwifery Officer in response to letter dated 8 September regarding Black maternal health, 3 November 2022

68 Q87 [James Morris]

2 Tackling the disparities—work undertaken to date

20. Whilst ethnic disparities in maternal health outcomes have been reported for over 20 years, targeted Government and NHS action has only been evident in the last few years.

21. The Government's Women's Health Strategy, published in August 2022, acknowledges the disparities set out in the MBRRACE-UK surveillance reports.[69] The strategy sets out the following actions specifically aimed at addressing those disparities:

- the implementation of continuity of carer for Black, Asian and mixed ethnic groups and those living in the most deprived areas;
- The Maternity Disparities Taskforce, set up last year;
- guidance and £6.8 million in funding for local maternity systems to produce and implement their equity and equality action plans.

22. More broadly, the strategy mentions the importance of safe, personalised care for all women. It states that NHS England will develop a refreshed delivery plan for maternity and neonatal services that brings together actions required following the final report of the Ockenden Review.[70] It also reiterates the £127 million funding committed in March 2022 for maternity services, "on top of £95 million this year".[71] The strategy says the Government will prioritise personalised maternity care including the roll out of midwifery continuity of carer, the establishment of 15 maternal medicine networks across England to reduce rates of maternal mortality,[72] development of the iDecide project, and provision of funding to the Avoiding Brain Injury in Childbirth Collaboration.[73]

23. We focus on the targeted measures described by the Government - continuity of carer, the Maternity Disparities Taskforce, and use of equity and equality guidance and action plans - below.

Continuity of carer

24. Continuity of carer refers to consistency in the midwife or clinical team providing care for a woman and her baby throughout pregnancy, labour and the postnatal period. The aim is for a woman and her responsible clinician to develop a relationship over time, so that she receives coordinated, timely and appropriate care that meets the needs of her

69 Department of Health and Social Care, Women's Health Strategy for England (August 2022), p 30

70 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022)

71 The £127 million funding was announced by the NHS on 24 March 2022; the £95 million funding for maternity services recruitment was announced in 2021: NHS England, NHS announces £127 million maternity boost for patients and families, accessed on 9 February 2023.

72 Maternal medicine networks provide pre-pregnancy, antenatal and postnatal care for women who have significant medical problems that pre-date or arise in pregnancy or the puerperium: NHS England, Maternal medicine networks: service specification, 18 October 2021, accessed on 9 February 2023

73 Department of Health and Social Care, Women's Health Strategy for England (August 2022), p 73

and her baby. However, the Health and Social Care Committee's Expert Panel noted there was a lack of consistent understanding about the meaning of continuity of carer or whether it applied for the whole pregnancy pathway.[74]

25. Continuity of carer has been a flagship policy for improving maternity care since at least 2016.[75] In 2019, NHS England's Long Term Plan set out a number of goals. One was that most women will benefit from the 'continuity of carer' model by 2021, with an interim aim of 20% of women by March 2019. This provision would be targeted so that by 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.[76] Core20PLUS5, an NHS England and NHS Improvement approach launched in 2021 to reduce health inequalities, also repeats the aim to ensure continuity of carer for women from Black, Asian and minority ethnic communities and from the most deprived groups.[77]

26. Although there is a strong evidence base as to the benefits of continuity of carer for mothers and their babies,[78] there is also compelling evidence that the health service does not currently have enough staff with the right skillset to deliver this safely or effectively. Both the Health and Social Care Committee's Expert Panel[79] and the final Ockenden review report[80] considered that staff shortages had hindered the implementation of the continuity of carer model. The Ockenden report recommended "suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present".[81] The Expert Panel also said that continuity of carer should not be viewed as the 'fix -all' solution to inequality in outcomes, pointing out that barriers such as geographical displacement and language barriers could prevent women receiving the full benefit. They emphasised further measures, in addition to continuity of carer, would be needed to eliminate the racial and socio-economic disparity in outcome.[82]

74 Health and Social Care Committee, First Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, HC 18, p 126

75 NHS England, The National Maternity Review Report - Better Births: Improving outcomes of maternity services in England - A Five Year Forward View for Maternity Care (February 2016), p 9

76 NHS, The NHS Long Term Plan, (January 2019), p 41 and p 48. The Long Term Plan stated that midwifery-led continuity of carer is linked to significant improvements in clinical outcomes for women from BAME groups and those living in deprived areas (p 48)

77 NHS England, Core20PLUS5 (adults) – an approach to reducing healthcare inequalities, accessed 9 February 2023. 'Core 20' refers to the most deprived 20% of the population. 'Plus' refers to population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups. '5' is an additional five areas are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding.

78 Letter to the Chair from the Chief Midwifery Officer in response to letter dated 8 September regarding Black maternal health, 3 November 2022

79 Health and Social Care Committee, First Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, HC 18, p 8

80 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022), p 149

81 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022) p xi

82 Health and Social Care Committee, First Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, HC 18, p 90

27. In July 2021, the Health and Social Care Committee recommended that the budget for maternity services be increased by £200–350 million per annum with immediate effect and kept under close review.[83] In March 2022, the Ockenden review supported and endorsed this recommendation. The review also underlined the urgent need for a robust and funded maternity-wide workforce plan.[84]

28. Dr Jolly told us that that he and Professor Dunkley-Bent agreed continuity of carer should not be implemented by units until the required staffing is in place. He stressed it was an important initiative and that some units had chosen to focus continuity of carer on the "most deprived areas of their communities, so they are doing it in a way where they can deliver it without causing major problems."[85] Professor Dunkley-Bent told us that, as of 21 September 2022, there would no longer be a national target date for services to deliver midwife continuity of carer. Instead, services would be supported to develop local plans "until maternity services can demonstrate sufficient staffing levels".[86]

29. The Minister told us that the Government had recently invested a further £127 million into the maternity system to address the long-term workforce challenge.[87] When challenged on this falling short of the recommendations of Ockenden and the Health and Social Care Committee, William Vineall told us the Government "had committed as much as we are able to commit at the time" and that this was a "significant uplift" on what had been committed pre-Ockenden.[88] Professor Dunkley-Bent told us that NHS England would publish a refreshed delivery plan for maternity and neonatal care in early 2023, which would set priorities to drive further improvement and support safer, more personalised and more equitable care.[89] We note that the delivery plan was published on 30 March 2023.[90]

30. **Continuity of carer is a cornerstone of the Government and NHS commitment to deliver safer maternity services for all women. It is simply not possible to implement it safely, however, due to the considerable staffing shortages across maternity services. A fully staffed, properly funded maternity services workforce is fundamental to delivering safe, personalised care to pregnant women and new mothers, and a prerequisite to rolling out any measures to combat inequalities. Government funding falls short of the £200–350 million per annum recommended by the Health and Social Care Select Committee in July 2021 and endorsed by the final Ockenden report in March 2022.** ***The Government should commit to increasing the annual budget for maternity services to £200–350 million from the next financial year.***

83 Health and Social Care Committee, Fourth Report of Session 2021–22, The safety of maternity services in England, HC 19, para 37
84 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022) p xi and p 149
85 Q61 [Dr Matthew Jolly]
86 Letter to the Chair from the Chief Midwifery Officer in response to letter dated 8 September regarding Black maternal health, 3 November 2022
87 Q61 [James Morris]
88 Q76 [William Vineall]
89 Letter to the Chair from the Chief Midwifery Officer in response to letter dated 8 September regarding Black maternal health, 3 November 2022
90 NHs England, Three year delivery plan for maternity and neonatal services, March 2023

Maternity Disparities Taskforce

31. In September 2020 the Government established the Maternity Inequalities Oversight Forum to "bring together experts from key stakeholders to consider and address the inequalities for women and babies from different ethnic backgrounds and socio-economic groups".[91] The Forum met on 13 October 2020 and 21 April 2021 but had not made any specific recommendations to the Department as of 29 September 2021. The Government declined to publish the membership of the Maternity Inequalities Oversight Forum.[92] It is not clear when the Forum was disbanded, but on 23 February 2022, the Government announced a new Maternity Disparities taskforce.[93] The taskforce was originally to be co-chaired by the then Minister for Patient Safety and Primary Care, Maria Caulfield MP,[94] and the Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent OBE. We are aware the taskforce has so far met on 8 March, 16 May and 18 July 2022. We were told in March 2023 that the taskforce would next meet in April 2023 "with a revised approach", but were not told any more about the reason for the lack of meetings since July 2022, or about the revised approach.[95]

32. The terms of reference of the Taskforce were not published until July 2022 and are summarised in Box 1.[96]

91 Department of Health and Social Care, Consultation outcome - Women's Health Strategy: Call for Evidence, Ministerial Foreword, 13 April 2022, accessed 9 February 2023

92 PQ 52485 [on Maternity Inequalities Oversight Forum], 29 September 2021

93 Department of Health and Social Care, New taskforce to level-up maternity care and tackle disparities, 23 February 2022, accessed 9 February 2023

94 Maria Caulfield MP was Minister for Primary Care and Patient Safety from 17 September 2021 to July 2022. She was appointed as Minister for Health on 7 July 2022, and James Morris MP was appointed as Minister for Primary Care and Patient Safety. Maria Caulfield was then appointed as Minister for Mental Health and Women's Health Strategy and Minister for Women on 27 October 2022.

95 Letter to the Committee from the Minister for mental health and the women's health strategy on black maternal health, 21 March 2023

96 Department of Health and Social Care, Maternity Disparities Taskforce: terms of reference, 18 July 2022, accessed 9 February 2023

Box 1: Maternity Disparities Taskforce: summarised terms of reference

The Taskforce will particularly focus on improving pre-conception care and access to maternity care for women from ethnic minorities and those living in most deprived areas and "will look to explore and consider evidence-based interventions for the following areas":

reduce rates of smoking, drinking and drug use in pregnancy

improve education and awareness of pre-conception health with a focus on planning for pregnancy such as taking folic acid supplement before pregnancy and maintaining a healthy weight

improve personalised care and support plans and focus on addressing wider social determinants of health

improve access to maternity care for all women and develop interventions for women from the most vulnerable groups

improve access and support for informed decision-making during childbirth for all women

Members include representatives from the Department of Health and Social Care, Department for Levelling Up, Housing and Communities, NHS England, Office for Health Improvement and Disparities, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing, MBRRACE-UK, Health and Wellbeing Alliance Maternity Consortium.[97] Meetings will be held every 2 months.

Source: Maternity Disparities Taskforce: terms of reference – GOV.UK (www.gov.uk)

33. Minister Caulfield told the Committee that whilst the Taskforce did not have a "specific timetable for reporting or making recommendations, it will seek to drive ambitious reductions in disparities". The terms of reference state "the actions developed and agreed in the taskforce will be monitored by officials and members will be responsible to provide update on progress between meetings."[98]

34. The taskforce has been welcomed by some, including charities Tommy's[99] and Sands.[100] However, Tinuke Awe said the failure in the original press release to specifically acknowledge the considerably higher mortality rate for Black women in particular, had upset and angered many stakeholders.[101] Amy Gibbs emphasised the need for the Taskforce to address the issue of racial bias in the maternity system,[102] and Dr Ekechi hoped that the Taskforce would focus on the "social and structural drivers that underpin the poor quality of health and poor outcomes".[103]

35. We shared Amy Gibbs' concerns and wrote to the then Minister, Maria Caulfield MP, on 1 March to ask how the taskforce would address concerns that structural racism and/or racial bias from medical staff plays a part in poor outcomes for Black and Asian

97 A full list of members can be found within the Terms of Reference.
98 Correspondence to the Chair from the Minister for Primary Care and Patient Safety relating to the Maternity Disparity Taskforce, 6 May 2022
99 Tommy's, Tommy's joins new taskforce to tackle disparities in maternity care for women from minority ethnic backgrounds and poorer communities, 23 February 2022, accessed 9 February 2023
100 Sands, New maternity care taskforce welcomed by Sands & Tommy's, 23 February 2022, accessed 9 February 2023
101 Q31 [Tinuke Awe]
102 Q34 [Amy Gibbs]
103 Q33 [Dr Ekechi] Q33

mothers and babies. In her response on 6 May, the then Minister assured us the Taskforce "will explore workforce related issues, and structural racism and racial bias".[104] We note, however, that this does not feature in the terms of reference eventually published on 18 July, although the meeting on that date did hear presentations from Birthrights and Muslim Women's Network on their respective reports.[105] We remain concerned that the Taskforce's terms of reference and focus do not reflect the multiple and complex reasons underlying the disparities which we have explored earlier in this report.

36. We were further concerned to hear from the then Minister in oral evidence that no specific metrics, targets or measurable objectives had been adopted by the Taskforce to gauge whether it was achieving its objectives.[106] We raised our concern with him that the Taskforce risked becoming a talking shop. He emphasised that this was not the intention and that he hoped the taskforce would generate evidence-based solutions, action and recommendations.[107]

37. **We note that, at the time of writing this report, the Maternity Disparities Taskforce has not met for nine months. If it continues, it must have tangible metrics to measure its success.** ***The Government should publish measures for gauging the success of the Maternity Disparities Taskforce. It should commit to publishing the dates of meetings in advance, and the minutes of the meetings soon after. The Taskforce should update this Committee on a six-monthly basis on the progress the Taskforce has made to tackling maternal health disparities.***

Equity and equality guidance

38. The NHS Equity and Equality Guidance, published in September 2021, sets out guidance for Local Maternity Systems. It is aimed at improving maternal health outcomes with a focus on mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas.[108] It covers a wide range of interventions across five priority areas and requires Local Maternity Systems to respond with co-produced Equity and Equality Action Plans by the end of February 2022.[109] £6.8 million has been provided to support Local Maternity Systems to implement Equity and Equality Action Plans and implement targeted and enhanced continuity of carer. The Guidance states that the NHS will measure progress towards improving equity for mothers and babies through perinatal mortality metrics and the English maternal morbidity outcome indicator.[110]

104 Correspondence to the Chair from the Minister for Primary Care and Patient Safety relating to the Maternity Disparity Taskforce, 6 May 2022

105 Department of Health and Social Care, Maternity Disparities Taskforce discusses faith and human rights recommendations, 20 July 2022, accessed 9 February 2023

106 Q83 [James Morris], Q84 [William Vineall], Q90 [James Morris]

107 Q89 [James Morris; William Vineall]

108 NHS England, Equity and Equality: Guidance for local maternity systems (September 2021)

109 NHS England, Equity and Equality: Guidance for local maternity systems (September 2021), p 8. These priority areas are: 1) Restore NHS services inclusively; 2) Mitigate against digital exclusion; 3) Ensure datasets are complete and timely; 4) Accelerate preventative programmes that engage those at greatest risk of poor health outcomes; 5) Strengthen leadership and accountability

110 A tool to monitor near-miss or severe maternal morbidity and measure changes in care quality: Manisha Nair, Jennifer J. Kurinczuk, Marian Knight, Establishing a National Maternal Morbidity Outcome Indicator in England: A Population-Based Study Using Routine Hospital Data, PLoS ONE, Vol 11(4) (2016), pp 1–17

39. The Guidance has been cautiously welcomed by some groups, such as Maternity Action, but they have emphasised that implementation and resourcing will be key.[111] Dr Ekechi told us that local maternity systems were putting a "lot of thought and effort" into creating equity strategies, but she was concerned as to who would have the oversight for ensuring the implementation and the adherence to these strategies, particularly in light of staffing concerns in maternity services.[112]

40. We asked Dr Jolly for more information as to who would assess and monitor the equity strategies of local maternity services, and against what metrics. Dr Jolly told us that "that is not an easy question to answer," and that he wanted to go further than "simple metrics and data". He told us he and the Chief Midwifery Officer were developing a strategy which would try to triangulate data with other information including data from Healthcare Safety Investigation Branch investigations and Care Quality Commission inspections, perinatal quality surveillance group feedback and data from the perinatal mortality reporting tool.[113]

41. We also asked about the progress on developing a maternal morbidity indicator. In August 2022, the then Minister for Health, Maria Caulfield MP, told us that an English maternal morbidity outcome indicator was still under development as part of work being led by the Policy Research Unit in Maternal and Neonatal Health and Care at the University of Oxford.[114] Minister Caulfield told us in March 2023 that the work in assessing disparities in maternal morbidity outcomes was "almost" complete and would be sent to the Department of Health and Social Care for review "shortly". However a further project to adapt the indicator to use it to assess the impact of the new maternal medicine networks was only just starting and would not be complete until the end of the year.[115]

42. The Equity and Equality guidance specifically mentioned the indicator as a way of measuring progress towards equity, but we heard, above, that there are still no clear timescales for completion.

43. **It is unclear how the Equity and Equality guidance will be implemented and monitored. In response to this report, *NHS England should set out their approach for assessing and monitoring the strategies of local maternity services. The Government should also provide clear timescales for the roll-out of the maternal morbidity indicator.***

The need for targets

44. As we have set out, each of the main planks of the Government and NHS's approach is beset by problems concerning implementation and measurability. There appears to be no overall, focussed strategy for driving down the stark disparities in maternal outcomes.

111 Maternity Action, Equity and equality: new NHS guidance to improve maternal health outcomes is welcome, but implementation will be key, 29 September 2021, accessed 9 February 2023

112 Q29 [Dr Ekechi]

113 Q71 [Dr Matthew Jolly]

114 Letter from the Minister of State for Health relating to the evidence session on Black Maternal Health, 4 August 2022

115 Letter to the Committee from the Minister for mental health and the women's health strategy on black maternal health, 21 March 2023

45. A repeated theme which has been raised by the Joint Committee on Human Rights,[116] Health and Social Care Committee,[117] stakeholders including the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists,[118] and witnesses to our inquiry, including Dr Ekechi, Tinuke Awe, and Amy Gibbs,[119] is the need for a target to reduce and ultimately eliminate disparities in maternal outcomes.

46. The Joint Committee on Human Rights recommended that the Government introduce a target to end the disparity in maternal mortality between Black women and White women.[120] The Health and Social Care Committee agreed and recommended that:

> the Government as a whole introduce a target to end the disparity in maternal and neonatal outcomes with a clear timeframe for achieving that target. The Department [of Health and Social Care] must lead the development of a strategy to achieve this target and should include consultation with mothers from a variety of different backgrounds.[121]

47. Dr Ekechi, Amy Gibbs and Tinuke Awe all told us they supported setting a target for reducing maternal health disparities in order to focus political and national attention, attract funding and indicate that this was a priority for Government.[122] Professor Knight felt a target could make a difference and would result in a continued focus, though did not support "narrow focus on a single number".[123] She cautioned against the "unintended consequences of targets", pointing to the findings in the Ockenden review in relation to the negative effects of unofficial targets for reducing caesarean sections.[124]

48. Despite setting targets to achieve continuity of care,[125] and to reduce the number of maternal and neonatal deaths overall[126], the Government and NHS England have resisted setting a target to reduce maternal health disparities. Dr Jolly told us:

> There are real risks to targets. The counter-argument was that it creates funding and pressure to drive this forward. Our broader ambition to halve maternal deaths is creating a huge amount of drive already. We are working on this as hard as we can and the commitment that I see from maternity services around the country to do something about it is absolutely there.

116 Joint Committee on Human Rights, Eleventh Report of Session 2019–21, Black people, racism and human rights, HC 559 and HL 165

117 Health and Social Care Committee, Fourth Report of Session 2021–22, The safety of maternity services in England, HC 19

118 Royal College of Midwives, and Royal College of Obstetricians and Gynaecologists (RHR0002)

119 Q28 [Dr Ekechi; Amy Gibbs; Tinuke Awe]

120 Joint Committee on Human Rights, Eleventh Report of Session 2019–21, Black people, racism and human rights, HC 559 and HL 165, para 45

121 Health and Social Care Committee, Fourth Report of Session 2021–22, The safety of maternity services in England, HC 19, para 138

122 Q28 [Dr Ekechi; Amy Gibbs; Tinuke Awe]

123 Q27 [Professor Knight]

124 Q27 [Professor Knight]. The Ockenden review found that Shrewsbury and Telford Hospital NHS Trust had a lower than average caesarean section rate (and was often praised for this); and that "there was a culture within The Shrewsbury and Telford Hospital NHS Trust to keep caesarean section rates low, because this was perceived as the essence of good maternity care in the unit". The review noted that some mothers and babies had been harmed by this approach: Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022), p 161

125 NHS, The NHS Long Term Plan, (January 2019), p 41

126 Department of Health, Safer Maternity Care: The National Maternity Safety Strategy, Progress and Next Steps (November 2017), p 9

> The additional benefit of a target would be minimal. The risks of a target are significant, but that in no way means that we are not absolutely committed to driving down that disparity in maternal deaths and maternal deaths overall.[127]

Professor Dunkley-Bent told us the challenges for setting a target included the difficulty in ascertaining whether a change was statistically significant given the low number of maternal deaths overall. She pointed to the development of the English Maternal Morbidity indicator as an alternative measure.[128] We note that this is a departure from her position in evidence to the Joint Committee on Human Rights, where she appeared to support a target to reduce the racial disparity in maternal deaths.[129]

49. The Government's position is similar. In its response to the Health and Social Care Committee, the Government stated:

> Given that the social determinants of health are beyond the control of health services—requiring sustained and significant action across government, businesses and civil society—it would not be appropriate to set the NHS a hard target for a specific level of reduction in a particular health disparity over time. Instead, NHSEI have taken the approach of first setting metrics which have sufficient sensitivity (statistical power) to track changes in clinical outcomes for the groups most at risk, and second—through the equity and equality guidance—to identify priorities, design evidence-based interventions to address those priorities and promote an approach of continuous quality improvement.[130]

The Minister told us that he felt it was "premature" to set a target "that might have the unintended consequence of focusing on one particular element of […] a complex multifactorial problem."[131]

50. **The main solutions which have been put forward by the Government and NHS are necessary but insufficient to tackle the problem of the disparity in maternal deaths. A target for eliminating the disparity between Black and other minority ethnic women and White women, and the related disparity between those living in the most and least deprived areas, is needed. This will focus minds, help to embed a strategy, and keep the issue firmly on the political and health agenda. Focus on a single number alone is a crude and unhelpful measure. *There should be a cross-government target and strategy, led by the Department of Health and Social Care, for eliminating maternal health disparities. The Maternity Disparities Taskforce should be charged with consulting on this strategy within its membership and more widely, and for proposing and developing metrics by which this target can be achieved and measured.***

127 Q68 [Dr Matthew Jolly]

128 Letter to the Chair from the Chief Midwifery Officer in response to letter dated 8 September regarding Black maternal health, 3 November 2022

129 Oral evidence taken before the Joint Committee on Human Rights on 20 July 2020, HC (2019–2021) 559, Q21 [Professor Jacqueline Dunkley-Bent]

130 HM Government, The Government's response to the Health and Social Care Committee report: Safety of Maternity services in England, CP 513, September 2021, p 26

131 Q68 [James Morris]

3 Chapter 3: Research and data

51. We heard that a major ongoing challenge to tackling the disparities that have not been adequately addressed is the problem with existing data and research. We have often identified the lack of robust and timely data as a barrier to good policy making. In this inquiry we found it to be the case again.

Data on the experiences of black women

52. On 19 April 2021, the then Minister Nadine Dorries[132] stated that women from Black and other ethnic minority groups were under-represented in the responses to the Women's Health Strategy.[133] Tinuke Awe explained this was the impetus for Five X More to try to fill the gap in research about the experiences of Black women. She told us: "we were just so tired of hearing statements like, 'We can't find black women. We don't know where to reach them.'"[134]

53. Five X More ran their own survey in April 2021 as part of their report into black maternity experiences and received over 1300 responses.[135] One of Five X More's key campaign asks is "Black women are involved at every level when it comes to making decisions about their care" and their May 2022 report recommends an annual maternity survey targeted specifically at Black women.[136] The need to listen to women's experiences is a theme which has been repeated throughout evidence heard by us, in research by Five X More, Birthrights and Muslim Women's Network, and was an immediate and essential action recommended by the interim Ockenden review.[137]

Missing and inadequate ethnicity data

54. The Ockenden review of maternity services at Shrewsbury and Telford NHS Trust also found an issue with missing ethnicity data, stating that there were:

> 9,276 missing ethnic background details within the data provided by the Trust, which accounts for approximately 9 per cent of the overall data throughout the timescale of the review. It is also evident that the trend of incomplete data on ethnic background is increasing in recent years.[138]

The review stated that due to the evidential links of poor maternal and neonatal outcomes of women from ethnic minority backgrounds, all trusts should aim to improve the accuracy of their datasets as part of quality and safety monitoring.

132 Then Minister for Mental Health, Suicide Prevention and Patient Safety
133 HC Deb, 19 April 2021, Col 170WH [Westminster Hall]
134 Q28 [Tinuke Awe]
135 Five X More, The Black Maternity Experiences Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom (May 2022)
136 Five X More, The Black Maternity Experiences Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom (May 2022), p 39
137 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022), p 193
138 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022), p 31

55. Data is also not always disaggregated into specific ethnic groups. MBRRACE-UK have been unable to obtain data for specific ethnic groups since their 2016 report, instead having to present the data for larger ethnic groupings. The 2016 report attributed this to "restrictions, requirements and charges placed on us by the Health and Social Care Information Centre".[139]

56. Dr Jolly told us that the overall quality of data had improved significantly since 2015, when only about a third of Trusts held ethnicity data for women booked in for antenatal care. He said the use of the Clinical Negligence Scheme for Trusts maternity incentives scheme had helped improve data collection on ethnicity, which was now completed in over 90% of trusts.[140] [141] He acknowledged that there was more work to be done, including on capturing granular level ethnicity data, for which a new classification was being developed. However, neither Dr Jolly nor the Minister was able to tell us when NHS Digital would move to the new system of data collection.[142]

Data needed for MBRRACE-UK report

57. Professor Knight told us about the delays which contributed to the timing of the publication of MBRRACE-UK reports. These delays were:

- **Delays in the provision of records of deaths**; there is variability in the speed with **which hospitals notify MBRRACE**-UK when a woman has died, and the speed with which they return surveillance information and copies of medical records and maternity notes which are requested by MBRRACE. GP records and mental health records are also subject to delays in receipt. She asked that earlier submission of this data be required by statute or through the Maternity Incentive Scheme (and in the case of GP and mental health records, through equivalent schemes).[143]

- **four months' delay in the Office for National Statistics (ONS) providing birth and deaths data**;[144] the production of accurate data on maternal mortality rates depends on MBRRACE-UK cross-checking that they have been notified about all deaths (numerator data) and having data about all births and all women giving birth (denominator data). This is dependent on ONS data. MBRRACE-UK continue to work with the ONS but would be helped by receiving linked

139 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14, (December 2016), p 25

140 The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995: NHS Resolution, Clinical Negligence Scheme for Trusts, 3rd April 2020, accessed on 9 February 2023

141 The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. The scheme rewards trusts which meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The safety actions include 'submitting data to the Maternity Services Data Set to the required standard': NHS Resolution, Maternity incentive scheme, 17th January 2023, accessed 9 February 2023

142 Q45 [Dr Matthew Jolly; James Morris]

143 Letter to the Chair from Professor Marian Knight, Professor of Maternal and Child Population Health regarding Black maternal health, 31 October 2022

144 Q6 [Professor Knight]. Professor Knight told us: "I do not get the data to cross-check that hospitals have notified all deaths until between August and November of the following year. I then have to get the records from the hospitals to enable us to develop our statistics."

maternal deaths data[145] in January rather than June of each year and receiving pre-release data about all births and all women giving birth, which would mean receipt of that data in April of each year rather than June.[146]

- **five months' delay in NHS England approving the report;** Professor Knight explained that there was no guarantee that the standard three months' timetable for NHS England approval processes would be met. She said future process would be more burdensome as NHS England now require MBRRACE-UK to produce three maternal reports. Further, the expedited processed adopted for MBRRACE-UK reports produced during the pandemic had not been repeated. She noted that work funded directly by the Department of Health and Social Care had shorter, less onerous sign-off processes, and asked that these be adopted for the confidential enquiry reports.[147]

She said reduction or removal of those delays would save six to eight months in MBRRACE-UK being able to publish data and would help in evaluating the success of pilots or actions designed to tackle disparities.[148]

58. Emma Rourke, Interim Deputy National Statistician and Director General for Health, Population and Methods at the ONS, told us that the ONS had improved the timeliness of delivery of data over recent years although the pandemic had impacted on this. However, they had kept the National Perinatal Epidemiology Unit informed of delays and would be meeting with them to discuss further improvements.[149]

59. **Black women are regularly underrepresented in research or data and therefore in policymaking. Ethnicity data held by trusts is incomplete or inaccurate. Crucial data is delivered too slowly to the National Perinatal Epidemiology Unit, which delays MBRRACE-UK releasing the data and impedes their ability to evaluate progress on tackling disparities. We recommend that:**

- ***The Office for National Statistics, NHS England, hospital trusts and all relevant stakeholders should work with the National Perinatal Epidemiology Unit (NPEU) to minimise delays in the delivery of data. The NPEU should provide us with a progress update on this work within 12 months of the date of publication of this report.***

- ***NHS England and NHS Improvement (NHSEI) and NHS Digital must prioritise the accurate and complete capture of ethnicity data and ensure their new system for ethnicity data captures granular level data on ethnicity. NHSEI should provide us with a progress update on the implementation of this system within 12 months of the date of publication of this report.***

- ***The Maternity Disparities Taskforce must ensure a minimum number of seats or spaces at each meeting is reserved for representatives of organisations run***

145 Maternal deaths identified from linking death records with birth records from the previous year
146 Letter to the Chair from Professor Marian Knight, Professor of Maternal and Child Population Health regarding Black maternal health, 31 October 2022
147 Letter to the Chair from Professor Marian Knight, Professor of Maternal and Child Population Health regarding Black maternal health, 31 October 2022
148 Q7 [Professor Knight]
149 Letter from the Interim Deputy National Statistician and Director General for Health, Population, and Methods, Office of National Statistics, relating to the evidence sessions on Black Maternal Health, 12 August 2022

by and for Black women. Part of the Taskforce's focus over the next 12 months should be on working with stakeholders to ensure Black women can be better represented in maternal health research; both as participants and researchers.

Conclusions and recommendations

Causes of maternal health disparities

1. The causes of the appalling disparity in maternal deaths are multiple, complex and still not fully understood. Fixating on any one cause risks over-simplifying the problem and placing blame on the very women who are most at risk. Too many Black women have experienced treatment that falls short of acceptable standards, and we are concerned that the Government and NHS leadership have underestimated the extent to which racism plays a role. The maternity workforce must be properly equipped to understand and recognise the significant disparities that exist, and to use that knowledge to deliver personalised, effective and respectful care. *Health Education England must lead a co-ordinated review involving the National Midwifery Council, General Medical Council, Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, to ensure that both the training curricula and continuing professional development requirements for all maternity staff include evidence-based learning on maternal health disparities, its possible causes, and how to deliver culturally competent, personalised and evidence-led care.* (Paragraph 19)

Tackling the disparities—work undertaken to date

2. Continuity of carer is a cornerstone of the Government and NHS commitment to deliver safer maternity services for all women. It is simply not possible to implement it safely, however, due to the considerable staffing shortages across maternity services. A fully staffed, properly funded maternity services workforce is fundamental to delivering safe, personalised care to pregnant women and new mothers, and a prerequisite to rolling out any measures to combat inequalities. Government funding falls short of the £200–350 million per annum recommended by the Health and Social Care Select Committee in July 2021 and endorsed by the final Ockenden report in March 2022. *The Government should commit to increasing the annual budget for maternity services to £200–350 million from the next financial year.* (Paragraph 30)

3. We note that, at the time of writing this report, the Maternity Disparities Taskforce has not met for nine months. If it continues, it must have tangible metrics to measure its success. *The Government should publish measures for gauging the success of the Maternity Disparities Taskforce. It should commit to publishing the dates of meetings in advance, and the minutes of the meetings soon after. The Taskforce should update this Committee on a six-monthly basis on the progress the Taskforce has made to tackling maternal health disparities.* (Paragraph 37)

4. It is unclear how the Equity and Equality guidance will be implemented and monitored. In response to this report, *NHS England should set out their approach for assessing and monitoring the strategies of local maternity services. The Government should also provide clear timescales for the roll-out of the maternal morbidity indicator.* (Paragraph 43)

5. The main solutions which have been put forward by the Government and NHS are necessary but insufficient to tackle the problem of the disparity in maternal

deaths. A target for eliminating the disparity between Black and other minority ethnic women and White women, and the related disparity between those living in the most and least deprived areas, is needed. This will focus minds, help to embed a strategy, and keep the issue firmly on the political and health agenda. Focus on a single number alone is a crude and unhelpful measure. *There should be a cross-government target and strategy, led by the Department of Health and Social Care, for eliminating maternal health disparities. The Maternity Disparities Taskforce should be charged with consulting on this strategy within its membership and more widely, and for proposing and developing metrics by which this target can be achieved and measured.* (Paragraph 50)

Research and data

6. Black women are regularly underrepresented in research or data and therefore in policymaking. Ethnicity data held by trusts is incomplete or inaccurate. Crucial data is delivered too slowly to the National Perinatal Epidemiology Unit, which delays MBRRACE-UK releasing the data and impedes their ability to evaluate progress on tackling disparities. We recommend that:

    - *The Office for National Statistics, NHS England, hospital trusts and all relevant stakeholders should work with the National Perinatal Epidemiology Unit (NPEU) to minimise delays in the delivery of data. The NPEU should provide us with a progress update on this work within 12 months of the date of publication of this report.*

    - *NHS England and NHS Improvement (NHSEI) and NHS Digital must prioritise the accurate and complete capture of ethnicity data and ensure their new system for ethnicity data captures granular level data on ethnicity. NHSEI should provide us with a progress update on the implementation of this system within 12 months of the date of publication of this report.*

    - *The Maternity Disparities Taskforce must ensure a minimum number of seats or spaces at each meeting is reserved for representatives of organisations run by and for Black women. Part of the Taskforce's focus over the next 12 months should be on working with stakeholders to ensure Black women can be better represented in maternal health research; both as participants and researchers.* (Paragraph 59)

Annex: A timeline of relevant work on maternal health disparities

1) There have been a number of interventions and suggestions to date to improve the safety of maternity services generally. Work that is relevant to ethnic disparities amongst Black, Asian and other ethnic minority groups is summarised in the chronology below.

Table 1: Chronology of relevant work

Date	Event/report/investigation
1952	National Enquiry system into Maternal Deaths set up for England and Wales[150] Reports were initially published every three years[151] Information about mothers' countries of birth was included in the Reports for 1970–72 to 1982–84. This showed much higher mortality rates among women born in the 'New Commonwealth' than among those born in the United Kingdom. An analysis of death registration data for the years 1970–78 led to similar conclusions. The 1982–84 Report pointed out that country of birth did not necessarily equate to ethnic origin and the subject was dropped from subsequent Reports until analyses by ethnic origin were attempted in 1994–96.[152] Since 2012, MBRRACE-UK has been conducting the enquiries and publishes an annual report[153]
1994	Ethnic origin data starts to be collected on Enquiry notification forms[154]
1995	Government policy requires hospitals in England and Wales to record ethnicity in Hospital Episode Statistics[155]

150 Health Quality Improvement Partnership, Maternal, newborn and infant outcome review programme, accessed 9 February 2023

151 A M Weindling, The confidential enquiry into maternal and child health (CEMACH), Archives of Disease in Childhood vol 88 (2003), pp 1034–1037

152 Confidential Enquiry into Maternal and Child Health, (November 2004), p 309

153 MBRRACE-UK, MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, accessed 9 February 2023

154 The forms notifying the Enquiry of a maternal death: Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004), p 286.

155 Gulnaz Iqbal, Mark RD Johnson, Ala Szczepura, Sue Wilson, Anil Gumber & Janet A Dunn, UK ethnicity data collection for healthcare statistics: the South Asian perspective, BMC Public Health, Vol 12 (2012), pp 1–8. Hospital Episode Statistics (HES) is a database containing details of all admissions, Accident and Emergency attendances and outpatient appointments at NHS hospitals in England - NHS Digital, Hospital Episode Statistics (HES), 6 June 2022, accessed 9 February 2023

Date	Event/report/investigation
November 2004	Publication of 'Why Mothers Die 2000–2002 – The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom'[156] The report found, in particular, that: Black African women were almost seven times more likely than White women to die.[157] Black Caribbean women and Asian Bangladeshi women were just over twice as likely to die than White women.[158] Women living in the most deprived areas of England had a 45% higher death rate compared with women living in the most affluent areas.[159] The report stated that whilst ethnic group information was now being collected as part of the Hospital Episode Statistics (HES) system for England, it was not complete for the years covered by this Report. There was 67% HES coverage of births by ethnic group for the period 2000–02.[160]
December 2007	Publication of 'Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003–2005', the Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom[161] The report found that: Black African women were 5.6 times more likely to die than White women Black Caribbean women were almost four times more likely to die Women described as being 'Middle Eastern' were almost three times more likely to die Indian women were almost twice as likely to die[162] In England, women who lived in the most deprived areas were five times more likely to die than women living in the least deprived areas.[163]

156 Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004)
157 Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004), pp 46–47
158 Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004), pp 46–47
159 Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004), p 246
160 Confidential Enquiry into Maternal and Child Health, Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (November 2004), p 46
161 Confidential Enquiry into Maternal and Child Health, Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003–2005, the Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (December 2007)
162 Confidential Enquiry into Maternal and Child Health, Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003–2005, the Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (December 2007), p 30
163 Confidential Enquiry into Maternal and Child Health, Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer - 2003–2005, the Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (December 2007), p 37

Date	Event/report/investigation
March 2011	Publication of 'Saving Mothers' Lives Reviewing maternal deaths to make motherhood safer: 2006–2008', the Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom[164] The report found that Black African women and Black Caribbean women were just under four times more likely than White women to die.[165] In England, women who lived in the most deprived areas were more likely to die than women living in the least deprived areas.[166]
2012	MBRRACE-UK appointed to undertake the Confidential Enquiries into Maternal Deaths
December 2014	Publication of Saving Lives, Improving Mothers' Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–2012[167] The report showed a higher relative risk of death for almost all ethnic groups compared to White women. In particular: Women of Black African origin were almost three times as likely to die. Black Caribbean and Asian Indian women were both around twice as likely to die.[168] The report also found that women from the most deprived areas of England were around one and a half times more likely to die that those from the most deprived areas[169]
January 2015	Royal College of Obstetricians and Gynaecologists launches 'Each Baby Counts'[170] It did not explore ethnic disparities in neonatal (or maternal) mortality. The 2020 progress report accepted this would need to be an essential part of future work.[171]

164 Centre for Maternal and Child Enquiries, Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006–2008, the Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom, British Journal of Obstetrics and Gynaecology, Vol 118 (2011) pp 1–203

165 Centre for Maternal and Child Enquiries, Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006–2008, the Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom, British Journal of Obstetrics and Gynaecology, Vol 118 (2011), p 48. Again, the report advised some caution in relation to the small numbers and difficulties with coding. It stated HES coverage meant ethnicity was recorded for 75% of the deliveries in England for the period covered by this report (p 47).

166 Centre for Maternal and Child Enquiries, Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006–2008, the Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom, British Journal of Obstetrics and Gynaecology, Vol 118 (2011), p 5

167 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–2012, (December 2014)

168 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–2012, (December 2014), p 21

169 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–2012, (December 2014), p 21

170 Royal College of Obstetricians and Gynaecologists, Each Baby Counts, accessed 9 February 2023

171 Royal College of Obstetricians and Gynaecologists, Each Baby Counts: 2020 final progress report (March 2021), p 26

Date	Event/report/investigation
December 2015	Publication of 'Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2011–13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13'[172] The report showed a higher relative risk of death for almost all ethnic groups compared to White women, with little change from the December 2014 report.[173] Unlike earlier reports, there was no statistically significant difference between women living in the most deprived areas and those living in the least deprived areas.[174]
February 2016	NHS National Maternity Review- Better Births: Improving outcomes of maternity services in England[175] The review was commissioned in March 2015 by NHS England. The report observed that: Babies that are Black or Black British Asian or Asian British have a more than 50% higher risk of perinatal mortality.[176] However, the report did not explore why babies from these backgrounds have worse outcomes or make any observations about disparities in maternal mortality.
March 2016	Saving Babies Lives care bundle launched (SBLCB) by the NHS[177] The 2016 version does not refer to the ethnic disparity in stillbirths, save to list 'racial/ethnic factors' as a potential risk factor for foetal growth restriction or stillbirth.[178] In 2019, SBLCB was updated to address preterm births. The 2019 version states to "Continuity of carer models are particularly important in improving outcomes for women and babies from black, Asian and minority ethnic (BAME) backgrounds and economically disadvantaged groups."[179]

172 MBRRACE-UK, Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011–13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13, (December 2015)

173 MBRRACE-UK, Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011–13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13, (December 2015), p 16

174 MBRRACE-UK, Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011–13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13, (December 2015), p 16

175 NHS England, National Maternity Review- Better Births: Improving outcomes of maternity services in England (February 2016)

176 NHS England, National Maternity Review- Better Births: Improving outcomes of maternity services in England (February 2016), p 57

177 NHS England, Saving Babies' Lives: A care bundle for reducing stillbirth, (March 2016)

178 NHS England, Saving Babies' Lives: A care bundle for reducing stillbirth, (March 2016), p 23

179 NHS, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality, (March 2019), p 13

Date	Event/report/investigation
October 2016	National Maternity Safety Ambition and Safer Maternity Care Action Plan[180] published in response to Better Births181 and as part of a wider Maternity Transformation Programme[182] There was no specific mention of ethnic disparities in maternal mortality.
December 2016	Publication of 'Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14'[183] The report's findings largely reflected the 2014 report, with continued disparities for Black women in particular.[184]
December 2017	Publication of Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15[185] The report noted the need to use larger ethnic groupings rather than specific groups.186 Ethnic disparities remained largely similar to the last report. However, women living in the most deprived areas of England were over twice as likely to die than women living in the least deprived areas.

180 Department of Health, Safer Maternity Care: The National Maternity Safety Strategy, Progress and Next Steps (November 2017)

181 NHS England, National Maternity Review- Better Births: Improving outcomes of maternity services in England (February 2016)

182 NHS England, Maternity Transformation Programme, accessed 9 February 2023

183 MBRRACE-UK, 'Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14' (December 2016)

184 MBRRACE-UK, 'Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14' (December 2016). The report also stated that "in the previous reports incidence rates were presented for specific ethnic minority groups in England, however this year we were unable to obtain denominator figures for the specific groups due to restrictions, requirements and charges placed on us by the Health and Social Care Information Centre ….aggregate rates using larger ethnicity groupings are presented…", p.25

185 MBRRACE-UK, Publication of Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15, (December 2017)

186 The report stated that "denominator figures for the specific ethnic groups are no longer in the public domain and permissions processes and charges levied by NHS Digital render them unobtainable": MBRRACE-UK, Publication of Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15, (December 2017), p 15

Date	Event/report/investigation
November 2018	Publication of 'Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16'[187] The report noted the need to use larger ethnic groupings, as for the previous two reports.[188] The report found: Black women were almost five times more likely to die than White women Asian women were almost twice as likely to die, and Mixed ethnicity women were twice as likely to die Women living in the most deprived areas of England were over three times more likely to die than women living in the least deprived areas[189] The conclusions section of the report recommended that "the almost five-fold higher mortality rate amongst Black women compared with White women requires urgent explanation and hence development of actions to address this."[190]
January 2019	NHS Long Term Plan[191] NHS England's NHS Long Term Plan set out a number of proposals to "achieve a 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025", as set out in the National Maternity Safety Ambition (above).[192] Targeted support for Black, Asian and ethnic minority groups and vulnerable mothers is mentioned, with a focus on continuity of carer.[193]

187 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, (November 2018)
188 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, (November 2018), p 15
189 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, (November 2018), p 17
190 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, (November 2018), p vi
191 NHS, The NHS Long Term Plan, (January 2019)
192 NHS, The NHS Long Term Plan, (January 2019), p 47
193 NHS, The NHS Long Term Plan, (January 2019), p 41

Date	Event/report/investigation
December 2019	Publication of 'Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17'[194] The report noted the need to use larger ethnic groupings, as for the previous three reports.[195] The report found: Black women were more than five times likely to die than White women Mixed ethnicity women were three times more likely to die Asian women were almost twice as likely to die Women living in the most deprived areas of England were over twice as likely to die than women living in the least deprived areas[196]
March 2020	Better Births Four Years On: A review of progress[197] The review found that mortality rates remain higher for Black or Black British and Asian or Asian British babies. Whilst stillbirth rates for these groups had reduced over the period 2015 to 2017, neonatal mortality rates increased over the same period.[198]
June 2020	Government action during the Covid-19 pandemic In June 2020 the Government announced additional support for pregnant Black, Asian and Ethnic Minority women following research showing that they were at a heightened risk of hospitalisation with Covid-19. The announcement stated that NHS England's Chief Midwifery Officer, Jacqueline Dunkley-Bent, had written to all maternity units in the country calling on them to take four 'common sense steps' to minimise the additional risk of Covid-19 for Black, Asian and ethnic minority women and their babies.[199]
June 2020	Royal College of Midwives launch 'Race Matters' campaign[200]
July 2020	Royal College of Obstetricians and Gynaecologists launch race equality taskforce[201]
August 2020	Publication of 'Saving Lives, Improving Mothers' Care Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK (March - May 2020)'[202]
September 2020	Government establishes Maternity Inequalities Oversight Forum[203]

194 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17 (November 2019)
195 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17 (November 2019), p13
196 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17 (November 2019), p15
197 NHS England and NHS Improvement, Better Births Four Years On: A review of progress (March 2020)
198 NHS England and NHS Improvement, Better Births Four Years On: A review of progress (March 2020), p11
199 NHS England, NHS boosts support for pregnant black and ethnic minority women, 27 June 2020, accessed 9 February 2023
200 Royal College of Midwives, Race matters, accessed 9 February 2023
201 Royal College of Obstetricians and Gynaecologists, Race Equality Taskforce, accessed 9 February 2023
202 MBRRACE-UK, Saving Lives, Improving Mothers' Care Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK (March - May 2020) (August 2020)
203 Department of Health and Social Care, Consultation outcome - Women's Health Strategy: Call for Evidence, Ministerial Foreword, 13 April 2022, accessed 9 February 2023

Date	Event/report/investigation
13 October 2020	First meeting of the Maternity Inequalities Oversight Forum[204]
November 2020	'Black people, racism and human rights' report published by Joint Committee on Human Rights[205] This report recommended the Government introduce a target to end the disparity in maternal mortality between Black women and White women.[206]
December 2020	Publication of Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (the interim report of the Ockenden review)[207]
January 2021	'Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016–18'[208] The report noted the need to use larger ethnic groupings, as for the previous four reports. The report highlighted the change in response to the ethnic disparities: "These figures are fundamentally unchanged from those documented in the 2019 report, but the response to the disparity has changed dramatically. Individuals, groups of individuals, third sector organisations, research units, professional societies and NHS and government bodies have responded positively"[209]
31 March 2021	Commission on Race and Ethnic Disparities report into racial and ethnic disparities in the UK[210]
21 April 2021	Second meeting of the Maternity Inequalities Oversight Forum[211]

204 PQ 52485 [on Maternity Inequalities Oversight Forum], 29 September 2021
205 Joint Committee on Human Rights, Eleventh Report of Session 2019–21, Black people, racism and human rights, HC 559 and HL 165
206 Joint Committee on Human Rights, Eleventh Report of Session 2019–21, Black people, racism and human rights, HC 559 and HL 165, para 45
207 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022)
208 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016–18, (January 2021)
209 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016–18, (January 2021), p 1
210 Commission on Race and Ethnic Disparities, The report of the Commission on Race and Ethnic Disparities (April 2021)
211 PQ 52485 [on Maternity Inequalities Oversight Forum], 29 September 2021

Date	Event/report/investigation
June 2021	'The safety of maternity services in England' report published by the Health and Social Care Select Committee[212] The report made the following recommendations in relation to maternal health inequalities: those involved in delivering the 'continuity of care' model must have received appropriate training and that all professionals are competent and trained in all areas that they work in, particularly in relation to Black mothers where the disparities are the greatest.[213] The Government as a whole should introduce a target to end the disparity in maternal and neonatal outcomes with a clear timeframe for achieving that target. The Department of Health and Social Care must lead the development of a strategy to achieve this target and should include consultation with mothers from a variety of different backgrounds[214]
June 2021	'The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England', published by Health and Social Care Select Committee.[215] This report rated the Government's progress on its commitments in relation to maternity safety as 'requires improvement' overall, and on the specific commitment to reduce maternal deaths as 'inadequate'.
July 2021	Publication of 'Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020-March 2021'[216]
September 2021	Equality and Equity Guidance issued by NHS England and NHS Improvement[217]
1 October 2021	Office for Health Improvement and Disparities launched[218]
November 2021	NHS launches Core20PLUS5[219]

212 Health and Social Care Committee, Fourth Report of Session 2021–22, The safety of maternity services in England, HC 19

213 Health and Social Care Committee, Fourth Report of Session 2021–22, The safety of maternity services in England, HC 19, para 137

214 Health and Social Care Committee, Fourth Report of Session 2021–22, The safety of maternity services in England, HC 19, para 138

215 Health and Social Care Committee, First Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, HC 18

216 MBRRACE-UK, Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020-March 2021 (July 2021)

217 NHS England, Equity and Equality: Guidance for local maternity systems (September 2021)

218 Department of Health and Social Care, New body to tackle health disparities will launch 1 October, co-headed by new Deputy Chief Medical Officer, 3 September 2021, accessed 9 February 2023

219 NHS England, Core20PLUS5 (adults) – an approach to reducing healthcare inequalities, accessed 9 February 2023.

Date	Event/report/investigation
November 2021	Publication of 'Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017–19'[220] The report noted the need to use larger ethnic groupings, as for the previous five reports. The report found that little change in disparities compared to the last two reports.
23 February 2022	Government announces creation of the Maternity Disparities Taskforce[221]
18 March 2022	First meeting of Maternity Disparities Taskforce[222]
30 March 2022	Final findings, conclusions and essential actions from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust[223]
May 2022	Publication of 'The Black Maternity Experiences Report: A nationwide study of Black women's experiences of maternity services in the United Kingdom', by Five X More[224]
May 2022	Publication of 'Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care', by Birthrights[225]
16 May 2022	Second meeting of Maternity Disparities Taskforce[226]
July 2022	Publication of 'Invisible: Maternity Experiences of Muslim Women from Racialised Minority Communities', by Muslim Women's Network[227]
18 July 2022	Third meeting of Maternity Disparities Taskforce[228]

220 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017–19 (November 2021)

221 Department of Health and Social Care, New taskforce to level-up maternity care and tackle disparities, 23 February 2022, accessed 9 February 2023

222 Correspondence to the Chair from the Minister for Primary Care and Patient Safety relating to the Maternity Disparity Taskforce, 6 May 2022

223 Ockenden Report - Final: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, (March 2022)

224 Five X More, The Black Maternity Experiences Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom (May 2022)

225 Birthrights, Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care (May 2022)

226 Department of Health and Social Care, Maternity Disparities Taskforce explores women's health before and during pregnancy, 18 May 2022, accessed 9 February 2023

227 Muslim Women's Network UK, Invisible: Maternity Experiences of Muslim Women from Racialised Minority Communities, July 2022

228 Department of Health and Social Care, Maternity Disparities Taskforce discusses faith and human rights recommendations, 20 July 2022, accessed 9 February 2023

Date	Event/report/investigation
November 2022	Publication of 'Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20'[229] The report noted the need to use larger ethnic groupings, as for the previous six reports. The report found that: Black women were almost four more likely to die than white women Asian women were almost twice as likely to die than White women Women living in the most deprived areas were 2.5 times more likely to die than women living in the least deprived areas[230]

229 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022)

230 MBRRACE-UK, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20 (November 2022), p 13

Formal minutes

Wednesday 29 March 2023

Members present:

Caroline Nokes, in the Chair

Elliot Colburn

Dame Caroline Dinenage

Carolyn Harris

Kate Osborne

Black maternal health

Draft Report (*Black maternal health*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 59 read and agreed to.

Annex agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned until Wednesday 19 April at 2 p.m.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 30 March 2022

Dr Christine Ekechi, Co-Chair, Race Equality Taskforce, Royal College of Obstetricians and Gynaecologists; **Amy Gibbs**, CEO, Birthrights; **Professor Marian Knight**, Professor of Maternal and Child Population Health, National Perinatal Epidemiology Unit; **Tinuke Awe**, Co-founder, Five x More — Q1–36

Wednesday 13 July 2022

James Morris MP, Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care), Department of Health and Social Care; **William Vineall**, Director of NHS Quality, Safety and Investigations, Department of Health and Social Care; **Dr Matthew Jolly**, National Clinical Director for Maternity and Women's Health, NHSEI — Q37–98

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2022–23

Number	Title	Reference
1st	Menopause and the Workplace	HC 91
2nd	The rights of cohabiting partners	HC 92
1st Special	Ethnicity pay gap reporting: Government response to the Committee's fourth report of session 2021–22	HC 110
2nd Special	Equality in the heart of democracy: A gender sensitive House of Commons: responses to the Committee's fifth report of session 2021–22	HC 417
3rd Special	The rights of cohabiting partners: Government response to the Committee's Second Report	HC 766
4th Special	Menopause and the workplace: Government Response to the Committee's First Report	HC 1060

Session 2021–22

Number	Title	Reference
1st	Levelling Up and equality: a new framework for change	HC 702
2nd	Appointment of the Chair of the Social Mobility Commission: Katharine Birbalsingh CBE	HC 782
3rd	Reform of the Gender Recognition Act	HC 977
4th	Ethnicity pay gap reporting	HC 998
5th	Equality in the heart of democracy: A gender sensitive House of Commons	HC 131

Session 2019–21

Number	Title	Reference
1st	Unequal impact? Coronavirus, disability and access to services: interim Report on temporary provisions in the Coronavirus Act	HC 386
2nd	Appointment of the Chair of the Equality and Human Rights Commission	HC 966
3rd	Unequal impact? Coronavirus and BAME people	HC 384
4th	Unequal impact? Coronavirus, disability and access to services: full Report	HC 1050

Number	Title	Reference
5th	Unequal impact? Coronavirus and the gendered economic impact	HC 385
6th	Changing the perfect picture: an inquiry into body image	HC 274