HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Black maternal health, HC 1232

Wednesday 30 March 2022

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Watch the meeting

Members present: Caroline Nokes (Chair); Carolyn Harris; Anum Qaisar.

Questions 1 - 36

Witnesses

I: Professor Marian Knight, Professor of Maternal and Child Population Health, National Perinatal Epidemiology Unit; Tinuke Awe, Co-founder, Five X More; Dr Christine Ekechi, Co-chair, Royal College of Obstetricians and Gynaecologists, Race Equality taskforce Women for Refugee Women; and Amy Gibbs, Chief Executive Officer, Birthrights.

Written evidence from witnesses:

Examination of witnesses

Witnesses: Professor Marian Knight; Tinuke Awe; Dr Christine Ekechi and Amy Gibbs.

Q1 **Chair:** Good afternoon, and welcome to this afternoon's meeting of the Women and Equalities Committee and the short inquiry we are doing with some Members of the Health and Social Care Committee and also the Petitions Committee. Unfortunately, Cat McKinnell from the Petitions Committee cannot be with us as she has to attend a meeting of the Liaison Committee, but she will join us for future sessions of this inquiry. We were hoping to see Lucy Allan from the Health and Social Care Committee, but she is now not coming.

We held two sessions—I am going to say last year; I have a nasty feeling it was the year before, but that is Covid, is it not? You lose track of time—talking about black maternal health and the disparities. This piece of work is really to bring together the different work that has been going on with the Petitions Committee, with the Health and Social Care Committee, with JCHR and this Committee so that we can continue the scrutiny of Government and hopefully, in due course, make some recommendations around what we have learnt.

I thank our witnesses for coming to speak to us this afternoon. We have Dr Christine Ekechi, the co-chair of the Royal College of Obstetricians and Gynaecologists Race Equality Taskforce; Tinuke Awe, co-founder of Five X More, who is with us by Zoom; Professor Marian Knight, professor of maternal and child population health, who is also with us on Zoom; and Amy Gibbs, the chief executive of Birthrights.

Good afternoon, and thank you, all of you, for coming to join us. Can I start off by asking the witnesses to briefly introduce themselves, starting with Dr Ekechi, please?

Dr Ekechi: Thank you. I am a consultant obstetrician and gynaecologist at Queen Charlotte's and Chelsea Hospital, part of Imperial College Healthcare NHS Trust in London. I am also one of the co-chairs of the Race Equality Taskforce for the Royal College of Obstetricians and Gynaecologists.

Chair: Thank you. Amy?

Amy Gibbs: I am the chief executive of a charity called Birthrights. We promote respectful care in pregnancy and childbirth by protecting human rights. We have been invited today because we have been running our own inquiry into racial injustice in maternity care over the past year and I am very pleased to be here to talk about some of our findings.

Chair: Marian?

Professor Knight: I am a public health physician and researcher based in Oxford. I lead the national confidential enquiries into maternal deaths, which produced the unfortunate statistic about maternal mortality

amongst black women being four times higher than for white women. Obviously, through that, we have undertaken quite a bit of work to investigate this further.

Chair: Tinuke?

Tinuke Awe: I am the co-founder of the Five X More campaign. I founded Five X More in 2019 alongside my colleague Clo following a traumatic experience giving birth to my son. In Five X More we take a three-pronged approach to the campaign. We empower women with our advice and our free resources, we train health professionals, and we also lobby those in power to make a change.

Q2 **Chair:** Members of the Committee will ask you questions in turn, but I will start. Tinuke, there has been evidence for many years about the disparities in health outcomes, particularly for black mothers but also for other ethnic minorities, yet there has been very little action. I think we have 20 years' worth of evidence. Have you seen a step change of action over the last few years?

Tinuke Awe: That is a good question. Before I start, I would like to point out that black women are not a homogenous group so I do not speak on behalf of all black women. However, through running both the Five X More campaign and Mums and Tea, together with what Clo does with Prosperitys supporting black mothers, we are obviously speaking to a lot of black women all the time across the country who are experiencing these poor outcomes. My motivations for starting the campaign were due to the very reason that we just felt that not enough was being done. There is a lot of information and a lot of data telling us that black women have had a high risk for a very long time, but not enough is being done.

As I mentioned before, I had a terrible experience giving birth to my son in 2017. I had preeclampsia and that was diagnosed very, very late, which led to me being induced. I will not go into the specific details because I do not think there is enough time for that, but certainly I was left feeling that I was not listened to, that my pain was not taken seriously, and that it was just not important. I did not feel like I was important.

In 2018, the MMBRACE report came out which said that black women have this fivefold higher risk. That is why we wanted to start this campaign because what we were hearing from MMBRACE just validated our experiences and our voices. We started this because we felt that nothing was being done. I have a daughter now, and will she be campaigning about the same thing in 20 years' time if we do not do anything now?

One of the key messages from the campaign is that black women should be involved at every single level when it comes to decision-making about their care. What we found is that there are some serious gaps in the data when it comes to black women. For example, in last year's debate

following our petition on improving black maternal outcomes, Nadine Dorries mentioned that there was a lack of data and responses from black women in their survey at the time. We aimed to fill that gap within the campaign because we were just so tired of hearing statements like, "We can't find black women. We don't know where to reach them. We don't know how to find them". We did, indeed, launch a survey to capture black women's experiences, and I hope I will have the chance to tell you a little bit more about that soon.

Certainly, Five X More exists because we do not feel that enough is being done. This issue has been around for a long time, but we still do not know exactly what the reasons are and why this risk is higher for black women.

Q3 **Chair:** Thank you. Amy, can I pose the same question to you, please?

Amy Gibbs: We have definitely seen growing awareness of this issue, not least the fact that this Committee is looking at it. I would like to pay tribute to Tinuke and Clo at Five X More, to Dr Ekechi and other experts, and to the black and brown women who lead our inquiry for their tireless campaigning on this issue, some of them for decades.

There has been increased recognition of the problem. The statistics around mortality, with black women being four to five times more likely to die, and South Asian women being twice as likely to die, are more well-known now. We have seen initiatives like the Royal College of Obstetricians and Gynaecologists' taskforce, which Dr Ekechi will no doubt talk about, which are really positive, but the action is too slow.

The expert panel that leads our inquiry says to us time and again, "Yes, there's more talk, there's more noise, there's more rhetoric, but there is not enough urgent action." The RCOG's taskforce is a really good example of action in a very wide-ranging way.

If you look at some of the Government responses to date, we at Birthrights feel that they are overlooking the role of racial bias within maternity care. They look at issues like preconception health and at pre-existing conditions, which are, of course, factors in some cases, but our inquiry has heard numerous accounts of how systemic racism and racial bias impacts at an institutional level, at a systemic level and at an individual level in some interactions with caregivers, and that causes deep trauma, worse outcomes and worse experiences for black and brown women.

I hope I can share some of those findings with you today, but we absolutely need to see more urgent action. It is crucial that we shift the conversation away from black and brown bodies being seen as the problem—as "other" or defective—which is often how some narratives emerge.

For example, I know this Committee has talked in public before in the Petitions debate about the NICE proposals, which were to induce people at 39 weeks based on their ethnicity. That is a blanket response, probably well-intentioned to try to drive down some of these inequalities, but there was huge uproar amongst the community—black and brown birth activists, women, and lots of charities like ours—because it was a blanket solution based on black and brown bodies being the problem and did not recognise the role of racial bias and systemic racism. I would be really keen to talk more about that with you today.

Q4 **Chair:** Thank you for that. Dr Knight, the confidential enquiries have been running since the 1950s and yet—as I think Tinuke mentioned—Nadine Dorries said there was not enough data. When did the enquiries start to focus on ethnic disparities?

Professor Knight: The figures are comparing mortality rates of women from different ethnic groups and have been published since the early 2000s. I took over and produced my first report in 2014, and it was evident that there was a disparity and that that disparity was widening. That information was published within a table within the report every year, but it was only when I put it very clearly in an infographic in 2018—as Tinuke has pointed out—that it could no longer be ignored. It took Tinuke and, indeed, everyone else giving evidence today becoming advocates, developing groups and pushing for action to ensure that the issue got on the agenda such that it cannot be ignored any more. It is absolutely the case that this issue has been ignored for a very long time.

I do see the green shoots beginning, but very much only beginning. There are some announcements, for example, that focus on preconception care and improving preconception care, which can make a difference if that genuinely comes about. There are a lot of good intentions to say we would like to improve preconception care, but we are not seeing concrete improvements in making sure that women are getting the care they need.

I absolutely agree with what Amy said: we must get away from thinking that there is something different about black and brown bodies. What I am seeing from the women whose care I investigate is that there are many and complex problems, including the fact that women have to go for multiple appointments in multiple places; that they have not had conversations before pregnancy to enable them to get the correct medication; and that their voices are not listened to. All of those things need actions much wider than maternity care. I see green shoots, but we are not there yet.

Q5 **Chair:** I think you will get plenty of questions about the green shoots later on. Have you seen differences in outcomes achieved yet? Has the change in emphasis—the fact that we are all talking about this, the fact that an infographic appeared four years ago that made it really obvious, and people could interpret those statistics easily—resulted in any changes that are bringing about improvements in the data you are seeing?

Professor Knight: The best news I can give you is that there has not been a worsening of the disparity. The maternal mortality rate for black women is not increasing. I cannot say statistically that it has decreased, but it has not increased. One challenge I have is the delay in data. The latest figures that I have published are from 2019, because it takes that long for me to get the full data through to enable me to produce the rates.

Q6 **Chair:** Is that a Covid delay or is that standard?

Professor Knight: That is not a Covid delay; it is a standard delay. 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. We then have to give our report to NHS England and it takes about five months for NHS England to approve the report for publication. All of this adds to the delays in me getting numbers to you publicly.

Chair: Of course it does.

Professor Knight: I can say, though, that it will not get better for 2020 because we have the Covid deaths in 2020.

Q7 **Chair:** What could be done to speed up that collection of data and how much of a difference could that make? Would we just be collecting the same information faster, and could that, in itself, help?

Professor Knight: If we got records from hospitals when we asked for them, if we got data from the Office for National Statistics about four months earlier and if we did not have a five-month delay with NHS England, I could give you the figures for 2018 to 2020 now. It would save at least six or eight months if all of those delays were shortened or if they were removed.

Chair: A six-month reduction in the delay of data could very clearly tell you whether a pilot was working or not, could it not?

Professor Knight: It could, yes.

Chair: You could choose to ramp up something that was proven to be effective, or stop doing something that was proven to be ineffective. You would not waste another half year.

Professor Knight: Absolutely, because that is the most important thing for me. I am a researcher, but the most important thing for me is that we need to evaluate what we are doing. I do not disagree with anybody that we need action, but we need to evaluate those actions because we have, all too sadly, today seen what happens when you do not evaluate what seems like a good idea at the time.

Chair: Thank you. I will hand over to an Anum Qaisar who is going to ask the next set of questions.

Q8 **Anum Qaisar:** Dr Knight, in December 2020 you told the Health and Social Care Committee that whilst there was not necessarily a difference in the causes of maternal death for black, Asian and other ethnic minority women, there was a difference in the care that they received. Can you please tell us how and why they received different care?

Professor Knight: It expands on the answer I gave before. We did a specific inquiry where we looked at the care received by black women who died, Asian women who died and white women who died. What we saw was that, particularly for black women who died, they needed more complex individualised care and culturally sensitive care. The number of women who were not receiving that care was overrepresented amongst black women, so it speaks to the recognising of individual needs.

You have probably heard me say before that for too long in maternity services we have tried for a one-size-fits-all model or we have designed the model for what suits us as health professionals rather than thinking about women's needs. When you have to get a bus to different hospitals, you are working full time, you have to pick up your children at 3.15 pm—all of these factors make it incredibly difficult for you to get the care that you need as an individual. On top of that—and there are others on this panel who are much more competent than me to speak to this—thinking about specific cultural needs and, as Tinuke pointed out, black women are not a single group. There are many different cultural nuances that we need to understand when we are talking to individuals and working out how we can deliver the maternity care that any individual black woman needs.

Q9 **Anum Qaisar:** Tinuke, is there anything you would like to add to that?

Tinuke Awe: Yes, I would definitely like to add to that. In terms of what potentially are some of the reasons for this disparity, and from listening to Dr Marian Knight, what we definitely know is that black women are not dying from anything more than what white women are dying from. They are just dying at a higher rate. We also know that for every one woman that passes away there are about 100 more behind her who are suffering from morbidity and from poorer outcomes and that kind of thing. We know that the poorer outcomes for black women do not stop at just death. Indeed, you need to look at the rest of maternity and even the whole lifecycle. We see there are disparities there too.

For instance, black women are three times more likely than white women to have a miscarriage or a stillbirth, or to have reproductive conditions such as fibroids. Also, black women are less likely to be diagnosed with things like endometriosis. There are some deep-rooted, deep-seated issues there that are yet to be addressed in terms of the disparities we see. I want to give you an example. I am a mum; I have two kids. I am speaking as a very concerned mum. In December 2021 there was an outbreak of hand, foot and mouth at my son’s nursery and we were told, “Go on the NHS website and try to see what it looks like”. You only have to go on there to see the euro centric nature of the medical professional

at work. There were no images of black children with hand, foot and mouth on the NHS website.

The NHS is supposed to be inclusive and have images for everybody; it is supposed to be for everybody. This is just an example to show that there are so many intersecting barriers of discrimination that black people face every day. I do not know what else I can add to that, but you can see the pattern there. There is discrimination in all of the outcomes all round, not just in maternity.

Q10 **Anum Qaisar:** Dr Knight, following on from what Tinuke has suggested there, you have suggested that there might be a bias in care or microaggressions that may play a part in the care that black and Asian women receive. Can you tell us a little bit more about that and what evidence you have to suggest that?

Professor Knight: Again, that came from the specific confidential enquiry that I mentioned earlier where our assessors, who were midwives and doctors from a range of different professional groups, looked at the medical records of women who had died. They identified myths that we all know are wrong, for example that black women have lower pain thresholds. Other microaggressions that they recognised were where women, in the same set of medical records, were described as being from a variety of different backgrounds, so, from Ghana, Jamaica and Afro-Caribbean which is clearly wrong.

Our assessors felt this was a microaggression and was clearly a reflection that the staff who were caring for them did not recognise the importance of individual background and individual culture, and how that, therefore, might impact on their care. We absolutely have to recognise what we cannot tell from a set of medical records. We saw no evidence of overt racism in medical records, but we would not have expected to see that. We have to recognise what I cannot tell you from the data I have. That is where Tinuke, Amy and Christine have many more examples of women's experiences that can speak to those aspects of care.

Q11 **Anum Qaisar:** Tinuke, I see that your hand is up. I have a few more questions, so I will come back to you in just a moment. Christine, to what extent should there be a focus on looking at pre-existing health conditions that are a cause of poor outcomes in these groups of pregnant women? Are there any limitations to that approach?

Dr Ekechi: The first thing to say is that I will use the word "women" predominantly, but there are many people using maternity services who may not identify with that term. The reason I raised this point is that when we are looking at inequalities, often when we are thinking about black and Asian women, we often forget that there are also black and Asian people who may not recognise the term "women" but also fall into this group as well as other groups.

It is important, first of all, to note that the majority of women who die in the UK from maternity complications—65%—die with pre-existing medical conditions. Tinuke made a very good point, which is that this figure includes all women, but black women and Asian women tend to be overrepresented in that group of deaths. We need to understand why black and Asian women or people who present within the maternity space with pre-existing medical conditions have a greater rate of death or morbidity.

Professor Marian Knight, Tinuke and Amy have spoken a little bit about this, but as an obstetrician and gynaecologist it would be wrong for me not to also point this out. What we do understand is that women are presenting with more complex medical conditions in maternity care and this creates a lot of challenges for those providing that care. There has also been a great change in the way maternity care is being delivered. There are a number of barriers to their access to that care and, in particular, accessing high quality care for those that have not only pre-existing medical conditions but pre-existing mental health conditions. The barriers are higher for black and Asian women, with the cultural understanding, sensitivity and competency that we afford to one group of women over another. This constellation of factors and biases that Professor Knight has spoken about in her latest report really contributes to the outcomes we are discussing today.

The National Maternity and Perinatal Audit looked at over 1 million births, and they published their audit report in The Lancet earlier this year. They found that some conditions were overrepresented in black and Asian women, for example, with diabetes and hypertension. Often that nuance is missed when we have this discussion, and often the discussion can then result in individual blaming rather than having a discussion as to why black and Asian women are overrepresented in this particular group. Why do black and Asian women have a greater instance of hypertension and diabetes? It is not because of any genetic reason. What is often left out of the conversation is understanding the social drivers to inequalities in health, and we have very strong data that shows the overlap between the socioeconomic class that a woman presents from and the greater risk of health conditions.

I cannot say all of this without mentioning the impact of racism—implicit and explicit bias—which we know plays a significant role as to how a woman has access to care and is treated. It is a combination of all of these factors that results in death, mortality and morbidity statistics.

Q12 **Anum Qaisar:** Thank you so much for that incredibly full answer. Following on from that, Amy, does racism or racial bias play a part in maternal health disparities?

Amy Gibbs: Building on the points that everyone else has made, Birthrights would say, yes, absolutely. Over the past year we have heard from over 300 women and birthing people, healthcare professionals and lawyers who have given in-depth testimony to our inquiry. The report is

due out in May, but I can share some of our themes in the findings with you today which I hope will help the Committee's work.

Some of these have been raised before, but a major theme is about the lack of safety. As Tinuke said, for every woman who dies, there are hundreds more who will have a poor experience, potentially a near miss, potentially at risk of life. We heard about black and brown women feeling deeply unsafe during their maternity care and examples of serious trauma, harm and death, particularly from the lawyers that we spoke to. A really strong theme that we heard was around being ignored and disbelieved, so repeatedly raising concerns about your own health, your unborn baby or the baby after birth and just being completely ignored and having those concerns dismissed. A theme that has come out very strongly in the Ockenden report today in relation to many women is denial of pain relief— not taking pain seriously during pregnancy, in labour and postnatally are also part of that theme of being ignored and disbelieved that we have heard about.

To build on the points that Professor Knight made, we also heard about the direct impact of race on people's care. Racial stereotyping, microaggressions, the failure to recognise often very serious medical conditions such as jaundice in black babies or sepsis in black and brown women also came up as strong and deeply worrying examples. Many women described a lack of choice and consent, not knowing they had any options within their care or, if they did know, those choices being denied. Something that links to the points that have been made about overrepresentation of black and brown women in some of the conditions that have been talked about are assumptions being made that someone is high risk based on their ethnicity, and not based on any medical indications. For example, being sent for weekly blood tests even if you have normal blood pressure and being told, "No, you can't choose those care options because you might be high risk," based on assumptions about their ethnicity, not based on the medical information about that individual.

Finally, we have also heard about structural barriers that are embedded within national policy and this is where the Committee can absolutely play a role. For example, NHS charging, which has a real impact on safety for particularly migrant and refugee women, and a lack of interpreting services, which has a direct impact on the ability to give consent to care or to understand what is happening during childbirth.

The last point is about workforce, and we should not forget that there are many black and brown staff within maternity services. They also experience racial bias and discrimination in their work, and that can have an impact on the care that is provided to women and birthing people, but also on them as professionals, and on leadership and inclusivity within the workforce. As Dr Ekechi said, there are multiple factors, but we are absolutely seeing in the evidence we have gathered that racial bias plays a key role.

Q13 **Anum Qaisar:** Thank you so much for that. Dr Ekechi, is there anything you would like to add to that?

Dr Ekechi: No, thank you.

Q14 **Anum Qaisar:** Tinuke, just to follow on from that same question, does racism or racial bias play a part in maternal health disparities?

Tinuke Awe: I had my hand up before because I wanted to just quickly touch on Marian's point about datasets. The Ockenden report was released today. I have not had a chance to go through the full thing, but what I found was that they suggested that all trusts should aim to improve the accuracy of all of their datasets. Within the report, 10% of the maternity population were identified as BAME. One of our recommendations that we mentioned in the Health and Social Care Committee evidence session back in 2020 is that we really do need to minimise this use of the word BAME, especially when it comes to maternity services, because, as you know, it is basically a catch-all for anybody who is not black. The danger of labelling people as BAME is that we do not have accurate or specific data on black and Asian women, and it disregards the fact that black women have the highest risk and have done for a very long time.

We believe that when it comes to maternity services, you should say black if you mean black. The investigation also reported over 9,000 cases of missing ethnic background details within the data that was provided by the trusts. They also reported that the trend of incomplete data on ethnic background has increased over the years, which I am sure you can see will pose quite a big problem when it comes to quality and safety monitoring. If the data is incomplete or missing, you cannot get a full picture of what is happening to black and ethnic minority women within your services, and you cannot move forward towards change because you do not really know what is going on there.

Q15 **Anum Qaisar:** Thank you so much. Professor Knight, we have heard about the racism and racial bias that women experience in maternity care. Are there any other potential causes for these disparities that we should be considering?

Professor Knight: You heard from Christine that there is a constellation of biases that is impacting women and disproportionately impacting black women across the whole of the healthcare system. One of the challenges is that people want one solution, but there is no one solution. We have to look at every level, at every aspect of our care, to see how it is disproportionately disadvantaging black and brown women.

You heard some very clear examples from Tinuke in relation to her son, but we have to think at that level across everything. We need to think preconception, pre-pregnancy. For example, Asian women are more likely to have diabetes, therefore, we have to ensure that we have pre-pregnancy services specifically for Asian women with diabetes that enable them to have those conversations about how best to keep themselves as

healthy as possible for pregnancy. We need to think even earlier than pregnancy. We need to potentially think about education in schools to ensure that contraceptive advice and family planning advice is accessible to women from all different ethnic backgrounds. It is going to be very different depending on what your cultural background is.

We also need to think much more widely than just maternity care. For me, very much part of the problem is that pregnant women are seen as scary, and a black pregnant woman—if you are not used to recognising illness and caring for women with black and brown skin—is even more scary. We need to make sure that pregnancy medicine and the recognition of the disparities and outcomes is part of medical education and is understood throughout all parts of the health system with which pregnant women might come into contact.

We definitely need to make sure that pre-pregnancy care is seen as everybody's role. We need to recognise the pivotal role of the GP both before and after pregnancy as they are one person who can provide continuity throughout that period of time. In terms of thinking about contracts with GPs we have to make sure that those aspects of care are recognised. The simple answer to your first question is there are lots of other things that we can and should be doing because there is not going to be one answer.

Q16 **Chair:** Can I ask a really complicated question? I am not sure whether I am aiming this at Marian or at Christine, but we have heard from Tinuke that she felt ignored when she was—I am not sure whether that was while she was pregnant or when she was in labour—but she did not feel that she was "important"; I think that was the actual word that she used. We have heard from Christine that women with more complicated conditions are presenting to maternity services, and you specifically said mental health conditions. This might be a really unfair question—I am sorry—but does anybody who collects data have any evidence on women with mental health conditions in pregnancy and labour and what their outcomes are, or women with learning difficulties? Christine, you look like you want to answer.

Dr Ekechi: The first thing to say is that we should look at two main groups. We have the group that has pre-existing medical and/or mental health conditions, and we know that their risk of mortality and morbidity is higher. We also know that due to barriers to accessing quality medical obstetric care and perinatal mental health services, that is not equal across the country. However, we have the other group of women who are not categorised as being high risk in pregnancy but are not seen as being equally valuable.

What we should not do is to amalgamate those two groups, so as to not erroneously believe that it is only those that present with pre-existing health conditions and/or mental health conditions that have the poorer outcomes. They are the majority, but often it could be the low-risk women who come from black or Asian backgrounds who are not

necessarily treated with the same care—either within that pregnancy, or they or a family member have had prior poor experiences with the medical profession. For me, it can be reflective of attitudes within society and where we place value; it may be about not necessarily just stopping using the racial lens but, for example, how we treat people who have more money or who are more eloquent, I suppose, with the language that they use; they are better able to advocate for themselves within the medical space. As a medical professional who delivers that care and sees that, and maybe erroneously has been part of that, a lot of work for us as healthcare professionals is to work within our own biases as to how we treat people who present to us to ensure that we are listening to people equally whether or not they have a pre-existing medical or mental health condition. I hope that answers the question.

Q17 **Chair:** That absolutely does answer it. Is part of the problem that it is women that get pregnant?

Dr Ekechi: Of course. Again, being an obstetrician and gynaecologist, being a woman and being a black woman, I intersect all of these areas. I have also been a patient. We have to admit, sadly, that medicine started off with a patriarchal and paternalistic approach. We are learning and we are getting better at listening, but there are a lot of factors and barriers that need to be unpicked and reversed. Often what we see is that the funding around maternity services has often lagged behind many other services within the trusts. Again, Ockenden will speak to this, but this is where organisations such as the Royal College of Obstetricians and Gynaecologists work very hard to champion the health of women.

I really want to touch upon the life course approach, which Professor Marian Knight has talked about. Often, when we are talking about some maternity inequalities, we have to understand that at the point at which a woman presents to the maternity health setting a lot of these inequalities are baked in, and if we really want to reduce these inequalities, we have to start much earlier. We have to start with gynaecological health and wellbeing. We need to start educating young girls and boys at school so that by the time a woman comes along and she is pregnant, a lot of these pre-existing health conditions are not there or they have been mitigated by very good care.

Q18 **Chair:** Thank you for that. Marian, did you want to add anything to that?

Professor Knight: The other point that I was going to add, and it links to pregnant women being women, is around the normalising of symptoms. There is this tendency to assume that all symptoms are due to pregnancy. I suspect if I was a middle-aged man clutching my chest going, "I've got chest pain and it's going down my arm," you would make a diagnosis. If I were a pregnant woman with those symptoms, the diagnosis may well not be made because it is assumed to be because of pregnancy. You are absolutely right; if you are also black or Asian, your voice is ignored even more and there is that tendency to be dismissed. It is not an easy message. Why is it not an easy message to say, "Listen to

women"? We have to recognise the elephant in the room, and I know that others on the panel will say that time is what we need—time to be able to listen properly and get women's stories and get a full understanding of their symptoms. If we do not have enough people, we do not have enough people with enough time to do that listening.

Chair: Thank you. Carolyn Harris.

Q19 **Carolyn Harris:** I am just getting over the struggle with being believed. Being a woman is very difficult, is it not, when it comes to health? No sooner are we giving people problems by having babies than we bother them about menopause. How very dare we? Marian, to what extent do the Government and the NHS address the concerns and the recommendations of MMBRACE?

Professor Knight: As I said, I have seen some green shoots. We have been talking about pre-pregnancy care for quite a long time—not just specifically in relation to black women, to be fair—and that was a focus that was brought out at the first meeting of the Maternity Disparities Taskforce. It is obviously a tricky problem to sort out—it is one of those things that everybody sees as somebody else's job—which is why I was a little bit sceptical as to whether that had actually happened yet. There are some changes in structures which could help: maternal medicine networks are one of those things. We have been saying for a long time that we need experts in pregnancy medicine throughout the country so it is no longer a postcode lottery—they are just developing and could help, but I am not sure yet.

The other example is integrated care systems, because another point that I have been making repeatedly is about where women fall through the gaps. If you have high blood pressure and you leave hospital, if nobody hands that responsibility for helping you manage your blood pressure to your GP, or indeed keeping an eye on your mental health to your health visitor, that could mean that you fall through the gaps. I am still on the fence about all these things; they could be great, but I am not sure yet. It is very heartening that maternity and maternity disparities are at the forefront of every written strategy document. Everybody has been required to produce a plan to address them and that is at least better than nothing, but I cannot say whether it is working yet.

Q20 **Carolyn Harris:** Do you have any actual examples of holistic or coherent strategies, if you like, for tackling the maternal health disparity?

Professor Knight: NHS England have got their Core20PLUS5, which is their strategy focusing on the 20% in the most deprived areas, plus ethnic minority women. The main focus of that is continuity of carer. Tinuke talks to this very eloquently, but continuity of carer is very dependent on that carer being the right person and the right person for you. Too often we just assume that as long as it is the same person, any person will do, but we have to recognise that if you have other health problems it is not reasonable to expect a newly qualified midwife with no

expertise in diabetes etc, to be able to care for you—it needs to be the right midwife, who has been trained in the areas of care that you need.

Q21 **Carolyn Harris:** Thank you, Marian. Christine, what is the focus of the Royal College of Obstetricians and Gynaecologists in tackling the issue?

Dr Ekechi: The Race Equality Taskforce was created in 2020. It was not necessarily a direct response to the MBRRACE report, as this was something that we had been talking about for a number of years, but essentially the Race Equality Taskforce was set up to address not just maternity inequalities but existing inequalities throughout women's health. Tinuke mentioned earlier that if we use the racial lens, we will see inequalities throughout gynaecology, maternity, post-menopausal health and cancer. We also understood that we could not just be an outward speaking group—we had to look internally. We are the foremost organisation supporting obstetricians and gynaecologists both inside and outside of the UK, for which we provide a number of guidelines around the treatment and care of pregnant women, and indeed for gynaecology care. It was important to make sure that our guidance really did reflect our approach, that it addressed the inequalities and was fit for purpose. We are reviewing all of our guidance to create a framework to ensure that we really do consider the advice that we give, that it targets the groups that are most at risk and that it provides care for everybody we serve.

As I said, we are the organisation for obstetricians and gynaecologists, and unfortunately one of the things that we understood is that racism affects not just the outcomes for women, but also indeed the outcomes for our doctors and our trainees. There is something called differential attainment—the fact that the outcomes for black, Asian and other ethnic minority doctors is not the same. They are less likely to have training positions and less likely to be consultants.

An interesting point to mention is some data that came out of America where they looked at 1.8 million births and found that the outcomes for black babies were improved when they were cared for by black doctors. Now, that is not to say that everybody should have a doctor that is matched to their ethnicity, but it is a significant reflection about the importance of a diverse workforce, not just at the lower levels but also at the senior levels; at the level of decision making, only 3% of consultants are black. We have been working tirelessly towards closing that gap, but also improving the education for our clinicians and colleagues in terms of how we deliver culturally competent care. Marian mentioned that we are a workforce that is working very hard to deliver the best care that we can, but we must also address the elephant in the room around our midwifery workforce and the gaps that we have. We are an overstretched workforce, and when we are overstretched it is very difficult to deliver the quality care that we strive to do.

The third arm of the Race Equality Taskforce is to address the women's health inequalities. The Race Equality Taskforce works as an umbrella

group. We meet quarterly with all the important stakeholders, such as Birthrights and the Royal College of Midwives. We have representatives from the devolved nations as well, working together to make sure that there is no duplicity in the work, that we understand where the gaps are and that we can use it as a space to address a way forward, not just in maternity, but throughout women's health.

Q22 **Carolyn Harris:** Thank you, Christine. You mentioned midwives, but what kind of work is going on with other medical professionals? I would argue that people like community pharmacists, sexual health nurses and prescribing nurses may be more in the community and more in touch with the individuals; is there much work going on around that?

Dr Ekechi: Yes, absolutely. The Race Equality Taskforce acknowledges this and has representatives from all of these organisations, because we understand about the life arc approach, which means we need our colleagues in sexual health, pharmacists, nurses, GPs and public health. For example, I sit within the maternity stakeholder group for the NHS Race and Health Observatory, and I have also attended many roundtables such as this. We work towards trying to shape policy in this area, and to have joined up thinking. When I talk about the social drivers and the structural drivers for inequalities, we also have to think about education, housing and transport in addressing the issues. By having representatives in all of these areas within the Race Equality Taskforce and members within the Race Equality Taskforce sitting on these committees, we can make sure that we are part of this conversation which will shape these policies going forward, so that hopefully the next time we have this discussion we will bring positive news.

Q23 **Carolyn Harris:** Thank you so much, Christine. Amy, given what Christine and I have just discussed around the focus upon community care and continuity of care and tailored care and interventions, are the right areas being focused on?

Amy Gibbs: First of all, I absolutely welcome the focus on personalised care; it is really important that that is underpinned by human rights law. It is a really important principle of Better Births, which is the NHS Maternity Transformation Programme, and a really important principle to hold on to: listening to women and birthing people, putting them at the centre of their care, putting them genuinely in control of decisions about what happens to them and their babies, and helping them make informed decisions and weigh up the risks of different options and so on. All those things are too often not happening, as the Ockenden review has shown today, but also, as I described earlier, our inquiry is showing it particularly seems to happen to black and brown women. That is a really positive and longstanding focus for the NHS, and I think we at Birthrights were really pleased that the RCOG and the RCM both came and spoke to us in our inquiry sessions.

The RCOG was quite ahead of the curve on this compared to other parts of the system, and both royal colleges are taking action, and explicitly

acknowledge that racial bias is part of this—they are not trying to pretend that that is not part of the picture. The RCM have invested in anti-racism training throughout the college, and are repeating that training, which is a really important initiative that needs to happen much more widely across the system.

Just to build on what others have said, it is really positive to hear Marian's feedback from the Maternal Disparities Taskforce that has recently been set up and it is a positive step forward that that is a Government-led initiative. Our concern is that most of the current policies from Government and NHS England are not explicitly recognising racial bias and discrimination—a glaring gap. All of these other factors are important, but if you overlook systemic racism and racial bias, you will not find the right solutions. One of our expert panel said, "Vitamins don't cure racism". You cannot just provide additional supplements or look at healthy weights and hope that that alone will solve the maternal disparities—all of these things need to be looked at. A midwife told our inquiry, "One of the things that is really embedded in the system is the blame that is put on black bodies, that this is somehow our fault because our bodies do not work in the correct way". That is from a midwife, and I think it is really crucial, and this committee can play a really important role in making sure that well-intended Government and NHS action does not perpetuate that bias. That is what we are calling for.

Q24 **Carolyn Harris:** Thank you. Tinuke, the same question.

Tinuke Awe: Sorry, can you repeat the question please?

Carolyn Harris: We have heard a lot about what we think the problems are; are they the right focus, or what are the gaps in the current focus?

Tinuke Awe: If you look at one of the immediate and essential actions from the Ockenden report that was released today, it actually says that there needs to be a "Suspension of the midwifery continuity of care model until—and unless—safe staffing is shown to be present". Now in my case, as I mentioned before, I had late diagnosis preeclampsia and I saw a different midwife for every appointment. That meant that my preeclampsia was not picked up, along with not having the correct documentation in place. Honestly, I feel that if continuity of care was there it would have helped in spotting the signs and may have led to a better birthing outcome. We have spoken to many women who have actually not experienced continuity of care and have ended up having really good experiences because, as Marian said before, it is about having the right set of midwives. There is no point in having continuity of care if the midwives themselves are not aware of what the issues are for women, and especially for black women in general.

If the Ockenden report is saying that if we cannot implement continuity of care, then it has to be scratched and we need to move towards making sure that we have the right midwives doing the right things and moving towards respectful maternity care because actually the problem we see is

this is not necessarily the only thing that is going to change what we see here. I do not know how I feel about continuity of care, if I am honest; it is probably best for those who have really high or complex needs, but it does not and cannot work for everybody because we just do not have enough staff to be able to do that. A lot of emphasis has been placed on continuity of care as the answer over the past couple of years, and that is why I am answering in this way.

Q25 **Carolyn Harris:** Do health professionals have enough training in all the issues that are currently causing the problems?

Tinuke Awe: Just to jump in there, we have our training with Five X More; we train health professionals and we are currently training medical professionals in the South East London trust and some trusts in Birmingham. The pilot that we had with Guy's and St Thomas' Hospital last year received feedback from one of the women who had seen a health professional who was wearing the Five X More badge because they had undertaken the I Am Here To Listen training. This lady reported that she had gone into the hospital feeling a little bit on edge as a black woman due to those statistics, but she noticed that badge and felt at ease, because she knew that that health professional had done the Five X More training and was aware of what black women face within maternity services. She reported feeling listened to, and that the midwife was taking her concerns into consideration, and she came back and gave us a positive testimony. We are doing what we can, but on a wider scale there is definitely not enough being done.

Q26 **Carolyn Harris:** But does that mean that for those people the training course is a personal investment of their own time and money to actually upskill themselves to that level?

Tinuke Awe: That is correct.

Dr Ekechi: As an obstetrician and gynaecologist, the first thing to say is that the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives are committed to training, and we wish to plug gaps where we see them. For example, the Race Equality Taskforce was able to secure external funding to create an e-learning module. I place a huge caveat around that, because you have to find time to do an e-learning module, and there is only so much that one can obtain by doing a course online. When a trainee midwife or trainee doctor has training, the first thing that the training is focused on is delivery of safe care. Traditionally, the communication skills training came afterwards, whereas it should really be at the centre, baked in to the training, and medical school education and training is changing to reflect that.

The truth of the matter is that many people undergo training, and they can tick the box and they can have a certificate, but then they have to enact that in real life. This is where staffing issues becomes front and centre, because if you are a midwife that is working in a department that is three or four midwives down and you are having to look after three or

four high-risk women, we know that for any individual, the first thing that goes is empathy. As the Royal College we really welcome the £127 million that was announced by the Government last week for funding, and we hope that the extra £250 to £300 million per year will come about. The training that Tinuke and Five X More are providing is excellent, but if we do not have the staff, there really is no real way that we can see that in practice, and ultimately it is the women, their partners and their family that suffer.

Carolyn Harris: Thank you so much, Christine. Thank you, Chair.

Q27 **Chair:** I do not think anyone has mentioned the Government's resistance to setting targets so far. Ahead of the debate we had in Westminster Hall, I believe it was Five X More who were very keen to emphasise to all of us the importance of targets. I will ask each of you in turn how targets would help, and I will ask Marian first.

Professor Knight: We have some really clear illustrations of where targets have made a huge difference. Internationally, we had a millennium development goal to halve the rate of maternal mortality; I believe it was between 2000 and 2015. Now, maternal mortality was not halved, but it went a long way towards that, and there were actions globally in most countries, so we know that targets can make a really important difference. On the other hand, we know that targets have unintended consequences, and the caesarean section target that we have heard about from the Ockenden report is obviously one of those.

For me, a target means that there will be a continued focus, and that is its main benefit. If there is another way of making sure of that continued focus, I do not think we necessarily need a specific target, and the challenge that we will always have with maternal mortality is that numbers of women are small, and it would be difficult to show as statistically significant that we are meeting the target.

Actually, there are many wider things that I would want to know as well, rather than just a narrow focus on a single number. Hearing about women's experiences, thinking about maternal morbidity, we know that severe illness is about 60% higher amongst black women compared with white women, so my simple answer with targets is that I do not know. I know that they can make a difference, but that difference is, "This is something we have to focus on". If it is recognised that this is something that we have to focus on, I am not sure that adding a specific number to a narrow aspect is necessarily the right thing, particularly with something like this, where we recognise that there are so many different aspects that we need to address. What would be good is actually seeing, "Okay, we want to ensure that everyone is able to access a pre-pregnancy care appointment by whenever", rather than "I want to see a 50% reduction in maternal mortality by 2035 or whatever", if that makes sense.

Q28 **Chair:** Yes, perfect sense. Amy?

Amy Gibbs: We would support a target in the sense that, as Marian has described, it often does focus political attention, national attention and drive around an issue. We need to see much more explicit commitment to ending maternal disparities, not just in terms of higher rates of death, but also of illness and worse experiences. That would need to be a basket of measures, not just one number, which might be less meaningful to track. We absolutely need to see much more drive, and a target may be helpful to achieve that focus, but what we would not want to see is an unintended consequence of that that led to blanket policy decisions that actually may cause more harm and less rights respecting care. For example, if a target to bring down the higher death rates for black women and black babies led to far disproportionate levels of induction for black women that they did not want, that would be deeply problematic and a potential breach of the human right to decide how you give birth. If coercion to be induced was part of what happened as an unintended consequence, that would be really problematic.

We do want national commitment and national action, which might be through a target or a basket of targets, but that has to be underpinned by nuanced solutions which above all are rooted in listening to women, in putting them at the centre of their care, and ensuring personalised care with a full range of healthcare input that people have described as part of that solution.

We also need to look at our system of education for the workforce. We have had a number of examples today of how the white body is often centred as the norm within the way we educate and train our healthcare workforce, and the way that images are used on the NHS England's website, as Tinuke said earlier. We have to decolonise the way the NHS gives information to women and birthing people and trains its workforce. One target is not the one easy solution, but driving that national commitment supported by nuanced solutions is the right way forward.

Dr Ekechi: I very much agree with what has been said so far. Personally, I would support a target, not least because it attracts the funding that is needed to implement these issues. I have to approach it in that way because we could have great ideas, but if we do not have the funding to enact these ideas or plans, we are still on the same square, and that is what a target allows us to access.

Again, thinking about where we apply these targets, one thing that has not been mentioned today is medical research and the importance of making sure that black, Asian and other ethnic minority women are involved within medical research, in design, trials and implementation. I sat on a group interviewing expert witnesses to try to understand the barriers for safe medicine use in pregnancy—which we hope to report on later this spring—but one of the things that we have often found is that there have been erroneous narratives around women, pregnant women and indeed black and Asian women, wanting to participate in research.

We have often found that they are disadvantaged when the outcomes from the research are found and implemented. A target is needed around making sure that the participants for any research trials are reflective of the population that the researchers are trying to serve and improve; it is not just the people who are involved in research trials, but also the people who are conducting research trials. Essentially, we often find that the subjects with whom we are trying to research often still remain in a situation where conditions that predominantly affect them are disadvantaged by having safe medicines to use, whether in pregnancy or outside pregnancy, and many of the conditions that attract the funding for research trials affect women who are not black and Asian; so we also just have to think a little bit wider around targets.

Tinuke Awe: We 100% support bringing in a target. In America they have a very similar problem with regard to poor outcomes for black women in maternity; however, the Biden Administration has outlined several action plans specifically looking at addressing these maternal issues with a lot of funding behind that. As Christine mentioned, if you have targets, you will have some money behind those targets to put some things in place. Without a target, it honestly just feels like it is not a priority, even though the statistics have remained high for black women and have been this way for a number of years.

We also know that there is not enough data when it comes to these near misses, the morbidity and the poorer outcomes for black women in general. As Christine mentioned before, a lot of these datasets do not contain evidence from black women, and unless you can start uncovering their experiences you will not be able to move towards the target.

At Five X More we actually gathered an all-black expert panel, and we launched our black maternity experience survey last year. Within 24 hours, we had gained over 500 responses from black women, and by the end of that survey we had over 1,300 respondents: black women across the country telling us in detail of their experiences of giving birth whilst in this country. This study was self-funded and it was an analysis of antenatal and postnatal lived experiences of black women who are currently residing in the UK and had given birth within the last five years. This type of data has certainly never been collected before within the NHS.

As I mentioned before, Minister Nadine Dories said that there is no data on black women when it comes to women's experiences. We are currently working on finalising this report, but I did want to give a couple of early findings. More than half of the women that responded reported facing challenges with healthcare professionals during their maternity care. Over 42.9% of these women reported feeling discriminated against during their maternity care, with one of the most common reasons being because of their race. 47.9% of women shared that despite not being satisfied with their care, they did not make a complaint; this means that actually the NHS does not have the whole story of what is going on for women. At

Five X More it is really important for us to make sure that these voices and experiences of women are heard—good and bad—so that we can learn from both. If we do not have these targets in place, with some funding behind looking at some of these experiences and trying to delve further in so we can actually put the right things in place, I am afraid we are just going to keep going round in circles and getting the same results.

Q29 **Chair:** Thank you. Marian, I will come to you in a minute. I just wanted to ask a quick follow-up, and I think Christine is the right person to ask, but it may come back to you, Marian. Have you seen any evidence of the guidance that was introduced last year about equality and equity in practice, and how is its effectiveness being monitored?

Dr Ekechi: This is in relation to NHSEI equality and equity strategy documents, for which they asked the local maternity systems to create their own equality and equity strategy. Local maternity systems will be maternity units within a particular region that work together to provide care to women in that area. I can only speak for the region I am in, and I know that a lot of thought and effort was put into trying to create their own equity strategy for that region. There was some money allocated for LMSs to provide this strategy document: £6.5 or £6.8 million. Whilst it is good because it makes stakeholders within the region focus their minds in a way that they have not had to, or had the time or the inclination to before, my concern is about who has the oversight for ensuring the implementation and the adherence to the documents that they have created. Will that be NHSE or Government, for example? Again, will they be able to provide the staffing to then carry out the strategy that has been put in place? Often before there have been grand ideals for these strategies that have been put out, but they have been undermined by the increasing problem we are currently experiencing with staffing.

Q30 **Chair:** Marian, did you want to add anything?

Professor Knight: I just wanted to add to what Tinuke said. Quite often people criticise surveys to say, "Well, you've only got one part of the picture", and I just want to add that from the national maternity surveys there are very clear differences in comparing experiences of black and white women—you can quite clearly see in that comparison that the experiences of care are poorer for black and other ethnic minority women compared with white women.

To add to the question asked of Christine: it is always a worry for me when local maternity systems are asked to do something without really having a good understanding of what works and what does not work, and indeed resources to actually evaluate what is and what is not working. Those are my biggest concerns about the instructions to develop your own strategy because, again, what we really want is to know, "Well, this brilliant thing has worked here, so let's do it there", but that is not built into the strategy as it currently stands.

Q31 **Anum Qaisar:** Tinuke, how confident are you that the Maternal

Disparities Taskforce and the associated work is going to actually achieve positive change?

Tinuke Awe: The taskforce is welcomed, but I must point out that in the press release of the taskforce there was a huge oversight in the section detailing what some of the disparities were for people from ethnic minority backgrounds. It clearly stated that the mortality rate for Asian women was two times higher, and considerably more for black women. Now I am sure you can see why that statement would be an issue: it was almost like it was dismissive of the fact that black women have got this higher risk, and it begs the question of "Well, is this important enough?" This is a taskforce that is supposed to be addressing these very disparities, and this issue does not even get a mention. The press release tells the world what the reasoning of the taskforce is, and one of the biggest statistics on the issue was not detailed in it. It was almost as if it were skating around the issue, and a lot of black women felt very angry about this.

But, as I said, we do very much welcome the taskforce and it is a step in the right direction. A few years ago a taskforce like this did not exist and we were not having these kinds of conversations, so yes, we definitely welcome the taskforce and hope that there will be some tangible actions and change to come from it.

Q32 **Anum Qaisar:** Thank you. Professor Knight, your thoughts on this?

Professor Knight: As I said earlier, it is good that one of the elements of focus is getting pre-pregnancy care right. There is still nothing about postnatal care, and that is a huge vacuum that we do really have to think about. Most women who die do not die during pregnancy; they die after pregnancy, so that is really important. Thinking about future health, that is a really crucial time to be getting your blood pressure right and things like that, so there are definitely aspects that could be improved.

Like Tinuke said, the fact that it is there and it is happening in and of itself is a welcome thing, and it seems to be more action-orientated than things we have seen before. I agree that the press release is obviously really challenging; if it means that black women have been alienated or feel alienated from the start, then that is really difficult. I sensed much more energy in the room than I have ever sensed before, so from that point of view it felt positive.

Q33 **Anum Qaisar:** Dr Ekechi, how confident are you that the taskforce will achieve positive change?

Dr Ekechi: It is very important to always start from a position of confidence. It is a step in the right direction. We at the RCOG welcome it, and it is important that we all work together. As I said before, it is important to avoid duplication of work; there are a number of stakeholders in this area, all focusing on reducing maternal deaths, particularly for black and Asian women, and as such there is a risk of a grand degree of overlap. Where this group and this taskforce have

greater leverage is in their ability to really work with other departments within Government to address the social determinants of health, which is often overlooked. When we have these taskforces, we often wish to go for the low-hanging fruit and easy interventions, but the much harder things are really addressing the social and structural drivers that underpin the poor quality of health and poor outcomes that we see. This is where I feel positive that this particular taskforce can have its greatest power.

Q34 **Anum Qaisar:** Amy Gibbs, any thoughts?

Amy Gibbs: I agree with the other witnesses. It is a positive step, and it is good to hear from Marian that there is an action-focused kind of mood within the group. We would really welcome more public information about the exact focus and the membership of the taskforce. We would particularly welcome, as I said earlier, a recognition of the role of racial bias within this, not just in maternity care itself, although that is important, but if the focus of the taskforce is on those wider determinants of health—on preconception health and pre-existing conditions—there is lots of evidence, particularly from the United States, about how racial bias and racism throughout your life can impact on your health; it is often called the weathering effect. If it is looking at life course and preconception health, this taskforce needs to look at racial bias in that context, and it needs to look at racial bias in terms of previous interactions with services and the lack of trust that people may have when they go into maternity care because of previous experiences that they may have had with public services in the UK.

Finally, we would really like to share our evidence from our inquiry with the taskforce directly. Marian knows lots of it, so I am glad that she is in the room. But there are lots of us who, as Christine has said, are doing work on this and on different parts of the puzzle, if you like, around how this impacts on black and brown women. I am sure we would all be really willing to contribute that to the taskforce, whether that is through this Committee and what happens after today's meeting, or directly.

Anum Qaisar: Thank you so much, each and every one of you, for your contributions. I will hand back to the Chair.

Chair: Carolyn Harris is going to have the last question.

Q35 **Carolyn Harris:** If there was one thing that you would prioritise to help with the immediate and the short-term problems, what would that be? I will start with you, Christine, because you are nodding away there with confidence.

Dr Ekechi: Only because I have first-hand direct experience, of course, and tomorrow I will be working on the labour ward in a very busy unit.

The one thing that I would want to address straightaway is staffing. We cannot overstate the burnout amongst the workforce. We have mentioned about midwives and obstetricians, but also our allied

colleagues, for example, the healthcare workers supporting the amazing work that is undertaken every day within the labour ward. There is a high degree of burnout, there are huge vacancies and we have problems with retention, and this is something that we are seeing replicated across the country. I understand that for us to be able to deliver not only safe but quality and individualised care for every woman who crosses the threshold on to my labour ward tomorrow, I need to have staff that are not burnt out and that feel appreciated, so that they can give their best.

Amy Gibbs: I agree with all of that, and to address the points I have made about racial bias, we would want to see a commitment and real investment now across the system in anti-racist and culturally safe education, training and practice at all levels. No one is immune to bias; we all need to do the work to understand our own biases and unlearn them, and then that has to be part of respecting care going forward. But, as Christine rightly said, you cannot just push more training on to an already burnt-out workforce: the two have to go hand in hand. Sorry, I know that is a bit cheeky to say.

Q36 **Carolyn Harris:** That is perfectly fair, thank you. Tinuke?

Tinuke Awe: I agree with everything that Christine and Amy said, but there definitely also needs to be a move towards respectful and safe maternity care. It is a fundamental human right, and it has a direct effect on the mother and baby's experiences and outcomes.

I wanted to squeeze in another point, if I may, on the topic of the Ockenden report. One of the immediate and essential actions is that maternity services must ensure that women and their families are listened to; that their voices are heard. Anecdotal evidence in speaking to women across the country via our campaigns shows us that black women do feel that they are not listened to within maternity services. At the end of our black maternity experience survey, we actually asked what black women feel needs to be done in order to improve maternity services, and the word "Listen" came up over 250 times.

Carolyn Harris: But you need time to listen, to get that time you need the staff. It all comes back to staff, in the end.

Tinuke Awe: It does.

Professor Knight: For me, it is to make sure that our service model gives the care that women need in a one-stop shop. We still expect women to go to appointments here, there and everywhere with different teams. I want women to be able to go to one place to see all of the people, get all of the tests and things they need at the same time, in the same place. That would at least tackle all the challenges that women, and black women in particular, have in getting the individual care that they need.

Chair: Can I thank all of the witnesses for their contributions this

afternoon? They have been incredibly helpful. We will hopefully also be hearing from the Minister in due course, but I have to call this afternoon's meeting to a close.