HOUSE OF COMMONS

# Women and Equalities Committee

## Oral evidence: Black maternal health, HC 94

Wednesday 13 July 2022

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Watch the meeting

Members present: Caroline Nokes (Chair); Dame Caroline Dinenage; Jackie Doyle-Price; Kim Johnson; Bell Ribeiro-Addy.

Questions 37 - 98

### Witnesses

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

# Examination of witnesses

Witnesses: James Morris, William Vineall and Dr Matthew Jolly.

Q37 **Chair:** Good afternoon and welcome to this afternoon's session of the Women and Equalities Committee and our work on black maternal health. I thank our witnesses for joining us this afternoon. We have James Morris, the Parliamentary Under Secretary of State; William Vineall, Director of NHS Quality, Safety and Investigations at DHSC; and Dr Matthew Jolly, the clinical director for the maternity review and women's health at NHS England and NHS Improvement.

Can I start with a question to the Minister? There has been significant concern about black maternal health outcomes over a long period of time. This morning I was at a meeting of the Muslim Women's Network UK and the APPG, talking about health outcomes specifically for Muslim women in maternity. We heard anecdotally that there have been concerns raised since the late 1970s. Can you explain to us why we have only seen Government action on this in the last few years?

***James Morris:*** The Committee is right to address this extremely important issue. Thank you for inviting us along today to talk about it. It is not acceptable that there are disparities—we would all agree with that—and the Government are committed to reducing those disparities in health outcomes. We are where we are in terms of the situation, and we need to take action to address it.

As you will be aware, the root causes for these disparities are complex and interconnected in terms of the provision of maternity services, and we can get into why there may be issues in terms of disparities in the delivery of maternity services and the way that they are handled, but it is also the case that a lot of other socioeconomic factors are in play when it comes to the issue we are discussing today. My predecessor as Minister, Maria Caulfield, established a Maternity Disparities Taskforce in February 2022 because she and the Department recognised the need to take this issue seriously and to start to do deep dives into the issues that were arising.

On 6 September 2021, NHS England published their equity and equality guidance for local maternity systems, which focuses on actions to improve equity for mothers and babies from ethnic minorities, so action has been taken there, but I am in no way underplaying the seriousness of the issue that we are discussing today. Further work is required.

I just wanted to say one thing before moving on to the questions, if I may, Chair. I am afraid Professor Jacqueline Dunkley-Bent, the Chief Midwifery Officer, is unable to attend today. I acknowledge that you have here three white men giving evidence on black maternal disparities, but I am sure that I speak on behalf of the other people on the panel in making the point that we are all committed to resolving and working to narrow those disparities and getting this right.

Q38 **Chair:** Deep dives started in February of this year; when are we expecting to see any outcomes from them?

***James Morris:*** I have been a Minister for a very short period of time, and the taskforce held its second meeting in May, but my expectation is that they will start making significant progress very quickly.

***William Vineall:*** As the Minister says, the taskforce has only met twice, but one of the messages that comes out from all the reports is that we do not hear enough different voices about people's experience of maternity care. One of the helpful things about the taskforce is it is a place where you can convene a group of leaders, who can then listen more readily to a set of information that is not often heard. After that, the challenge is how you turn that into tangible action that will start to improve the disparities over time.

Q39 **Chair:** The taskforce was set up in February, we are now in July, and it has met twice; do you think that conveys a sense of urgency or priority?

***William Vineall:*** It conveys a sense of priority and has an urgency to it, and we expect the taskforce to continue meeting regularly.

Q40 **Chair:** What does regularly mean?

***William Vineall:*** I cannot give a definition of that. I suppose every couple of months.

Q41 **Chair:** Perhaps this can help us: if this is a priority, how often would you anticipate that the taskforce should be meeting?

***James Morris:*** It is difficult to be precise, but I would expect such a taskforce to be meeting at least quarterly and coming up with some specific actions arising out of those meetings.

Q42 **Chair:** One of the concerns raised with us by stakeholders has been that they feel a lack of confidence, that they are not being listened to, and they have lost trust in the DHSC. What specific actions are you going to put in place to try to build that trust?

***James Morris:*** It is an interesting question. As I referred to at the beginning, the Department has issued this equity and equality guidance to local maternity systems, which will be helpful. The Department also launched a new £7.6 million health and wellbeing fund in 2021, which is part of the Starting Well theme, supporting projects throughout England to attempt to reduce health inequalities. All this activity will be designed to rebuild the trust where trust has been lost. Does anybody else want to comment on that?

***Dr Jolly:*** I am happy to comment. We have had a series of reports which, as you say, show some really heart-rending problems with the way that some women have experienced their maternity care, and we need to take that really seriously. Jacqui and I are both national maternity safety champions—we work together as a team and ideally you

would have us both sitting here today, but I will do my best to convey her opinions on things as well.

It is not the whole story, because actually, even in the reports they talk about 70% of women having a good experience, which means the NHS knows how to provide a great experience but we are just not doing it for all women all the time. We need to understand why so we can improve things, and we are absolutely determined to do that.

If you triangulate the three reports that have come through, there are recurring themes about what needs to be done, and we have plans in place to address many of those themes. You have pointed out that this problem has existed for some while, but our understanding has changed over those years.

When Professor Marian Knight gave evidence to the first meeting, she referenced her first report in 2014, which did show disparities in outcomes between different ethnic groups. The narrative about that makes really interesting reading, because at that stage they were talking about different possible explanations, but in 2014 people had not really drilled down to understand what was going on.

It is as we have seen the MBRRACE reports coming in that we are seeing a better understanding of where things go wrong and what we need to do about it. Sometimes it was a combination of best practice care just not being available because it was not there, and at other times even when best practice care was available the women who needed it did not get access to it, whether that was because they did not feel they had a voice, they were not heard or listened to or they did not have people to advocate for them, or there were barriers in the way to how women accessed the care to address these issues.

With that recognition of what the underlying problems are we can start to address what Professor Marian Knight described as the constellation of biases that lead to some of these bad outcomes. We are now seeing, in some of the actions we are putting in place, ways that we are going to address those issues.

Q43 **Chair:** This morning at the APPG for Muslim women, the point was made that women felt they had to fight for the care to which they were entitled, that their voice was not heard, they were not listened to, and they were ignored and marginalised. Why should they have to fight? Should it not be available to all women equally as of right?

***Dr Jolly:*** I absolutely agree: that is what we are aiming to deliver and that is what many women do have already. There are initiatives in place to change that. For instance, I have been working really closely with Birthrights on developing a new consent tool that we call IDECIDE.

In the report it talks in one place about people not being heard and an action not happening, and in another part of the report it talks about

people being coerced into induction. So there are problems either side of how you do things, and actually getting that middle ground about how you convey information properly, but at the same time respect women's autonomy, is really important. We have worked with experts in the field and are now piloting a way that we can guide and help women, providing the right information in an individually appropriate way, and respecting their views to make sure that they are in charge of what happens next in their care.

Q44 **Chair:** Mr Vineall.

***William Vineall:*** I was only going to say that we want to try to be more specific in the initiatives already set up about how they impact on people from different ethnic minorities. We set up maternity investigations in 2018 and we announced that we would have a special health authority for maternity investigations this year to continue to work for five years.

The forthcoming report from the Healthcare Safety Investigation Branch says they are going to establish a race equality group to look at optimising the use of data, including ethnic data, and understanding bias better, so it is getting more granular and detailed about some of these issues. That is going to give us better evidence in the future and hopefully improve care.

Q45 **Chair:** Are we already collecting that better data? Are we already collecting granular detail that is going to help to drive that?

***William Vineall:*** It is one of the five requirements in the equity and equality guidance, so it should be collected.

***Dr Jolly:*** Yes, there has been a real change in the quality of data. In 2015 we had some data about when women booked for their antenatal care from about a third of the trusts in the country, and that was it. Now we have comprehensive data from all trusts about the whole of the pregnancy journey.

It is not perfect yet. A couple of years ago there was a recognition that things like recording a woman's ethnicity was completely inadequate and not done in a reliable way, so we use something called the CNST—the Clinical Negligence Scheme for Trusts—maternity incentive scheme, which is essentially a financial lever to encourage trusts to do that. If you go on the national maternity dashboard today, you will see that that ethnicity data is completed to over 90% in most trusts.

We need to do better though, because at the moment that is the old classification for data, and a new classification is coming out which will give much more granularity—rather than just Asian, it will say Asian/Pakistani, or will capture categories like Travellers, et cetera, which has been a really complicated bit of work. I will not go into details about data dictionaries and so on, but our plan is to move to that more sophisticated way of collecting ethnicity data in the future.

Q46 **Chair:** When?

***Dr Jolly:*** I am not able to say, as this is a really complex process that NHS Digital are involved in. My role is in the maternity services data set, and I have talked to the data team, who are waiting for something that happens with the data dictionary, but I am an obstetrician, not an expert on every component of the data.

Q47 **Chair:** Thank you Dr Jolly, I appreciate that so will turn to the Minister. What assurance can you give us of the date on which the improved data will start to be collected?

***James Morris:*** I apologise for not being able to give you a specific date, Chair, but I recognise the absolute imperative to get clarity on the data collection as part of the effort we are making to address these disparities, having had an opportunity to look at the issues related to this area.

The other thing that I wanted to pick up on was that clearly some of the reports you have cited mention a sort of disempowerment, if you like, of women not feeling as though they are listened to—that was your phrase. There is much needed work going on to develop what you might call cultural competence within maternity, in order to address some of these issues.

We would all recognise that maternity services have been under a lot of pressure over the last few years, and I know that from 2019 the Nursing and Midwifery Council have developed new proficiency standards and so on. All the cultural stuff, if I may refer to it in that way, is pretty critical when it comes to addressing some of these issues about people feeling as though they have not been listened to, or their real concerns not having been taken into account in their care.

Q48 **Chair:** This is going to be an issue the Committee will return to, because I do not feel we have had a satisfactory answer about the urgency of that data. You knew in 2018 that you needed to do better. I absolutely accept that you have been in the job for a few days, so I am not going to press you on that, but expect the Committee to return to it in future.

How can we be confident that this is going to stay on the agenda? The Government have a wonderful habit of moving on to the next issue once something is out of the headlines. How are you going to keep this foremost in the Department's mind?

Q49 ***James Morris:*** It is a priority because it is obviously something on which, if you look at it, you can see that some progress has been made, but clearly it would not be right to say that we are in a perfect place. An evidence base is building, both in terms of the data and the reports that you have cited, that shows this issue needs to have maintained focus in order to be resolved, and I think it is—

Q50 **Chair:** Will part of the women's health strategy reference it?

***James Morris:*** I believe that is correct, yes—there is a section in the women's health strategy on this issue.

Q51 **Dame Caroline Dinenage:** When is the women's health strategy due to be published?

***James Morris:*** Very soon.

**Chair:** Your predecessor told us that.

Q52 **Jackie Doyle-Price:** We know that the risks are enhanced with pre-existing medical conditions—diabetes and high blood pressure being two particular ones. Could I ask the Minister what the Department is doing to understand why certain underlying conditions are more prevalent among black and Asian ethnic minority women?

***James Morris:*** That is a question I may have to ask Matthew.

***Dr Jolly:*** I am happy to help. There are a number of components there. Black and Asian women die of the same things that white women do and, as Dr Ekechi pointed out in a previous hearing, people are not a sort of homogeneous group—the term black carries all sorts of other groups in there—but there are certain genetic predispositions to some conditions. Professor Marian Knight referenced the fact there is an increased risk of diabetes in the Asian population, and there is a genetic basis to that. Hypertension—

Q53 **Jackie Doyle-Price:** Is it genetic, or is it lifestyle?

***Dr Jolly:*** It is not just one thing, but an interaction between the two, and the same with hypertension. If you are slim and healthy and have a healthy diet, you are much less likely to have high blood pressure, but if you live in a deprived part of the world where there are lots of highly processed food and fast-food stores, and no access to be able to exercise, then you are more likely to end up with hypertension. That is part of the challenge we face about understanding all those little problems that add up into a sum effect that is really very significant. In America, they describe it as weathering—the constant microaggressions, the constant loss of opportunities—that sum up into deteriorating health and problems. In maternity we will fight as hard as we can to do our bit to mitigate those risks, but as a country—you are the experts on Government—the wider social determinants of health are things that are beyond the scope of what we in maternity services can do.

There are all sorts of exciting things we can do in future. The mother is such an important role in terms of what the children's diet is going to be. If you can win the mum over then you win the children over, so I would argue that if you ever wanted a great target for resource, maternity services are the place to put it, because then we can have an impact on the future children and future generations as well. But I would say that, would I not, as an obstetrician?

Q54 **Jackie Doyle-Price:** Yes, of course you would. It is an obvious place to have an intervention, but the logical flow from that is that there needs to be a whole of the NHS and Department of Health approach to this, because we are basically talking about interventions that enable women who may become mothers to make sure they are managing those conditions before conception, when you think about some of the causes. Ultimately, if we do not make those interventions early enough, we are stacking up a problem when we get to maternity. What are NHS England and NHS Improvement doing to encourage more sensitive discussions with women ahead of conception?

***Dr Jolly:*** First of all I would just like to say that there is a real opportunity with the development of integrated care systems and integrated care boards, and taking that more holistic view, rather than a secondary care focus—we can get upstream of the problem. That includes what we do with public health, which is really important in terms of access to contraception for women so they can have more control over when they get pregnant and prepare for pregnancy properly. That is one of the themes that has come through very strongly in the MBRRACE reports.

In terms of your specific question about pre-pregnancy care, one of the things we have done since I have been national clinical director is develop maternal medicine networks. We now have a maternal medicine network with 14 around the country, and we are exploring how we can extend the scope of what they do. This is an iterative process that we are hoping will help to improve the care they give.

One of the things we are exploring is how they could deliver pre-pregnancy care and counselling. I was talking to a member of our policy team yesterday about a bid for some funding to potentially provide that service and, if that bid fails, we have some ideas about other ways we might drive that. But as you say, pre-pregnancy care is a really important thing, and our maternal medicine networks are potentially a great way of delivering that.

Q55 **Jackie Doyle-Price:** You mentioned unplanned pregnancy in your answer; is there a higher incidence of unplanned pregnancy in our BME communities?

***Dr Jolly:*** I do not have the numbers to hand and I cannot answer with 100% confidence, but I am pretty sure there would be.

Q56 **Jackie Doyle-Price:** Following on from that, would you say an unplanned pregnancy is more likely to lead to a less healthy outcome?

***Dr Jolly:*** There is good evidence for that, yes,

***William Vineall:*** Can I make two points? The women's health strategy is the first time a Government have ever produced a strategy for 51% of the population, which is surprising. But the serious point is that it is

meant to develop and improve women's health in the round, which ought to be a precondition of improving maternity care.

The Starting Well health and wellbeing fund that the Minister mentioned is 19 smallish projects over three years, but is meant to be bespoke projects to different communities, including one group suffering from diabetes, disproportionately, to see how you can plan a group of services around the needs of the individual, both pre and post pregnancy, and, to the point the Chair made earlier, to try to get back to some of the cultural factors which actually get in the way of providing an effective service.

Q57 **Jackie Doyle-Price:** I have to say to Dr Jolly and William Vineall, this Committee has been around the block a few times on these issues about women's health but the point that the Chair made about women not feeling listened to is an experience of all women, and it becomes particularly acute when we look at it through this issue, because the biases sort of multiply. The women's health strategy will help to address that, but we still have to make sure we tackle some of the other things.

***James Morris:*** The other aspect of it is about the work the Government have been doing on perinatal mental health, which you will be aware of, where coverage is now a lot more extensive than it was four or five years ago. Addressing the area of perinatal mental health, pre-pregnancy and post pregnancy and whatever is a critical part of that picture.

Q58 **Jackie Doyle-Price:** It is, and I was just about to come to you, Minister, in the sense that in order to properly address this, we have to properly address the underlying inequalities that affect our different communities. Could you tell us whether there is any work being done with the Department for Levelling Up, Housing and Communities with regard to the social inequalities impact on health?

***James Morris:*** I am not aware of any at the moment, although there might be and probably should be some because, as you are identifying, quite a lot of the elements that we are discussing today are not all within the remit of the health service. Other social determinants are obviously very important factors in this, so this is not something that can be looked at in isolation. It does require cross-Government work and work with other Departments.

Q59 **Jackie Doyle-Price:** Perhaps I could give you an example in this space. As Dr Jolly will confirm, one of the things that we were big on tackling with expectant mothers was smoking, because smoking prevalence had a big impact on healthy births. I can remember when I was the Minister, seeing these great studies that had been done in Blackpool with expectant mothers, and getting that smoking down. Clearly that was something where the Department of Health was working with whatever it was called then, but now is DLUHC, and with local authorities to deliver that kind of thing on the ground. I would just suggest that perhaps you could take away that we would expect a similar programme of work to

see whether we can tackle these issues.

***James Morris:*** That sounds like something I would be very happy to take away and consider.

***William Vineall:*** It is part of the reason we set up the Office for Health Improvement and Disparities—to start to have a focus that in a sense is not only medical but is looking at some of the wider conditions. Obviously, the Maternity Disparities Taskforce is itself part of the response to the Inclusive Britain action plan and was one of the five main objectives. It is early days, but we do want to go broader than just the medical solutions.

Q60 **Jackie Doyle-Price:** Absolutely. Back to you, Dr Jolly, and this issue of the interaction between medical professionals and patients. We have heard that women do not feel that they are being listened to. We know there is often a very deferential relationship, and perhaps the conversations are not always right, so there needs to be efforts made on the part of medical professionals to really understand what is going on with the person in front of them. We have heard evidence from witnesses about the levels of unconscious bias among health professionals, and specifically where distress can be perceived as something more aggressive, for example. Is there any work being done to make people more aware of how they can manage those things better in their relationship which, for a large number of reasons, can become dysfunctional by accident?

***Dr Jolly:*** Absolutely, that is something we take very seriously. I do not in any way play down what you say, but I would not want you to think that every woman's experience going through the health service is like that, because it really is not. We have fantastic midwives, obstetricians and maternity care workers who are delivering great care every day, and the CQC survey comes back showing very high levels of satisfaction.

But when we get it wrong, we need to learn, and we need to do something about it. Even if we get it right 90% of the time, that is not good enough. We want to do better. Health Education England are developing a tool to improve cultural competence, and in our equality and equity plan we have challenged our local maternity neonatal systems to be putting local, tailored training into to every unit as well. We need to understand that it is part of a bigger problem about the culture within services, and understanding why the culture sometimes goes wrong, which can be a number of reasons. But the theme that comes through from a lot of work is that if you stretch a service too far, things start to crack, and we start to lose some of those really important parts of the care, because tired, stressed people do not always do things as well as they should do.

We need to think about how we equip and enable services to deliver great care and then, as you say, put in that expert training. It really needs to start from medical school—in fact I would argue that it needs to

start at school generally, because it is something that all society needs to do because bias and racism are not problems exclusive to the NHS. It is a societal problem. In the NHS we would like to champion the way in actually addressing the issues and be really good at sorting that out.

Q61 **Jackie Doyle-Price:** You are absolutely right to say it is about culture rather than practitioners. One of the ways that we manage services within the NHS is by process, which by definition is dehumanising really, because it is a unit, not a patient. To what extent do you think the move towards continuity of carer, for want of a better term, and a strengthened personal relationship between the patients and their medical professionals will help to address this?

***Dr Jolly:*** Continuity of carer is a really important intervention, but it is part of a suite of interventions you have available. Continuity of carer is absolutely right for some women, but some people need a proper multidisciplinary team, because they have a whole host of problems, which ideally is delivered in a one-stop-shop, so the poor woman does not have to go from pillar to post to get that care.

In terms of looking at the bad outcomes that happen to some of our most vulnerable women, it is because no one managed to get them access to the care they needed. Having someone who really understands that woman's needs, who builds up a relationship with that woman and can champion their cause, is potentially a really effective way of addressing one of the underlying causes for that. It has its weaknesses and vulnerabilities, and we need to think about how we put in ways of mitigating where that continuity of care relationship is not working. People were taught that as a theoretical issue, but in the vast majority of cases, it seems to have worked really well if you can resource your service properly to implement it. That is one of the things that we have learned: in our eagerness to try to drive improvement, we probably went too fast with continuity of carer.

The thing that Jacqui and I have been very clear about is that we think it is the right direction of travel, but do not try to implement it until you have your staffing in place. Some units have been very disappointed by that and are still pushing the continuity of carer, but they are targeting it to the most deprived areas of their communities, so they are doing it in a way where they can deliver it without causing major problems. It is a really important initiative if done right.

***William Vineall:*** Matthew said that the NHS should be a leader in terms of equality and equity. The Messenger report, called "Leadership for a collaborative and inclusive future", came out last month. As you would expect, it found there were a lot of good behaviours in the NHS, but it still found some poor behaviours to do with discrimination. It actually said that the current cultural environment in the NHS needs to improve to promote a fully diverse workforce, and if you get the right workforce you are going to get right continuity of carer. There is still room for

improvement there, but it was quite a powerful message from that report.

***James Morris:*** It is worth saying that we have recently invested £127 million into the maternity system to address the long-term workforce challenge. Now, that is a long-term plan, but it will go towards building the maternity NHS workforce we need in order to deliver the services, but to also work to address some of the issues we are discussing today.

Q62 **Jackie Doyle-Price:** The Birthrights inquiry into racial injustice concluded that there is structural racism within the maternity system. Perhaps I can ask Dr Jolly to comment first and then you, Minister. What is your reaction to that, and how do you intend to work with Birthrights to address the concerns they have raised?

***Dr Jolly:*** To be honest, when I first heard that my reaction was that I felt quite hurt, because I thought, "We have these amazing people who are doing a great job," but actually I have looked at the other reports and now really understand what they are getting at, and they are correct. I cannot remember the phrase that Dr Ekechi used, but it is this concept that the generic woman's body is portrayed as a European white body. The way we train people to assess babies, whether they need resuscitation or not, is called the Apgar score, which is not really tailored to the concept of black babies rather than white babies. We are actually doing something about that and there is work under way on that. The same with the way we teach people to address jaundice in newborn babies—it is too white centric.

I was talking to a really inspirational black doctor the other day who said, "Do you know what? I've been doing Apgar scores for years and only recently that dawned on me," so there is a growing insight within the NHS that there are some areas where there is institutional, or we are structurally racist, but that is not to say that the staff are. Every organisation will have people who are problems, so I am not saying everyone is perfect, but there are an awful lot of amazingly good people there. Yet there are structural reasons why we could do a lot better, so it is an interesting challenge, and one that we have to accept and understand how we can do better. There is a determination to do that, and action has already been put in place to address this, and there is more learning to be done.

Q63 **Jackie Doyle-Price:** The fact that you have just answered in that way is actually really encouraging, because the default position is, "Of course we are not," but when you dissect it you think, "Well, actually these are our approaches, and their impact is discriminatory in effect because you are ignoring that." Minister, what is your reaction to that? If we are committed to fairness and social justice and tackling inequalities, we clearly need to make sure our NHS is actually reacting to this.

***James Morris:*** Yes, and I take the recommendations and conclusions of these reports very seriously. Everything that we need to do, and the

nature of the discussion we have already been having, is about how we dismantle that institutional structure and make sure we narrow these disparities as quickly as we can.

**Jackie Doyle-Price:** Thank you. Any final comments, Mr Vineall?

***William Vineall:*** The reports and the challenges are good, and we are addressing quite a lot of them at the moment, but we need to go further and faster. More of these kinds of reports will keep this issue on the agenda.

Q64 **Jackie Doyle-Price:** I have a final observation. Birthrights have issued what is effectively a very challenging report that wallops you in the face—"How can you be racist?" When we set these targets, when we set the Better Births strategy, it was all about the headline figure of reducing neonatal mortality, but we do need to be that much more granular to make sure we are really tackling some of these risks, which are behavioural as much as about resource.

***Dr Jolly:*** Yes, and there is making sure there is better care available for everybody, and then there is that sort of proportionate universalism approach about going further for the people who are disadvantaged in whatever way, who are with the bad outcomes. How do we do additional resource? Because it is not about equality of care—equality of care is not good enough. What we need is equity of outcomes, and that means that you go further for the people who need it to get the right outcomes. Jacqui and I are both really clear on that, and you will see that in the equity and equality strategy we have put together. That is what we are really trying to do and the way we are trying to transform our maternity services.

***William Vineall:*** When you read some of the HSIB maternity reports, they talk about things that look like small oversights but probably appear like microaggressions. Things like thinking somebody can speak English well enough that you do not need the interpreter, and actually the absence of the interpreter is the difference between the care being good or bad, so it is a small decision that makes a big impact.

**Jackie Doyle-Price:** Excellent, thank you.

Q65 **Chair:** Birthrights did not just identify structural racism; they heard accounts of racism by caregivers, and racial stereotyping. What has been done, Dr Jolly, to specifically challenge those behaviours and address the very legitimate concerns that were raised in that report?

***Dr Jolly:*** I agree, and that is where the Health Education England training is particularly targeted but, as I say, in some ways that is the canary in the coal mine. I doubt it is just that people treat black and Asian women badly and then treat deprived white women really well. I suspect it is a wider problem about the culture in that group of people. That is why the leadership training we have for our leaders of maternity services involves developing that culture of kindness, listening, making

sure women are properly heard—those are the values that we are trying to put in in place, which is why we work with Birthrights.

I proactively contacted Birthrights about the IDECIDE tool, and we have worked with a whole range of people. Birthrights writes a report that is challenging to us but do not think that we spit upon an outsider: we work together really closely on how we try to address these issues.

We are also working with the Maternity Voices Partnership. It is relatively early days, but one of the interventions I am most excited about is developing what we are now calling patient-reported experience measures, and how we can get that rapid iteration of feedback about what it is like for a woman using our maternity service anywhere in the country, so that rather than having to wait for another Birthrights report or another CQC survey, people are getting rapid feedback about what it is like to use their maternity services. Chief executives can understand what it is like to use their maternity service and have an early identification of where there are problems, so we can put targeted initiatives in place. The initiative has just started, and they are incredibly complicated things to put in place. I have been trying to do something about that since I have been NCD, but we are now beginning to get some traction on this as part of our personalisation work.

As I say, there are a number of initiatives. It is about training the broader culture, training specifically about cultural sensitivities and then much better feedback about what it is like to consume your services, so that we can understand where the problems are. Also, where the good care is—again, I am sorry to keep going back, but the report published today talks about 70% of women having good experiences and there is also a lovely section about what good care can be like with some great quotes in it—and where we identify people who are really good, let us share their learning, share their experiences, so that we can correct where the learning is bad.

Q66 **Bell Ribeiro-Addy:** Thank you, Minister, and the rest of the panel for coming to answer these questions. Following on from the questions about institutional racism in healthcare, one of the studies that you might have touched on earlier is the one from Five X More, which is which is a small black maternal health charity focused specifically on black women. Their recent study, which I believe is the largest of its kind in terms of the number of respondents they had who were specifically black women who have experienced issues with their maternal health, miscarriages and stillbirth, found that black women still felt that their race, ethnicity, age or class affected their care. Over 61% of the women that had a miscarriage or early pregnancy loss were not offered additional support following their outcome, and a third were concerned about the care they received more generally.

Minister and Dr Jolly, you both touched earlier on the fact that historically it was always thought to be a result of socioeconomic status and also comorbidities more generally, which we know are definitely factors that

directly lead to poor outcomes. But the charity found that the majority of the women who took part in this study earned above the national average, were degree-level educated and were married or in relationships at the time that they took part in the study, which kind of refutes a lot of what has been said. I just wanted to know your reaction to that, and I suppose what is being done specifically to, again, directly address institutional racism instead of turning the focus on to looking at other factors.

***James Morris:*** As I said earlier, the underlying work that is done by Birthrights is quite shocking—

**Bell Ribeiro-Addy:** This is Five X More.

***James Morris:*** Sorry, Five X More—it is quite shocking in the way that you describe it. Building on what we have already discussed about the importance of culture within the health service and within maternity, the work that is being done in order to develop that competence, so that black women do not feel they are not being listened to, that they are getting the correct care, and the kind of personalised care that they deserve—that everybody deserves—is absolutely fundamental, so I take that very seriously. I do not know whether Matthew has any further observations.

***Dr Jolly:*** Absolutely, first of all the loss of a baby at any stage in pregnancy is awful. As soon as that test goes positive, you are already imagining the future, and so miscarriage is an absolute tragedy for a couple. Historically, people have perhaps sometimes not acknowledged that. There is growing recognition that we could do better in the way we manage miscarriage for all women, and there has been some fantastic work from the Tommy's charity on this, and they set up one of their Tommy's centres to do work on that. New guidance has come out supported by the RCOG about how we can provide better care for all women in miscarriage. As you say, the Five X More report then specifically talks about black women's experience, and again, we need to understand what we can do to improve those experiences.

I suppose there is so much wrong with white women's experience, or any women's experience, on miscarriage that part of what we need to do is just improve the quality of care for all women in miscarriage, and then again understand if there are specific issues there. The best way to understand that is to listen to women and hear what they are saying to us, which is why these reports are so valuable. I chair the group that commissions lots of the MBRRACE reports and confidential inquiries, and they include world-class epidemiologists providing us with information, but that is only one lens on the problem, and so these reports have provided a different sort of a lens on the problem which is really valuable.

Again, it is a constellation of problems that requires a multi-faceted approach. It is about how you recruit to your workforce—the women who work in your early pregnancy clinics—so the more we recruit women who

reflect the community they look after, the more we will get some of those better cultural understandings. Where you do not have that, I talked before about the Health Education England training to create those cultural competencies.

The way we will eventually get to really good care is an aggregation of a number of different initiatives—it is not one silver bullet. It is listening, learning, a culture of continuous improvement that will get us to where we need to be. It will not be just flicking a switch, but there is a real determination and recognition out there to do something about it, and particularly this latest initiative from Tommy's is really raising the bar about how we manage miscarriage in general, and if you triangulate that with the work from Five X More, we are starting to understand the problems and learn how we move forwards.

***William Vineall:*** I think they made a good set of recommendations. We are addressing some of the things like quality of coding, as Matthew was saying, in the equity and equality guidance, trying to improve the maternity incentive scheme, and the community-based approaches, such as the Starting Well fund. In terms of feedback systems, again, there is the equity and equality guidance, and then the last one—those training healthcare professionals to understand disparities and outcomes. There are, obviously, the RCOG curricula and the NMC standards. There is also ensuring induction training includes the findings of MBRRACE reports, because they do a dissemination event every year, and we need to get sharper on making sure all clinicians take onboard those recommendations.

Q67 **Bell Ribeiro-Addy:** Minister, where are we in terms of making sure that all healthcare providers are recording the ethnicity of maternity patients, and perhaps other factors such as other comorbidities and BMI, for the purposes of us having the information that Dr Jolly spoke about and making sure that we have good overview of what the situation is?

***James Morris:*** As I said earlier, I understand that there have been some historical issues with the collection of data. I am not 100% sighted on where we have got to in terms of the specific types of datapoints that you are referring to, but it does strike me as being important that we have that dataset and can capture it.

***Dr Jolly:*** From the maternity side of things, the work is underway and there has been huge improvement, but we aspire to be even better. For early pregnancy problems—miscarriage et cetera—there is a real issue. I remember talking to you, Jackie, when you were Minister, about the concept of developing more of a women's health dataset because I think that would be really powerful in tracking what women's experiences are like.

We move on to, I suppose, the women's health strategy. Given the number of problems that we have seen with mesh, endometriosis and access, collecting the data would be really valuable. There is a broader

strategy that NHSX is delivering about people moving to digitalised notes and that will put the NHS at the forefront in the world. The generation coming through at the moment in maternity services—the babies that are going to be born in the next few years—are probably going to be the first people to have a digital record from in utero all the way through their lives. We are getting that direction but, for me, if you were going to target one area, trying to get that women's health dataset, collecting those data about those early pregnancy experiences and some of the other broader issues related to women's health would be something I would love to see develop, but I do not know where we are going with this.

Q68 **Bell Ribeiro-Addy:** Previously, when I and others have spoken to Ministers about this subject, and particularly the different campaigns, there has been a reluctance to set a target to bring down the rates in respect of black maternal health, in that black women are four times more likely to die in pregnancy and childbirth. What target are the Government going to set to change this? Is this still the case, or are we looking at a target moving forward?

***James Morris:*** Given the situation that we are addressing in relation to these disparities, it would be premature to set a target that might have the unintended consequence of focusing on one particular element of what policy wonks would call a complex multifactorial problem. Setting a target might have unintended consequences that might be a barrier to us making progress, but I would be interested in other's views.

***Dr Jolly:*** I thought the first hearing you had on this subject was really interesting because you had a selection of different appearances. You had Marian Knight's very scientific analysis of the problems with targets and small numbers and data interpretation, and she is a world-class epidemiologist. Then we heard the view from Amy Gibbs at Birthrights about the danger of targets impacting on women's autonomy. There never was a caesarean section target, but people individually started to try to chase caesarean section numbers, and we saw how damaging that could be. In the report today, we talked about people feeling they were being coerced into induction. 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. 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. That is my summation of where I think we are with that.

***William Vineall:*** We are right, for all the reasons Matthew said, not to have a target. I think it is important that we understand the conditions that we can set through the wider policy—the women's health strategy

and the Maternity Disparities Taskforce—to stress that addressing disparities within those targets is a significant and important issue so that you do not lose sight of them, while maintaining the overall national targets that, as Matthew says, people are familiar with and are working well towards.

Q69 **Bell Ribeiro-Addy:** I want to follow up with a question to yourself as well. As part of the response to the Commission on Race and Ethnic Disparities the Government announced that they were piloting a new AI screening tool to reduce racial disparities. Would you be able to give us an update on the use of this screening tool and how it is going to be used alongside individualised care to reduce maternal health disparities?

***William Vineall:*** No, because I do not know about that I am afraid. I will have to take that away.

Q70 **Bell Ribeiro-Addy:** Does anybody know?

***William Vineall:*** Can we give a note back?

***James Morris:*** Can we take that one away? I am not aware of this tool, but I will—

***William Vineall:*** Apologies.

**Chair:** I am very happy that we get a response in writing on that.

Q71 **Bell Ribeiro-Addy:** Dr Jolly, who will be assessing and monitoring the equity strategies of local maternity services, and against what metrics do we plan to do that?

***Dr Jolly:*** That is not an easy question to answer. One of things we learned from Morecambe Bay is an overreliance on just simple metrics and data. It is a very simplistic way of trying to assess what is going on. If you look at our quality surveillance strategy now, we are trying to do something much more sophisticated than that. We will have metrics and we are working with the Core—I forget the number—PLUS5.

***William Vineall:*** Core20PLUS5.

***Dr Jolly:*** Core20PLUS5. Sorry, I was having a blank—Bowler will give me a kicking for that, I'm sure, and rightfully so.

We are looking into developing metrics that are very specific about those groups. Some of it is about access to a continuity carer. There are also some complex morbidity metrics that NHS Digital are helping to try to develop about a sort of cumulative score of poor outcomes in different ethnic groups. I am not completely sure how well they will work.

In terms of the strategy that Jacqui and I are developing, rather than just relying on data alone it is about how you triangulate that with the work we get from our investigations, from HSIB and the perinatal mortality reporting tool. It is what we do from the CQC inspections and the

information we get from that, and what is really important is what we get from intelligence and what is going on in different units. We have a perinatal quality surveillance group that gets feedback from lots of different organisations all fed up to Jacqui and myself about what is going on. We will have to look at the ethnicity-specific outcomes, but we should also be looking at it through the lens of these other ways of looking at outcomes as well because that will tell us more than just data alone.

***William Vineall:*** There is a research project going on at the moment to look at population-based health interventions in pre-conception health that includes an angle on ethnicity, so there is some research to look at whether we can be more granular about that.

***Dr Jolly:*** Sorry, that was a bit of a complex and rambling answer. I do apologise for that, but we will do what we can with the data, but data has proven in the past not to be good enough. We need to go further than just data.

Q72 **Chair:** Can I just clarify something? Did we have an earlier answer that you were not collecting enough data and we have now had an answer that data does not give you the answer anyway?

***Dr Jolly:*** I think that is a misinterpretation of what was said.

**Chair:** Okay.

***Dr Jolly:*** My answer about data is that our data is an awful lot better. We have the ethnicity data and we are going to make that even better. That data works really well at national level—the big numbers—but the smaller you drill down, the smaller the numbers you get, the more you have statistical variation, the more that data alone does not give you the answer, so you have to think about other tools. There are statisticians who are more knowledgeable than I am on this but, essentially, once you look at rarer outcomes in smaller numbers, the statistical noise drowns out the real signal about what is happening. So do not rely on data alone.

Even with Morecambe Bay, their mortality data did not make them an outlier, but if you started talking to junior doctors going on rotation through there, they knew there was a problem. That is why we are not relying on data alone. We are using intelligence inspections, investigations and all these things and triangulating them together to get a better understanding about where there are problems in outcomes.

Q73 **Bell Ribeiro-Addy:** Minister, what was your response to the Ockenden review's recommendation to suspend continuity of care until safe staffing is in place?

***James Morris:*** We take that very seriously. If it was in part of the review, we will be looking at it very closely.

Q74 **Bell Ribeiro-Addy:** Finally, do you agree with the figure of £200 million to £350 million to expand the maternity services workforce?

***James Morris:*** I am not sure where your figure comes from, but we have committed £125 million for the development of the workforce. That is committed over the next three to four years and is designed to address the workforce issues we have. Obviously, we are doing lots on retention too. That is what the Government are doing in order to drive change in the workforce and to address some of the issues that we have been talking about today in terms of the challenges in maternity.

Q75 **Bell Ribeiro-Addy:** The question would then be: do you agree we need much more?

***James Morris:*** We have committed £125 million. We constantly review what is required. That is what we have committed to in order to drive up the numbers of people working in the maternity service.

Q76 **Chair:** Can I just help on that? Those numbers come from the Health and Social Care Committee and, indeed, from Ockenden. Apologies if I have my maths wrong, but it sounds like you are committing less than half of what was recommended.

***James Morris:*** That is the commitment we have.

***William Vineall:*** We have committed as much as we are able to commit at the present time.

***James Morris:*** Correct.

***William Vineall:*** That was quite a significant uplift on what we were committing pre-Ockenden.

**Chair:** Thank you for clarifying that point.

Q77 **Dame Caroline Dinenage:** Thank you very much. Welcome, everybody. Can I talk to you about the Maternity Disparities Taskforce? The first thing I am really keen to know about is the terms of reference. We wrote to the previous Minister at the beginning of May, and she told us that the terms of reference would be published following the meeting on 16 May. Were they?

***James Morris:*** I am not aware of whether they have been published or not. I will seek enlightenment on that.

Q78 **Dame Caroline Dinenage:** Are you aware, Mr Vineall?

***William Vineall:*** I am not aware. I do not think there is any secrecy in the terms of reference. If they have not been published, they ought to be published shortly.

Q79 **Dame Caroline Dinenage:** Can we get a commitment from you that they will be published imminently—urgently—and before the summer recess?

***James Morris:*** We can certainly review that.

Q80 **Dame Caroline Dinenage:** Thank you. Do you know who was consulted on what those terms of reference should be?

***James Morris:*** Not definitively, but the membership comprises representatives of DHSC, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing, primary care leads and institutes of health. In terms of membership and input into that taskforce, it sounds pretty wide-ranging. I do not know whether or not there was formal consultation in the way that you described, but it strikes me that the membership is pretty broad-ranging in terms of touching upon all those people who are relevant and are required to be involved. I do not know whether William wants to answer.

***William Vineall:*** I think we were trying to be as broad based and inclusive as possible. Is there an issue behind the question?

Q81 **Dame Caroline Dinenage:** No. Any taskforce, investigation, inquiry or committee that comes together to work towards an end goal is going to be very much guided by the terms of reference with which they start. It would be really interesting to know—

***James Morris:*** Broadly speaking, the taskforce has a particular focus on exactly the issues we are discussing today, which is tackling disparities for mothers and babies by improving access to effective pre-conception and maternity care. The way you are describing the terms of reference is slightly more formal, but that is essentially what this taskforce was set up to do. It will look at lessons learned from previous experience in terms of tackling disparities. It will touch on issues to do with unconscious bias, which we have been discussing today. I would imagine that it would look to make some recommendations and actions and focus on some of the interventions that we have been talking about today in order to stimulate action.

***William Vineall:*** We tried to set it up in such a way that it was not just going to duplicate all the other work that was going on. We would hear from different groups of people, different voices, the kinds of people who produce the reports today. We do want to look for evidence-based interventions, and we want to use the taskforce as a place where you can have an open discussion to take things further and not just replicate the things that we are already doing. That goes back to what Matthew was saying earlier.

Q82 **Dame Caroline Dinenage:** I feel a little bit guilty asking this question because I know the Minister has literally only been in post for a few days—he is doing very well—and so has not had the pleasure of attending any of these meetings, so it feels a little unfair. It strikes me that in order to get the most out of a gathering of this nature and a bringing together of minds of this calibre, you first of all need to have a very clear idea of where you are going and what you want to achieve, but also what good looks like. Has that been established?

***James Morris:*** The two initial meetings of the taskforce have focused very much on deep dives into particular issues and that is the kind of methodology that is being used for the taskforce in order to really understand particular aspects of the issues that we are talking about today. That is the methodology that is being used in order to drive knowledge and establish parameters for action.

Q83 **Dame Caroline Dinenage:** Will the findings, targets and guidelines be published? Will there be measurables? What does success look like? What is the point of doing this unless we are going to have something where we can hold it up and say, "Look, this is—"?

***James Morris:*** That is a fair point. The taskforce is going to focus on evidence-based interventions. That has to be its primary purpose because, particularly in this area, as we have been discussing today, there are lots of complex factors. Evidence base is critical and understanding some of the complexities in the evidence base is critical to drive action. That is the purpose of the taskforce, and that is what it is focused on.

Q84 **Dame Caroline Dinenage:** How will we know whether it has achieved its objective? What are the measurables that will come out of it?

***William Vineall:*** We have not defined any specific measurables for the taskforce, but the reason the taskforce was created was not to replicate work we are already doing but to have a sharper focus on the particular issue of disparities in outcomes for different ethnic groups. I suppose, in the long run, if we did not make any impact on that, then the taskforce would not have been as successful as we would wish.

Q85 **Dame Caroline Dinenage:** How many women from ethnic minority backgrounds were included in the setting up of the terms of reference and are included on the taskforce?

***William Vineall:*** I do not know the answer to that.

Q86 **Dame Caroline Dinenage:** Could you let us know?

***William Vineall:*** Yes.

Q87 **Dame Caroline Dinenage:** Thank you. Is your sense that the members of the taskforce are in agreement on the action that the Government need to take? Is this taskforce a meeting of minds or is there a dispute about the sense of direction?

***William Vineall:*** We have only had two meetings, and I suppose the first one was an establishment meeting. There is some sense of agreement, but we have not brought the taskforce together just to agree. We brought it together to help generate different solutions that are evidence based. If there is debate about the way to go forward, then the taskforce is probably doing its job. It is not just there to replicate the situation it inherits.

***James Morris:*** If it is helpful, the taskforce is meeting again on 18 July and the meeting will have a presentation from Birthrights on their inquiry into racial injustice in maternity care and a presentation from the Muslim Women's Network on their research on black, Asian and minority ethnic Muslim women's maternity experiences. That is the focus of the next session of the taskforce as I understand it.

Q88 **Dame Caroline Dinenage:** We do not know what the terms of reference are so it is difficult to answer this question, but do you think there might potentially be among them a task of looking at how you address the disparities between the different ethnic groups? For example, there is a higher mortality rate for black women as opposed to other ethnicities. That to me seems like a really sensible thing for the taskforce to look at.

***James Morris:*** It strikes me as being a very useful suggestion for inclusion in the work of the taskforce, but I am not aware if that is a focus of the next session. It may be, but I do not know the answer.

**Dame Caroline Dinenage:** It sounds like you are going to be writing us quite a long letter, Minister, and we look forward to receiving it.

Q89 **Chair:** Thank you. Can I just take us back to the terms of reference of the taskforce? Do you think it is fair to ask whether it is more of a talking shop than something that is going to drive action?

***James Morris:*** I hope it is not going to be a talking shop. I do not know what my colleagues think. I would hope, given the range of stakeholders that are involved in it, given the importance of the issue, and given the establishment of the taskforce from the previous Minister demonstrating a will and a commitment to address some of these issues, that it will not be a talking shop and that it will identify issues that will lead to action and recommendations.

***William Vineall:*** I do not think it should be a talking shop. It was one of the five specific recommendations coming out of the Inclusive Britain reports, so I think that is a good start. The proof of the taskforce will be whether it can impact on the disparities we have and whether it pushes us further and faster in listening to different groups of people and different sets of voices in developing our policies to address these issues. I very much hope it is not a talking shop. It is not there to duplicate or replicate or completely undo the existing maternity strategy we have and the things that Matthew has been talking about. It is there to challenge those things in terms of the impact on different ethnic groups, which we know is different at the moment and we need to do something about it.

Q90 **Chair:** With no metrics or measurables, are we remotely worried that the impact of the taskforce will be unmeasurable and, therefore, we will not know whether it has had any impact or not?

***James Morris:*** I would hope that we would be able to evaluate its effectiveness because I do not think it would have been established without that in mind.

**Chair:** Let us keep optimistic, shall we?

**Kim Johnson:** Good afternoon, panel. Congratulations, Minister, on your new brief.

***James Morris:*** Thank you very much.

Q91 **Kim Johnson:** Last year, we had a very important debate on black maternal health in Westminster Hall and one of your former predecessors, the hon. Member for Mid Bedfordshire, committed to commissioning some research into near misses and to develop an English maternal morbidity outcome indicator to measure the impact of changes on health outcomes. This was something that was pushed by the Five X More campaign. I just wanted to know—if possible, because I know that you have only been in your position for a couple of days—whether you could give us an update on the progress along with any data that is being collected?

***James Morris:*** I am going to have to refer to Dr Jolly again on this particular question.

***Dr Jolly:*** I have heard of the indicator, but I do not know any detail about it. It is not a bit of work I have been involved in directly.

***William Vineall:*** I know the Policy Research Unit at Oxford has been commissioned to look at whether an English maternal morbidity outcome indicator can be developed partly based on those near misses, but I do not think it has come out with any conclusions yet, so the work is ongoing.

Q92 **Kim Johnson:** Perhaps that is something to follow-up with a letter again? The list is adding to this letter. Dr Jolly, what can NHS England do about reducing the delays in hospitals providing their data for the MBRRACE-UK work?

***Dr Jolly:*** My understanding from Marian Knight's evidence when I watched it is the measure delay was with the Office for National Statistics data—what is called the denominator data, so they could generate rates. I talked to the Healthcare Quality Improvement Partnership team yesterday and data flows from ONS came up. I understand they are now managing to provide data six months earlier than they were doing before. Our conversation was about perinatal mortality data, but it is essentially the same denominator data, so I would hope that would help with the maternal mortality rates as well.

My understanding is that ONS have worked with MBRRACE, and data is now going to be delivered much quicker. As far as data from trusts are concerned, the CNST maternity incentive scheme has something specifically about that. That means that trusts are much better at submitting their data to MBRRACE than they used to be. My understanding from Professor Kurinczuk who runs that is it is not really such an issue any more.

The final area Marian Knight challenged us on was how quickly NHS England processes the reports and gets them signed off. That is an area where we need to think about how we can drive improvement. We have had an example of how we can do that because during covid MBRRACE produced a special report for us about covid and we worked together with MBRRACE about pre-publication and developed some of the recommendations in a more collaborative way, which made it easy to get the whole thing signed off quicker. There are new ways of working that we might be able to implement to do that. There are a number of things going on and they are all going in the right direction.

Q93 **Kim Johnson:** Are you assured that data collation and collection is being undertaken in a consistent way right across all the trusts in the UK at the moment to bring about this data?

***Dr Jolly:*** For the MBRRACE report, what they are really talking about is a full comprehensive set of the notes that they then use as part of their confidential inquiry. In terms of data items, NHSX is leading the work with a whole series of different organisations which I can list, but what we are doing is updating something called the digital maternity record standard. That is the way that you digitalise clinical events, and that is being updated to be much more comprehensive and will then be aligned with something called the maternity services data set, which is a secondary user dataset which collates all the data together and links it with the neonatal data. That is the data that then flows not only to MBRRACE for some of their work, but also to our national maternity and perinatal audit.

All those data items are being upgraded, and in conjunction with that there is a £45 million initiative with NHSX about improving the digital maturity of maternity systems. That is part of the drive for all women to have access to their own electronic patient record. If we move to something that is paperless and all the relevant information is recorded on that paperless medical record, it suddenly becomes much easier to flow really comprehensive data and collate it together to use for that research. There are a number of components to this, but there is work in each of those components. Again, NHSX is really determined to make this happen and I know it is something that is very close to Baroness Cumberlege's heart, and she is not letting them off the hook. If any of you know Baroness Cumberlege you will know how determined she is to make sure we are going to get this over the line. There are a lot of initiatives going on to transform the quality of data.

Q94 **Kim Johnson:** I really appreciate your response to that question. However, I have experienced poor communication at first hand because my daughter had a baby a couple of months ago. There is very poor communication between departments and professionals within the system. Luckily, she was okay, but for someone whose health was not as good as my daughter's, that could have been very detrimental, so it is about making sure those processes that are in place are undertaken in an

effective manner.

***Dr Jolly:*** I absolutely agree with that. I was talking slightly at cross-purposes because I was doing a bit of a technical thing about the data side of it, but in terms of communication that is really important and, certainly, Tim Ferris, the chief executive of NHSX, has a vision of really trying to unify how data flows in trusts. That should reduce the number of different software providers that are involved so that you get seamless data flows around the system to address those very issues. There is an ambitious project to address that.

Q95 **Kim Johnson:** I think that is really important. I came into the meeting at the back end of the discussion about institutional racism and how black women are treated differently within the sector. You talked about training, but I would like to know whether you feel that training is sufficient and whether it is more about changing the cultures within the organisation, because we have had a plethora of reports and recommendations. The "snowy white peaks" survey identified challenges within the NHS. It is about how you think and what you think needs to happen to make some significant changes within the NHS to ensure that this no longer takes place.

***Dr Jolly:*** That is an absolutely fair challenge. I was probably concentrating so much on giving my answer I did not know quite when you came in, but I did talk about the wider cultural issues. Professor Michael West has done a really great book about compassionate leadership and setting benchmarks within an organisation, and how you treat people is really important.

You have covered a whole series of areas because the "snowy white peaks" issue is another really important issue. It is something that Jacqui and I take very seriously in the way we appoint our teams, and we managed to recruit some absolutely fantastically talented midwives and doctors from all sorts of different racial backgrounds. We are really privileged to work with such an amazing team. We are looking to a series of ways of improving that leadership and the representation of that leadership. Part of that is about improving the leadership pipeline, identifying the leaders early in their careers and bringing them on to do that. I think the Messenger report does some things about that as well.

There are important components about trying to recruit from the populations that you serve now. For a whole lot of technical reasons, that probably relates better to maternity care workers, et cetera, but those maternity care workers then, through apprenticeship, can go on to become midwives and there are enough roles in midwifery for more than one sort of midwife. Although there is a fantastic focus on this university-developed midwife, I have worked with some fantastic midwives who were maternity care workers whose education perhaps did not go well the first time round. They had children early on, became maternity care workers and then progressed on to midwives who are real forces for good

and really understand where they have worked. All these things together will change the dial. It is not about one thing alone.

***William Vineall:*** There are a couple of programmes that the Leadership Academy is putting forward for ethnic minority staff who want to progress. There is the Stepping Up programme, which is for the mid-band people Matthew was talking about to allow progression and to see what the blocks and enablers are for people from black, Asian and mixed ethnic groups. Then there is an equivalent programme, the Ready Now programme, which is for leaders and making sure that we get the skills from those BAM leaders so that you have a more inclusive culture and better leadership. In a sense, that goes back to the Messenger report. I think those things are important because you need a diverse workforce to make sure that you have the right cultures to deliver the correct care.

**Kim Johnson:** Thank you, Mr Vineall. We also need the resources to be able to do that and implement that more effectively as well. As has been pointed out, it looks like we are only receiving half the amount of funding that was originally suggested.

Q96 **Chair:** I have two questions that I wanted to sweep up with, but I will let you say whatever it is you want to say, Minister.

***James Morris:*** I just wanted to come back to the taskforce issue because I have sought some enlightenment, which may be of use to the Committee. We are intending to publish the terms of reference by the summer recess, which I think may be helpful to the Committee.

Q97 **Chair:** On the point about the taskforce, for the sake of complete transparency, are you taking over as co-chair?

***James Morris:*** I presume that will be the case, yes.

Q98 **Chair:** Thank you. Can I just go back to Dr Jolly? With the issue of Professor Knight's evidence—correct me if I have misunderstood you—you suggested that the delay was with the ONS, but Professor Knight was absolutely explicit in saying: "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." She then went on to say that there was also a delay with the ONS and a delay with NHS England, but it is very clear that there is a delay with the hospital data. What can be done to speed that up?

***Dr Jolly:*** I am not sure I completely understand what Marian is talking about. I will ring Marian and speak with her. For the confidential inquiries they, for the actual deaths, get the full set of notes and they describe the inquiry process in the documents, and that is the notes review. When they do deep confidential inquiries into morbidity, those are bespoke inquiries, so their data-collection features are different. From my conversations with her, it was that she was worried about the delays in the ONS data. If it is about maternity services dataset data which is, in

effect, the collation of the medical record, it now takes NHS Digital only three months from those data arriving to actually then populating on the national maternity dashboard.

There is another data flow process called the DARS process and I know that is being sped up as well. I am happy to have a conversation with Professor Marian Knight to understand the specifics. I suspect there is talking at cross purposes going on somewhere here.

**Chair:** I suspect the Committee might want to write to Professor Knight to check that there is no talking at cross purposes and that some clarification goes on between the two of you. If no other Members have anything they wanted to ask, I shall bring the Committee meeting to a close and thank the witnesses for their participation today. It has been very helpful.