

Health and Social Care Committee

Oral evidence: Black maternal health, HC 895

Wednesday 18 June 2025

Ordered by the House of Commons to be published on 18 June 2025.

[Watch the meeting](#)

Members present: Paulette Hamilton (Chair); Ben Coleman; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Alex McIntyre; Joe Robertson; Gregory Stafford.

Women and Equalities Committee member also present: Sarah Owen.

Questions 67 - 161

Witnesses

[I:](#) Janet Fyle MBE, Professional Policy Advisor, Royal College of Midwives; Sylvia Owusu-Nepaul, BSOL LMNS (Bump) Programme Director, Birmingham and Solihull United Maternity & Newborn Partnership; Professor Hassan Shehata, Senior and Global Health Vice President, RCOG.

[II:](#) Baroness Merron, Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health; Professor Lucy Chappell, Chief Scientific Adviser, Department for Health and Social Care; Kate Brintworth, Chief Midwifery Officer; Professor Bola Owolabi, Director, National Healthcare Inequalities Improvement Programme, NHS England

Examination of witnesses

Witnesses: Janet Fyle, Sylvia Owusu-Nepaul and Professor Hassan Shehata.

Q67 **Chair:** Today is our second session on black maternal health. Can I ask our first panel to introduce themselves?

Sylvia Owusu-Nepaul: Hi. My name is Sylvia Owusu-Nepaul. I am a midwife by trade and I work for Birmingham and Solihull local maternity and neonatal systems.

Professor Shehata: Hello. I am Hassan Shehata, senior vice-president of the Royal College of Obstetricians and Gynaecologists. I am a practising obstetrician working in south-west London.

Janet Fyle: My name is Janet Fyle. I am a practising midwife and I currently work for the Royal College of Midwives as a professional policy adviser.

Q68 **Josh Fenton-Glynn:** Thank you all for being here today. This is a really important session. We are seeing outcomes for black mothers go entirely in the wrong direction, and much quicker than for white women, so it is important that we get this right. Sylvia, you are part of the learning and action network, which seeks to address the inequalities in outcomes for black women. I am wondering what specific actions your trust is taking to deliver these improvements.

Sylvia Owusu-Nepaul: We were part of the learning and action group, as you say. We looked at women, black women particularly, who had postpartum haemorrhages. One thing that we were trying to do was see whether we could get some data on how it was recorded whether women had risk assessments to determine whether they were at risk of having postpartum haemorrhages. Then we wanted to look and see whether we can reduce the amount of PPHs they had by 1% by the year 2027.

In doing that, we went back to the hospital trusts and evaluated the PPHs that women had. We realised that, among the black Caribbean and particularly African women, they had a higher percentage of having postpartum haemorrhages. We again looked at the risk assessments and have put things in place.

Q69 **Josh Fenton-Glynn:** Can I just pause you a second? Bear in mind that, despite being on the Health and Social Care Select Committee, I know nothing about medicine. There are a great number of postpartum haemorrhages, which I read in the research. Is that physiological or to do with the way people are treated?

Sylvia Owusu-Nepaul: I think that it is to do with the way people are treated, to be honest. Would it be okay if I gave my personal experience? I had my son. I was five years qualified as a midwife. My placenta was stuck, basically, after I had the baby. I had the baby where I was working, and I was told that I had to go into the operating theatre to



HOUSE OF COMMONS

have it removed. For the first time, I felt that I was actually going to die, because I explained to people that I was losing a lot of blood. Even as a midwife, with my counterparts, nobody took that into consideration. I felt like I was dying.

It is often about not being listened to and not recognising the signs, even though people are stressing that this is what the issue is. There are some physiological aspects to it, but a lot of the time, when people are expressing that they have certain conditions, they are not being listened to.

- Q70 Josh Fenton-Glynn:** Thank you. That is really helpful. There have been a few Government interventions on this. In 2019, in the long-term health plan, one main aim was to improve things for black mothers. Do you think that the Government interventions are working at the moment and making things better?

Sylvia Owusu-Nepaul: For maternity services and black women, no.

- Q71 Josh Fenton-Glynn:** That is a very simple and easy answer to that. I am going to come on to some of the more targeted work you do. There are some issues. There are more pre-birth issues with Asian mothers. There are various cultural issues that are involved. In terms of your trust, you serve a diverse area and are innovating a lot. What measures do you put in place in order to make sure that you are more culturally sensitive and doing a better job to support those mothers?

Sylvia Owusu-Nepaul: There are two things. We are doing some culturally competent training with our staff, so we are talking about that. Unfortunately, it is not mandatory and therefore not everybody is accessing the training. In terms of the patients or service users, we currently have what we call maternity link support workers, who are advocates for the women. They are part of the community, so they are culturally competent themselves. They walk alongside the women from the booking appointment, or pre-booking once they find out that they are pregnant, all the way until six months post-natally. That is the kind of work that we are doing specifically around the top six languages of Birmingham.

- Q72 Josh Fenton-Glynn:** Could you explain the role of that support worker to me? That is a non-medical professional but with a greater cultural understanding, so almost like a doula or something like that.

Sylvia Owusu-Nepaul: It is all of that, yes.

- Q73 Ben Coleman:** Thank you all. It is great to see you all today. I should say that Janet and I know each other from the North West London ICS and from anti-racism health initiatives run in one of my local authorities as well—Hammersmith and Fulham, not Kensington and Chelsea. It is a great pleasure to see you all here today and thank you very much. This is a huge issue and I have to say that we are really chuffed as a Committee that we can get our teeth into it.



HOUSE OF COMMONS

There is a whole issue around training and support, and the fact that the particular circumstances around black women may or may not be properly understood, and therefore people, such as midwives, doctors and others, including obs and gyns, need proper training. Janet and Sylvia, what support and training do healthcare professionals get to ensure that black women are listened to and supported to make informed choices at childbirth?

Janet Fyle: One thing that the Royal College of Midwives is very keen on is around this focus on cultural competence for the midwives. Say, for example, you go to El Salvador, you do not speak the language, you happen to find yourself in A&E and there is no one to translate for you. No one understands where you are coming from and your culture. We want midwives to understand the impact that someone's cultural imperative can have on care.

We teamed up with the NHS and developed the cultural competence e-learning training and have encouraged our midwives to undertake that training where they are. Also, one has to think about the fact that our midwives are in trusts and the trusts have priorities. Sometimes the training is not always consistent across the board, but we are pushing it from a membership organisation's perspective.

Q74 **Ben Coleman:** If you have the training, which is great, you need the trust to take it up.

Janet Fyle: Yes.

Q75 **Ben Coleman:** A green light would be that everybody is taking it up. A red light would be that nobody is taking it up. Are we red, amber or green? That is a very bad way of putting it, actually. Out of 10, when 10 is everyone is doing it and 1 is no one is doing it, where would you say the general take-up of the training you offer is?

Janet Fyle: I would not want to comment on where the training is. It is hit and miss. I will say possibly red. I also want to say something about the fact that all the clinical guidance and recommendations for practice are quite white. It is coming from a white European perspective. People are not considering the fact that the women we are talking about today are black and brown women. Their DNA, physiology and anatomy are totally different. We treat all women the same, like one size fits all.

We need to take a step back and look at what the needs of this group of women are. Say, for example, where I come from, birth is not perceived as something that should be in hospitals. It is perceived as a psychological, family, enlightening event that everyone participates in. It has been clinicalised for black women over a period of time. We need to do things differently from how we are doing them now.

Q76 **Ben Coleman:** Does that mean more births at home in that particular case?



Janet Fyle: It does not mean that, but many black women who turn up for antenatal care are not always offered midwife-led care, which is suitable for them sometimes, or access to birth centres. Continuity of care and carer is an important aspect. It has been proven by the research and the evidence that it delivers very good outcomes for every woman, including black women, but it has been implemented in a patchy way. It needs to be funded and it needs more midwives to enable that initiative to work better.

Q77 **Ben Coleman:** That is very helpful. When women are not offered midwife-led care, is that all women, white and black, or do you find that white women will be offered it more than black women, or is there no difference?

Janet Fyle: Articulate women would come in and ask for it, if that is what they want. If it is an initiative that is in the trust, they will get it. It is very difficult sometimes for black women who are pregnant to demand from midwives and doctors what they want, because, primarily, the decisions are not always shared. There is this hierarchy and these power relationships within the consultations. There are the power dynamics. It is not easy for black and brown women to negotiate that power dynamic.

Q78 **Ben Coleman:** That is really helpful. I am going to turn to Sylvia in just one sec, but I am going to ask you a kind of off-beam question. Power dynamics are really important and exist within every society. Does it make a difference whether the midwife, nurse or doctor is black or white in terms of how black women get treated?

Janet Fyle: It does not. It is the system itself. Midwives and doctors work within a system that has its own rules and regulations and, "You must do what you are asked," or "This is what we are offering." We need to have a diversity of offer for black and brown women, and vulnerable women, because black and brown women are not the only ones suffering or having poor outcomes. You have vulnerable women and poor women, and I am sure you will hear about that later on. We need to have a broader spectrum. We cannot look at black and brown women through one lens alone. We have to look at it from a broader spectrum.

Q79 **Ben Coleman:** Sylvia, is there something you would like to add to that?

Sylvia Owusu-Nepaul: I agree with everything that Janet is saying. I also think that we talk about cultural competence quite a lot. In actual fact, you have already articulated what we need to say. It is about cultural intelligence. It is about everybody being able to understand the layers that Janet has spoken about, as opposed to just a tick-box exercise.

Q80 **Ben Coleman:** Looking at the research, Professor Shehata—we have been looking at lots of research—we see that black women often face higher rates of clinical intervention, so things like caesareans or assisted deliveries during childbirth. That can be quite traumatic for people. Why do you think that this is?



HOUSE OF COMMONS

Professor Shehata: That is a very good question. I want to comment as well that there is also a lack of trust in our profession.

Q81 **Ben Coleman:** Who does not trust whom?

Professor Shehata: Patients, and in particular black and brown women, do not trust us.

Q82 **Ben Coleman:** Patients do not trust you. Do medical professionals trust their patients?

Professor Shehata: Of course we trust our patients, but the issue is really quite complex, because it is also historic if you go back to what happened to black women with all the research and how things were invented, so there is always that lack of trust. Research is actually poor into women in general, let alone black women and all the drugs that we have.

Going back to your question, it is absolutely right that there is lack of cultural training, although it is available, going back to your original question as well about how many people take it up. Is it just a tick box, or do people actually believe in what they are doing? We have problems with data collection. We assume these situations about higher caesarean section, higher forceps, etc., but the data collection in the NHS at the moment is pretty poor, in particular when it comes to ethnicity data. Unless we have clear ethnicity data to empower us with the information, it becomes difficult to find the solutions.

Q83 **Ben Coleman:** You have raised that, presumably, where you work. You have raised the need to collect better data. What sort of response have you received?

Professor Shehata: I think that it is money and finances. I lead on a maternal medicine network. Maternal medicine networks were actually brought in to address, in particular, the issue of equity and accessibility for black and brown women and deprived women. Money was initially pumped in, but, unfortunately, not any more. Although the ICBs have been given more money, at the same time they are merging. They have been asked to reduce their costs. The data collection has now become more or less very difficult for a lot of the networks to gather, because we do not have actual funding for people to collect the data within the ICSs and the ICBs, but also within trusts.

It is interesting. If you go to private hospitals, for example, data collection is very important because of how they code everything appropriately to get the cost, even to the clinics that they use and the tissue. When you look at the NHS, it depends on the trust you are working in and the ICBs. We have a big problem about ethnicity data. We do not have ethnicity data at the moment of a high calibre to empower us to address the solutions.

Q84 **Ben Coleman:** In the second session, my colleague, Dr Beccy Cooper, is



going to look at that more with the Government, so to perhaps inform that part of the discussion, there is obviously a cost in collecting the data, but does having good data enable better outcomes and therefore save money, or am I just making a spurious argument there?

Professor Shehata: Of course, absolutely, because you get the right information.

Q85 **Ben Coleman:** Are there any examples of where that could be shown to be the case?

Professor Shehata: I will think of an example. As somebody who has worked in this field for the past 30-odd years, every time we have MBRRACE or inequalities reports, there are the same outcomes and we come up with certain solutions, which sometimes look good, but implementation and execution leads to no change and we end up again with the same problems. We need a dramatic change in how we approach things. It is about the whole concept of how we approach the care, being culturally sensitive and understanding language barriers that sometimes arise. I am surprised at the different quality of language facilities from trust to trust, from really good quality services to very poor services.

Going back to the original question about postpartum haemorrhage, for example, if we have the right data on why exactly black women and brown women are having this increase, is it due to how we recognise it or due to physiological changes? I do not believe that there are any physiological changes. All women are the same. I can tell you that it is more likely that it is about recognition, because people assume that we cannot really see the changes in colour.

I have seen that with communications between midwives and doctors, because they think that it is very difficult to assess that the black person is losing blood and people do not understand that, or they assume that actually it is fine because they can tolerate pain more. There are lots of serious issues that should not belong to the century in which we live. At the moment, we need to collect the data properly to have the solutions.

Ben Coleman: That is great. What I hear running through this is that we can do it and make it better if we want to. The question is how much society wants to. Obviously our Committee wants to make it better, but I will stop there for the moment.

Q86 **Jen Craft:** Janet, this is to you. My apologies for being a bit late this morning. I wanted to clarify what you were saying. Is there a general feeling in the profession that midwife-led, low-intervention maternal care achieves better outcomes, but black women are not necessarily accessing that in the way that they should? The purpose of this inquiry is to get to the heart of why black women have such poor maternal outcomes. Is the reason that that form of care is possibly the gold standard but black women are not able to access it?



Janet Fyle: No, I do not think that I was saying that. I was saying that it is one of many initiatives. Regardless of where the care or the method of birth is, at least she is starting from somewhere where she has one-to-one care and could relate to a clinician who would speak to her and personalise the care. I was trying to say that, whether it is midwife-led care or birth centre, continuity of care is personalised.

When you personalise the care, you know exactly where the woman is coming from, what her needs are and what her wishes are. That is what I was saying. I was not necessarily saying that that is the gold standard. I cannot say that that is the gold standard because I do not know. We do not know where she would end up, for example a caesarean section or a normal birth, but at least she would be in a place where she feels comfortable, feels respected and has options.

Q87 **Jen Craft:** I am trying to get to the nub of low intervention in maternity care. That midwife one tends to have slightly better outcomes. Could the fact that black women are currently prevented from accessing that as fully as they should be something that is driving poor outcomes?

Janet Fyle: It is coming from a perspective of perception and the fact that decisions are made and not shared with the woman. Speaking of assumptions, people think, "You are at risk of XYZ." Instead of assuming, "The woman who is coming in has no existing medical conditions, so let's offer her this and see where she goes," we assume that sometimes black women's pregnancies are not normal. That intervention in the mind starts from them and leads on to real intervention.

Q88 **Joe Robertson:** Good morning. I am going to ask questions on funding, if I may. The Government have reduced the amount of ringfenced funding—they would say not overall funding but ringfenced funding—for the national service development funding for maternity services. Can you tell us what activities this money currently funds?

Professor Shehata: I can start because, as I have said, I lead a maternal medicine network. The ringfencing had its pros and cons. One of the pros is that you know the money is coming to a particular service, which I can run very well. The con is that that means every year I have to wait for that letter and sometimes that gets delayed.

Currently, because that funding has been put on the bottom line and at the same time ICBs have been asked to reduce their funding, I am, and lots of other networks are, left with a reduction in the funding that is coming to that particular service, which means that we are compromising the service that we run on a daily basis. We are at the mercy of the trusts to decide what their priorities are. A trust may decide smoking is a priority. Some may think that collecting ethnicity data is a priority. It becomes a mismatch of what you want to run.

I can see that the Government have said clearly, "We need to look at maternity services and make sure they improve". I am hoping that it will



HOUSE OF COMMONS

come out in the 10-year plan, which we have not seen yet. For me, it is really important that what is currently happening is affecting us negatively and not working for people on the ground, who do this day in, day out. That affects a lot of the maternities. I do not know, from a midwifery point of view, what you think as well.

Janet Fyle: Say, for example, a woman turns up for her initial antenatal booking. The midwife has 20 minutes to book her. Maybe she is somebody who has existing medical conditions, or she has problems with housing or other social issues. Twenty minutes is not enough to take down somebody's history. You have this approach where you treat the women as though they are on a conveyor belt. We have to do that because of the funding we have.

We shut off midwives. I suppose that a lot of them are sat in the trust. As I said earlier, over the years we have clinicalised pregnancy and birth. We need to take it back into the community, where the women live and work and where their families are. If we need them to come into hospital, we will. It costs an awful lot of money to do things the way we are doing them now. Is it £90 million that was spread out? The NHS has many priorities. ICBs and trusts will decide what their priorities are. If their priority is maternity, they will get the money. If their priority is waiting lists, they will get the money.

Professor Shehata: In this period of transition, how will the Government ensure that all maternity services receive the right level of funding and support to ensure safe, personalised care? How will they ensure that it does not lead to significant differences between living areas so it will be a postcode lottery? That is a concern.

How will the Government ensure that ICBs continue to engage with people with lived experiences? We have lost that as well. We do not have any lived experiences involved as voices and it affects training. We mentioned training earlier. Training now does not have a lead at all in NHS England, so it is somewhere there. We welcome clarity from the Government. What is the future of training overall, in particular cultural sensitivity training? That is lacking at the moment and it is a concern.

Janet Fyle: I understand that money is tight, so with the money being given has to come some form of reforms and you have to look at the way the system is organised. We need a systems change in order to improve things for black and brown women and vulnerable women, because those categories of women are the ones who are having the poor outcomes.

Sylvia Owusu-Nepaul: I was just going to concur with everything that they said. Once the funding goes down, inevitably what happens is the vulnerable people get hit first.

Joe Robertson: I think that the Government would say that the money is the same but there is no ringfence there, but as soon as you remove a ringfence there is then competition for other priorities that end up raiding



the pot, or part of the pot. That is very helpful, unless you want to add anything by way of questioning, Chair.

Q89 Chair: I do, actually, following on from what you said about funding. Funding is key to whatever we do, but some of that funding needs to be for when they are actually training as midwives. What work has been put in? There is this culturally sensitive training that you need funding for. What work has been done to ensure that we do not just keep wanting to give funding retrospectively, and that it is there from when a person says they want to become a midwife, so they are not just being trained? Does where I am getting at make sense?

Janet Fyle: Yes, it makes sense. As a professional organisation, we have done the work around the cultural competence of NHS England. It is open to student midwives as well. Secondly, the Royal College of Midwives has done two pieces of work, which were backed by a position statement, on decolonising midwifery education. Implicit in that toolkit, which is around all the universities at the moment, we have made sure, because we have done that piece of work, that the universities, professors and teachers of midwives take it on board. There is a decolonising toolkit that has been well received. That is not only around education. Also, we did another one around midwifery practice.

There are all our initiatives to ensure that midwives understand the cultural context of women's lives, especially black and brown women. We work with the Nursing and Midwifery Council to ensure that the curriculum for midwifery training is up to date. That is the best we can do, because the money we use for that is coming from our members, not from the Government. As a professional organisation, we are doing our best to equip our midwives and develop them in that area. It is one of our objectives as a membership organisation over the next three to five years.

Q90 Dr Cooper: My question comes back to funding and trying to understand, with the NHS 10-year plan and devolution moving forward, in terms of local government, what health devolution might look like. For integrated care budgets, I am interested in how those conversations are going at the moment. It relates back to the data paucity, I think. In an ideal world, data would lead funding allocation, so you would be able to identify need and then allocate funding accordingly. Therefore, across the UK you would have perhaps different funding for different areas, depending on socioeconomic factors, etc. At the moment, what level of accuracy in terms of funding allocation do you think there is for maternity services? I think I can see the answer on your face, but I am going to ask the question anyway.

Professor Shehata: It is not great. There is also an issue about workforce, which we should not forget. Workforce is really important. We were commissioned by the Government to do a fantastic piece of work as a royal college on the obstetric workforce. That has been shelved and has



HOUSE OF COMMONS

not been used at all. I do not know whether it is even up to date now. There is also racism within the workforce.

If we do not know the complexity of how each trust or ICS works, we cannot relate any particular funding to that particular unit. I work in two very interesting units between Epsom, Surrey, a very affluent area, and St Helier, where you have big deprived regions. You can see the difference even when I go to work between the two units on the same day. It is difficult. I now have to work with three ICBs to run my maternal medicine network, so the difficulties are there.

We need more robust workforce data, and we encourage the Government to release the workforce data that we have, but also to have absolutely mandatory training for culturally sensitive approaches. The most important thing is that we should not forget that the work that the college recently has done has shown problems with racism within the workforce. If you have a burnt-out, unhappy workforce, they will also find it difficult to deliver a good service, in my opinion. They all go together.

Q91 Gregory Stafford: Your comments lead us neatly on to my questions, which are around workforce. Janet, how effective do you think the Government's current strategies have been in addressing the midwifery workforce challenges and what more needs to be done?

Janet Fyle: We do not have the correct staffing levels so staff midwives are not being deployed appropriately. There is a piece to be discussed there. Secondly, we hear every day from our members that they are overworked, burnt out and leaving the profession. A couple of weeks ago, one of my colleagues called up and said, "Do you know what? I am resigning." I said, "Get on with it. You have always been..." She said, "No, I am burnt out."

I gave a description earlier of midwives having 20 minutes to do a history, taking on a woman who has a whole host of complex issues. You would leave that woman after 20 minutes and go home and cry, or you have another 10 women to do 20 minutes on and you go home thinking, "Have I done the right thing?"

The staffing levels are not okay on the maternity unit, because there are a lot of things, such as caesarean sections and instrumental deliveries. There is so much that is put upon midwives that—you know the old phrase—you cannot see the wood for the trees. Staffing level is absolutely key in whatever funding is given to the maternity services, but also it must come with reforms. You cannot have more midwives who are going to be sitting on a labour ward instead of being out there in the community, helping women and families.

Sylvia Owusu-Nepaul: I agree, again, with everything that you say. We also need to think about the complexity of the women as well. It is not just about seeing a woman for 20 minutes. She has lots of complexities. When you go and see her in clinic, you cannot just spend that 10



HOUSE OF COMMONS

minutes. It is about the complexity. Women with a lot more comorbidities are having babies now, so that needs to be taken into consideration when we are looking at workforce.

- Q92 **Gregory Stafford:** Janet, when we come to the long-term workforce plan, what would you like to see in it that would ensure the sustainable workforce that you are talking about?

Janet Fyle: I would like to see explicit mention of midwives and what they can offer. It really has to be, because there are opportunities in that long-term plan. If they are limited, we are not recognising the unique role that midwives can play and the potential of skilled midwives. They have this ability to link in with obstetricians, GPs, health visitors and the community itself.

When we think about where midwifery comes from, it came from the background of public health and public protection. You are not protecting the public by sitting in hospital labour wards or carrying out an assessment of a pregnant woman in 20 minutes. There need to be opportunities within that plan that actually name midwives in the plan.

Professor Shehata: Can I add something here?

- Q93 **Joe Robertson:** Yes. You might be anticipating my next question, which was to you, which was around what the knock-on effects of the shortage of midwifery on obs and gynae are that you deal with.

Professor Shehata: The long-term workforce plan was a good first step. In the upcoming refresh, we would recommend that they really absolutely focus on retaining the skills and staffing that we have, tackling high levels of burnout and boosting the workforce numbers. We work together as a team. You cannot have obstetricians without midwives and vice versa. We have an issue within the obstetric workforce itself, not just in midwifery.

We need to understand that, because of the changes we have, physiological and pathological, complexity has gone up. We need to address that in how we train midwives and doctors, and how we then manage together this workforce data collection that will enable us to run the services properly.

- Q94 **Joe Robertson:** Just so I am clear, going back to my very first question, do you feel the Government's current strategy is effective—yes or no?

Professor Shehata: The strategy is. The implementation is not.

- Q95 **Joe Robertson:** That is helpful. Janet, during our previous session there was a discussion around task shift. What potential do you think this has to help to mitigate some of the shortages that you were talking about?

Janet Fyle: I have written this here, so can I read it for you?

Joe Robertson: Of course, yes.



Janet Fyle: The role of the midwife is unique in the United Kingdom and other western countries, if they have them. Midwives are seen as the most appropriate and critical carers for pregnant women. Their training stems from normality and wellness, as opposed to a medical perspective. They train differently to nurses and doctors. They train from the physiological perspective. If you do not understand that, you will not understand when things go wrong.

The midwife's role is not a series of tasks. We do injustice to women if we see that role as task-oriented. Midwifery care should be a measure of quality and safety for women, which is what we are talking about today. We acknowledge also that there are others who participate in supporting women, midwives and obstetricians. These roles can be anything, such as supporting women with feeding when they have gone home.

For example, I will not even encourage or ask somebody to take a woman to the shower who has had an epidural. If people are thinking about task shifting, you need to think about what it is. The midwife is accountable. The support workers can do a lot of things, but we need to give women the respect, safety and quality of care that they deserve. If they deserve care, that needs to be either from a midwife or an obstetrician, because they are the ones who are accountable at the end of the day.

Q96 **Joe Robertson:** My next question was going to be whether you have any examples of where this worked well. Having listened to you, you seem to be very clear that task shifting is not something you favour.

Janet Fyle: The role of the midwife is the role of the midwife. It is in law. If you are accountable for your action, you cannot shift it to somebody else to say, "Sorry, I did not do that blood pressure," or, "Sorry, I did not walk that woman who had an epidural and she fell over." It is very specific.

Q97 **Joe Robertson:** Do you have examples of where there may have been potential impacts on patient safety because of task shifting? You do not have to give me names and examples.

Janet Fyle: No, I do not. I would not call it task shifting, but I have positive examples of where support workers have been very good in the maternity services, as long as you focus what it is you are wanting them to do and they are not taking on board the task of doctors or midwives.

Joe Robertson: That has been very clear. Thank you.

Q98 **Sarah Owen:** Thank you to the Health and Social Care Committee again for allowing me to guest from the Women and Equalities Committee. Thank you very much to the panel, again, for your expertise and your knowledge.

Before I start, I wanted to come back to language. Language is incredibly important in this. We have talked a bit about C-sections that have also



HOUSE OF COMMONS

been referenced alongside “normal birth”. I think that “normal birth” is not an appropriate term to be using. Any birth is a normal birth for the person who has had that birth. If we mean vaginal unassisted delivery, we should probably just say that.

Janet, we hear that the NHS has an incredibly diverse workforce all the time. It is one of the things that it prides itself on, and absolutely rightly so. Often, that diversity is not reflected the more senior you go up the NHS, whether that is trust to trust or in management as an organisation. Even when it does, you come across the systemic racism that we heard about earlier. Why do you think it is that the workforce diversity is not reflected well at senior levels? Why is progress so slow? This is not a new issue that we have been talking about, but progress is so slow. What do we need to do to change it? Is it better management? Is it targets? Is it positive discrimination? What do we need to do to see change?

Janet Fyle: I think that it is none of what you have listed. My contribution would be to hold the chief executive to account for the fact that his or her workforce at a senior level is not diverse enough. That is the thing that needs to be done. We have talked about this so many times and we continue to talk about it. It would be unfair to set targets. I do not know whether that is appropriate. The person at the helm needs to be held responsible. We have the CQC and all these other august institutions that monitor trusts and their activities. Maybe that is where it should come from. You talk about data. If the data is telling us something else, that way we could hold the chief executive to account.

Q99 **Sarah Owen:** How would you hold the chief executive to account? Accountability will mean that there are consequences for not improving. What mechanism do you think we should see so that we can hold these chief executives fully to account? I recognise that problem. Quite often, chief executives of trusts can be quite removed from the communities that they serve.

Janet Fyle: That is all part of the accountability, because how could one be a chief executive and be removed from the things you are meant to be doing for a group of people, especially in health? They cannot just escape accountability because most times people say, “Oh, they are too busy.” It should be part and parcel of what ICBs or trusts do around diversity, whether it be about female leaders, black and brown leaders within the NHS or a combination, of course. Ways can be found to hold the person in charge accountable.

Q100 **Sarah Owen:** One thing that we hear quite often is, “We have sent our diverse cohorts on training sessions.” Actually, they are not the people who need the training. The people who need the training are the middle management to the senior management, who need to recognise cultural diversity as a strength or that leaders do not look necessarily how they did in the past. Have you seen any good examples of this, where we have seen some improvement? Are there any trusts where we have seen steps to this?



Janet Fyle: There are some. Usually, in the ones that we know about, the diverse leadership within maternity services or maternity units has been actually pushed by the chief executives themselves. That is why I said that they are the ones who should be held accountable.

Within the maternity services of a trust, people think that, if you are a manager, you have made it. We need leaders. Possibly, if we have a diversity of leaders, you have a diversity of thought. Then we might not be coming here and telling you that all these things are happening to women, because you will have diverse voices coming together to ensure that we reach that goal and that objective that we set ourselves to improve care for women.

Professor Shehata: Diversity training should be for all. I do not think that it is only middle management. We have issues at lower management as well.

There are good examples. I can see that that kind of old-fashioned, clubby way that jobs have been given in the past is getting less and less, I have to say. If you look at our Royal College of Obstetricians and Gynaecologists, we have a British-Indian president. We have three ethnic minority vice-presidents out of the five. Things are changing and we welcome that.

The reality is that it is slow, but it is also not just about ethnicity. As Janet said, it is also women's opportunities. It is really interesting. We have a specialty with a high percentage of female clinicians—obstetricians—but a small number of them being leaders. The same applies for the ethnicity diversity.

As an immigrant who came here from Sudan 30 years ago, to look at what I have achieved over the years, I feel that I have been given the right opportunities and I am lucky to be where I am, both in my clinical expectations and in my managerial expectations from the royal college. Not everybody has that opportunity. Certainly, some people feel that they sometimes face racism in how they approach things. Things are better, but there is more to do.

I do not know how we hold chief executives accountable, but we need more black MPs and brown MPs. Even if I look at football, there are more black footballers, but not enough black managers. Lots of work needs to be done around the country, not just in medicine.

Sylvia Owusu-Nepaul: On holding people to account, certainly from my perspective, within my trust, getting data from WRES and WDES is very difficult. If people actually had a look at that information and saw what was going on, they could be held accountable: "Where is your diversity?" I find it increasingly difficult to actually access that data. Is that a barrier that we need to overcome as well?

Q101 **Jen Craft:** We have touched on it quite a lot already, but I wanted to



HOUSE OF COMMONS

look a little more at training. Specifically, would you support cultural competency training becoming mandatory? Are there moves to make it that way?

Professor Shehata: Yes. I do not know whether there are any moves to make it that way. I totally agree with you. As doctors, in order to get our appraisals on an annual basis, there are lots of mandatory things that we have to do, such as—what do you call it?—the moving and handling, which is mandatory, but culturally sensitive training is not mandatory. We have mandatory safeguarding, for example. It is really important for obstetricians, midwives and paediatricians. It is a no-brainer, but I have no idea what the restrictions are.

Sylvia Owusu-Nepaul: It should be mandatory, but also it should not be a one-day tick-box exercise. I know that they are doing Black Mothers Matter in Bristol, which is a six-month-long programme. It is really important that people immerse themselves in the actual experience, instead of just, "I have done this and now I am competent at doing it." There really has to be a willingness for people to do it and a willingness for trusts to take those sorts of things on board.

Janet Fyle: I am young enough to remember those EL letters that went out to trust chief executives and others. This is the second iteration of the cultural competence and safety training. The NHS has done brilliant work together with professional organisations and it needs to be mandatory for all trusts to do that.

Q102 **Jen Craft:** Sylvia, you said that it should not just be a tick box but actually immersive. Would that be something along the lines of continual professional development?

Sylvia Owusu-Nepaul: Absolutely, yes.

Q103 **Jen Craft:** I am assuming that it would be across the board, so midwives, managers and senior management.

Sylvia Owusu-Nepaul: Yes, it would be everybody.

Q104 **Jen Craft:** Would you imagine an initial, like you said, fairly immersive thing, where you could potentially even say, "I have done this training. I am qualified in this," but then a continually—

Sylvia Owusu-Nepaul: Yes, absolutely.

Janet Fyle: The training itself is an e-learning package and it is not just a one-off. You go through it and then come back for a refresher as often as required.

Q105 **Jen Craft:** There is training that exists, an e-learning package. Have you had any feedback from people who have done the training?

Janet Fyle: For the current one that we updated I think last year, we have not had any feedback yet. I suppose that that is something I could



HOUSE OF COMMONS

take back and speak to my colleagues in the NHS about. I am not putting ourselves up to do that, but I will talk to my colleagues in the NHS.

Professor Shehata: It is not just the feedback from the people who are using it, but we need to see the impact on actual patient experience. That is really important. That is, again, going back to how we collect that data, because we are not.

Q106 **Jen Craft:** I was going to ask how you measure that, but if you are not collecting the data—

Professor Shehata: We will not be able to.

Q107 **Jen Craft:** Would you find it helpful to be able to not just collect end point data, so maternal outcomes, but also things along the way? Janet has spoken at length about that kind of experience, interaction, being treated and consistency of care. Would it be helpful to be able to measure whether women are accessing this along their journey?

Professor Shehata: Yes, qualitative assessment is really important and feedback from patients is to be taken seriously. How you phrase the questions is really quite important. I agree with you. The problem always comes down to funding. Who is going to be doing the data collection and so on? There are targets that people look at and, unfortunately, this is not one of the targets.

Q108 **Jen Craft:** Sylvia, I understand that the trust that you work with is already doing quite a lot of work to improve staff's knowledge around cultural competency and supporting their knowledge and confidence to support black women throughout their pregnancy. Is there anything that is working particularly well and how has that been adopted?

Sylvia Owusu-Nepaul: In terms of staff competency, it is something that is relatively new. It has been a non-mandatory tick-box exercise. I have to put it like that. Birmingham city council was doing a cultural humility package, but it only started, I think, in November. We only got on board in November. Because it is just implementing it, we will not have the evaluation and know exactly how it is until June, July or maybe even August. The people who have actually been on that course have evaluated it quite well. Sorry, what was the latter question?

Q109 **Jen Craft:** Is there anything that is working particularly well and how is that being adopted and taken up?

Sylvia Owusu-Nepaul: As I said before, we have maternity link support workers who support our service users, particularly if they are from different ethnic backgrounds. As I said before, they are from the culture and it is working really well. It is very difficult to quantify emotions and how people feel emotionally, but we are going to start looking at what the targets are. It is almost like continuity of care and seeing what the outcomes are at the end of it, but obviously it is more than a year's worth



HOUSE OF COMMONS

of work. You have to carry that woman through the pregnancy and then evaluate it over a period of time.

Q110 **Jen Craft:** I imagine that it has knock-on effects. You may see the impact on the child's life chances. It could be endless, really.

Professor Shehata: The NHS Race and Health Observatory has developed seven anti-racism principles, which have been adopted by 10 ICBs. That is currently being used and evaluated. I think that lots of outcomes will come from that. That would be a good example to look at.

Q111 **Jen Craft:** Professor Shehata, how well are medical professionals currently supported to identify medical conditions such as jaundice or rashes in black women and babies?

Professor Shehata: There is lots of work we have done at the Royal College of Obstetricians and Gynaecologists, but more needs to be done. At the moment, we do not have any national way of teaching that, but that is why we have these maternal medicine networks, which have really improved how we work together at recognising such problems. Of course, we have to go back to medical school and how this is taught even at medical school. There is lots of work that is being done, but more is required.

Q112 **Chair:** Could I ask one quick question? We are running late, so it really is just a quick question. You have talked a lot about cultural competence training, but who would need to decide that this is mandatory? Who would do this so that it gets ownership?

Janet Fyle: I think the chief executive of the trust.

Professor Shehata: It should come from the NHS. It is very simple.

Q113 **Chair:** Where in the NHS? You have to give somebody ownership.

Professor Shehata: At the moment, NHS England, Wales and Scotland.

Q114 **Chair:** Who do you think should say that this needs to be done?

Professor Shehata: The trust executives.

Chair: Executives. Thank you for that.

Q115 **Andrew George:** Hassan, I will direct questions at you in view of the time pressures. Your specialty clearly does not, these days at least, exist in the shadows. Yesterday we were debating your subject in a rather different context, very heavily in a very acute manner within the Chamber itself, as you are aware. Also, such brilliant dramas, such as "This is Going to Hurt" and so on, have highlighted some of the issues. I will take that as an example. Do you think that that drama reasonably represents the pressures and difficulties that your specialty faces, or is it a misrepresentation? What was the feeling in the profession?



Professor Shehata: Some of it, yes, but some of it is a little bit different from reality. It is always difficult to have a generalisation of people's experiences. Some people have had really good experiences as clinicians and some not. I think that the profession thinks that that drama is a little bit exaggerated.

Q116 **Andrew George:** Yes, as dramas often are. Thank you for that. Leading into that, earlier you were mentioning—I think you used the expression—the old boys' network and certainly the sense of club-ability, as it were, within the profession, in terms of one's career development, being selected and those who rise to the top on that basis. What has been identified by the royal college only fairly recently, with the King's Fund support in researching it, was, I think, described as a colonial legacy within the royal college and the specialty itself. Do you think that that is now completely driven out, or are there vestiges of that culture still remaining?

Professor Shehata: Yes, there are still vestiges, definitely. That will not go away. We are currently going through presidential elections and you can just hear of some of the language that has been used.

Q117 **Andrew George:** To what extent are those conversations public, or do you have to work in the shadows within the profession? Clearly, you are in the public arena here, so you are speaking openly, but to what extent do you feel that you can speak openly within the royal college?

Professor Shehata: Absolutely, yes, 100%. I think that that applies to most colleges. Things have definitely moved on from where they were and it will definitely get better over the next few years. Even if you look at the members and fellows of the royal colleges and what they were telling us before and now, they feel they belong more. You also have to look at your membership diversity. At some stage, it was felt that they do not belong. Now they feel that they belong more over the last decade or so, so things are definitely improving.

Andrew George: Moving on to the workforce tool that you have been working on for some time, where are you with that? To give a little more background, as I understand it, there is a 12% attrition within three years, which is a very high level. That shows that there is a tremendous amount of pressure within the specialty itself, which is obviously extremely worrying.

Secondly, do you not think that, in order to operate safely, there should be mandated safe staffing levels, particularly at critical stages in the process?

Professor Shehata: 100%, yes. That is a very good question and thank you for asking it. We were commissioned as a royal college by NHS England to do the work. The toolkit belongs to NHS England. We gave it back to NHS England, ready made to be used, and it has been shelved. This is as blunt as I can put it. We kept going to meeting after meeting.



HOUSE OF COMMONS

Our members and fellows keep asking us as a college, "Where is your toolkit?" It is not our toolkit.

We actually developed it, commissioned by NHS England, and NHS England has its ownership, but it has not been released. Unfortunately, now it is a little bit outdated. It needs refreshing. I would urge this Committee to ask NHS England to refresh and release that toolkit, which was actually commissioned by it and done by us as a royal college. It has the ownership and that is the reality. This is as bluntly as I can put it.

Andrew George: The conversation has stopped. You are not getting answers when you ask. We have all heard what you have said and we will be speaking to Ministers, who are sitting behind you—

Professor Shehata: I am aware of that.

Q118 **Andrew George:** And to NHS England before they are merged as well. I am sure that the Committee is listening to this. In terms of the detail of the tool itself, are there proposals within it for mandation of certain safe staffing levels? It seems to me that having guidance is all very well, but we all know that guidance is merely guidance and the reality is that guidance cannot always be followed.

Professor Shehata: It is not a perfect toolkit because, as we said, we lack data with regard to, for example, ethnicity data. It is mainly working on numbers, but the complexity built into it is not great. Maybe that is one of the reasons. Maybe the Ministers sitting behind me might tell you that that is the reason why it was shelved. The reality is that it is as best as we can get information from what we are currently doing.

Andrew George: We have notified the Minister of a question we may ask in a moment.

Chair: We will stop there. Can I thank all three of you? I normally ask the question, "If there was something you wanted the Government to hear, this is your opportunity to say," but we are absolutely out of time. If you do not mind, the Committee will write and ask you that question if you feel you have not said something that we need to hear. Thank you all very much.

Examination of witnesses

Witnesses: Baroness Merron, Professor Lucy Chappell, Kate Brintworth and Professor Bola Owolabi.

Q119 **Chair:** Welcome. Can I ask each person on the panel to introduce themselves? We will then get started quite quickly on questions relating to black maternal health.

Baroness Merron: Thank you very much for inviting me and my colleagues to come and give evidence. I want to say how much I



HOUSE OF COMMONS

welcome the work that the Committee is doing in this area. It will certainly help me to do my job. My name is Baroness Gillian Merron and I am the Minister for Patient Safety, Women's Health and Mental Health.

Professor Chappell: My name is Professor Lucy Chappell. I am chief scientific adviser at the Department of Health and Social Care, and I am chief executive of the National Institute for Health and Care Research. In my 20% job, I am professor of obstetrics doing clinical trials in pregnancy and a consultant obstetrician at Guy's and St Thomas'.

Kate Brintworth: I am Kate Brintworth, chief midwifery officer for NHS England.

Professor Owolabi: I am Professor Bola Owolabi, NHS England's national director for health inequalities. I am also a general practitioner.

Q120 **Dr Cooper:** Thank you to the panel for being here this morning. The opening set of questions for you is around data and data collection. This has been a recurring theme, you are probably going to be unsurprised to hear, in our previous sessions on black maternal health.

In the first evidence session, Professor Marian Knight highlighted the fact that we are not collecting maternal morbidity data, which has some serious implications for what we know, how we can commission services and how the health force is working. We also had the "Better Births" report, which said that health professionals are working under significant pressure and spend a great deal of their time collecting data and filling in forms, yet the data produced is often of poor quality. The professor in the previous panel also raised the issue of data collecting and said that it was really quite difficult to commission appropriately sized and resourced maternity units based on the data that are available.

Specifically looking at maternity care for black women—Minister, perhaps I can come to you first—do you believe that you have the data that you need to effectively hold NHS trusts to account for their performance? If not, perhaps you could expand on what you think is missing and how you are planning to address that.

Baroness Merron: There are some limitations on data, but, in direct answer to your question, I would certainly agree that we need better data.

I am sure that the Committee is aware of this, but it is just worth mentioning. Every maternal death is a tragedy. We want to avoid the avoidable maternal death. For me, maternal death is not just about the time of giving birth. This is something that I feel very strongly about. It is anything in relation to giving birth. That includes after giving birth. When I look at the statistics, every one is a person. Every one is a woman who has given birth and who has died for reasons in relation to childbirth. A number have taken their own lives. That really brings it home to me. I hope we can all look at it more broadly.



HOUSE OF COMMONS

I use these words carefully. Low numbers make it more challenging—please bear with me—to get useful figures that are as accurate as we would like on the numbers of maternal deaths. There is a bit of a limitation.

However, I absolutely agree. We need better data. The reason for that is we have to understand the interventions, what is working and what is not working. One of the things that we are doing already is issuing a call for research to tackle inequalities in maternity through the NIHR £50 million fund. We are exploring a severe maternal morbidity indicator to get data more rapidly and to allow comparisons between trusts. To the question, that is extremely important. It is the case that trusts are currently incentivised to gather ethnicity information. Certainly, 96% of women who gave birth in 2024 have this recorded.

Q121 Dr Cooper: I am sorry, Baroness Merron. Could I just interject here? Is that maternal morbidity indicator, through NIHR research, something that is actively being piloted—I hate that word, but it probably is—in various trusts? When do you expect the results to be back on that?

Baroness Merron: Perhaps I can bring in Lucy on this, but they are two separate points. We are exploring a severe maternal morbidity indicator. Separately, the NIHR has issued a £50 million challenge. Lucy can add more detail to that.

Professor Chappell: Kate may also be able to come in. Your point on data is right. If we are not tracking what is going on or what the impact of our interventions is, we will not see progress or know where progress is happening. We have heard of three different interrelated data points: mortality; morbidity, which means severe complications; and experience. They all intersect.

We can learn from where we have good examples, for example, in real-time perinatal mortality. That is for babies. Where we can see real-time perinatal data, we can enable trusts to act on it without waiting months or years. Certainly, there are opportunities to look at how we do that. As we have heard, it is much harder to do that for maternal mortality because of the small numbers, which is why the focus on maternal morbidity can be critical in terms of early warning.

Kate may want to talk more about our HES data—hospital episode statistics—and how we use that to derive a not perfect indicator. That is lagged to some extent, but it will always be because of how we collect and collate hospital episode statistics data.

The new work that is being planned, which is linked to the severe maternal morbidity care bundle, is about how we tackle things before they become maternal deaths. That is critical. I see that as an obstetrician every week. This links to the NIHR application and the maternity disparities consortium, which the NIHR chose to fund. It is about developing a care bundle, developing the means to measure it and



then seeing how we can improve on the existing HES data composite to drive change.

- Q122 **Dr Cooper:** I am sorry, Professor Chappell. I just want to get clarity on the maternal morbidity indicator, which I know was something that was raised in the Women and Equalities Committee report. Just to be clear, is it being developed? Is it being trialled? Is there a timeline?

Kate Brintworth: It is in development at the moment because the health issues that lead to women dying are often things such as severe bleeding in pregnancy or blood clots. Those things happen to women who survive at a frequency that we can track in a meaningful way. Using that as a proxy indicator will enable us to have confidence in the measures that we employ.

- Q123 **Dr Cooper:** Just so the Committee is clear, if we were looking for data—I do not know—over the next three or five years, is there a point where we will be able to go, “We are going to look at this maternal morbidity indicator for trusts across the country,” and we will be able to get the data collected? Is that something that is built in? Will it be in the next three years or the next five years?

Kate Brintworth: It will be less than three years.

Professor Chappell: A composite indicator is not the be-all and end-all. You have to understand the data both by the condition and by what we are talking about here today, ethnicity and deprivation. It is about the nuances. The national maternity and perinatal audit is run by the royal college. We have maternal morbidity indicators. It is what you do with the data, how you interpret it and how you then act on it that really counts.

Just to call out Bola’s work here, one of the reasons that the NIHR funded the maternity disparities consortium first is because of Core20PLUS5. If we collect an indicator but do not then understand what is driving the inequalities, we will miss the point. It is about both the indicator and the granularity of data.

- Q124 **Dr Cooper:** Thanks, Professor Chappell. That is a point really well made. Before I hand back to the Chair, I will quickly follow on from what you are saying. In March 2025, as I am sure you know, the former NHS England issued a statement saying that it had been working with midwives, obstetricians, nurses and other clinicians to create a digital maternity record standard relating to direct patient care, describing the optimal data structure and format of maternity records. Could you please give us an update on the digital maternity record standard and where you are with that process?

Kate Brintworth: This was about unifying how we collect data. One of the things that you have pointed out is the importance of the quality of data. The record standard is about making sure everybody measured the same thing in the same way.



Just one example is the weight of a baby. You can measure it in pounds, ounces, grams or kilograms. If it gets entered in the wrong way, you end up spending a lot of time cleaning the data. Going into that level of technical clarity was a really important point. In a complex pregnancy, you might have 1,900 points of data collection for a single woman. Getting the right data with the right quality is a massive undertaking. Bola, did you want to come in?

Professor Owolabi: I would say three things. First of all, NHS England set out five strategic actions for addressing health inequalities. One of those is to ensure that datasets are timely and complete, especially ethnicity coding. In response to that, we have developed an ethnicity recording improvement plan, which was literally just approved through our quality performance committee yesterday and is going through the publication process. We have also worked to develop a set of metrics and indicators to track key metrics within maternity, such as stillbirths and neonatal death rates. Again, we are working to incorporate that into NHS England's performance and assurance framework in the coming period.

Dr Cooper: That is very helpful. Thank you so much.

Professor Chappell: Can I just come back to the role of women in this? We know we need to actively involve women in data, both as a general concept in terms of public trust in data and in terms of their experience. The work that is being done to co-create that experience is important. It is easy to say, "Can you produce this in three months?" I could, but it would not involve meaningful co-production with women.

To get back to understanding how we triangulate these different types of data and what they mean, women can have technically good care, but, if they have a poor experience with it, we have not delivered what we are setting out to.

Dr Cooper: Yes, that is an excellent point, Professor. I could talk to you for hours about quantitative and qualitative data, but I will hand back to the Chair.

Baroness Merron: We would be happy to.

Q125 **Chair:** I want to ask a really quick question before handing over to my colleague. You talked about exploring adequate data. Beccy articulated it really well. The question that I have is for our clarification. In the Women and Equalities Committee report back in June 2023, you said you were exploring this issue around data. Why are you still exploring it? I am struggling with that one. Could I ask Baroness Merron? If you are not sure, you can hand it to one of your colleagues.

Baroness Merron: It predates us.

Professor Chappell: I can give an example.



HOUSE OF COMMONS

Baroness Merron: We will go to an example. I did want to say that the long and the short of this is that we do not believe we yet have the right data to do the job that we want to do.

Lucy, could you give an example? From a ministerial point of view, if I can put it this way, it has renewed the focus and energy on this whole area.

Professor Chappell: I will give one example. Kate may be able to draw on another one.

This is not going to be once and done; it has to be iterative. One of the challenges that we had was the time lag on our data. You need both a numerator, a top number for an event that has happened, and a denominator, which is over how many live births. We have worked actively with the Office for National Statistics to provide early data on the total number of births, which relates to registration six weeks after birth, so we can meaningfully interpret it. That is an example of where we have made demonstrable progress so our data are less lagged.

We have to see this as a constantly moving target. We are improving our data both through design and the technical foundations of getting better data flows. This is not about asking midwives to do yet more data collection; it is about using technical improvements through the reform shifts that the Government have talked about, the move from analogue to digital, so that we release time to care.

Q126 **Chair:** I absolutely hear what Baroness Merron is saying. If you are not asking the right data questions at the moment, how long is it going to take to get those questions right? If your baseline is not correct, any results that you talk about will not be correct, no matter how sophisticated the language is.

Professor Chappell: We are asking a lot of the right questions, but we should seek to improve the data that relates to the severe morbidity indicators rather than just focusing on mortality because of the numbers issue. Kate might want to give some other examples.

Chair: You do not have to. It was just a missing piece in what you were saying. I will hand swiftly over to Ben. You may feel like you want to come in at that point, but I will let Ben ask his supplementary.

Q127 **Ben Coleman:** I just want to clarify this. Minister, it sounds very encouraging. I am going to try to talk in non-ministerial language. I am getting the impression that when you came in, you saw how crap things were—data was not being collected; mortality is increasing generally; maternity services are decreasing in quality generally; and it is worse for people of colour—and you are trying to change things. I hope that is what I have understood.

Baroness Merron: It is a good summary, but I could not use words such as those in the House of Lords.



HOUSE OF COMMONS

Ben Coleman: I agree. I have not tested it yet, but I probably should not use those words in the House of Commons.

Chair: You should not be using words such as those in this Committee.

Baroness Merron: I am not telling you off.

Chair: Ben, could you ask your question quickly, please? It is a supplementary, so speed is of the essence.

Josh Fenton-Glynn: Use parliamentary language.

Q128 **Ben Coleman:** My concern and the Committee's concern is that there has been a lot of waffle around this for a long time. My colleague Dr Cooper was trying to get some idea of the timing of when we are going to see improvements. I was very heartened to hear that an ethnicity recording improvement plan was agreed yesterday, purely coincidentally the day before you are due to appear at this Committee. It is extremely encouraging for us that that is happening. What is the deadline that has been set for producing that plan, please?

Professor Owolabi: I hope it demonstrates our absolute commitment to improving ethnicity recording because, of course, as we have said, the baseline figures do matter.

Yes, indeed, it was approved at our quality performance committee yesterday. We are literally just going through the publication process now. My view is that it should be published certainly over the next month or so because we have been through all the various governance processes to make sure it is fit for publication. On that basis, for that specific plan, I am confident that we should be publishing within the next month.

Q129 **Ben Coleman:** That is going to be setting out a series of things that need to happen to get ethnicity data properly recorded.

Professor Owolabi: That is right.

Q130 **Ben Coleman:** What are the timings by which you expect that the plan will state that this data should be properly recorded? Beccy was talking about three years; you said less than three years. Do we expect to achieve that within a year?

Professor Owolabi: It is really important to understand that maternity data are complex and varied. The plan is essentially setting out a direction of travel for national integrated care boards and providers, and the expectations of what the system needs to be doing at each one of those levels to improve the recording of ethnicity data. For example, migrating to the 2021 census ethnicity classification rapidly is a specific example of the sort of thing that we are asking providers to do.

Q131 **Ben Coleman:** I am sorry to interrupt you. It sounds brilliant. "Rapidly" is great. By when are you asking them to do this?



Professor Owolabi: In 2023, we published a statement of expectations on information regarding health inequalities. Our expectation is that from 2023 those improvement actions should have been taking place. This plan is a consolidation of those expectations.

Chair: That is a good place to stop.

Q132 **Joe Robertson:** My questions are on funding and planning guidance. The Government have reduced the amount of ringfenced funding, though not necessarily the overall funding, for national service development funding for maternity services. That has been transferred to the core ICB budget. This has been justified as providing greater flexibility in how it can be spent. How did the previous system restrict spending? Was there a problem, in your view, that would naturally lead to wanting to remove that ringfence?

Baroness Merron: Thank you for raising this point. I know it is an area of concern. I would look at it slightly differently. Yes, indeed, it is the removal of a ringfence. This was not implied, I know, but I want to put on record that this is certainly not a cut in any way in terms of maternity funding. It is a different mechanism. As a Government, we have seen the change.

To the point about planning guidance, maternity is still—

Q133 **Joe Robertson:** I will come on to that as a separate question. Just sticking with funding, how will you monitor how ICBs are spending money now that the ringfence has been removed? There will always be a concern—it is a natural concern—that, if you remove a ringfence, it makes that money more vulnerable to other priorities and makes it vulnerable to being raided. How will you ensure that ICBs are responsible in the way that they spend the money?

Baroness Merron: I appreciate the concern. This is very much linked to Lord Darzi's report and one of the many points of concern that he raised about how the NHS could function better. That includes reducing the number of targets, which we will come on to, and allowing ICBs to reflect and meet the needs of their local populations. Clearly—I know the Committee knows this—every ICB is not the same as the next. It is not about flexibility for the sake of flexibility. It is a genuine route to ensure the right decisions are made and provision is made properly.

It would make me nervous—let us put it another way—if we were dictating from the Department how all your constituencies were going to provide maternity services because the needs are different. There are baselines. There is no question about that. Let me say that patient safety and patient experience is totally key, particularly when we are talking about maternity, as we are here.

The reason is to allow better provision. There are requirements on ICBs in terms of delivery, as you will also well know. We will come on to that in



HOUSE OF COMMONS

terms of what is expected. Currently, NHSE holds ICBs to account for delivering in the way that they should.

- Q134 **Dr Cooper:** I appreciate that NHS funding is incredibly complicated, but has there been a conversation about whether all maternity services are going to need a certain level of funding to provide basic maternity services, regardless of their indices of deprivation, etc.? Is there a conversation in which you say, "Here is the baseline. All ICBs must fund to this level"? I understand that the data issue is quite difficult, but if you had decent data you could tell the ICBs to allocate additional funding to maternity services based on the data that you have. Are those conversations happening in the NHS at all?

Baroness Merron: Yes, they are. It is probably also worth referring to the upcoming 10-year plan. Committee members will not have to wait too long. You do not often hear a Minister say that about something that is to be published.

I would emphasise that there is significant and ongoing investment. We have instructed the NHS to improve preventative healthcare as well as maternity care as a priority in the planning guidance. We will come on to discuss that. It is probably worth my colleagues adding some of their experiences.

- Q135 **Joe Robertson:** I have some questions on the planning guidance, although that discussion about funding was quite interesting. The latest planning guidance is less detailed than in previous years on lots of things, including maternity. How will you ensure that ICBs still prioritise maternity care? What tools are available to hold them to account? It is a similar principle. It is not about funding but about prioritising maternity.

Baroness Merron: First, as I said earlier and as you have identified, it is within the planning guidance. That is helpful. We may come on to this later—I do not know—but I will mention it now. Of course, there are expectations of the Government, as clearly set out in the manifesto and in the missions, in terms of maternity and improving healthy life expectancy, just to name one other.

Later this year, we will be setting out our new ambitions for maternity and how they will deliver improvements. If I may, Chair, I will invite colleagues to add some detail.

Chair: Yes, but can we be succinct?

Baroness Merron: Yes, of course.

Professor Chappell: To give you just one specific, we have to ask how we look at maternity differently, starting from pre-pregnancy. There has been a huge shift in the complexities that I have seen over my lifetime as an obstetrician. We cannot just start after booking at 12 weeks. It is just not going to work for tackling the inequalities that this Committee has heard about.



HOUSE OF COMMONS

We need to look at that wider piece about pregnancy being an event in a woman's life course and focus on the move to prevention. We have to ask ICBs to see this in the round rather than just in terms of maternity services.

Q136 Joe Robertson: Government have made a decision to do what we would probably call devolving down, pulling powers from planning guidance in NHS England down to ICBs. Regardless of whether people have a view on whether it is a good thing that is being done, how do we ensure that does not lead to uneven care on the ground, postcode lotteries and arbitrary and irrational decision making? It is a more principled basis that could apply to all sorts of care situations, including maternity care in this case.

Professor Owolabi: NHS England has set out the Core20PLUS5 approach for tackling healthcare inequalities. It is intended to drive action at system and provider level. One of the five clinical areas within that framework is maternity. On that basis, Core20PLUS5 is included in the 2025-26 priorities and planning guidance, requiring ICBs and providers to continue to drive action in terms of interventions across the clinical areas identified within that framework. Because maternity is one of the five, there is therefore an ongoing commitment and requirement of ICBs not just to address maternity broadly but to address maternal health inequalities specifically in the current planning guidance. That is likely to be the case going forward as well.

Q137 Josh Fenton-Glynn: Just very quickly, Baroness, you talked about delivering what was in the manifesto about improvements. You have talked about the 10-year plan coming soon. We are 20% into the first term of this Government, almost a year. What one thing have we done so far that will improve health outcomes for black mothers?

Baroness Merron: My immediate response is to acknowledge that there is a problem. That is why I said at the outset that I very much welcome this Committee's deep dive into what is happening. It will help. The first thing is not to be defensive. I have never done anything other than accept the situation and commit to resolving it. That is a change of approach and culture, which feeds down.

I am sure that we will come on to it and that the Committee has been made aware, but we have taken a number of actions. Honestly, it is about accepting the situation, accepting that there is racism and putting actions in place already rather than waiting. That may not be one thing, but it gives an idea. It is the acceptance of the situation and the resolve that is the big change.

Q138 Josh Fenton-Glynn: We often say that what gets measured gets mended, and hopefully that is what we will see. Very quickly, what one material thing would you say is going to start us down the right path?

Kate Brintworth: We have asked every ICB to undertake a review of their own data. We have asked them to look at their datasets to accelerate prevention. They need to understand their population. They



HOUSE OF COMMONS

were given a series of metrics and asked to pull this together in an equity and equality plan.

It sounds like, "Oh, that is just more planning," but the Equality and Human Rights Commission has said that in doing that we have increased the quality of the data and the number of projects. In every service that I go to when I am visiting organisations, I see the effort that people are putting in. They are digging in. I see projects where women are getting free bus passes or projects where they are employing doulas or maternity mates to work with women with complex disadvantage. They are increasing collaboration with service users.

All of this is creating the foundation for change and creating what we need to do, which is to stimulate that curiosity and drive. What is going on in your local population? That has been a really significant trigger for making services sit up and understand their own data and what changes they need to make. That is not just about services but across the system. Building on Lucy's point, it starts before pregnancy and carries on afterwards.

Q139 Sarah Owen: We have already touched on this. I wanted a little more clarity about it, but time is short. I am going to ask this question, but I am going to ask the panel to write back to the Committee, if they can. It is a bit more on data. I chair the Women and Equalities Committee; I am very grateful to be guesting here today. As we have already heard from the Chair, we published a report on black maternal health in 2023. We highlighted that data was an issue and data collection was an issue. We have heard about timelines of within three years, from what I understand, but we have not heard about the quality of this data. What is a measure of success when it comes to ethnicity data monitoring for you? What are you measuring success by? How is it going to be reviewed? That answer could be written back to the Committee because I have other questions around racism in maternity care.

Though black people make up 8% of the NHS staff in its entirety, less than 3.5% make up any senior positions. We have heard time and again, for decades now, that the NHS senior management and decision-making powers rest far too much on a very narrow group of people, predominantly white men. What is being done to tackle this? We heard from a previous panel that a lot of this has to do with the leadership of NHS trusts and the individual NHS trusts, with chief executives at the head of this. When it has worked, they have taken a lead on it. When it has not worked, they have ignored it. We need accountability to chief executives. As decision-makers around this table, we need to be able to say that there is accountability, but that does not seem to be happening. What can be done to improve that?

Baroness Merron: I will share a few general points and then turn to Kate. I certainly understand the point that has been made. We will gladly write further on how we measure whether the data is giving us what we need. I am happy to do that.



HOUSE OF COMMONS

Leadership is absolutely key. In my view, culture is the big issue. Turning around culture, as I am sure Committee members are fully aware, will not happen overnight. I know there is no expectation of that, but it is a bit of a tanker to turn around.

Going back to acknowledgement, the culture is not set right. That does come from the top. When the Secretary of State Wes Streeting says, "Racism is abhorrent. We will not tolerate it"—we can have many discussions about where it manifests, and it does—that is leadership and culture, for a start. It is quite right to talk about ICB leadership, by the way. More generally, we have a workforce plan, which will be published after the 10-year plan. Again, we will see that. That will look at all areas.

If I may, Chair, I will turn to Kate to get NHSE's point of view.

Q140 Sarah Owen: Before you do, as much as the Secretary of State says it is not tolerated, it is tolerated. It is the very experience that black mothers are having every time they go into maternity units. That is what they are scared of. It is the experience of staff. The CQC is writing reports declaring that some maternity services across the country—some of them are very good—have problems with racism. It is being tolerated and it has been tolerated for far too long. I am glad that the leadership within Government have said they are not going to tolerate it, but I want to know what happens when local leaders are failing to deliver.

Kate Brintworth: Thank you for the question. It is absolutely the right one to ask because we need to have diversity in our leadership. We are weaker without that diversity. Within maternity, it is one of the things that we have been actively tackling. Each of the regions has been undertaking leadership programmes to support staff from black and ethnic minority backgrounds. They are doing that at different levels of the system. We need to build this for the future. We cannot tackle one element and expect that to be the answer. We have to do it at different bands and grades. We have been doing reverse mentoring with senior leaders so they understand experiences, which was extraordinarily well evaluated.

The chief nursing officer and I have a strategic advisory group, which is made up of senior leaders from black and ethnic minority healthcare, that is very clear on what we need to do and that challenges and drives us to do this differently all the time. It is about tackling it from a multitude of perspectives.

Professor Owolabi: I just want to acknowledge that indeed racism is a real lived experience of black mothers in our services and black members of staff. I just wanted to acknowledge that.

I am the senior responsible officer in NHS England for the NHS Race and Health Observatory. One of the things that I tasked the observatory with doing was to prioritise maternal health inequalities in its annual work plan. That has translated into a couple of things. First, we are working



with the Institute for Healthcare Improvement in the US and nine local trusts in England on a quality improvement approach to addressing racism. That is called the learning and action network. It went live in January 2024. We are looking forward to seeing some of the results and outputs from that in September of this year, with a view to seeing the lessons learned from a scale and spread of best practice point of view. Secondly, the Race and Health Observatory has also published its anti-racism principles, which have been adopted by a range of organisations across the country, including our NHS services.

On the point of racism specifically, first, we are trying to take a quality improvement approach to learn what works on the ground and, secondly, we are implementing a set of principles to guide organisations' actions in that space.

Q141 Sarah Owen: That is fantastic. As Baroness Merron said, the leadership from the Government is very clear on this, but what happens when all that good work is not implemented? Whose shoulders should that fall upon?

Professor Owolabi: NHS England is very soon going to publish its new management and leadership framework and expectations. That is in development as we speak. Health inequalities is a significant feature of that. It will be setting out the expectations and the implications when people do not comply with the standards. It is a set of standards for managers and leaders across the NHS. We have worked incredibly hard with the people writing those standards to make sure that expectations around health inequalities are absolutely integral to that. It will include some of those expectations and the implications of non-compliance.

Sarah Owen: There is no point in having expectations if there are no implications for when it is not met. That might just be the voice of my mother speaking.

Baroness Merron: Wise woman.

Q142 Sarah Owen: She was a nurse for 42 years, so very wise. I have one last question. We have heard from the panel—it was brilliantly outlined—how maternal health for a woman, whether they are black or another ethnic minority, depends very much on their health throughout their life. The Women and Equalities Committee heard in its inquiry on medical misogyny and this Committee has heard that women are just not being listened to.

On the first panel, Sylvia—she is somebody who knows how to advocate for herself and who works in this field—said she was not listened to. This seems like a really basic thing to get right. Just listen to women. In this instance, just listen to black women. One of the things that women are crying out for is a strategy for women's health. Where are we with the women's health strategy?



HOUSE OF COMMONS

Baroness Merron: One of the things that I was shocked about when I came into post was women's voices not being heard repeatedly. We are seeing the effects of that, frankly. That is women who are users of the service and women who are working in the service, remembering that the NHS is the greatest employer of women. Very quickly, on accountability and all these things, I think there is an issue with accountability. I will ensure that we work on that.

The women's health strategy was published under the last Government. We are working through where we could improve it and making sure that it is doing the job that it should. There are a number of improvements that could be made. Of course, we need to make sure that it sits within the 10-year plan, but it is already being actioned. Could it be better? Yes. However, we are working with it. Around the system, people are very used to it and comfortable with it, but not so comfortable that we are not going to drive people to do better, perhaps I should say.

Q143 **Alex McIntyre:** Thank you very much for your answers so far. I am going to build on Sarah's questions. It is very welcome to hear a Minister addressing the fact that there is institutional and structural racism within our health service, and particularly within maternity services.

Having represented the NHS for a number of years, I know that the number of policy documents within NHS England would probably take us to the moon and back, if you printed them out and piled them up. My question is a multi-part question. What steps are the Department and ICBs actively taking? Other than introducing more frameworks and policy documents, what active steps are we taking to address institutional and structural racism? Are ICBs fully cognisant of the issue as much as the leadership in the Department is? What conversations have you had as a Minister with ICBs about this? How are we going to hold them to account on those? What measurable outcomes will you be looking at to see whether they are taking on board this new culture that the Government are setting?

Baroness Merron: Let me start by being clear that I have not used the words "institutional racism". I spoke of racism. As Professor Bola said rightly, it is a true and real experience for staff and service users. It is one of a number of shocking discoveries that we are working on. I just wanted to be clear on that. That was the first matter.

As I said earlier, NHSE works directly with ICBs. It might be helpful to ask colleagues to give their day-to-day examples of how they are working on this. Again, I have to emphasise that, particularly as we make change with NHSE coming into the Department, this is a great opportunity to reduce duplication and to make sure the accountability and the systems are correct. To me, it is a big change that will produce results.

Kate Brintworth: When I was regional chief midwife in London, we developed and co-produced with service users an anti-racism framework, which services were then able to take and work through the microcosm



detail that is so important in the unpicking of people's experiences of racism. As the Baroness has said, we acknowledge that women are having suboptimal experiences. We see this. Their harrowing descriptions of racist care are unacceptable. When I talk to the services, the message that I get really clearly is they want to know what to do. They want to know how to tackle it. That is why we put a framework together with lots of detail.

Q144 Alex McIntyre: Can you give a couple of examples of the practical steps within that framework?

Kate Brintworth: Sure. It is things such as unpacking recruitment practices, speaking to the point about people not progressing because of them being black or Asian. How do you make your recruitment anti-racist? How do you make sure that you are listening to all your staff properly and it is not certain people who get a voice? Do you have equitable voices who can then drive system improvement? How are you making sure that cultural competency is embedded in your service? These are the pieces of work that are going on all the time.

Just yesterday, the south-east region, for example, sent me their new resource for undertaking the assessment of jaundice in a newborn baby who has black or brown skin. All the time, these pieces of work are going on and services are recognising this.

This also builds on what Professor Bola was saying about the work of the Race and Health Observatory. Again, that is services looking in great detail at what might seem on the face of it a very straightforward policy about the management of bleeding, but, when you get under that and you look at your own data, how you are implementing it and the assumptions in it, you start to reveal the areas that you need to tackle. There is a lot of work going on.

Professor Owolabi: Just building on Kate's point, as a GP myself, I absolutely agree that it really is about the actions that we are taking on the ground. Multi-layer action, as I said before, in terms of getting the ethnicity recording right, is incredibly important. There is work that is already going on. As we said before, the ethnicity recording in the maternity services dataset is 96% complete, which is by far and away one of the best datasets. That is really important to note.

The other thing is that we have recently published the patient safety healthcare inequalities reduction framework. In that framework, we talked about the need to provide language and interpretation services. As MBRRACE told us last year, the inconsistent provision of language and interpretation is a material contributor to some of these adverse outcomes. Again, we have literally just published our community language translation and interpretation framework, which sets out our expectations of what the provision needs to be at practice level. That is absolutely crucial. When we talk about equitable access, the first thing about equitable access is to understand and be understood. As that



framework is being implemented, I am confident that people will start to notice a material difference.

Finally, picking up on Kate's point, the RHO has demonstrated that the props that we use in our training do not necessarily reflect the population that we are serving. The simulation units in pretty much every maternity unit across the country now have different skin tones in the mannequins that are used for training, both for the women and the newborns, so people can understand how different conditions present differently depending on skin tone.

Professor Chappell: I would add two very brief examples. The first is the work more broadly around our devices being not just for white men but for women or babies, as Kate suggested. The other is something that we have not really touched on, which is our mental health provision, particularly after birth. We need to understand that in a cultural context, not just a medical context. It is about how we tackle racism across all the services.

Q145 **Alex McIntyre:** During a recent Westminster Hall debate, Minister Ashley Dalton highlighted the role of leadership—we have touched upon that today—in tackling racism, and referred to the fact that all maternity and neonatal units in England had signed up to the perinatal cultural leadership programme. How is the Department monitoring and evaluating the impact of that programme? Have there been any early findings or data that you can share with the Committee today?

Kate Brintworth: The point of this was, as you have identified, to tackle culture and leadership. If you do not have the leadership and the drive, you do not get the attention. It is about the data, but it is also about drive, curiosity and creating a culture in your unit where you ask difficult questions of yourself. You need to look yourself in the eye, hold a mirror up to what you are doing and say, "This might be good, but this needs improvement. We need to lean into that."

What was really important about that is it was multidisciplinary. It was not just midwives, obstetricians, neonatologists or managers; it was all of them coming together. Over three quarters of them said that they immediately had better relationships by virtue of being on that programme. Although that might sound like a small thing, better relationships are key. If you are not working as a team, you are not going to create a safe environment for work. We are actively considering whether we will do a further iteration of this programme. It is something that we are very interested in rolling out.

Q146 **Alex McIntyre:** I want to move on to the patient safety incident response framework. Is the Department satisfied that the framework is ensuring that incidents involving black women are properly identified, investigated and used to improve services?



Kate Brintworth: The point about what is known as PSIRF is that it has moved away from looking at an individual incident, unpicking it and saying, "This practitioner didn't do the right thing," or, "We didn't put that guideline in the right place," and is trying to understand the culture and the human factors that go into the creation of an incident. No one goes to work to have a bad day, do the wrong thing or behave badly, but we know that is what happens on occasions. We are trying to understand the factors that underpin that and the commonality of it across incidents.

This feels like a great opportunity. We should look at incidents on an individual level, 100%. Every maternal death is appalling and deserves that scrutiny, but we also need to have that more thematic or systemic review so we really get under the skin of culture. You will not do that by looking at individual incidents.

Professor Chappell: Can I just give an example from MBRRACE? As a clinician, one of the things that the MBRRACE confidential inquiry into maternal deaths has done is call out those trends. There are data to show that where a national recommendation on either adopting guidance or driving guidance has been made, you then see a change in outcomes. We are making sure that we are learning from what works, understanding and listening to women on individual incidents and then asking how we can spread and scale the change that needs to happen as a result.

Professor Owolabi: Very quickly, if I may build on that, in addition to the PSIRF, we recognise the intersectionality between patient safety incidents and health inequalities. That is the reason we have published the patient safety health inequalities reduction framework. One of the five things that it is asking providers to do is disaggregate the data about patient safety incidents. If we just work on the basis of aggregate data, we risk not seeing the differential impact of suboptimal care on different population groups, such as black women and other ethnic minority women. One of the five asks of the reduction framework is absolutely about disaggregating that data.

Q147 **Alex McIntyre:** I will move on quickly to workforce. As the MP for Gloucester, I am delighted that my local hospital has made really good progress recently on recruiting more midwives. We have a fully staffed maternity service. Could the Minister update us on the target to recruit an additional 1,000 midwives by 2026? Do we expect to meet that?

Baroness Merron: As the Committee will be aware, one of our manifesto commitments in this area is about training thousands more midwives. I cannot give a specific answer to that question. What I can say, if it is helpful to the Committee, is that we now have 1,400 more full-time equivalent midwives than we had in July of last year, to give you some sense of progress.

I should not just focus on midwives, of course, because we are talking about a team. I am sure the Committee has considered that matter. There are more full-time equivalent nurses in neonatal settings as well,



HOUSE OF COMMONS

some 300 more than there were a year ago. Compared to five years ago, there are 1,400 more. I am happy to continue. If you would like any more statistics about increased numbers in the whole team, including midwives, we would be delighted to offer them.

Alex McIntyre: That is very helpful.

Chair: You can write to us on that.

Baroness Merron: I think that would be helpful. Let me emphasise one point. Am I satisfied with that? No. Am I looking forward to the workforce plan? Yes.

Q148 **Alex McIntyre:** Without wanting you to pre-empt something that is not yet published, will the workforce plan set out how we can increase the diversity of the workforce as we seek to increase numbers?

Baroness Merron: Yes, that is crucial.

Q149 **Alex McIntyre:** The previous panel—you may have heard them as you joined at the back—referred repeatedly to burnout and retention of the workforce, in particular midwives. What is the Department doing to address that? We can recruit additional midwives, but, if we are losing them at the same time, it is really difficult to improve the service.

Baroness Merron: I will just make a few general points and then turn to colleagues to add more. In terms of the retention of midwives, there has been a change, which has created a new situation for us. We have a bit of a time lag in terms of the training of midwives. Some concerns have been reported about the availability of vacancies so midwives can be employed. That is because retention has improved. We have a more stable workforce than we originally started with, which is good.

Is it complete? No. Do we want new people being trained and put into vacancies? Yes, we do. Our regional teams are working on that. The situation has changed. Perhaps my colleagues might wish to embroider that, if there is time.

Q150 **Alex McIntyre:** The evidence was quite clear from the first panel that morale was still pretty low.

Baroness Merron: I understand that.

Q151 **Alex McIntyre:** What steps can the Department and NHS England take to improve morale?

Kate Brintworth: One of the things that we have done is fund a retention midwife in every unit, which was a really important intervention to focus on the wellbeing of staff. We have also increased the number of professional midwifery advocates. These are midwives who receive extra training specifically to support, supervise and develop the workforce to make sure that they have that safety wrapped around them.



HOUSE OF COMMONS

We have taken that very seriously. We have started with students. We have put in something called the safe learning environment charter to create an environment that is appropriate for students to learn. We recognise that the emotional labour of being a midwife, an obstetrician or an anaesthetist is hard and the need for that support and supervision has never been more apparent.

Q152 Alex McIntyre: I have one final question, which is probably to ask Professor Shehata's question. The Royal College of Obstetricians and Gynaecologists was working on the workforce planning tool, which is now sat with the Department, as we understand it. Where is the roll-out of that? When is it expected to be rolled out?

Kate Brintworth: We are very grateful to the royal college for the work that it did on understanding the current situation of the workforce based on averages of what we were seeing at the moment. Everyone will acknowledge that we are in a period of particularly rapid change in services and the health needs of our population. The caesarean section rate as a whole is now between 40% and 50%. The induction of labour is up to around a third of all women. That has significantly shifted what we need to do. We are grateful for the baseline that they have created, but we want to work in partnership with them to say what future state is required.

Q153 Andrew George: On that last point, you heard the exchange between me and the panel earlier. There was an expression of frustration on their part that this workforce planning tool has been sitting within the Department, effectively, or NHS England, for some time. From what I have just heard from you, Kate, it sounds like there is a plausible reason to kick the can down the road a little further. Will there ever be a right time to implement such a thing? Surely it would be far better to implement it and adjust it as you go along.

Kate Brintworth: There is absolutely no intention of kicking the can down the road, but we cannot go down the road of doing something for the sake of it when the environment has changed beyond recognition in the last 10 years. As an obstetrician, Lucy would agree with me on that.

Professor Chappell: Yes.

Kate Brintworth: The situation is very different. It is also recognising that most obstetricians hold dual roles as obstetricians and gynaecologists. How they play out their PAs, as they call their allocations of time, to different elements of work varies hugely. It is a very complicated and shifting picture.

Q154 Jen Craft: Organisations that have given evidence to this Committee, including the previous panel, have called for mandatory training on cultural competency. Indeed, when I asked this question to the previous panel, they were fairly unanimous in their response about whether that would go some way to addressing the concerns around maternal health.



HOUSE OF COMMONS

Is this something that you would support?

Baroness Merron: From my point of view, what matters is ensuring that the care is culturally competent. That is what we are all concerned with.

Chair: I never butt in, but that was not question that you were asked, if you do not mind me saying so.

Baroness Merron: I am sorry. I should be simple with my answer.

Q155 **Jen Craft:** Would you support mandatory training on cultural competency?

Baroness Merron: I cannot give a yes or a no. Let me be honest about that. What matters to me is that we have the right training and it is making a difference. Whether it is mandatory—people have different views about what “mandatory” means, Chair—is not the bit on which I would spin. Personally, I would want to say, “What do we need? How do we train? How do we get that out?” Across the NHS, it is variable. It should be based on output—not the how, but what it delivers. I cannot give a direct answer in that respect.

Q156 **Jen Craft:** One of the concerns that has been raised, particularly by the previous panel, is that there is no mandatory training across the board. Cultural competency is not included on midwifery training programmes. The availability of cultural competency courses in university training courses is fairly low, if it is offered at all to students. It is not ongoing or offered as part of continuing professional development.

There is a concern that mandatory training can be a tick-box exercise. It can be, “You’ve done a one-day course. Well done you. You can print it off.” However, they were fairly clear that they would like to see, across the board, a commitment to training that is meaningful, in depth and ongoing. This is something that has come up again and again. If you do not support mandatory training as such, how do you ensure that midwives, obstetricians and everyone working in the maternal space receive some degree of training and knowledge on cultural competency?

Baroness Merron: I may turn briefly to a colleague, but one of the ways—

Chair: If you are going to turn to a colleague, turn straight to the colleague. We are so out of time.

Baroness Merron: I will turn to my colleague.

Professor Chappell: There is a broader look across mandatory training across the NHS because of the burden of repeating. It is not just the training; it is what you do with it that counts. I would really call out multi-professional training that is particularly situated in real-world scenarios and really addresses the cultural drivers of behaviour and the outcomes that matter to women. There is a huge amount of culturally



competent training. It is about how we enact it in our day-to-day interactions with women that is really going to make the difference.

Q157 **Jen Craft:** How do you do that?

Professor Chappell: It is bigger than just a day of training. It is not about the day of training; it is about the other 364 days of the year. It is about working with colleagues such as Kate and Bola in practice to live it, not just going and watching some slides.

Q158 **Jen Craft:** I do not think the previous panel would disagree with that—I do not want to put words in their mouths; they are still in the room—but I think they would say that, at the moment, the level of cultural competency training for people who work in the whole maternal space is so very low, and that is having an impact across the board.

Professor Chappell: We would like to work with the royal colleges, which should be leaders in this. I am a fellow of the Royal College of Obstetricians and Gynaecologists. We all own this as a team. You are describing the universities, the trusts and the royal colleges. This is a team approach to changing outcomes for women.

Q159 **Chair:** Because of time, I will cut my question very short. It is around initiatives aiming to improve maternity outcomes. I will ask the Minister to answer first and Professor Bola to follow on. Why does it appear that we are making very little to no progress with these initiatives? What is causing the failure of the many initiatives that have been started? Is it because they are not being delivered correctly? Are the initiatives not the right ones, or are they not at the right levels? There are just so many of them, and they just do not seem to be impacting what is going on. Baroness Merron, I will definitely understand if you pass it straight on.

Baroness Merron: I will make a brief comment. The persisting inequalities are completely unacceptable. There have been some improvements, but I would put a bit of a health warning on some of the statistics about the decrease in mortality rates for black women, for example. We need to look at the fact that that is a bit distorted by mortality rates for white women rising faster as well. There is quite an issue about data interpretation, which is why we need better data. That is my point on that one. We also suffer rather from the data lags, which we have talked about.

This will be my final comment to the Committee. We will shortly be announcing a package of new actions to tackle some of the endemic issues, some of which we have covered today. We have to develop longer-term actions with the involvement of families and those with lived experience.

Q160 **Chair:** Thank you for that. Professor Bola, I was talking about some of the initiatives that have been undertaken but have not been very successful. Do you have any response to that?



Professor Owolabi: I absolutely agree with you that we have a significant amount of work to do. To echo the Minister's point, we have seen a 17% reduction in black maternal mortality since 2018. Is that good enough? Absolutely not. As it stands, the mortality rate is twice as likely in black women than in white women. For Asian women, it is 1.4 times as likely.

Q161 **Chair:** Can I be honest with you? Everybody is giving their own statistics. From the statistics we have been given, the difference between black women and white women is 3.7 times. You have said two to one, which is another statistic. We do not seem to get the figures right in the first place when we go out to the public.

I will ask again: a lot of initiatives have been completed. What have been the failings? Why do we not seem to have consistency on the reduction? Why are people still adding confusing statements into what they are saying?

Professor Owolabi: It goes back to the point about data, which we talked about right at the beginning of this conversation. I am quoting the MBRRACE data, which is the robust dataset that we rely on to tell us the actual state of affairs. That is our most comprehensive and robust dataset. It shows us that there has been a 17% reduction in maternal mortality in black women since 2018. However, I really want to emphasise that the fact that black women are twice as likely to die is still unacceptable. That is not just about black maternal mortality. It is also in relation to neonatal deaths and stillbirths.

To your point, why have we not seen the scale of progress that we would like to see? I will mention four things. First, there is something about leadership and holding ourselves to account to consistently implement the plethora of initiatives that we have talked about through the course of the Committee today. There is a leadership question.

The second factor, to your point, is the data. We need to make sure we are consistently telling the data story on the basis of the most robust dataset that we have. Thirdly, we need to communicate that clearly to our women, their families and their communities. There is a lag between what the data is telling us quantitatively and what we are also sharing with women and their families.

Finally, there is something material about co-producing solutions with women and the communities. The danger is that we lift and shift national initiatives into a local context that has its own particular issues. I will give an excellent example from Bradford. They have looked at their community. They have a significant proportion of women who are asylum seekers and refugees from ethnic minority communities. They brought in doulas. The doulas have been going for 10 years now. We can see the material difference that it is making in women's experiences. The doulas are from the community, of the community. They are trusted. They are trusted voices and faces to the women and their families.



HOUSE OF COMMONS

To my mind, those are the key things that we need to think about. As the 10-year health plan gets published, as the Secretary of State declared at NHS ConfedExpo last week, I am confident that health inequalities are back. When the 10-year health plan is published, people will see that that is indeed the case.

Chair: That is a really good place to end this session. Thank you all for coming. There will be a couple of questions that we will forward in writing to the Minister for a response. Other than that, thank you all for being so honest, frank and open.