



# HOUSES OF PARLIAMENT

## Joint Committee on Human Rights

Oral evidence: [Black people, racism and human rights](#), HC 559

Monday 20 July 2020

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Members present: Ms Harriet Harman (Chair); Ms Karen Buck; Joanna Cherry; Lord Dubs; Mrs Pauline Latham; Baroness Ludford; Baroness Massey of Darwen; Dean Russell; Lord Singh of Wimbledon; Lord Trimble.

Questions 11-21

Witnesses

**I: Professor Jacqueline Dunkley-Bent OBE**, Chief Midwifery Officer, NHS England and NHS Improvement.

## Examination of witness

Professor Jacqueline Dunkley-Bent OBE.

Q11 **Chair:** Good afternoon and welcome to this meeting of the Joint Committee on Human Rights. We are a parliamentary committee. Half our members are from the House of Commons and half are Members of the Lords. As our names suggests, our concern is with human rights. Those are the basic, fundamental human rights: freedom of speech, freedom of association, the right to participate in democracy, the right not to be detained unlawfully, the right to a fair trial and suchlike, including the right to life and the right to value life.

In the context of the Black Lives Matter movement, we as a committee are looking at whether there is equal protection for the rights of black people compared with non-black people. This is our second session on that issue, and we will be reporting in the autumn on the basis of this inquiry. We have two panels of witnesses giving evidence to us today, and we are very grateful to them. The second panel is from the Equality and Human Rights Commission, and we are grateful to have its chair and executive here.

For our first panel, we are very grateful to Professor Jacqueline Dunkley-Bent, who is the chief midwifery officer of the NHS. Thank you for joining us. We know that there has been a welcome reduction in mortality of women from complications in pregnancy over the last decade or so, but within that there are significant variations based on race.

While seven in 100,000 white women die of pregnancy complications or childbirth, for black women that figure is 38 out of 100,000, meaning that the death rate for black women is five times higher than for white women. Obviously we are looking at this in the context of the right to life and the right to family life.

I would be grateful if you could deal with the first question. Why is this the case, and when was it first established beyond doubt that there was this racial disparity in deaths among black and non-black women during pregnancy and childbirth?

**Professor Jacqueline Dunkley-Bent:** Any maternal death is an absolute tragedy. Having, like others who work in maternity care, supported and delivered hundreds of babies throughout my career, I still find this unpalatable. These data sometimes obscure the human experience. This is a precious life, and that is why colleagues and I in this space at NHS England try to reduce the mortality and morbidity of black and Asian women and women who

are socioeconomically disadvantaged. We take our lead from the data from the report by MBRRACE-UK—*Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries*—which has indicated to us that there is an inequity in health outcomes for black and Asian mothers and the socioeconomically disadvantaged.

There are plausible explanations for that. The data relating to black African women show comorbidities that may well be associated more with ill health, such as the obesity challenge. For example, the data say that some 33% of black women are more likely to experience obesity at booking compared with 22% of white women. That then creates a challenge during pregnancy. Equally, heart disease and other such conditions are more likely to occur in certain communities like the British black African community. If I may step into the Asian women's space, we know that if you are Pakistani, for example, you are more likely to experience neonatal mortality. Some of the explanations for that relate to close-relative marriage, and you are more likely to have a baby who has a congenital abnormality and is therefore less likely to have a good outcome.

With all those examples, there is more that we need to do to make sure that we close that gap. We need to be timely with our intervention and be responsive to the needs of women and their families. That is why we have *Better Births*, a report by the National Maternity Review, which is four years into a five-year programme, and the *NHS Long Term Plan*. Both those policy documents lend themselves to focusing on socioeconomically disadvantaged women but, in this space, black and Asian women in particular.

As an example, we are asking for a model of care called "continuity of carer", which would improve outcomes for mums and babies. Continuity of carer is care that is provided by the same midwife throughout the antenatal, labour and postnatal periods. We know that if you have that continuity and build a relationship, you are 24% less likely to have a pre-term birth, less likely to lose your pregnancy, and more likely to have an improved maternal experience throughout the pregnancy. Those data have informed our policy, which is why 75% of women from a British black African or black Caribbean background will receive a continuity of carer. That is one of our policy ambitions.

Q12 **Chair:** As with everything, the situation is of course made more pronounced with Covid. The Royal College of Obstetricians and Gynaecologists has reported that 55% of pregnant women admitted to hospital with coronavirus were from black, Asian or

minority ethnic backgrounds. How are you dealing with that, which is added to the existing racial disparity—the Covid racial disparity, which is like a multiplier in this situation?

**Professor Jacqueline Dunkley-Bent:** Yes, Covid has shone a light on inequality. We had information before on inequality in health outcomes, but Covid has shone a light on this situation. We know that if you are from an Asian background you are four times more likely to be in hospital when pregnant with Covid-19, and if you are black you are eight times more likely.

Like everywhere in the NHS, with the evidence that is emerging we are in a space of learning. What we have done at pace and intensity is provide communication to women and their families through our local maternity systems, our head directors of midwifery and any of our health professionals who are engaging with pregnant mums, so we are responsive to these concerns. We have used social media platforms and websites and developed animations and leaflets to deliver key messages that encourage women to engage with pregnancy services in a timely way rather than sitting at home.

We have anecdotal evidence telling us that pregnant mums are fearful and scared of engaging with maternity services for fear of catching Covid-19. Along with the UKOSS data that you cited, showing that black and Asian minority women are disproportionately in hospital in comparison with their white counterparts, our anecdotal evidence tells us that women are fearful, so they are more likely to sit at home with a problem that, in a world without Covid, would have taken them into hospital to receive timely care.

As the evidence emerges, we are learning more about why this group is affected. The reasons are similar to the rest of the population, but what can we do in the maternity space at this time? We have reached out to women and their families to reduce their anxiety, fears and concerns through the media that I have mentioned to encourage them to engage with us early.

A week or so ago, I and Dr Matthew Jolly, a consultant obstetrician and the national clinical director—the two of us work hand in hand as midwife and doctor to support our maternity providers—published a four-point plan that was sent out to local maternity systems and the wider NHS, particularly maternity. The four points include lowering the threshold for black, Asian and minority ethnic women who use maternity services so that we are more sensitive to timely referral, screening, diagnostics and all the things that one

would do, heightening the sense of astuteness to focus on this group and thus lowering the threshold for admitting and referring.

The second point in the four-point plan is encouraging local maternity systems and maternity providers to change the way in which they communicate with women and their families. We have done an awful lot of surveillance work with black women, Muslim groups and women's networks to try to understand what is driving them and influencing them to stay at home. So the second point in the four-point plan is communication, and it is influenced by what they have said to us. The communication needs to be in a way and in a language that they understand. They need to see people who look like them giving the message. Their antennae may well be raised to hearing that message and then acting on that communication and that message.

- Q13 **Chair:** With over half of the pregnant women who are admitted to hospital with coronavirus being of black, Asian or minority ethnic background, if you add that to the five-times-greater likelihood of black women to die in pregnancy or childbirth, are you expecting that the racial disparity between white women and non-white women will be even worse than the fivefold disparity that we already have between black women and non-black women because of Covid?

**Professor Jacqueline Dunkley-Bent:** If you follow the narrative that you have just shared, one would think so. However, our stillbirth rate generally is reducing, for black babies too, and the maternal death rate is reducing. I do not want to scare people; maternal death is not as common as the data may make it sound. Five times more likely to die in pregnancy is a real statistic, but in real terms that may equate to some 70 women out of the 660,000 births that we have in England every year.

Now, one maternal death is tragic, and I am not trying to suggest that it is not, but with our interventions, communications, our working with women and our maternity voices partnerships, users of maternity services are telling us what we need to do to get it right for this group of women. So with all the interventions that we have, the United Kingdom Obstetrics Surveillance System study tells us that the maternal death rate is not increasing commensurate to the death rate from Covid generally for the population. The numbers are below eight for pregnant mums who have died as a result of Covid.

As I say, one maternal death is one too many, but we are working really hard to make sure that our messaging is heard and that it is

on point and relevant so that it can be acted on by the communities who need it the most.

Q14 **Joanna Cherry:** Can I take you back to what you said about the four-point plan that has recently been published? Did we cover all four points? I have noted the first and second points. Could you iterate the third and fourth for me?

**Professor Jacqueline Dunkley-Bent:** I mentioned lowering the threshold, and I talked about the communication plan. Another third point relates to ethnic coding. We need to make sure that we record ethnicity in an appropriate way and record the comorbidities. Some of the pre-existing conditions that women experience outside of pregnancy are really important. If we have those data, we can have good surveillance and then we can sharpen our focus on ensuring that women get the most appropriate care.

**Joanna Cherry:** Is that point four? I am just looking at the written evidence which the Royal College of Midwives has provided for this Committee session, and I think point three is ensuring that hospitals discuss vitamin supplements and nutrition in pregnancy with all women. The four-point plan has just been published, within the last couple of weeks or even more recently than that. How does it relate to the NHS long-term plan, which you told us had established a principle of continuity of carer for pregnancy and beyond?

**Professor Jacqueline Dunkley-Bent:** Apologies, I did not mention vitamin D. Our four-point plan specifically talks about nutritional requirements and vitamin D, particularly for women who cover up when they are out in daylight or indeed for dark-skinned women like me. The similarity with the long-term plan is that this is focused on BAME women. In the long-term plan we are asking for 75% of women to receive continuity of carer. While the four-point plan does not say "continuity of carer", local maternity systems already have that action as a part of their action plan for implementation.

**Joanna Cherry:** So how does the four-point plan fit into the NHS long-term plan?

**Professor Jacqueline Dunkley-Bent:** With regard to continuity of carer, every midwife carries a case load of women and provides antenatal labour and postnatal care. The good outcomes of continuity of carer are predicated on relational continuity—a relationship that builds up. A woman is more likely to listen to a person who she knows and trusts. In the antenatal period, if a

woman was from a black, Asian or minority ethnic background, vitamin D would sit within that conversation, for example, so the care is focused and personalised.

On communication, the leaflets that I talked about in the four-point plan are in different languages. They cover pregnancy, the sick baby and the sick mum. That would be very much focused in a personalised way, so the continuity midwife would select the appropriate leaflet for that woman.

**Joanna Cherry:** I would like to focus on the long-term plan for a moment. Other than the continuity of care plan, did it include any other suggestions for improving the data that we are discussing?

**Professor Jacqueline Dunkley-Bent:** We have a universal offer. We are utilising Michael Marmot's principle of proportionate universalism, which is care at a scale and intensity that is equal to the level of disadvantage. In the long-term plan entry, continuity of carer is for those who need it most. We need to have a model of care applied to those women because continuity of carer improves outcomes and reduces pre-term birth. If you are black African or Caribbean, or Asian, you are more likely to experience a very pre-term-birth baby.

Another thing that we are doing in the long-term plan that sits in this space is another universal offer, the saving babies' lives care bundle. That is a toolkit that includes four elements that help to improve outcomes. Because of evaluation and the government target to reduce pre-term birth, we have now included a fifth element targeted at reducing pre-term birth. So, in the long-term plan, the saving babies' lives care bundle firmly sits in the space of a targeted effort. While it is a universal offer, black, Asian and minority ethnic women will benefit from an area where they are considered to be more likely at risk. Then we have two other items in the long-term plan for maternity.

Another item in the long-term plan for maternity is pelvic outreach clinics, for pelvic floor integrity. We want all women who may experience leaking before or after childbirth to have timely intervention so that they can have quality of life in future. That affects all women, but the evidence tells us that certain women are less likely to disclose some of these concerns and challenges. We know, for example, that black women and immigrant women are less likely to disclose anxiety and depression concerns, so we have hypothesised that if they are less likely to disclose items like that, how likely are they to disclose leaking of urine if they do not know the person who is caring for them? That is why our platform for

delivering equality in health outcomes is continuity of carer. That relationship is key.

Q15 **Joanna Cherry:** That is very helpful. In preparation for this session, we in the Committee were particularly shocked to learn that the death rate for black women specifically was five times higher than for white women. Drawing on your expertise, and having regard to all the measures that you have talked about, do you think that enough is now being done, or could more be done to address that rather shocking statistic?

**Professor Jacqueline Dunkley-Bent:** That is a good question and a pertinent one. While we have come a long way, we have much to do. My view is that we need to learn from the people who are experiencing these challenges. That is why the maternity voices partnerships will be set up for black, Asian and ethnic minority groups, not those who are usually around the table but the women who would not ordinarily want to go to a committee or indeed complete a survey. There are many things that we are looking at doing in this space. What we have done we have done well, but I believe that we need to move further faster so that we do not have this inequality in health outcomes.

**Joanna Cherry:** So you are saying that it is important to hear from the women who have not experienced these health inequalities. Does that still need to be done?

**Professor Jacqueline Dunkley-Bent:** We have done that, but we need to do it better. The CQC survey last year told us that black women in particular reported that they were more likely to be listened to, so the percentage of women who reported that they were listened to was higher than their white counterparts. That was one indicator, and an example of the fact that some of the plans and interventions that we have put in place are creating and making improvements. Covid has shone a light, again, on the fact that we need to do more.

While I am speaking about maternity voices partnerships, I could also speak about reaching out to certain communities via our networks and engaging with the leaders of those communities to tell us what is blocking them from engaging, and what we can do to put it right. That is the space that we are in at the moment. I have personally run two events in the last four weeks of that nature, one in the West Midlands and one nationally.

Q16 **Chair:** I would like to follow up on that question. You have talked about issues relating to heart conditions and obesity, and disclosing in order to get early treatment. That is all focused on the woman

herself. What about the services? Is there anything about the services that you think might be contributing to this racial disparity, or is the racial disparity centred—in the way that you have put it—in the woman's own health and actions? Is it nothing at all to do with how the service treats black women differently from non-black women? Is that not an issue, in your view?

**Professor Jacqueline Dunkley-Bent:** It is very much an issue. It is multifactorial. The maternity providers are not going to reduce this inequality gap by themselves. I mentioned the principle of proportionate universalism, providing care at a level of scale and intensity that is equal to the level of disadvantage. We are frequently messaging out to the 30 maternity providers: "Know your geography, know the people who use your service", and they all do. We urge them to apply maternity care that is personal and safe for that group. For example, there are some services that set up female genital mutilation clinics for women who experience FGM. They do not just put them in hospital; they put them in the community.

On our own policy, *Better Births*, the report of the National Maternity Review, talks about community hubs. That means that the maternity provider should find a place in the community, be that a GP surgery, a children's centre or a community centre, where they can provide health services so that they are providing care in the heart of the community. We learned an awful lot from Sure Start about the benefit of being within the community, so that when a woman goes for her maternity care she can also be exposed to speech and language therapy, a dietitian for nutritional health and so on. Our policy, which was published four years ago, very much talks about growing community hubs.

In relation to stereotyping, we have much to do in that space. We want every health professional to think about unconscious bias and think how that might influence the consultation with women and their families. That is in part why we have the workforce race equality standards, the WRES, which were published several years ago and which all NHS services, not just maternity, are required to meet.

Q17 **Lord Dubs:** Thank you very much for what you have been telling us, Professor. I wonder whether you feel that you have all the necessary data and research to enable you to understand and monitor black women's experiences of maternity services. You have quoted some statistics up to now, but do you have enough background in data and research?

**Professor Jacqueline Dunkley-Bent:** That is a really significant question. With the appropriate data, we can sharpen and focus our interventions. We are grateful for our reports and to our colleagues who are working at speed to develop information and produce data. However, I am still not confident that we know why there is an inequality in health outcomes between a black woman and a white woman. We have plausible explanations and the evidence on comorbidities is compelling, but there is something more.

That is why the Department of Health has commissioned our colleagues to undertake an additional piece of research to understand the disparity in health outcomes for black, Asian and minority groups for mother and baby, and we are looking forward to receiving the outcome of that research towards the end of the year.

In answer to your question, I do not think we have enough data, but I am looking forward to the research that will be published towards the end of the year. Also, colleagues in south London, led by Professor Jane Sandall from King's College, are doing a discrete piece of work for south London, an inquiry into black, Asian and minority ethnic groups and the disparity in health outcomes.

**Baroness Massey of Darwen:** Professor, you are giving us a lot of information. Is there any monitoring of the age range of women with whom you come into contact?

**Professor Jacqueline Dunkley-Bent:** I will work from the data. The data tells us that more women are choosing to have their babies when they are older, and that will also be reflected in the black population. One of the areas of risk is having a baby when you are later in life. I talked about the four-point plan, and one of the markers, in relation to lowering the threshold for surveillance for women who are engaging with maternity services who are from a black, Asian and minority ethnic background, is age during pregnancy.

**Baroness Massey of Darwen:** What about very young women?

**Professor Jacqueline Dunkley-Bent:** I will speak through the data on teenage women and young women. That does not appear to be of concern with regard to mortality or things going wrong. That said, any teenage pregnancy would have a specific focus of care—if not a continuity of carer midwife, care that was continuous by a few people in a team.

**Chair:** You mentioned the interesting work that is ongoing. Within that, bearing in mind that a black woman is five times more likely

to die in pregnancy or in childbirth than a white woman, do you have any target for reducing that racial disparity?

**Professor Jacqueline Dunkley-Bent:** That is another good question. We have the national ambition set by the previous Secretary of State for Health and Social Care.

**Chair:** But is that about racial disparity?

**Professor Jacqueline Dunkley-Bent:** No.

**Chair:** Is there any target for reducing the racial disparity between deaths in pregnancy or childbirth of black women compared with deaths in pregnancy or childbirth of non-black women?

**Professor Jacqueline Dunkley-Bent:** We do not have a target.

Q18 **Lord Trimble:** I must say that I was a bit surprised when looking at our material that there was virtually nothing about employment for people seeking jobs and how they are treated in jobs. Is there not some danger of there being discrimination in this situation?

**Professor Jacqueline Dunkley-Bent:** That is another good question. For employers, students coming through the system and those who get jobs we have the workforce race equality standards. In the maternity space, we did not think that we should reinvent something that was working. The workforce race equality standards are a set of nine standards which employers respond to, and that relates to equity for black, Asian and minority ethnic staff to have the same benefit as their white counterparts in continuing professional development and opportunities for progression and board level positions, for example. Within that space, we felt that that was sufficient. The WRES is not perfect, but it encourages the whole NHS to examine the equity for their employers.

With regard to what women and their families who use maternity services tell us, I was in a meeting only a few hours ago with a midwife colleague from Newham general only a few hours ago. Some 60% of the population who use that hospital are from a BAME background, and it was criticised many years ago for not having a workforce that was reflective of its community. Now it has that workforce, so the people it serves can see people like them providing their care. That has been received really positively in surveys.

**Lord Trimble:** As I say, I am a bit surprised, because what I read, and what was said a few minutes ago, is all in a health context. I would have thought that problems in recruitment, the retention of people and how they are treated in employment were broader. Is

anything else being done to look at these broader issues?

**Professor Jacqueline Dunkley-Bent:** On the issue inequity for those trying to get jobs, part of the WRES is that if you are going for an interview, there must be someone on the interview panel who is from a black, Asian or minority ethnic background. That is to ensure that there is cultural sensitivity and cultural context in the questions asked and received. There is a whole science behind that. That is just one example, but I do not think I am answering your question very well. I will stop there.

Q19 **Dean Russell:** As you will know, the public sector equality duty, which is a duty on public authorities to consider how their policies or decisions will affect people who are protected under the Equality Act, has been around for a while now. Do you still think it is an effective tool for securing black women's human rights in maternity services?

**Professor Jacqueline Dunkley-Bent:** I think that every little helps. The principle of proportionate universalism that I mentioned talks about a scale and intensity—I refer to it as pace and intensity—that is equal to the level of disadvantage. While that is a good measure, I wonder whether it goes far enough and has enough levers to encourage that change at pace, or whether one would adhere to it as a good standard in the human rights space, think, "We've considered this", and then essentially go back to the day job, as it were. In answer to your question, every little helps, and it is good, but I question what true levers it actually has to effect the change that we need right now.

**Dean Russell:** With that in mind, may I very briefly ask what sort of levers you think would be needed? We heard earlier about a lack of data and wider contexts and issues. I would be interested in your thoughts on what levers would be needed to ensure that we had true equality in the system on this.

**Professor Jacqueline Dunkley-Bent:** I was thinking about accountability levels. How does one become accountable? We have the moral challenge, but true accountability may well be hidden in huge work programmes. For us to truly embrace the inequality in health outcomes, there is something about unconscious bias that needs to be embraced.

There is also something about how we engage with people. Do we truly listen, or do we hear what we want to hear? Having those who use maternity services, childbearing women from the black community, telling us, "This is what I didn't like, this is what I did

like, and this is what I didn't like but I think I should have more of", means that we can sharpen our focus.

That is why I mentioned the maternity voices partnerships, as well as the new and emerging black, Asian and minority ethnic maternity voices partnerships, which help us not just to think about this morally but to create some action that is felt in the home, at the bedside or wherever we are providing maternity care. That is the kind of lever that I am thinking of. Accountability is key for me.

**Dean Russell:** On that, would you say that the data and the voices, as it were—what people are saying, the stories they are sharing and the concerns that they have—have historically been in place? I suppose what I am getting at is whether you think that we should have better data collection of those voices to enable accountability, but also to ensure that those accountable are getting the right information.

**Professor Jacqueline Dunkley-Bent:** Absolutely.

Q20 **Baroness Massey:** I would like to ask your opinion on something. Do you think the Black Lives Matter movement gives us an opportunity to re-examine public services, including health services, and to confront racial inequality and the unequal protection of human rights for black people that we know is so persistent in this country? What could be done about that? Or is it all being done already?

**Professor Jacqueline Dunkley-Bent:** That is an interesting question. Black Lives Matter has shone a light on inequality. We all as human beings step into our own areas of influence. I look at maternity. Thinking more widely, we are now talking about race and inequality at every level, be that in a supermarket or in the highest parts of government. We are having that conversation and shining a light on issues such as the disparity in health outcomes. This Committee, for example, is enabling that conversation. However, I am fearful that the conversation becomes the conversation. I am keen that we are supported in having key actions that help us to get to the answer.

It is not just about the NHS; it is about social care, social housing, poverty, inequality and not having an equal start. I am always minded that the foundations for health and well-being very much start in childhood—in fact, they start in the womb. So there is a huge responsibility to support pre-conception and pregnant mums, because we know that the environment in the womb can influence socioeconomic advantage or disadvantage, heart disease and mental health. We have the evidence that tells us that. That is why

I am pleased that, thanks to the Black Lives Matter movement, the conversation is palpable at all levels.

**Baroness Massey:** What are the main levers that you would want to put into place to help things to move forward?

**Professor Jacqueline Dunkley-Bent:** For maternity generally?

**Baroness Massey:** Yes.

**Chair:** For the racial disparity. That is what we are looking at. Obviously the Health Committee looks at maternity services more generally. We are looking at the racial disparity in relation to human rights.

**Professor Jacqueline Dunkley-Bent:** I was asked before about a target for reducing that inequity in health outcomes. We have set a target in the long-term plan for 75% of black, Asian and minority ethnic women to receive continuity of carer. We set that target, because that model of care improves outcomes. Regarding the other 25%, the evidence tells us that some women do not want continuity of carer or are at high risk so have continuity through a medical obstetric model.

So we have a target, and I would like to see it implemented. We have set it out in the long-term plan, and we are working in the Covid space to look at how we can ensure that we implement that in a timely way. For that 75% of black, Asian and minority ethnic women to receive continuity of carer, we have to look at the workforce in terms of numbers, capacity, buildings, non-buildings, resource and so on, and that is what we are working through now.

Q21 **Chair:** Can I follow up with one final question? You have mentioned a target for an element of the care of black women, continuity of carer. However, I think we have all come to understand that when the NHS thinks that something is important, a target is set to achieve it. Obviously the achievement that we are talking about is reducing the racial disparity between black mothers dying in pregnancy and childbirth compared to non-black mothers dying in pregnancy and childbirth. Do you think it is surprising that there is no target to reduce that glaring racial disparity? Do you think there should be a target to reduce it?

**Professor Jacqueline Dunkley-Bent:** The short answer is absolutely, yes. One death where there is inequality because you are not on a level playing field is one death too many. However, I go back to the target that we have set for that provision of care. That provision of care is not just about one appointment; it is about a whole relationship for nine months. We know that women are

more likely to disclose domestic violence and substance misuse in that relationship. The evidence tells us that if you have this model of care, you improve outcomes for mums and babies. That is why we have set that target for that group of women.

**Chair:** Thank you very much for your evidence today, Professor Dunkley-Bent.