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DEBATE PACK

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Black maternal healthcare and mortality

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Summary

A Westminster Hall debate on 'e-petition 301079, relating to Black maternal healthcare and mortality' has been scheduled for Monday 19 April 2021 from 6:15pm. The debate has been initiated by the Petitions Committee and is being led by Catherine McKinnell MP.

Contents

1. Background

Analysis of maternal deaths, stillbirths and neonatal deaths shows mothers and babies from Black/Black British and Asian/Asian British ethnic groups and women living in the most deprived areas of the country have poorer outcomes.[1]

The table below shows data from the latest 2020 MBRRACE-UK report on the Confidential Enquiry into Maternal Deaths 2016-18 highlighting the number of maternities and associated deaths by ethnicity. The data is pooled over a three-year period because the small number of cases means that the estimated rates can be associated with a large degree of uncertainty. The associated relative risk of death for women from ethnic groups compared with white women is also provided, along with the confidence intervals associated with these ratios.[2]

The confidence intervals shown below suggest that women from Asian, Black or mixed race backgrounds have an elevated risk of maternal death compared to women from White backgrounds. Among Black women, the central estimate of the risk of maternal death is more than four times higher than for white women.

Maternal deaths by ethnicity
England 2016-2018

Ethnic group	Total maternities	Deaths	Death rate per 100,000 maternities	Relative Risk: BAME compared with white		
				Relative Risk ratio	Lower CI	Upper CI
White	1,486,428	117	7.9	1.0		
Asian	191,145	28	14.7	1.9	1.2	2.8
Black	81,704	28	34.3	4.4	2.8	6.6
Chinese/other	75,270	6	8.0	1.0	0.4	2.3
Mixed race	31,823	8	25.1	3.2	1.4	6.5

Source: Confidential Enquiry into Maternal Deaths 2016-18, Table 2.10

Further details of MBBACE-UK's work is available on its website.

[1] MBRRACE-UK, Saving Lives, Improving Mothers' Care, December 2020

[2] The uncertainty of a ratio can be estimated by calculating a confidence interval (CI) around the estimate to give an indication of the range within which the "true" ratio is likely to arise. The confidence intervals are important in interpreting differences. A confidence interval expresses the degree of uncertainty associated with a statistic and gives an indication that that actual "true" value may lie somewhere between the lower and upper confidence interval. You can use the overlap in confidence intervals as a quick way to check for statistical significance. In general, if the intervals do not overlap there is a statistically significant difference (at a certain level of confidence – usually 95%) whereas if there is an overlap, then the difference is not significant.

In a response to a PQ in 2019, the Secretary of State for Health and Social Care was asked why maternal mortality rates are higher among BAME women:

> **PQ [on maternal mortality: ethnic groups] 245969**
>
> **Anneliese Dodds (Oxford East)**:
> To ask the Secretary of State for Health and Social Care, for what reason maternal mortality rates are higher among BAME women.
>
> **Jackie Doyle-Price, Department of Health and Social Care**:
>
> The higher rates of maternal mortality experienced by black, Asian and minority ethnic (BAME) women is a complex and serious issue. The Department has commissioned the Policy Research Unit in Maternal and Neonatal Health and Care at Oxford University to undertake a research project in 2019-20 to investigate the factors associated with excess perinatal and maternal mortality. The Department will use findings from research to inform future maternity policies.
>
> Current plans to reduce inequalities are set out in the NHS Long Term Plan, we aim to tackle maternal mortality inequality through the introduction of an enhanced continuity of carer model. By 2024, 75% of women from BAME communities and other vulnerable women will receive continuity of care from their midwife. This will also help reduce pre-term births, hospital admissions, and the need for intervention during labour.
>
> [Answered on: 25 April 2019]

1.1 Maternity Review and the Better Births Plan

In March 2015, Sir Simon Stevens, Chief Executive of NHS England announced a major review of maternity services as part of the NHS Five Year Forward View. Drawing on wide-ranging evidence, and in consultation with women and their families and stakeholders, the review published its findings in February 2016. The Better Births: Improving outcomes of maternity services in England report[3] is a five year forward view for maternity care.

The review did not include any specific findings in relation to maternal mortality rates by ethnicity but did find that Black or Black British Asian or Asian British babies had a more than 50% higher risk of perinatal mortality.[4] The review report did not include specific recommendations or commitments for mothers from different ethnic groups. It set out how services might need to tailor their approach for mothers from different ethnic groups:

> a. For families from black and minority ethnic (BME) backgrounds, this might mean greater engagement between service providers and their communities. On an individual level, it might mean taking the extra time to gauge understanding of the language being used at an appointment or to understand cultural differences and the additional

[3] NHS England, Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care, February 2017

[4] *Ibid*, para 4.38

> support that might be needed for fathers to play a supportive role in the birth process, particularly during the antenatal stage.
>
> b. For those who have difficulty communicating, it might mean providing information in a format which is easy to read and understand, free from complex concepts or medical terminology. Alternatively, it might mean providing an interpreter or translating the key points into their native language.
>
> c. For women in the Gypsy and Traveller communities this might mean professionals taking extra time to discuss and understand their lifestyle choices and not make assumptions about their feeding preferences or about the safety of their home environment.[5]

In response to Better Births and as part of a wider Maternity Transformation Programme the Government launched its Safer Maternity Care action plan in October 2016 as "part of the national ambition to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth, by 2030."[6] The Plan states that in relation to maternal deaths:

> Public Health England (PHE) is leading the 'improving prevention' workstream of the Maternity Transformation Programme. This involves a range of work to prevent poor outcomes through action to improve women's underlying health, both in the preconception period and during and after pregnancy, since pregnancy is a window of opportunity to encourage women to live healthier lifestyles. The work focuses on reducing levels of the risk factors known to influence poor outcomes, including rates of stillbirths, neonatal deaths and maternal deaths. These include smoking during pregnancy, obesity and substance misuse.[7]

1.2 The NHS Long Term Plan

NHS England's NHS Long Term Plan, published in January 2019, set out a number of proposals to "achieve a 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025".[8]

Targeted support for BAME groups and vulnerable mothers included (emphasis added):

> Developing continuity of carer teams across the country – with the aim that in 2019, 20% of pregnant women will be offered the opportunity to have the same midwife caring for them throughout their pregnancy, during birth and postnatally. **By March 2021 the aim is that most women will receive continuity of the person caring for them during pregnancy, during birth and postnatally.**[9]

The plan stated that women who receive continuity of care were:

> 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth. This will be

[5] *Ibid*, p36
[6] Department of Health, Safer Maternity Care action plan, October 2016, Executive summary
[7] *Ibid,* p16
[8] NHS England, The NHS Long Term Plan, January 2019; para 3.9
[9] *Ibid,* para 3.13

> targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.[10]

The Plan also stated that recommendations from the 'National Maternity Review: Better Births' were being implemented through Local Maternity Systems:

> These systems bring together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting. **By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative.** Every national, regional and local NHS organisation involved in providing safe maternity and neonatal care has a named Maternity Safety Champion. Through the Collaborative and Maternity Safety Champions, the NHS is supporting a culture of multidisciplinary team working and learning, vital for safe, high-quality maternity care. Twenty Community Hubs have been established, focusing on areas with greatest need, and acting as 'one stop shops' for women and their families. These hubs work closely with local authorities, bringing together antenatal care, birth facilities, postnatal care, mental health services, specialist services and health visiting services.[11]

1.3 Better Births Four Years On: A review of progress

A review of progress report on Better Births was published in March 2020. The review found that mortality rates remain higher for Black or Black British and Asian or Asian British babies. Whilst stillbirth rates for these groups had reduced over the period 2015 to 2017 from 8.17 to 7.46 and from 5.88 to 5.70 per 1,000 total births respectively, neonatal mortality rates increased over the same period from 2.45 to 2.77 and from 2.50 to 2.86 per 1,000 live births respectively. The neonatal mortality rate for England and Wales for all groups was 1.6 per 1,000 live births between 2014 and 2017.

In relation to the care of Black, Asian and minority ethnic mothers, the review repeated the commitment made in the January 2019 NHS Long-term plan to improve maternity services by developing continuity of care services for all pregnant women, targeting vulnerable groups including women from BAME groups. The 2020 review stated (emphasis added):

> Inequalities in outcomes from maternity services for women and babies must be tackled if we are to offer families the best start in life. The NHS Long Term Plan set out in January 2019 clear and costed plans to prioritise improvements in maternity services for the most vulnerable groups – **Black, Asian and ethnic minority families, and those from the most deprived areas –particularly rolling out the continuity of carer service model to 75% of this group by March**

[10] *Ibid*
[11] *Ibid,* para 3.12

2024. These improvements, and identifying how transformation can reduce health inequalities across all fronts, are key priorities for the Maternity Transformation Programme as it enters its next phase.[12]

1.4 Support for pregnant Black, Asian and Ethnic Minority (BAME) women during the pandemic

In June 2020 the Government announced additional support for pregnant Black, Asian and Ethnic Minority (BAME) women following research showing that they were at a heightened risk of hospitalisation with Covid-19. The announcement stated that NHS England's Chief Midwifery Officer, Jacqueline Dunkley-Bent, had written to all maternity units in the country calling on them to take four 'common sense steps' to minimise the additional risk of Covid-19 for Black, Asian and minority ethnic women and their babies. The steps are:

- Increasing support of at-risk pregnant women – e.g. making sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women from a BAME background.
- Reaching out and reassuring pregnant BAME women with tailored communications.
- Ensuring hospitals discuss vitamins, supplements and nutrition in pregnancy with all women. Women low in vitamin D may be more vulnerable to coronavirus so women with darker skin or those who always cover their skin when outside may be at particular risk of vitamin D insufficiency and should consider taking a daily supplement of vitamin D all year.
- Ensuring all providers record on maternity information systems the ethnicity of every woman, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes.[13]

1.5 Parliamentary reports

Joint Committee on Human Rights Inquiry

The Joint Committee on Human Rights, in its wider inquiry on Human Rights, Black people, racism and human rights in 2020-21 examined the issue of higher rates of death among Black pregnant women. During an evidence session with Jacqueline Dunkley-Bent, the Chief Midwifery Officer at NHS England and NHS Improvement (NHEI) told the Committee that the Government did not have a target to reduce the racial disparity in death rates of pregnant women[14].

[12] NHS, Better Births Four Years On: A review of progress, March 2020; p5
[13] NHS England, NHS boosts support for pregnant black and ethnic minority women, 27 June 2020
[14] Oral evidence: Black people, racism and human rights, HC 559; Q17

In its report on the inquiry, the JCHR said of the Government's approach to improving the care of Black, Asian and ethnic minority mothers:

> The NHS's Maternity Transformation Programme, "Better Births" which began in 2016 made no specific commitments in relation to women from Black, Asian and ethnic minority backgrounds. Not until the NHS Long Term plan was published in January 2019, was a commitment made to ensuring that by 2024, three-quarters of pregnant women from Black, Asian and minority ethnic minorities will receive care from the same midwife before, during and after they give birth. This pledge was repeated in the review of the Better Births programme, published in March 2020. It was the only specific recommendation relating to Black, Asian and minority ethnic women. When we questioned Professor Jacqueline Dunkley-Bent about this, she stressed that the NHS Long Term plan works on "the principle of proportionate universalism, providing care at a level of scale and intensity that is equal to the level of disadvantage." So, while elements such as "continuity of care" are a universal offer, "black, Asian and minority ethnic women will benefit where they are considered to be more likely at risk."

The report included specific recommendations that the Government: introduce a target to end the disparity in maternal mortality between Black women and White women;[15] and implement the Chief Midwifery Officer's four-point action plan to better support ethnic minority women during the Covid-19 pandemic as a matter of urgency.[16]

The full report and the Government's response to the inquiry are available on the Committee website.

Health and Social Care Committee Inquiry

In July 2020, the House of Commons Health and Social Care Select Committee launched an inquiry into The Safety of Maternity Services in England. The Committee's call for evidence announced that the focus of the inquiry was to examine "recurrent failings in maternity services" and the action needed to improve safety for mothers and babies.

Although the remit of the inquiry was to examine the provision of NHS maternity services for all women, evidence of the inequalities faced by Black and ethnic minority mothers emerged as a recurring issue in the evidence presented to the Committee during the inquiry. During an evidence session with Professor Ted Baker, the Chief Inspector of Hospitals at the Care Quality Commission (CQC), the Committee asked what steps CQC was taking to understand and address the racial disparities in maternal and neonatal deaths.[17]

Professor Baker's view was that the statistics were a measure of the lack of understanding of the issues of safety in some health services. He told the Committee that CQC were examining building "ethnic differences in

[15] Joint Committee on Human Rights, Black people, racism and human rights, 11th report of 2019-21; HC 559/HL paper 165, November 2020; para 45

[16] Ibid, para 48

[17] Health and Social Care Committee Oral evidence: Safety of maternity services in England, HC 677, 29 September 2020

outcomes into our inspections because we recognise that is an important aspect of safety."[18] He added:

> Not only is it about the safety of individual women; it is also about the safety culture of the organisation that it does not allow such disparities to occur. We think it is very important to focus on that going forward, and to see it as an important measure of the overall safety of the unit and the leadership culture of the unit. We will be focused on that going forward. For too long, we have seen major disparities, particularly in maternal mortality for black and minority ethnic women, but also, as you say, neonatal mortality.[19]

The Committee's inquiry into the safety of maternity services is on-going. Further information, including evidence submitted to the inquiry, is available on the Committee website.

[18] Ibid Q36
[19] Ibid

2. Parliamentary Material

2.1 Committee Material

Black people, racism and human rights
11th Report of Session 2019–21
House of Commons & House of Lords Joint Committee on Human Rights
HC 559 HL Paper 165
11 November 2020

Black people, racism and human rights: Government Response to the Committee's Eleventh Report of Session 2019–21
Fourth Special Report of Session 2019–21
House of Commons & House of Lords Joint Committee on Human Rights
HC 1210
11 February 2021

Oral evidence: Safety of maternity services in England
Health and Social Care Select Committee
HC 677
29 September 2020

The Safety of Maternity Services in England
Health and Social Care Select Committee inquiry
24 July 2020

2.2 Early Day Motions

Black maternal health
EDM 1709 (session 2019-21)
12 Apr 2021
Bell Ribeiro-Addy

That this House recognises the existing racial inequalities in maternal health; notes with great sadness that Black women in the UK are four times more likely to die in pregnancy and childbirth, that women of mixed heritage are three times more, and Asian women are two times more likely to die in pregnancy and childbirth; further notes that women of Black African heritage are 83 per cent more likely to suffer a near miss in childbirth, and women of Black Caribbean heritage are 80 per cent more likely; acknowledges the MBBRACE analysis which has found that black babies have a 121 per cent increased risk for stillbirth and a 50 per cent increased risk of neonatal death; supports the work of Five X More and their efforts to raise awareness of Black maternal health inequalities; is shocked by the 2020 Black people, racism and human rights report which confirms statistics but reveals that there is no target to end it; and urgently calls on this Government to fully acknowledge these disparities and commit to working with the NHS to improve Black maternal health outcomes.

2.3 Parliamentary Questions

Maternal Mortality: Ethnic Groups

11 Jan 2021 | 133765

Asked by: Ms Lyn Brown

To ask the Minister for Women and Equalities, what conclusions were reached on further actions that can be taken to tackle ethnic disparities in maternal mortality, following the roundtable of 2 September 2020.

Answering member: Kemi Badenoch | Department: Women and Equalities

Following the roundtable on 2 September, officials in the Cabinet Office Race Disparity Unit are supporting the Department of Health and Social Care in driving positive actions through a number of interventions on maternal mortality from an equalities perspective.

For example, NHS England and Improvement are introducing a funded and comprehensive national support offer which will be mobilised later this year. This will require Local Maternity Services to work towards achieving the ambition that 75% of Black and Asian women receive continuity of care by 2024.

Maternal Mortality: Ethnic Groups

11 Jan 2021 | 133764

Asked by: Ms Lyn Brown

To ask the Minister for Women and Equalities, what conclusions were reached on the causes of ethnic disparities in maternal mortality, following the roundtable of 2 September 2020.

Answering member: Kemi Badenoch | Department: Women and Equalities

At the roundtable on 2 September, leading experts in the field clarified that underlying health conditions and comorbidities largely explain ethnic disparities in maternal mortality rates.

Maternity experts also linked this to a reluctance by some women from minority backgrounds to attend routine appointments and check-ups where many of these conditions are typically identified.

The government continues to work with maternal health practitioners and ethnic minority women to drive positive actions and interventions in this area so that our actions can benefit more women. This includes the recently launched NHS campaign ‘Help us Help You’, informing pregnant women about the importance of attending check-ups, and providing reassurance that the NHS is there to see them safely.

Maternal Mortality: Ethnic Groups

06 Jan 2021 | 120861

Asked by: Jackie Doyle-Price

To ask the Secretary of State for Health and Social Care, what steps he is taking to reduce the rate of maternity deaths among Black, Asian and minority ethnic women.

Answering member: Ms Nadine Dorries | Department: Department of Health and Social Care (DHSC)

The NHS Long Term Plan outlines plans to reduce health inequalities and address unwarranted variation in maternity care. This work is led by NHS England through the Maternity Transformation Programme. Targeted and enhanced continuity of care from the same midwife, or group of midwives can significantly improve outcomes for women. The NHS Long-Term plan sets out that 75% of black women will receive continuity of carer from midwives by 2024.

Work to reduce health inequalities around maternal mortality rates is being led by Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer. This includes understanding why mortality rates are higher, considering evidence about what will reduce mortality rates and taking action.

Maternal Mortality: Ethnic Groups

07 Dec 2020 | 122820

Asked by: Kate Osamor

To ask the Secretary of State for Health and Social Care, if he will make it his policy to introduce a target for the NHS to end the disparity in maternal morality between Black women and white women.

Answering member: Ms Nadine Dorries | Department: DHSC

Work to reduce health inequalities around maternal mortality rates is being led by Professor Jacqueline Dunkley-Bent OBE, the Chief Midwifery Officer. This includes understanding why mortality rates are higher, considering evidence about what will reduce mortality rates and taking action.

We have established the inequalities oversight forum, with a group of clinical experts, to understand the reasons why the death rate for black women in childbirth is five times higher than for white women and to find out what we can put in place to ensure that, by addressing those issues, we reduce the number of deaths.

Maternal Mortality: Ethnic Groups

12 Oct 2020 | HL8603

Asked by: Baroness Ritchie of Downpatrick

To ask Her Majesty's Government what discussions they have had, and with whom, about reducing the number of maternal deaths among Black, Asian and minority ethnic women.

Answering member: Lord Bethell | Department: DHSC

Discussions regarding reducing the number of maternal deaths among black, Asian and minority ethnic women have been addressed at two recent roundtables. The Minister of State for Patient Safety, Suicide Prevention and Mental Health, (Ms Nadine Dorries MP), chaired a Ministerial roundtable on Inequality in Maternity, and the Parliamentary Under-

Secretary of State for Equalities (Kemi Badenoch MP) led a discussion between frontline midwives, medical experts, academics, and regional health representatives.

Maternal Mortality: Ethnic Groups

25 Apr 2019 | 245969

Asked by: Anneliese Dodds,

To ask the Secretary of State for Health and Social Care, for what reason maternal mortality rates are higher among BAME women.

Answering member: Jackie Doyle-Price | Department: DHSC

The higher rates of maternal mortality experienced by black, Asian and minority ethnic (BAME) women is a complex and serious issue. The Department has commissioned the Policy Research Unit in Maternal and Neonatal Health and Care at Oxford University to undertake a research project in 2019-20 to investigate the factors associated with excess perinatal and maternal mortality. The Department will use findings from research to inform future maternity policies.

Current plans to reduce inequalities are set out in the NHS Long Term Plan, we aim to tackle maternal mortality inequality through the introduction of an enhanced continuity of carer model. By 2024, 75% of women from BAME communities and other vulnerable women will receive continuity of care from their midwife. This will also help reduce pre-term births, hospital admissions, and the need for intervention during labour.

3. Press and journal articles

The following is a selection of news and media articles relevant to this debate.

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3.1 Press articles

'I felt humiliated': parents respond to NHS maternity care racial bias inquiry
Hannah Summers, *The Guardian*
13 April 2021

New dedicated mental health services for new expectant and bereaved mums
NHS England
6 April 2021

NHS commits £95m to maternity safety after Shrewsbury scandal
Mimi Launder, *Nursing in Practice*
1 April 2021

The Black Maternity Scandal: Women react to the Dispatches documentary on black mothers' mortality rates
Ellie Abraham and Nadine White, *The Independent*
30 March 2021

The Black Maternity Scandal: Dispatches
Channel 4 Dispatches
26 March 2021

My pregnancy nearly killed me and my daughter did not survive, says MP
Lewis McKenzie, *Press Association* via Nexis News [may require subscription]
11 March 2021

Black women in the UK four times more likely to die in pregnancy or childbirth
Hannah Summers, *The Guardian*
15 January 2021

Black mothers in the UK are four times more likely to die in childbirth than their White counterparts. Little is being done to find out why
Tara John, *CNN*
14 January 2021

Human rights of Black people not equally protected, say Committee
Human Rights (Joint Committee), *UK Parliament*
11 November 2020

'Something has to be done': tackling the UK's Black maternal health problem
Alexandra Topping, *The Guardian*
2 October 2020

NHS boosts support for pregnant black and ethnic minority women

NHS England

27 June 2020

3.2 Journal articles

Structural racism is a fundamental cause and driver of ethnic disparities in health [requires subscription]
Mohammad S Razai, Azeem Majeed and Aneez Esmail, *BMJ*
12 April 2021

What did the Commission on Race and Ethnic Disparities say on health?
Gareth Iacobucci, *BMJ*
9 April 2021

Disparity in maternal deaths because of ethnicity is "unacceptable"
Matthew Limb, *BMJ*
18 January 2021

3.3 Press releases

Government working with midwives, medical experts, and academics to investigate BAME maternal mortality
Government Equalities Office, Race Disparity Unit and Kemi Badenoch MP
2 September 2020

- Maternal mortality now occurs in fewer than 1 in 10,000 pregnancies, but the disparity between Black women and White women has widened
- Government brings together frontline midwives, medical experts, and health academics to ensure every mother has access to a safe, special birth
- Minister for Equalities, Kemi Badenoch, says: "Whoever you are and wherever you live, the birth of a child should be a wonderful, momentous time"

RCOG Position Statement: Racial disparities in women's healthcare
Royal College of Obstetricians & Gynaecologists
6 March 2020

4. Further Reading

4.1 Reports

Saving Lives, Improving Mothers' - Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18
MBRRACE-UK
December 2020

Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust
Donna Ockenden
11 December 2020

Ockenden review of maternity services (Letters)
NHS England
11 January 2021

Better Births Four Years On: A review of progress
NHS England and NHS Improvement
4 March 2020

Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care
NHS England
February 2017

4.2 Websites

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Five X More
A grassroots organisation committed to changing Black women's maternal health outcomes in the UK

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