

Health and Social Care Committee

Black Maternal Health

Third Report of Session 2024–26

HC 895

Health and Social Care Committee

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Summary

Black women in England continue to face disproportionately poor outcomes in maternity care, shaped by systemic failings in leadership, training, data collection, and accountability. Failure to confront deep-rooted inequities in maternity care is unjust and carries deep human and systemic costs, including increased financial strain on health services, diminished workforce resilience, and erosion of public trust—all of which compromise the system's ability to deliver safe, effective and equitable care. Despite numerous efforts to address this situation, progress has been slow and uneven.

This crisis in care for Black women is happening in the context of a maternity system that is failing women more broadly, which may give the misleading impression that outcomes for Black women have improved. The NHS has faced an estimated £27.4 billion bill for maternity negligence in England since 2019. This figure exceeds the total maternity budget for the same period and reflects a devastating toll of preventable deaths and life-altering injuries to mothers and babies.

In this report we identify four key areas the Government must focus on to drive progress in improving maternity care.

- **Culture, leadership and racism.** We heard of a culture where women, particularly Black women, are not listened to and their concerns are not taken seriously. This is reinforced by bias and stereotyping underpinned, in some cases, by racist assumptions. Addressing this requires both operational change—including mandatory and meaningful cultural competency training—and effective leadership, with senior leaders being meaningfully held accountable.
- **Workforce.** Shortages undermine the ambition to improve maternity care. Midwives and obstetricians are burnt out, unable to consistently deliver good quality, safe care, and many are considering leaving the profession. The Government must take decisive action on training, recruitment and retention, core priorities in its upcoming overhaul of the NHS Long Term Workforce Plan.
- **Data.** The lack of robust, real-time data, particularly on maternal morbidity and patient ethnicity, means the system remains blind to its failings. Information, like the Maternity Services Data Set, suffers from missing or incomplete entries and the Government appears to have

made no progress developing a maternal morbidity indicator since it was recommended by the Women and Equalities Committee over two years ago.

- **Funding.** The Government has cut the Maternity Service Development Fund from £95 million to £2 million, transferring the money to core Integrated Care Board (ICB) budgets. The Government must ensure that this change does not leave maternity funding deprioritised.

Since we launched this inquiry, the Government has announced a rapid national investigation into NHS maternity and neonatal services. We welcome this decision, but it must lead to a step change in the Government's response to this issue, supported by sustained investment, representative leadership, mandatory and meaningful training, and a willingness to name and tackle racism where it exists.

1 Introduction

1. England’s maternity services are in a state of crisis. A wave of scandals,¹ and damning Care Quality Commission reports have revealed systemic failures - with services that are overstretched, under-resourced, and a workforce that is burnt out.² The NHS has faced an estimated £27.4 billion bill for maternity negligence in England since 2019. This figure exceeds the total maternity budget for the same period and reflects a devastating toll of preventable deaths and life-altering injuries to mothers and babies.³
2. The situation is particularly grave for Black women, who face significantly worse outcomes and frequently report receiving poorer-quality maternity care, including delayed treatment, unclear communication, and support that fails to meet their emotional or cultural needs.⁴
3. There have been several reviews and initiatives that have sought to address this situation.
 - The 2016 NHS Better Births report, which found that “[B]abies that are Black or Black British Asian or Asian British have a more than 50% higher risk of perinatal mortality”,⁵ set out a vision for more personalised care, continuity of care, and better data use.⁶ This report led to the creation of the Maternity Transformation Programme.⁷
 - In 2022, the Maternity Disparities Taskforce was created to tackle inequalities in outcomes for minority ethnic and deprived communities.⁸

1 These include avoidable deaths and injuries at Shrewsbury and Telford, East Kent, Nottingham, and more recently Leeds and Sussex, where systemic failures in safety, culture, and compassionate care were uncovered.

2 Care Quality Commission, [National review of maternity services in England 2022 to 2024](#), 19 September 2024

3 The Guardian, [NHS facing ‘absolutely shocking’ £27bn bill for maternity failings in England](#), 20 July 2025

4 Five X More, [THE FIVE X MORE BLACK MATERNITY EXPERIENCES REPORT: CONTINUING THE CONVERSATION ON BLACK MATERNAL CARE IN THE UK](#), July 2025

5 NHS England, [BETTER BIRTHS: Improving outcomes of maternity services in England, National Maternity Review](#), 22 February 2016, p. 57

6 NHS England, [BETTER BIRTHS: Improving outcomes of maternity services in England, National Maternity Review](#), 22 February 2016

7 NHS England, [Maternity Transformation Programme](#)

8 Department for Health and Social Care, [New taskforce to level-up maternity care and tackle disparities](#), Department of Health and Social Care, 23 February 2022

- In 2023, the NHS produced its Three-Year Delivery Plan for Maternity and Neonatal Services⁹ which consolidated national commitments and responses to independent inquiries such as the Ockenden and Kirkup reviews.
 - Since we announced this inquiry, the Government has launched a rapid national investigation into maternity and neonatal care.¹⁰
4. As discussed later in this report, we acknowledge the significance of issues relating to the collection of ethnicity data in maternity care. Nonetheless, over time, the data has demonstrated little improvement in maternal outcomes for Black women.
 5. Between 2014–2016, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) reported that Black women were almost five times as likely to die in pregnancy, childbirth, or the postnatal period than White women.¹¹ Between 2018–20, MBRRACE-UK found that Black women were 3.7 times more likely to die than White women,¹² with the figure falling to 2.3 in 2021–23.¹³ We note that this reduction is partly attributable to a deterioration in outcomes among other ethnic groups, rather than a significant advancement in care for Black women themselves.¹⁴
 6. This inquiry set out to understand why, despite growing awareness and repeated policy commitments, improvements in Black maternal health remained elusive and what the barriers were in translating this ambition into action.
 7. We are very grateful to all those individuals and organisations who gave evidence to our inquiry, especially those who took the time to share their experiences in our online roundtable event in May. We are also grateful to East London NHS Foundation Trust for hosting a visit for our Interim Committee Chair, Paulette Hamilton. We would also like to thank the Women and Equalities Committee’s Chair, Sarah Owen MP, for guesting at our evidence sessions.

9 NHS England, [Three year delivery plan for maternity and neonatal services](#), 30 March 2023

10 Department of Health and Social Care, [National maternity investigation launched to drive improvements](#), , 23 June 2025

11 MBRRACE-UK, [Saving Lives, Improving Mothers’ Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16](#), November 2018

12 MBRRACE-UK, [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](#), December 2020

13 MBRRACE-UK, [Maternal mortality 2021–2023](#), January 2025

14 [Q159](#)

2 Culture, racism and leadership

8. During this inquiry we heard repeatedly that racism is one of the core drivers of poor maternal outcomes for Black women. Shanthi Gunesekera, co-founder of Birthrights, told us that poor outcomes for Black women were attributable to “racism in all its forms”.¹⁵ We received accounts from both clinical experts and Black women sharing their own experiences of cases where racist assumptions and microaggressions directly harmed Black women’s care. These included:
- A midwife explained slow labour by blaming an “African pelvis” rather than checking for complications.¹⁶
 - One mother was told that, as a “big and strong” Black woman, she could “handle the pain,” even as she was losing a concerning amount of blood.¹⁷
 - Despite pleading that she was in labour, staff told a Black woman she was “making noise,” ignoring her distress until she was nearly ready to give birth.¹⁸
9. We also heard testimony of racist behaviour directed at Black women during their inpatient postnatal care. A woman who attended our roundtable reported that a midwife said to her, “This isn’t Africa you know” when she had family members visiting her after giving birth.¹⁹ A woman from Sudan told us that midwives raised concerns she was the victim of female genital mutilation, despite there being no evidence of this.²⁰ Another Black woman described how White midwives offered her no help or support in learning how to breastfeed for the first time. It was only when a Black student midwife came on shift that she received any help.²¹

15 [Q30](#)

16 [Q5](#)

17 [Q5](#)

18 [Q4](#)

19 Committee Roundtable summary (unpublished)

20 Committee Roundtable summary (unpublished)

21 Committee Roundtable summary (unpublished)

10. Five X More published a new report in July this year which further outlined the continued poor experience of Black woman during pregnancy, birth and the postnatal period. The report highlighted:

- **Lack of pain relief.** “I asked for pain relief but was told they had no gas and air on my ward despite me seeing others have it. They gave me a paracetamol and told me I wasn’t in labour. My baby was born 10 minutes later.”²²
- **Discriminatory behaviour.** “The nurses seemed more receptive and caring to my non-Black counterparts in the ward. For me, they did the bare minimum...The difference was crystal clear.”²³
- **Lack of compassionate care.** “I waited over an hour to be assisted to the bathroom. I had been given no communication about my health and the care plan that was to follow. When asked about discharge I was laughed at and told doctors won’t be coming as it was a Sunday.”²⁴
- **Poor postnatal care.** “The GP barely checked me at the 6–8 week appointment and gave me incorrect advice (that I didn’t need contraception because I was breast feeding).”²⁵

11. The report also found that racism was “embedded in the assumptions and behaviours of staff”.

- “The midwives were not relatable. They didn’t help with showing me how to breast feed, one looked like they didn’t really want to touch me.”²⁶
- “[The] health visitor said in Africa they let their women die, so it was lucky I had the care I did in the UK. This was problematic on multiple levels...she was ignorant and racist, and quite frankly reflected my entire experience of the medical system while pregnant.”²⁷

22 Five X More, [THE FIVE X MORE BLACK MATERNITY EXPERIENCES REPORT: CONTINUING THE CONVERSATION ON BLACK MATERNAL CARE IN THE UK](#), 20 July 2025, p. 29

23 Five X More, [THE FIVE X MORE BLACK MATERNITY EXPERIENCES REPORT: CONTINUING THE CONVERSATION ON BLACK MATERNAL CARE IN THE UK](#), 20 July 2025, p. 30

24 Five X More, [The Five X More Black Maternity Experiences Report: Continuing the conversation on Black Maternal care in the UK](#), 20 July 2025, p. 31

25 Five X More, [The Five X More Black Maternity Experiences Report: Continuing the conversation on Black Maternal care in the UK](#), 20 July 2025, p. 32

26 Five X More, [The Five X More Black Maternity Experiences Report: Continuing the conversation on Black Maternal care in the UK](#), 20 July 2025, p. 39

27 Five X More, [The Five X More Black Maternity Experiences Report: Continuing the conversation on Black Maternal care in the UK](#), 20 July 2025, p. 39

12. As the Government has acknowledged, one of the main causes of services failing to deliver compassionate care is a failure to listen to women.²⁸ The Ockenden report into maternity services at Shrewsbury and Telford, for example, talked about how families who raised concerns were “brushed aside, ignored, and not listened to.”²⁹ The Care Quality Commission’s 2024 maternity found that 1 in 10 women were sent home during labour when they were worried about themselves or their baby.³⁰
13. While this issue can affect women of any ethnicity, we received evidence of Black women facing particular challenges in being listened to and believed by staff. Many Black women reported being ignored when highlighting symptoms or communicating that they were in pain. Witnesses told us that this linked to the enduring trope of the ‘strong Black woman.’³¹ Professor Hassan Shehata, Senior and Global Health Vice President, Royal College of Obstetricians and Gynaecologists, suggested that there could be a false perception that Black women had a higher pain tolerance and greater emotional resilience than other ethnicities.³² This has been linked to delays in receiving appropriate care that may prevent timely medical intervention.³³ These failings in care can be compounded by language barriers, lack of interpreter services, or a lack of understanding around cultural and familial norms.³⁴
14. As the King’s Fund has emphasised, racism in the NHS not only harms patients; it also affects healthcare professionals from minority ethnic backgrounds.³⁵ These staff may encounter discriminatory behaviours, microaggressions, and structural barriers to progression in their working environments. The King’s Fund argues that such experiences can erode their wellbeing and confidence, and in turn hinder their ability to deliver safe, compassionate care.³⁶
15. When we discussed the best way to tackle racism, witnesses suggested two main solutions: training and leadership.

28 Department of Health and Social Care, [National maternity investigation launched to drive improvements](#), 23 June 2025

29 Health Service Journal, [The NHS is still not listening hard enough to families on maternity care](#), 16 December 2024

30 Health Service Journal, [The NHS is still not listening hard enough to families on maternity care](#), 16 December 2024

31 Five X More, [The black maternity experiences survey: a nationwide study of black women’s experiences of maternity services in the united kingdom](#), May 2022, p. 34

32 [Q85](#)

33 [More deaths, worse care: inquiry opens into NHS maternity ‘systemic racism’](#), The Guardian, 7 February 2021

34 [Q40](#)

35 The King’s Fund, [Workforce race inequalities and inclusion in NHS providers](#), 7 July 2020

36 The King’s Fund, [Workforce race inequalities and inclusion in NHS providers](#), 7 July 2020

Training

16. We received evidence about two key training-related gaps that witnesses believed contribute to both cultural insensitivity and the presence of conscious and unconscious racism faced by Black women in maternity care. The first was the need for cultural competency training. The second was the need to improve staff knowledge of the specific medical needs of pregnant Black women.

Cultural competency training

17. Cultural competency training is a structured educational programme aimed at enhancing a person’s ability to interact effectively with individuals from diverse cultural backgrounds. It begins with raising awareness of one’s own cultural biases and assumptions. Participants on courses typically learn about different cultural norms, values, and practices to better understand the perspectives of others.
18. Research has demonstrated that interventions offering culturally appropriate maternity care significantly improve women’s use of maternity services.³⁷ One such strategy—employing staff who share linguistic and cultural backgrounds with service users—not only enhances cultural competence but also fosters trust and increases engagement among racially minoritised women.³⁸ When we asked for examples of programmes that had enabled communities to provide culturally competent care, Sonah Paton, co-Founder of Black Mothers Matter, told us that Bristol and the southwest had developed a “fantastic model of care” which had built a “much more connected picture of maternity where everyone is included and considered [and which] makes a massive difference in outcomes and experiences for those most at risk.”³⁹
19. We also heard that, where cultural competency training does exist, it can be considered a “tick box” exercise.⁴⁰ Witnesses argued that training needed to be co-produced with Black women. The Royal College of Midwives, for example, emphasised that women’s lived experience had to be “at the centre of” efforts to improve cultural competency within maternal care, and that co-production was the best way to ensure that this happened.⁴¹

37 Jones et al, [Interventions to provide culturally-appropriate maternity care services: factors affecting implementation](#), 31 August 2017

38 Jones et al, [Interventions to provide culturally-appropriate maternity care services: factors affecting implementation](#), 31 August 2017

39 Q 45

40 [Q101 - 103](#)

41 Royal College of Midwives, [RCM gives evidence to inquiry on Black maternal health](#), 20 June 2025

20. During our evidence sessions, we heard a strong consensus amongst witnesses that cultural competence and anti-racism training should be mandatory across the NHS, especially for those in leadership roles, and should form part of their continuing professional development.⁴² Professor Hassan Shehata told the Committee that “diversity training should be for all.”⁴³ This view is reinforced by NHS Confederation who, in 2022, said that “leaders and managers seemed to be a particular source of racist treatment.”⁴⁴

Understanding the specific health needs of Black women

21. Another issue that can perpetuate racial disparities is a lack of medical knowledge about Black women’s specific health needs. Despite the national standards for neonatal qualified in specialty (QIS) education stating that “all education providers must [...] ensure teaching and clinical assessments are relevant and appropriate for all newborns, regardless of skin tones,”⁴⁵ we heard that training, reference materials, and clinical frameworks that midwives rely on do not equip them to recognise and respond equitably to the needs of Black patients.⁴⁶
22. The Royal College of Midwives explained that clinical training materials and diagnostic guidelines for maternity care have historically been developed with white skin as the normative reference point, particularly in the identification of conditions such as rashes, sepsis, and neonatal jaundice.⁴⁷ Janet Fyle MBE, Professional Policy Advisor, Royal College of Midwives, told us that “clinical guidance and recommendations for practice are quite white... [they come] from a white European perspective.”⁴⁸

Provision of training

23. In the UK, mandatory elements of pre-registration midwifery training are set by the National Midwifery Council (NMC), which includes national standards for education and practice.⁴⁹ The NMC’s standards state that

42 [Q101-Q103](#)

43 [Q100](#)

44 NHS Confederation, [Shattered hopes: black and minority ethnic leaders’ experiences of breaking the glass ceiling in the NHS](#), 17 June 2022

45 NHS England, [National standards for neonatal qualified in specialty \(QIS\) education](#), 18 November 2024

46 British Medical Journal, [Does training affect understanding of implicit bias and care of black, Asian and minority ethnic babies?](#), 2 March 2022

47 Royal College of Midwives, [Decolonising midwifery practice](#)

48 [Q75](#)

49 Nursing and Midwifery Council, [Standards for midwives](#)

midwives should respect cultural and religious beliefs, however there is no requirement for training on racism, cultural competency, or unconscious bias, for staff as well as leaders.⁵⁰ Individual NHS Trusts are responsible for organising and delivering workforce specific post-registration⁵¹ training programmes which meet the needs of their local populations.⁵² Individual NHS Trusts have flexibility to implement additional training requirements tailored to their specific needs, such as specialised courses or local competency frameworks.⁵³ Professor Hassan Shehata told us that the Government's recent decision to merge NHS England with the Department of Health and Social Care meant it was unclear who would be responsible for training in the future.⁵⁴

24. Where training does exist, it is often limited in scope, poorly embedded,⁵⁵ and left to individual discretion or policies of each Trust.⁵⁶ Tinuke Awe, co-founder of Five X More, argued that cultural competency training should be embedded as part of continued professional development for midwives.⁵⁷ Janet Fyle told us that the Royal College of Midwives has developed an e-learning tool to deliver cultural competency training but that uptake of the e-learning was dependent on Trust priorities and noted that “training is not always consistent across the board”.⁵⁸ Janet also highlighted that this progress has relied on membership funding rather than Government funding.⁵⁹

25. When we raised cultural competency training for midwives with Baroness Merron, Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health, she said that she was currently unable to commit to making such training compulsory, telling us that “I cannot give a yes or a no.”⁶⁰

50 Nursing and Midwifery Council, [Standards for pre-registration midwifery education](#), p. 46, and [Q30](#)

51 Pre-registration training refers to the education and clinical preparation required to qualify as a midwife or obstetrician, while post-registration training includes the continuing professional development and specialist training undertaken after qualification to maintain and enhance clinical competence.

52 [Q73](#)

53 NHS England, [Core competency framework version two](#), 31 My 2023

54 [Q82](#)

55 Health and Society Knowledge Exchange (HASKE), [Review of Midwifery Education and Training and Newly Qualified Experience: Thematic Analysis](#), March 2023, p. iii

56 [Q73](#)

57 [Q11](#)

58 [Q73](#)

59 [Q88-Q89](#)

60 [Q155](#)

26.

CONCLUSION

Safe maternity care for Black women is dependent on a workforce equipped to understand and respect their needs. Given the current disparities in maternity outcomes for Black women it is indefensible that cultural competency training is optional for NHS staff and leaders working in maternity services, and especially midwives.

27.

RECOMMENDATION

We recommend the Department work with the NHS, the Royal College of Midwives, and the NMC to introduce mandatory, ongoing cultural competency training for all midwives, informed by co-production. A working group should review and update training materials to ensure they meet the needs of all ethnic groups.

Leadership

28. Baroness Merron told us that “leadership is absolutely key”⁶¹ in addressing cultural issues in the NHS. She said that while the Secretary of State had been clear in stating that racism would not be tolerated in the NHS, currently, “the culture is not set right” and that “turning around culture [...] will not happen overnight.”⁶²
29. The NHS Race and Health Observatory⁶³ has published seven “anti-racism principles.” The first two principles are to:
- a. **Demonstrate leadership by naming racism**, engaging seriously and continuously with the ways in which racism impacts the lives of the patients and the public, and actively working to dismantle it, and
 - b. **Understand and acknowledge** that structural, institutional and interpersonal racism all impact on health and be clear about where accountability lies for improvement and progress.⁶⁴

However, we heard from Shanthi Gunesequera, Co-CEO, Birthrights UK that, while many Trust leaders are willing to admit racism exists ‘somewhere’ in the NHS, some Trusts refuse to acknowledge it may be happening in their own service.⁶⁵

61 [Q139](#)

62 [Q139](#)

63 An independent body, hosted by NHS Confederation, established by the NHS to identify and tackle inequalities experienced in health and healthcare by Black and minority ethnic patients, communities and the workforce in England

64 NHS Race & Health Observatory, [Seven Anti-racism principles](#)

65 [Q47](#)

30. Janet Fyle, Royal College of Midwives, argued that Trust chief executives must be directly accountable for diversity and equity outcomes, embedding clear consequences for failures in these outcomes into ICB and Trust performance frameworks.⁶⁶ She suggested that the CQC be utilised to monitor Trusts and their activities and that accountability for improving diversity be embedded into the role of leaders.⁶⁷
31. Baroness Merron agreed that greater accountability was needed:
- “I think there is an issue with accountability. I will ensure that we work on that.”⁶⁸

Professor Bola Owolabi, Director, National Healthcare Inequalities Improvement Programme told us that that NHS England was currently developing a new management and leadership framework and expectations, which it was going to publish “very soon”.⁶⁹

Leadership diversity

32. Witnesses also told us that greater diversity in NHS leadership would have a big impact.⁷⁰ NHS Confederation argued that ensuring diversity in NHS leadership would “lead to significant improvements in the standards of care delivered within its institutions.”⁷¹ Janet Fyle told us “if we have a diversity of leaders, [we] have a diversity of thought”.⁷²
33. According to the NMC register of all nurses, midwives and nursing associates, there are now more Black, Asian and minority ethnic professionals than ever at 277,716 or just under a third (32.5%). This is proportionally up from 30.6% on 31 March 2024.⁷³ By contrast, only 12.7% of senior managers in the NHS were from minority ethnic backgrounds in 2024.⁷⁴ In 2023, it was reported that 95% of midwifery educators were white.⁷⁵ An article in the British Journal of Midwifery argued that this

66 [Q99](#)

67 [Q98](#)

68 [Q142](#)

69 [Q141](#)

70 [NHS must tackle racism and sexism for the benefit of patients, staff, and society](#), Bamrah et al, 01 July 2025

71 NHS Confederation, [Chairs and non-executives in the NHS: The need for diverse leadership](#)

72 [Q100](#)

73 Health Professional Academy, [Data shows greater diversity in nursing and midwifery but international hiring is down](#)

74 NHS England, [One in eight in senior NHS staff from black and minority ethnic backgrounds](#), 25 June 2025

75 Royal College of Midwives, [State of midwifery education 2023](#)

lack of diversity in the midwifery educational workforce meant that the perspectives, experiences, and health needs of Black women were often underrepresented, if not entirely absent, in midwifery training.⁷⁶

34. The Nursing and Midwifery Council has introduced a clear set of equality, diversity and inclusion (EDI) targets to address longstanding disparities in regulation, education, and workforce outcomes.⁷⁷ These commitments, shaped by the Ambitious for Change research, include eliminating ethnicity and gender disparities in fitness to practise processes by 2030, tackling disproportionate referrals from employers, closing attainment gaps in education by 2035, and improving ethnic minority representation and pay equity within the NMC itself. It has also appointed two new Heads of EDI - one focused on regulatory fairness and the other on internal workforce equity - and has undertaken work to integrate de-biasing measures into its Fitness to Practise processes, enhance EDI-focused staff training, and revise regulatory guidance and standard operating procedures to embed equity and inclusion.
35. Kate Brintworth, Chief Midwifery Officer, explained that “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.”⁷⁸ Baroness Merron also pointed towards the upcoming workforce plan, which, she said, “will look at all areas.”⁷⁹

36. **CONCLUSION**

NHS leaders have a vital role in improving maternity outcomes for Black women and addressing the underlying culture and racism that underpin those outcomes. However, the current system does not incentivise leaders to focus on this issue or effectively hold to account Trusts that fail to make progress.

37. **RECOMMENDATION**

The NHS leadership framework should set clear expectations for tackling racism and fostering an inclusive culture, reflected in chief executives’ performance agreements. It must also equip Ministers to hold Trust leaders accountable for creating anti-racist organisations and improving maternity outcome inequalities.

76 British Journal of Midwifery, [The diversity debate: is midwifery higher education addressing the challenges of systemic racism?](#), 2 July 2024

77 Nursing and Midwifery Council, [NMC sets EDI targets to eliminate disparities and drive culture change](#), 25 June 2025

78 [Q140](#)

79 [Q139](#)

38. CONCLUSION

Addressing the current lack of diverse representation within NHS leadership and midwifery education is one practical action that can be taken to address concerns. When those entrusted with shaping clinical knowledge and practice and leading our healthcare organisations overwhelmingly reflect a single demographic, it limits the breadth of what is taught, prioritised, and thus, how care is delivered.

39. RECOMMENDATION

The Government should also ensure the forthcoming workforce plan explicitly includes targets and strategies to diversify NHS leadership, specifically maternity service leaders and educators. This must be accompanied with robust monitoring mechanisms that can be used to track progress and hold Trusts to account for their performance.

National investigation into maternity and neonatal care

- 40.** As we saw in Chapter 1, the Government has recently announced a rapid national investigation into maternity and neonatal care. The investigation will consist of two parts. The first will urgently investigate up to 10 of the most concerning maternity and neonatal units. The second will undertake a system-wide look at maternity and neonatal care, bringing together lessons from past inquiries to create one clear, national set of actions to improve care across every NHS maternity service.⁸⁰ When we questioned the Secretary of State about the plans, he told us that “the inequalities side of maternity failures is absolutely integral to the work of the investigation.”⁸¹
- 41.** The Health Service Safety Investigations Body published a report in August 2025 which highlighted systemic national failures in maternity and neonatal safety across England. They heard that the national architecture of maternity services should be the focus of any further national investigation work because of “previous and current inquiries into patient safety being limited in that they focus on individual Trusts and are predominantly focused on the front line”. They also said that insufficient attention to national organisations and the overarching governance framework has led to a limited understanding of broader systemic factors that affect safe practices

80 Department of Health and Social Care, [National maternity investigation launched to drive improvements](#), 23 June 2025

81 [Oral evidence taken on 14 July 2025, Q154](#)

in maternity care. As a result, obstacles to safety improvements at the national level are often overlooked and not treated as key components in driving overall system reform.⁸²

42. They also said that governance systems for maternity and neonatal services should be included in any investigation and that an investigation would need to identify how far the differences in governance systems act as a barrier to implementing change.⁸³ They also highlighted that there was no clear accountability for tracking the implementation of safety recommendations,⁸⁴ thus the investigation should define an accountability framework for maternity and neonatal services, and embed maternity indicators in this in the same way as other services.⁸⁵

43. **CONCLUSION**

While there have been multiple initiatives aimed at improving Black maternal health, progress remains too slow. We welcome the announcement of a rapid national investigation into maternity and neonatal care and the Secretary of State's commitment to inequality being an integral part of its work.

44. **CONCLUSION**

We hope that the national investigation will serve as a turning point for the country's maternity services, and particularly the experience of Black women, by laying the foundation for a more transparent, accountable, and equitable maternity system. We will monitor the progress of the inquiry closely and intend to revisit its findings, with a view to undertaking further scrutiny at an appropriate stage.

82 Health Services Safety Investigations Body, [An exploratory review of maternity and neonatal services](#), 19 August 2025, 4.2.6

83 Health Services Safety Investigations Body, [An exploratory review of maternity and neonatal services](#), 19 August 2025, 4.5.8

84 Health Services Safety Investigations Body, [An exploratory review of maternity and neonatal services](#), 19 August 2025, 4.1.1

85 Health Services Safety Investigations Body, [An exploratory review of maternity and neonatal services](#), 19 August 2025, 4.5.8

45.

RECOMMENDATION

We recommend that addressing racial disparities in maternal outcomes is one of the investigation's core aims, and that this features prominently in the terms of reference for the second stage. We recommend that the investigation aligns with the priorities outlined by the Health Services Safety Investigations Body, specifically the defining of an accountability framework for maternity and neonatal services. Additionally, we recommend that the review carefully considers the impact of the significant reduction of ringfenced funding as outlined in this report.

3 Workforce

Midwifery workforce

- 46.** The size of the maternity workforce has been increasing in recent years. There are currently 24,959 full time equivalent midwives working in NHS Trusts and other core organisations in England, an increase of 1,330 (5.6%) compared to April 2024, and an increase of 2,918 (13.2%) compared to April 2020.⁸⁶
- 47.** Despite this progress workforce shortages were repeatedly raised as one of the challenges preventing improvements in Black maternal health. In June 2024, the Royal College of Midwives (RCM) said that the NHS in England faces a shortfall of over 2,500 midwives, with many services operating below safe staffing levels.⁸⁷ In a June 2024 RCM survey, 87% of midwives reported their units were not safely staffed and 74% flagged unrealistic workloads, conditions directly linked to higher rates of complications and near-miss incidents.⁸⁸ These findings mirror repeated Care Quality Commission (CQC) warnings that chronic understaffing in maternity services is putting women’s lives at risk.⁸⁹
- 48.** We also heard concerns that what progress has been made in increasing recruitment could be undermined by a failure to retain existing midwives. A 2022 survey by the RCM found that 57% of midwives wanted to leave the profession with over half wishing to do so within a year.⁹⁰ Earlier research by the RCM found that more than half of midwives are considering leaving because they fear patient safety is being compromised by poor staffing levels.⁹¹
- 49.** The RCM have called for staffing shortages to be addressed by:

86 [Correspondence from Baroness Merron re Black Maternal Health](#), 11 July 2025

87 Royal College of Midwives, [Midwives give 100,000 hours of free labour to the NHS per week to keep England’s maternity services safe says RCM](#), 11 June 2024

88 Royal College of Midwives, [Midwives give 100,000 hours of free labour to the NHS per week to keep England’s maternity services safe says RCM](#), 11 June 2024

89 Care Quality Commission, [National review of maternity services in England 2022 to 2024](#), 19 September 2024

90 Royal College of Obstetricians and Gynaecologists, [RCOG Workforce Report 2022](#), 2022

91 [‘Midwives quitting because of unsafe staffing,’ warns RCM](#), Nursing in Practice, 4 October 2021

- increased investment, in line with previous recommendations made by our predecessor Health and Social Care Committee⁹² and the Ockenden Review, and more robust workforce planning measures;
- a greater focus on improving the health and wellbeing of maternity staff, more flexible working opportunities, a culture that values and respects staff and vigorous action to tackle unacceptable behaviours;
- better support for students and newly qualified staff, including more investment in mentoring, preceptorship, continuing professional development and career progression;
- increasing entry routes into midwifery, such as expanding programmes for nurses wanting to convert to midwifery, apprenticeship programmes for Maternity Support Workers and incentives for newly retired staff to return to support students and newly qualified staff; and
- better pay and conditions, both immediately and, longer-term, to redress the cumulative loss of earnings over the last decade.⁹³

50. In May 2025 the Government confirmed a 3.6% pay rise for NHS Agenda for Change staff in England for 2025/26, with wages backdated to April 2025.⁹⁴ The Department of Health and Social Care described the deal as an above-inflation increase and a sign of significant progress,⁹⁵ essential for recruiting and retaining staff and improving long-term workforce stability.⁹⁶ The Royal College of Nursing (RCN) criticised the award as inadequate, arguing that it failed to address long-standing concerns over pay erosion, workforce shortages, and unsafe staffing levels.

51. In August 2025, the Government announced a ‘graduate guarantee’ for newly qualified nurses and midwives.⁹⁷ The guarantee ensures that every newly qualified midwife in England will have the opportunity to apply for a role within the health and social care system, aiming to reduce transitional gaps and strengthen workforce stability. NHS England has committed £8 million in non-recurrent funding to temporarily convert vacant maternity support worker posts into Band 5 midwifery roles, creating immediate

92 Health and Social Care Committee, [Workforce: recruitment, training and retention in health and social care](#), p.5, 25 July 2022

93 Royal College of Midwives, [Addressing the impact of staffing shortages](#), 27 October 2022

94 Department of Health and Social Care, [NHS pay awards 2025 to 2026: Agenda for Change staff](#), 22 May 2025

95 Department of Health and Social Care, [NHS pay award 2025 to 2026: a fair deal for NHS staff](#), 22 May 2025

96 Department of Health and Social Care, [NHS Pay: everything you need to know about the 2025 pay award](#), 27 May 2025

97 NHS England, [Graduate guarantee for newly qualified nurses and midwives](#), 12 August 2025

employment pathways for new graduates. This initiative is designed to improve career progression, reduce reliance on agency staffing, and enhance retention. Trusts are expected to collaborate with regional teams to implement these measures and ensure long-term sustainability through strategic vacancy management and workforce planning.⁹⁸

- 52.** Despite widespread understaffing across maternity services, a 2025 RCM survey found that over 80% of student midwives due to qualify were not confident they would find a job upon graduation, with many citing recruitment freezes and lack of funded posts as the primary barrier.⁹⁹ Trusts have attributed this to budget constraints, leaving midwifery managers unable to hire even when services are short-staffed.¹⁰⁰ The RCM warned that this disconnect between workforce planning and actual service needs was contributing to temporary unit closures, as safe staffing thresholds could not be met.¹⁰¹

Continuity of Carer

- 53.** Continuity of carer throughout pregnancy is a key element of safe and effective care.¹⁰² Continuity models rely on women seeing the same midwife (or small team) throughout pregnancy, birth and the postnatal period, building trust, spotting warning signs early and tailoring support to each woman's needs.¹⁰³
- 54.** Continuity of carer has stood at the centre of maternity reform efforts since 2016, featuring heavily in the Better Births report, the final report of the National Maternity Review.¹⁰⁴ In its 2019 Long Term Plan, NHS England committed to rolling out this model so that the majority of women would benefit by 2021, with an initial milestone of 20% coverage by March 2019. The Plan then stipulated that, by 2024, three-quarters of women from Black, Asian and other minority ethnic backgrounds, and the same proportion of those in the most deprived areas, should receive uninterrupted midwifery

98 NHS England, [Graduate guarantee for newly qualified nurses and midwives](#), 12 August 2025

99 Royal College of Midwives, [New midwives ready to work, but no jobs available despite understaffed services says RCM](#), 4 June 2025

100 Royal College of Midwives, [New midwives ready to work, but no jobs available despite understaffed services says RCM](#), 4 June 2025

101 Royal College of Midwives, [New midwives ready to work, but no jobs available despite understaffed services says RCM](#), 4 June 2025

102 [Q76](#)

103 Women and Equalities Committee, Third Report of Session 2022–23, [Black maternal health](#), HC368, para 24

104 [BETTER BIRTHS: Improving outcomes of maternity services in England, National Maternity Review](#), 22 February 2016

support across pregnancy, birth and the postnatal period.¹⁰⁵ The 2021 Core20PLUS5 framework, introduced by NHS England and NHS Improvement to tackle health inequalities, reaffirms this objective for those priority groups.¹⁰⁶

55. Our Expert Panel and the final Ockenden review concluded that workforce shortages have significantly obstructed the effective implementation of this model.¹⁰⁷¹⁰⁸ Janet Fyle, Professional Policy Advisor, Royal College of Midwives, told us that continuity of care is personalised and “delivers very good outcomes for every woman...but it has been delivered in a patchy way.”¹⁰⁹ Professor Marian Knight, Director and Professor of Maternal and Child Population Health, National Perinatal Epidemiology Unit, advised us that continuity of care models might be improved by utilising the intended shift from hospital to community as part of the NHS 10-year plan.¹¹⁰
56. In September 2022, NHS England removed the national target date for delivering Continuity of Carer, citing insufficient staffing levels.¹¹¹ In a letter to us on 07 July 2025, Baroness Merron said that “Work is now underway on how we can re-organise the workforce in a way that facilitates continuity of care without impacting staff and patient safety” but gave no official date for the reintroduction of the target.¹¹²

Obstetrician workforce

57. We also heard that obstetricians staffing levels were an obstacle to improvement, with recent increases in number but continued problems. There are currently 3,008 full time equivalent obstetrics and gynaecology consultants working in NHS Trusts and other core organisations in England, 118 (4.1%) more compared to April 2024.¹¹³ However we heard that the

105 Royal College of Midwives, The NHS Long Term Plan, January 2019 <https://rcm.org.uk/wp-content/uploads/2024/06/nhs-long-term-plan-jan-2019.pdf>

106 NHS England, [Core20PLUS5 \(adults\) – an approach to reducing healthcare inequalities](#)

107 Health and Social Care Committee, The Health and Social Care Committee’s Expert Panel: Evaluation of the Government’s progress against its policy commitments in the area of maternity services in England, [HC368](#), para 26

108 Ockenden Review, Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, [HC 1219](#), 30 March 2022

109 [Q76](#)

110 [Q61](#)

111 Correspondence from Chief Nursing Officer, Midwifery Continuity of Carer, 21 September 2022 <https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf>

112 Letter to the Committee from the Parliamentary Under-Secretary of State for Patient Safety, Women’s Health and Mental Health, [11 July 2025](#)

113 Letter to the Committee from the Parliamentary Under-Secretary of State for Patient Safety, Women’s Health and Mental Health, [11 July 2025](#)

workforce continues to face significant staffing pressures, with persistent rota gaps despite workforce growth.¹¹⁴ Obstetricians report some of the heaviest workloads and highest levels of emotional strain, contributing to the highest attrition rate of any specialty just a few years into their careers.¹¹⁵

58. Professor Hassan Shehata highlighted one significant difference between obstetrics and gynaecology and midwifery: for obstetrics and gynaecology there is no formal tool to define safe staffing. The Department for Health and Social Care (DHSC) commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to develop a Workforce Planning Tool, which provided estimates of the obstetric and anaesthetic workforce required for safe, high-quality maternity care. However Professor Hassan Shehata told us this tool had now “been shelved.”¹¹⁶
59. When asked why the tool has not been implemented, Kate Brintworth, Chief Midwifery Officer for England, acknowledged the RCOG had provided a useful baseline for workforce planning. However, she did not commit to rolling out the tool, instead highlighting the challenges posed by rising caesarean and induction rates which she argued demonstrated the need for further modelling.¹¹⁷

Workforce plan

60. The NHS Long Term Workforce Plan sets out how the health service will train, retain, and reform its workforce over the next decade, but the Government has announced plans to revise it significantly. The original plan, published in 2023, aimed to address a projected shortfall of up to 360,000 staff by 2036/37 through expanded training, improved retention, and new roles.¹¹⁸ Under this plan it was projection that midwife numbers would go from 23,000 FTE¹¹⁹ midwives in 2021/22 to 31–33,000 by 2036/37 FTE. If the workforce plan fully delivered on this projecting the supply of midwives would fall short of projected demand by 6%-18%.¹²⁰ However, the Government has now committed to publishing a refreshed 10-Year Workforce Plan in late 2025, which will take a “decidedly different

114 [Preterm birth: reducing risks and improving lives](#), Chapter 4

115 [Work-related post-traumatic stress symptoms in obstetricians and gynaecologists: findings from INDIGO, a mixed-methods study with a cross-sectional survey and in-depth interviews](#), Slade et al, 2020

116 [Q90](#)

117 [Q152](#)

118 NHS England, [NHS Long Term Workforce Plan](#), 30 June 2023

119 Full Time Equivalent

120 NHS England, [NHS Long Term Workforce Plan](#), 30 June 2023, Table 3: Modelling outputs by professional groups

approach”.¹²¹ The Government has said this new plan will be central to delivering its wider 10-Year Health Plan, which seeks to reinvent the NHS and address long-standing workforce and productivity challenges.¹²²

61. Professor Hassan Shehata argued that the upcoming workforce plan should “focus on retaining the skills and staffing that we have, tackling high levels of burnout and boosting the workforce numbers.”¹²³

62. **CONCLUSION**

Workforce shortages remain a major barrier to safe maternity care, despite recent recruitment progress. We are disappointed the Government suspended its continuity of carer target, which is especially important for marginalised women, including Black women, who face greater challenges in being heard by the healthcare system.

63. **RECOMMENDATION**

The Government must give firm commitments in the refreshed Long Term Workforce Plan to deliver safe staffing levels for maternity services. Without this, safe and sustainable maternity care will remain out of reach. As part of the workforce plan the Government must commit to rapidly reaching a level of staffing that will allow it to recommit to its continuity of carer target.

64. **CONCLUSION**

Suspending adoption of RCOG’s safe staffing tool has left Trusts without clear guidance on safe staffing levels, perpetuating poor workforce supply and undermining efforts to stabilise and support maternity teams.

65. **RECOMMENDATION**

We urge the Department to update and publish the tool produced by RCOG in time for the rollout of the upcoming refreshed Workforce Plan, so that every maternity unit can use it to plan effectively, ensure appropriate staffing and deliver consistent, safe care to all mothers and their babies.

121 Department of Health and Social Care, [Fit for the future: 10 Year Health Plan for England](#), July 2025

122 Department of Health and Social Care, [Fit for the future: 10 Year Health Plan for England](#), July 2025

123 [Q93](#)

4 Data

66. Throughout our inquiry, we heard repeatedly that disparities in maternal outcomes could not be improved without both better, and increased, collection of data relating to maternal morbidity, specifically ethnicity data.¹²⁴ In their national review of maternity services in England 2022 to 2024, the Care Quality Commission found a “huge variation in the way trusts collect and use demographic data to address health inequalities and access.”¹²⁵ It had previously “highlighted the need for services to use ethnicity data to review safety outcomes for women from ethnic minority groups” and noted that it remained “concerned about a data gap at Trust-level, which could be preventing Trusts from making improvements.”¹²⁶ It also found that a lack of ethnicity data meant that “many services had no way to analyse whether national approaches, [...] were reaching those most in need of support in their local communities.”¹²⁷
67. The Maternity Services Data Set (MSDS) is a national, patient-level data set that captures detailed information on maternity care across NHS-funded services in England, spanning from the first antenatal booking to postnatal discharge. It includes demographic, clinical, and social data—such as ethnicity, complex social factors, care plans, and birth outcomes—making it a vital tool for understanding patterns of access, experience, and outcomes.

Completeness of data

68. A study by Public Health England on the quality of the MSDS found that the data set has a notable proportion of entries which record ethnicity as “unknown” or “not stated”.¹²⁸ While it concluded that these mostly relate to

124 [Qq82-84](#)

125 Care Quality Commission, [National review of maternity services in England 2022 to 2024](#), September 2024

126 Care Quality Commission, [National review of maternity services in England 2022 to 2024](#), September 2024

127 Care Quality Commission, [National review of maternity services in England 2022 to 2024](#), September 2024

128 Public Health England, [Health of women before and during pregnancy: health behaviours, risk factors and inequalities](#), 2019 p. 47

White women, it noted that the lack of robust ethnicity data, even where related to White women, distorted baseline metrics, an issue underscored by Professor Bola Owolabi, who affirmed that “baseline figures do matter.”¹²⁹

69. Giving evidence to the previous Women and Equalities Committee’s inquiry into Black Maternal Health in 2022, Dr Mathew Jolly, the then National Clinical Director for Maternity Review and Women’s Health at NHS England, said that the overall quality of data had improved significantly since 2015, when only about a third of Trusts held ethnicity data for women booked in for antenatal care. He said the use of the Clinical Negligence Scheme for Trusts¹³⁰ Maternity Incentive Scheme had helped improve data collection on ethnicity, which is active in over 90% of Trusts.¹³¹
70. However, there are clear, recent examples of individual Trusts failing to record ethnicity data. The 2022 Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust also found an issue with missing ethnicity data, stating that there were:
- 9,276 missing ethnic background details within the data provided by the Trust, which accounts for approximately 9 per cent of the overall data throughout the timescale of the review. It is also evident that the trend of incomplete data on ethnic background is increasing in recent years.¹³²
71. We heard repeatedly that a critical necessity for improving data collection was increased funding. Professor Shehata told us that this was “the fundamental obstacle” to reliable ethnicity data collection and reported that now that the initial ring-fenced allocations for maternal medicine networks had ceased, integrated care boards were operating under tightening budgetary constraints,¹³³ and that there was no dedicated funding to support the personnel responsible for gathering and analysing these data.¹³⁴

129 [Q128](#)

130 The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995: NHS Resolution, [Clinical Negligence Scheme for Trusts](#), 3rd April 2020, accessed on 8 June 2024

131 Women and Equalities Committee, Third Report of Session 2022–23, [Black maternal health](#), HC368, para 56

132 [Ockenden Report, Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust](#), 30 March 2022, para 3a.7

133 [Q88](#)

134 [Q107](#)

- 72.** Professor Lucy Chappell, Chief Scientific Adviser, Department for Health and Social Care, said that improving maternity data was an ongoing process. She explained that delays in data collection, particularly getting the total number of births, had been a challenge for the Department, but that collaboration with the Office for National Statistics has helped reduce that time lag by providing earlier access to birth registration figures. This, she said, was a tangible example of progress toward more timely and interpretable data.¹³⁵
- 73.** Professor Bola Owolabi told us that NHS England had recently agreed an Ethnicity Recording Improvement Plan, which she expected to be published “over the next month or so”.¹³⁶

Maternal mortality and morbidity data

- 74.** Maternal mortality data in the UK is primarily analysed through the work of MBRRACE-UK, which conducts detailed reviews of each maternal death to identify systemic failures and opportunities for improvement.¹³⁷ Findings are published in annual surveillance reports that highlight trends in cause of death, disparities across ethnicity and deprivation, and areas of clinical concern such as thromboembolism, cardiac disease, and mental health. These insights help shape national policy, update clinical guidance, and inform public health interventions aimed at preventing future deaths. Professor Knight, Professor of Maternal and Child Population Health, National Perinatal Epidemiology Unit, highlighted that the NHS uses a real-time data tool to track baby deaths—specifically stillbirths and neonatal deaths—enabling hospitals to identify patterns, respond swiftly, and assess the impact of interventions.¹³⁸ However, Professor Knight also told us that the relatively small number of cases each year limits the statistical power of these reviews.¹³⁹
- 75.** There is no equivalent framework for systematically monitoring maternal morbidity that matches the scope or analytical rigour of existing systems for tracking baby deaths or maternal mortality.¹⁴⁰ Maternal morbidity refers to non-fatal complications like haemorrhage, sepsis, or maternal mental illness. Whilst the Maternity Services Data Set (MSDS) compiles every NHS-funded maternity episode, including ethnicity and key clinical events: postpartum haemorrhage, eclampsia, gestational diabetes

135 [Q125](#)

136 [Q128](#)

137 [MBRRACE-UK](#)

138 [Q28](#)

139 [Q21](#)

140 [Q28](#)

and maternal critical-care admissions, it fails to systematically capture maternal morbidity data in a format that supports comprehensive analysis, benchmarking, or real-time monitoring.¹⁴¹

- 76.** Professor Knight called for the active collection and monitoring of maternal morbidity and severe complications in the same way,¹⁴² emphasising that without reliable, real-time data on maternal morbidity outcomes, especially severe complications, it became nearly impossible for clinicians, policymakers, and service leaders to understand which interventions were making a difference and for whom.¹⁴³ Creating a comparable data system for maternal morbidity, she argued, would unlock vital opportunities to drive improvement across the country.¹⁴⁴
- 77.** In its 2022 inquiry, the previous Women and Equalities Committee asked about progress on developing a maternal morbidity indicator. In August 2022, the then Minister for Health, Maria Caulfield MP, told that Committee that an English maternal morbidity outcome indicator was still under development, led by the Policy Research Unit in Maternal and Neonatal Health and Care at the University of Oxford.¹⁴⁵ In March 2023, Minister Caulfield stated that the work on assessing disparities in maternal morbidity outcomes was “almost” complete and would be sent to the Department of Health and Social Care for review “shortly.”¹⁴⁶
- 78.** However, when we raised the issue of a maternal morbidity indicator in June 2025, we heard from Baroness Merron that the Department was still currently developing “a severe maternal morbidity indicator to get data more rapidly and to allow comparisons between Trusts”¹⁴⁷ which could be expected within “less than three years”.¹⁴⁸

141 NHS England, [Maternity Services Data Set \(MSDS\)](#)

142 [Q21](#)

143 [Q28](#)

144 [Q28](#)

145 [Letter from the Minister of State for Health relating to the evidence session on Black Maternal Health, 4 August 2022](#)

146 [Letter to the Committee from the Minister for mental health and the women’s health strategy on black maternal health, 21 March 2023](#)

147 [Q121](#)

148 [Q123](#)

79.

CONCLUSION

Collecting robust, consistent, and equity-focused data on ethnicity and maternal morbidity is essential to enable health services to monitor and improve their services guiding improvements in maternal outcomes. Without it, it is significantly harder to produce accurate comparisons across all ethnic groups and evaluate disparities in maternal outcomes amongst different ethnicities, and gaps may obscure the true extent of disparities in outcomes for Black and other minority ethnic women.

80.

CONCLUSION

We are pleased that the Government has agreed an Ethnicity Recording Improvement Plan and look forward to seeing the details when it is published.

81.

RECOMMENDATION

We recommend that this Plan should include details on staff training, support for data collection, and accountability measures to ensure Trusts meet their responsibilities. The Government must establish transparent mechanisms to monitor compliance and address failures in timely, accurate reporting, and outline these in its response to this report.

82.

RECOMMENDATION

We are concerned that progress on developing a maternal morbidity indicator has been unacceptably slow, despite a Government commitment to do so over two years ago. We recommend the Department work with the National Institute for Health and Care Research to accelerate development and provide a clear timetable in response to this report.

5 Funding

- 83.** According to an NHS Board paper from 30 March 2023, the NHS spent around £3 billion on maternity services in that year.¹⁴⁹ In 2023–24 this increased to £5.2 billion.¹⁵⁰ As seen in Chapter 1, the NHS is also spending a significant amount of money on maternity negligence claims in England. It is estimated that since 2019 the NHS has paid £27.4 billion to cover these claims - covering both legal fees and settlements. This exceeds the total maternity budget, which was roughly £18 billion over the same period.¹⁵¹
- 84.** While the majority of the maternity budget goes towards staff costs,¹⁵² there has also been dedicated funding targeted at delivering specific service improvements. For example, while most of the additional £186m announced for maternity services in 2024–25 was directed at addressing workforce shortages, £36m was assigned to “provide additional resources to systems and supporting a range of projects including independent senior advocates, a culture and leadership programme,” and to support staff retention.”¹⁵³ Similarly, when the 2024 Spring Budget announced a £35m investment over three years in maternity service in English hospitals, this contained funding for the Avoiding Brain Injuries in Childbirth programme, as well as funding for training in neonatal resuscitation and obstetrics medicine.¹⁵⁴
- 85.** One funding source that was aimed at delivering service improvement was national service development funding (SDF). This is money provided to the Integrated Care Board (ICB) as additional programme funding on top of ICB baselines.¹⁵⁵ Guidance on SDF said that this money should be ringfenced for “specific, identified programmes of work in line with national ambitions and

149 NHS England, [Three-year delivery plan for maternity and neonatal services](#), 30 March 2023, accessed 18 July 2025

150 Sands & Tommy’s Policy Unit, [Investment in maternity and neonatal services in England](#) and Department of Health and Social Care, [Annual Report and Accounts 2023–24 For the year ended 31 March 2024](#), 17 December 2024

151 The Guardian, [NHS facing ‘absolutely shocking’ £27bn bill for maternity failings in England](#), 20 July 2025

152 NHS England, [Three-year delivery plan for maternity and neonatal services](#), 30 March 2023, accessed 18 July 2025

153 Sands & Tommy’s Policy Unit, [Investment in maternity and neonatal services in England](#), 2024, accessed 18 July 2025

154 Sands & Tommy’s Policy Unit, [Investment in maternity and neonatal services in England](#), 2024, accessed 18 July 2025

155 NHS England, [Primary care service development funding and general practice IT funding guidance 2024/25](#), 18 June 2024, accessed 19 July 2024

priorities”¹⁵⁶ and should not be used to fund business as usual staff costs or other ICB costs.”¹⁵⁷ In 2023–24 SDF’s maternity programme included the following “bundled” priorities: Local Ockenden and East Kent Response, Enhanced Continuity of Care for deprived areas and BAME, Genetic Risk Services, Independent Senior Advocate and Ockenden II Workforce.¹⁵⁸

- 86.** In April 2025 the Health Service Journal reported that there was to be a significant reduction in funding for SDFs.¹⁵⁹ This included reducing the maternity services SDF from £95 million in 2024–25 to just £2 million in 2025–26.¹⁶⁰ The NHS and Government have said that the money for maternity services was not being cut but being reallocated to wider allocations to ICBs to give local leaders more flexibility over how to spend it, and maternity funding, which formed part of the SDF in 2024–25, was transferred to ICB core allocations for the coming year. In a letter to us, Baroness Merron said:

Funding is therefore still being delivered as part of wider ICB allocations, giving local healthcare leaders – who are best placed to decide how to serve their local community – more flexibility in decision-making.¹⁶¹

- 87.** However, healthcare leaders and campaigners writing in the British Medical Journal warned that the withdrawal of ringfenced central funding for England’s maternity services would severely undermine efforts to improve safety. Dr Ranee Thakar, president of the Royal College of Obstetricians and Gynaecologists, said the college was “extremely concerned” that “substantial funding” was being removed from maternity services, noting:

If this ringfenced funding is removed, local systems and individual trusts will face incredibly difficult fiscal decisions, with potentially very serious consequences for women and families. Labour’s manifesto stated that “Never again will women’s health be neglected,” and we once again call on the Government to remember this promise.¹⁶²

156 NHS England, [ICB Allocation and Supporting tools](#), accessed 18 July 2025 via Healthcare Financial Management Association website

157 NHS England, [Primary care service development funding and general practice IT funding guidance 2024/25](#), 18 June 2024

158 NHS England, [ICB Allocation and Supporting tools](#), accessed 18 July 2025 via Healthcare Financial Management Association website

159 Health Service Journal, [NHSE budget cuts hit maternity, children and prevention](#), 29 April 2025

160 British Medical Journal, [Maternity care: Removing ringfenced funding will derail safety improvements, leaders warn](#), 2 May 2025

161 Letter to the Committee from the Parliamentary Under-Secretary of State for Patient Safety, Women’s Health and Mental Health, [11 July 2025](#)

162 The British Medical Journal, [Maternity care: Removing ringfenced funding will derail safety improvements, leaders warn](#), 2 May 2025

88. We asked Baroness Merron how the Government would be monitoring ICB spend in this area now that the ring fence had been removed.¹⁶³ She emphasised the importance of flexibility to “ensure the right decisions are made and provision is made properly.” She also noted that NHS England holds ICBs to account for delivering services,¹⁶⁴ and that the Government had set out clear expectations for maternity in its manifesto and the cross-Government missions.¹⁶⁵
89. Baroness Merron also told us that ICBs would be held accountable specifically for the quality of maternity and neonatal services under the forthcoming 2025–26 NHS Performance Assessment Framework (PAF).¹⁶⁶ Currently under consultation, the PAF introduces dedicated metrics for patient safety and patient experience in maternity care, with ICBs rated on a 1–4 scale. Where services are found lacking, NHS England may take action, ranging from targeted support to formal intervention, including enrolment into the Recovery Support Programme for the most challenged providers.¹⁶⁷

90. **CONCLUSION**

We are concerned by the Government’s decision to cut the Maternity Service Development Fund from £95 million to £2 million. While ICBs still have access to this funding, maternity services must now compete with other local priorities. While performance metrics in the 2025–26 NHS Assessment Framework aim to ensure accountability, they do not guarantee sufficient funding will be directed towards maternity services. Without sustained oversight and dedicated investment, maternity care risks losing momentum, widening disparities, including in Black maternal care, and compromising critical reforms. We are also concerned about how the dissolution of NHS England and its absorption into the Department of Health and Social Care might impact the NHS’s ability to monitor maternity spending and maintain national oversight of progress.

91. **RECOMMENDATION**

We strongly recommend that the Government restore the dedicated ring-fenced funding for the Service Development Fund for maternity care to £95 million. Properly targeted we believe this investment has the potential to reduce the substantial cost of maternity negligence claims to the NHS and more than pay for itself.

163 [Q133](#)

164 [Q133](#)

165 [Q135](#)

166 Letter to the Committee from the Parliamentary Under-Secretary of State for Patient Safety, Women’s Health and Mental Health, [11 July 2025](#)

167 Letter to the Committee from the Parliamentary Under-Secretary of State for Patient Safety, Women’s Health and Mental Health, [11 July 2025](#)

92.

RECOMMENDATION

More broadly, the Government must ensure that maternity services continue to be a priority within ICB funding allocations. We ask the Government to set out in its response to this Report how it will monitor ICB investment in these services, including the impact of the removal of the ringfence if that decision is not reversed, and how it will intervene if it sees evidence that ICBs are underinvesting in maternity services.

Conclusions and recommendations

Culture, racism and leadership

1. Safe maternity care for Black women is dependent on a workforce equipped to understand and respect their needs. Given the current disparities in maternity outcomes for Black women it is indefensible that cultural competency training is optional for NHS staff and leaders working in maternity services, and especially midwives. (Conclusion, Paragraph 26)
2. We recommend the Department work with the NHS, the Royal College of Midwives, and the NMC to introduce mandatory, ongoing cultural competency training for all midwives, informed by co-production. A working group should review and update training materials to ensure they meet the needs of all ethnic groups. (Recommendation, Paragraph 27)
3. NHS leaders have a vital role in improving maternity outcomes for Black women and addressing the underlying culture and racism that underpin those outcomes. However, the current system does not incentivise leaders to focus on this issue or effectively hold to account Trusts that fail to make progress.(Conclusion, Paragraph 36)
4. The NHS leadership framework should set clear expectations for tackling racism and fostering an inclusive culture, reflected in chief executives' performance agreements. It must also equip Ministers to hold Trust leaders accountable for creating anti-racist organisations and improving maternity outcome inequalities. (Recommendation, Paragraph 37)
5. Addressing the current lack of diverse representation within NHS leadership and midwifery education is one practical action that can be taken to address concerns. When those entrusted with shaping clinical knowledge and practice and leading our healthcare organisations overwhelmingly reflect a single demographic, it limits the breadth of what is taught, prioritised, and thus, how care is delivered. (Conclusion, Paragraph 38)
6. The Government should also ensure the forthcoming workforce plan explicitly includes targets and strategies to diversify NHS leadership, specifically maternity service leaders and educators. This must be

accompanied with robust monitoring mechanisms that can be used to track progress and hold Trusts to account for their performance. (Recommendation, Paragraph 39)

7. While there have been multiple initiatives aimed at improving Black maternal health, progress remains too slow. We welcome the announcement of a rapid national investigation into maternity and neonatal care and the Secretary of State's commitment to inequality being an integral part of its work. (Conclusion, Paragraph 43)
8. We hope that the national investigation will serve as a turning point for the country's maternity services, and particularly the experience of Black women, by laying the foundation for a more transparent, accountable, and equitable maternity system. We will monitor the progress of the inquiry closely and intend to revisit its findings, with a view to undertaking further scrutiny at an appropriate stage. (Conclusion, Paragraph 44)
9. We recommend that addressing racial disparities in maternal outcomes is one of the investigation's core aims, and that this features prominently in the terms of reference for the second stage. We recommend that the investigation aligns with the priorities outlined by the Health Services Safety Investigations Body, specifically the defining of an accountability framework for maternity and neonatal services. Additionally, we recommend that the review carefully considers the impact of the significant reduction of ringfenced funding as outlined in this report. (Recommendation, Paragraph 45)

Workforce

10. Workforce shortages remain a major barrier to safe maternity care, despite recent recruitment progress. We are disappointed the Government suspended its continuity of carer target, which is especially important for marginalised women, including Black women, who face greater challenges in being heard by the healthcare system. (Conclusion, Paragraph 62)
11. The Government must give firm commitments in the refreshed Long Term Workforce Plan to deliver safe staffing levels for maternity services. Without this, safe and sustainable maternity care will remain out of reach. As part of the workforce plan the Government must commit to rapidly reaching a level of staffing that will allow it to recommit to its continuity of carer target. (Recommendation, Paragraph 63)
12. Suspending adoption of RCOG's safe staffing tool has left Trusts without clear guidance on safe staffing levels, perpetuating poor workforce supply and undermining efforts to stabilise and support maternity teams. (Conclusion, Paragraph 64)

13. We urge the Department to update and publish the tool produced by RCOG in time for the rollout of the upcoming refreshed Workforce Plan, so that every maternity unit can use it to plan effectively, ensure appropriate staffing and deliver consistent, safe care to all mothers and their babies. (Recommendation, Paragraph 65)

Data

14. Collecting robust, consistent, and equity-focused data on ethnicity and maternal morbidity is essential to enable health services to monitor and improve their services guiding improvements in maternal outcomes. Without it, it is significantly harder to produce accurate comparisons across all ethnic groups and evaluate disparities in maternal outcomes amongst different ethnicities, and gaps may obscure the true extent of disparities in outcomes for Black and other minority ethnic women. (Conclusion, Paragraph 79)
15. We are pleased that the Government has agreed an Ethnicity Recording Improvement Plan and look forward to seeing the details when it is published. (Conclusion, Paragraph 80)
16. We recommend that this Plan should include details on staff training, support for data collection, and accountability measures to ensure Trusts meet their responsibilities. The Government must establish transparent mechanisms to monitor compliance and address failures in timely, accurate reporting, and outline these in its response to this report. (Recommendation, Paragraph 81)
17. We are concerned that progress on developing a maternal morbidity indicator has been unacceptably slow, despite a Government commitment to do so over two years ago. We recommend the Department work with the National Institute for Health and Care Research to accelerate development and provide a clear timetable in response to this report. (Recommendation, Paragraph 82)

Funding

18. We are concerned by the Government's decision to cut the Maternity Service Development Fund from £95 million to £2 million. While ICBs still have access to this funding, maternity services must now compete with other local priorities. While performance metrics in the 2025–26 NHS Assessment Framework aim to ensure accountability, they do not guarantee sufficient funding will be directed towards maternity services. Without sustained oversight and dedicated investment, maternity care risks losing momentum,

widening disparities, including in Black maternal care, and compromising critical reforms. We are also concerned about how the dissolution of NHS England and its absorption into the Department of Health and Social Care might impact the NHS's ability to monitor maternity spending and maintain national oversight of progress. (Conclusion, Paragraph 90)

- 19.** We strongly recommend that the Government restore the dedicated ring-fenced funding for the Service Development Fund for maternity care to £95 million. Properly targeted we believe this investment has the potential to reduce the substantial cost of maternity negligence claims to the NHS and more than pay for itself. (Recommendation, Paragraph 91)
- 20.** More broadly, the Government must ensure that maternity services continue to be a priority within ICB funding allocations. We ask the Government to set out in its response to this Report how it will monitor ICB investment in these services, including the impact of the removal of the ringfence if that decision is not reversed, and how it will intervene if it sees evidence that ICBs are underinvesting in maternity services. (Recommendation, Paragraph 92)

Formal minutes

Tuesday 11 September 2025

Members present:

Paulette Hamilton, in the Chair

Ben Coleman

Andrew George

Joe Robertson

Greg Stafford

In the absence of the Chair, Paulette Hamilton took the Chair

Black Maternal Health

Draft Report (*Black Maternal Health*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 to 92 agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Adjournment

Adjourned till Wednesday 15 October at 9.15 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Wednesday 14 May 2025

Tinuke Awe, Co-founder, Five x More

[Q1-16](#)

Shanthi Gunesekera, Co-CEO, Birthrights UK; **Professor Marian Knight**, Director, National Perinatal Epidemiology Unit, Professor, Maternal and Child Population Health; **Sonah Paton**, Co-Founder & Director, Black Mothers Matter

[Q19-66](#)

Wednesday 18 June 2025

Janet Fyle MBE, Professional Policy Advisor, Royal College of Midwives; **Sylvia Owusu-Nepaul**, Programme Director, Birmingham and Solihull United Maternity & Newborn Partnership; **Professor Hassan Shehata**, Senior and Global Health Vice President, Royal College of Obstetricians and Gynaecologists (RCOG)

[Q67-118](#)

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

[Q119-161](#)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2024–26

Number	Title	Reference
1st	Appointment of the Chair of NHS England	HC 743
2nd	Adult Social Care Reform: the cost of inaction	HC 368
2nd Special	Expert Panel: Evaluation on meeting patient safety recommendations: Government Response	HC 617
1st Special	Pharmacy: Government Response	HC 602