HOUSE OF LORDS

Preterm Birth Committee

Corrected oral evidence: Preterm birth

Monday 13 May 2024

3.15 pm

Watch the meeting

Members present: Baroness Wyld (In the Chair); Baroness Blackstone; Viscount Colville of Culross; Baroness Cumberlege; Lord Hampton; Baroness Hughes of Stretford; Lord Patel; Baroness Seccombe; Baroness Thornhill; Baroness Watkins of Tavistock; Lord Winston.

Evidence Session No. 16 Heard in Public Questions 214 – 229

Witnesses

I: Sam Pretlove, Deputy Chief Medical Officer, NHS Birmingham and Solihull ICB; Caroline Lacy, LMNS Clinical Programme Lead, NHS Somerset ICB; Catherine McClennan, Director, Women's Health and Maternity Programme and LMNS Senior Responsible Officer, NHS Cheshire and Merseyside ICB.

Examination of witnesses

Sam Pretlove, Caroline Lacy and Catherine McClennan.

Q214 **The Chair:** Good afternoon, and welcome to this afternoon's public session of the Preterm Birth Committee. I am Baroness Wyld and I am standing in for our Chair, Lord Patel. I thank our witnesses very much for joining us today.

Before we move on to questions, I need to provide a short update of my own declaration of interests. I am a board member of Ofsted and a member of the court of Newcastle University.

This session is being broadcast on the internet and a transcript will be sent to you in a few days' time for you to check. If you would like or need to provide supplementary evidence in writing after the meeting, you will be able to do so.

I will start by asking you to introduce yourself for the record. Please tell us who you are and where you have come from. Thank you.

Sam Pretlove: I am a consultant obstetrician by background. Today I am representing Birmingham and Solihull ICB.

Catherine McClennan: I am the SRO for the Cheshire and Merseyside ICB local maternity and neonatal system.

Caroline Lacy: I am a midwife and the clinical programme lead for the local maternity and neonatal system for Somerset's ICB.

Q215 **Baroness Watkins of Tavistock:** I will start by thanking you and others who have sent in evidence, which has helped to inform our questioning and where we are trying to go. What plans, including public health initiatives, do you have in place to reduce the rate of preterm birth in your region, and do you think that is achievable?

Catherine McClennan: Cheshire and Merseyside has quite a complex ICB. There are nine places in our geography, but we have been operating as a system via our local maternity and neonatal system for a number of years. Obviously, a reduction in preterm birth has been a priority for us for many years, even before the establishment of preterm birth networks.

The resource and focus on the development of preterm birth networks has been incredibly positive for us in working as collaboratives across all our providers, including our neonatal operational delivery network. That, together with our clinical interventions and our public health initiatives, where we are focusing on trying to help the women most at risk, means when we look at our latest statistics we can see that we have managed to achieve that rate of 6%.

It is a very complex area, which is not to say that we do not need to continue to focus in on this to ensure that we achieve the targets that are set. Obviously, our key focus is on spontaneous preterm births and the risk associated with that, which links with some of our key population risk factors such as deprivation in Cheshire and Merseyside and some of the other complex issues.

Baroness Watkins of Tavistock: You said that you have managed to achieve the 6% in your area. Which year's figures is that against?

Catherine McClennan: Our most recent data showed that our preterm birth rate at less than 27 weeks was 0.5%, and births at less than 34 weeks was 1.8%, although our rates for 34 to 37 weeks are probably more in line with the overall target. However, we also have a tertiary centre in our vicinity, so we will always be a key importer of the most complex women who are at risk.

Baroness Watkins of Tavistock: I am just trying to understand. Those data are for which year?

Catherine McClennan: They are for 2023.

Baroness Watkins of Tavistock: You are saying that it is a 6% reduction. Is that against the previous year or the previous five years?

Catherine McClennan: It is achieving the ambition of 6% of our total preterm births.

Baroness Watkins of Tavistock: I am not sure whether your data suggests that that is an improvement or whether you have always been in that situation.

Catherine McClennan: It is an improvement, sorry.

Baroness Watkins of Tavistock: That is fine. I just wanted to understand. Caroline, is it slightly different in your rural patch?

Caroline Lacy: We are a very different population in Somerset. We are quite unique in that we have recently merged, so we have the complexity of having one provider in our ICB, which has its own challenges of assurance and fresh eyes in what we are doing. We are very rural: 50% of our population live in what is described as a rural community.

On preterm birth figures, we have seen the trend go in the opposite direction. That is a surprise, given that Somerset was an early adopter of Saving Babies' Lives back in 2014. The PERIPrem bundle has grown from the south-west region. Against the five key interventions to optimise preterm births, we are doing really well. We can boast that 25% of babies are getting those five key interventions. If you compare that to other areas that are getting 10%—I think the national average is about 15%—Somerset and the south-west are doing really well.

We have, however, seen our preterm births go up. They were at 5.3% in 2001, but in the last year to date that has gone up to 7.5%, which is obviously in the wrong direction. Considering that we are doing so well on things like our SATOD rate, it is a surprise to me.

We talk about preterm birth being a perinatal team challenge that needs to be driven by the perinatal team, but perhaps we need to look at funding our fetal medicine networks and our maternity medicine networks in the way we fund the neonatal networks. The neonatal networks have clearly been a success story.

Baroness Watkins of Tavistock: Somerset's population has changed quite dramatically because of the planned new nuclear electricity site, so has your birth rate gone up? I think your younger population has gone up, so are your figures comparing similar birth rates over the years that you have just described?

Caroline Lacy: The birth rate has actually fallen in the last few years.

Baroness Watkins of Tavistock: That is interesting. It is a trend associated with other European countries.

Sam Pretlove: Birmingham and Solihull has a relatively high preterm birth rate, which is running at about 9%. Approximately 18,000 women give birth in our ICB annually. Of the preterm births, about 60% are spontaneous, and 40% are women we have delivered because of maternal or fetal well-being concerns.

We have two large tertiary centres with a level-3 NICU and two large preterm birth prevention clinics. Both see about 350 women per year. Those clinics have demonstrated a massive reduction in the number of women who give birth prematurely and of women whose babies die due to prematurity. Since the clinic started in 2015, in high-risk women we have seen a reduction from 24% giving birth prematurely to 17%. There has also been a reduction—from 26% to 1%—in those who had a stillbirth or neonatal death.

We are doing lots to try to reduce our preterm birth rates. The things we are doing are working, but we acknowledge that we still have high rates. Our plans in this area are to extend our cervical assessments to multiple pregnancies—those having twins or triplets—so that they get routine cervical assessments as well.

We would like to bring in reviews and follow-up appointments. If your baby dies, there is a review through the standardised perinatal mortality review tool, but if you have a preterm birth the care is not necessarily reviewed in the same way. Particularly if the baby survives, there is no follow-up appointment to discuss your risk factors and how you might do better in the next pregnancy. We have noticed that that is a gap with our really high-risk population and that we are missing an opportunity to talk to women about their hypertensive disease or whatever it may be that precipitated their preterm delivery.

As well as a high risk of preterm delivery, when we do our initial risk assessments of women, about 14% come up as high risk for fetal growth restriction, and another 14% are at moderate risk, so as well as having a group who give birth spontaneously early we have women who are very likely to be delivered early because of fetal well-being concerns.

Our public health colleagues are doing an amazing job. There are several things that they are introducing to help us with this. They are introducing the concept, in Birmingham, of a very brief intervention around physical activity. Every time a woman of reproductive age meets a healthcare professional, they ask how she would increase her physical activity. This is to reduce the rates of obesity and type 2 diabetes in our population.

We have a programme called Flourish. I will talk a bit more about this later—it might come out in some of the other questions—but it is about us having cultural competency with our global majority population.

Our public health team in Birmingham City Council is also helping us by implementing a strategy that has come from the US called One Key Question. It means that when a woman of reproductive age attends any healthcare professional, she is asked, "How would you feel if you conceived in the next 12 months?" The evidence shows that women welcome this question. They want to talk about being prepared for pregnancy or, conversely, about contraception and how they can avoid pregnancy, but they are not necessarily able to articulate that or bring it up themselves in each consultation.

Baroness Watkins of Tavistock: I can hear how much you are doing, but I am also aware that my colleagues have questions and I do not want those to be taken before we get to them, so I will just bring you back to the end of my question, if that is okay. What are the challenges to achieving the kind of reduction to get to 6%? You are giving us a description of a population where that might be quite difficult.

Sam Pretlove: I have given you the description, because I feel that we are doing everything we can and we are running at 9%.

Baroness Watkins of Tavistock: That is really helpful.

Q216 **Baroness Cumberlege:** I am really interested in your strategy, Sam. Clearly it has paid dividends already. Are you promoting what you are doing? It would certainly help others if they knew what you were doing.

My second question is about your clinics for the reduction in stillbirths. You described them as a large prevention-type clinic. I thought that was very interesting. Do you have any numbers for the women who have been helped and for the prevention of harm to unborn babies because of what you are doing? It might be difficult for you to assess that.

Sam Pretlove: I am extremely indebted to my academic colleagues at Birmingham Women's and Children's hospital. They have spent a lot of time classifying and cataloguing these results, and have published them, so they are available in the literature, particularly through the British Maternal and Fetal Medicine Society. Some of my colleagues then contribute to the Saving Babies' Lives care bundles and the academic input into that work.

We see approximately 700 women per year through the preterm birth prevention clinics. This year, we have had approximately 10 losses of babies. Most of those were through cervical sutures that, unfortunately, did not work as we had hoped. One was a woman who attended having had a bleed and then went on to deliver very quickly at 24 weeks. The others had live babies. We may not have been able to stop their prematurity completely, but it has been moved to later gestations.

Baroness Cumberlege: You have answered the question I was going to ask. That is very helpful. You have been doing a lot of work in Birmingham. How much have you spread your work, which has been successful, across the whole country?

Sam Pretlove: Through the academic route and sharing our results that way.

Q217 **Baroness Blackstone:** I must declare an interest as chair of the trustees of the Royal College of Obstetricians and Gynaecologists.

You will all be very familiar with the fact that there are large disparities between socioeconomic and ethnic groups in rates of preterm birth and their outcomes. Could you tell us a bit about the ways in which the ICBs have a role in tackling this problem? Caroline, you perhaps have less of a problem than the other two who are giving us evidence, because you are

in a less deprived area, although there can be rural deprivation.

Caroline Lacy: Some 11.3% of our pregnant population would identify as being black or Asian or from ethnic minority groups. The ICB's role is to understand how to translate that data into something meaningful, because we certainly would not just set up continuity of care teams for women who fall into those categories. That would not be appropriate. The ICB has to understand its demographics, the data and where the deprivation is at its most. That can then inform what we do regarding continuity of care, increased surveillance or bespoke parent education, for example. It is about understanding your data first and then, in co-production with your maternity and neonatal voices partnership, developing something that is fit for that community.

Fabulous work is going on. I have heard of work in Oxford, which has a large population from East Timor. They went into the community and recruited from it—not a healthcare professional but somebody from the community. They were able to deliver a fabulous package of midwifery care that meant that the community engaged. It is about understanding your population first, finding out what it is they need and going to the grass roots of the problem, and getting engagement that way. That is what we hope to do in Somerset from an ICB perspective.

Catherine McClennan: Deprivation is a real issue for us in Cheshire and Merseyside. Over a third of households in our population live in poverty. On ethnicity, our numbers are smaller but obviously still as complex. Some of those families are also living in deprivation.

From an ICB perspective, we have an LMNS—a local maternity and neonatal system—that has focused on this work for many years now and really tries to understand our population. We have a small engagement team that is reflective of our local population and some of those complexities. That team works out in the community, speaking to women and families about key issues that they face, not only health factors but those wider socioeconomic factors that we know absolutely do impact on health and on preterm birth. As an ICB, we have come together with our local authority and public health colleagues as a collaborative and implemented a strategy called All Together Fairer, which was also developed with the Institute of Health Equity. All nine of our health and well-being boards have signed up to that.

We have been doing work on prevention initiatives, particularly on key factors such as smoking in pregnancy and treating tobacco dependency. We have been working as a collaborative to ensure that smoker status is noted at a booking and that we can work with women on some key interventions, including monitoring peer support workers, social prescribing initiatives and the maternity team and signposting them to key services in maternity services. I am proud that, as a result of that collaborative model of working with all key partners, we have reduced smoking rates from 10% last year to 7.2% in our latest quarter. Across Cheshire and Merseyside, that is absolutely amazing. That is one of the key issues.

We have also worked with our local community, particularly with those who do not have English as their first language. We have introduced language classes and interventions and taken our maternity teams out into the community to aid their understanding of some of those health challenges, especially as there is a level of digital exclusion in these communities.

We have a Living Well Bus service, which we delivered during Covid to target vaccinations in pregnancy, which we take into the heart of the community. We try in particular to target the most challenged areas to offer lots of different health checks and initiatives, including immunisation and access to smoking support.

We have also developed a maternal mental health service called Silver Birch, which offers key interventions and support for anybody who has experienced loss or birth trauma.

Some of those key factors really do influence health outcomes. We are trying to tackle them from a community perspective and in partnership with our voluntary and community organisations. Our specialist clinics are working hand in hand with our clinical teams as part and parcel of that key prevention. We have enhanced continuity of care teams in Cheshire and Merseyside, which have been focused on working with women from ethnic minorities and deprived backgrounds.

Baroness Blackstone: Are these specialist clinics to which you have just referred targeted at socioeconomic groups where you can expect poorer outcomes or higher rates of preterm birth? Do you have a way of identifying the areas in the wider region for which you are responsible where you can spend more money to be more successful in bringing the rates down among the poorer communities?

Catherine McClennan: For a lot of our women and families, ethnicity and deprivation are the key risk factors. They would be in the Liverpool city region. We know by population where they would live and the community organisations they will be part of. We do go out to those communities. There are specialist birth clinics for the most complex women, which our community engagement team is part and parcel of, listening to some of the key issues that those women and families face.

We have in development a health justice partnership with Maternity Action, which is available for women and the maternity teams, whereby we can direct people for help and support on work, benefits and asylum status. We have been working with the Refugee Council to look at how we can offer help and support to women so that they can access and book pregnancy appointments as soon as possible.

We know our areas of greater risk, and the enhanced teams are focused on them. One of our key interventions is taking the community teams out to talk to women and really understand the key challenges for them in engaging with clinical teams. Often there is a real fear, so we take services out into the community. We wish we could do a lot more.

Sam Pretlove: Birmingham is a global majority city. We have a different population. We work with a population that is roughly 40% Asian, 40% white and 15% black. I am very conscious that when we use these ways of describing people, they are very limited, as there are very different people within the groups. In Birmingham in particular, the maternity needs of the black African population are very different from the needs of the black Caribbean population, and they would not necessarily see themselves as aligned.

We are very aware that the ICBs were designed to tackle health inequalities. Our role is to know our population and to look at the different strands of work from public health, city councils, CDOP and the LMNS, and to check that we have aligned strategies. In BSOL, 76 babies are born prematurely per year due to health inequalities. If everyone in Birmingham had the same risk as a white woman in the least deprived quintile, there would be 76 fewer babies born preterm.

As we have gone out into our population, one of the incredibly difficult things is that our qualitative work has highlighted that our women have a real lack of trust in us as maternity providers. For something like preterm birth, when it is very important to be able to discuss things like intimate partner violence and sexually transmitted infections with your care provider, not being able to trust us has a big effect. Birmingham City Council has commissioned a project called Flourish, which is about improving cultural competency, particularly in staff who are making the decisions about healthcare in Birmingham, and making sure that we are culturally intelligent and not just assuming what women want or what would make things better.

Q218 **Baroness Blackstone:** Have you found a way of looking at the impact of socioeconomic factors as distinct from ethnicity? It has been argued that there are no particular ethnic differences once you have held socioeconomic status constant. In other words, the differences that you are seeing for ethnic minorities relate to socioeconomic status rather than something that specifically relates to ethnicity. Do you agree?

Caroline Lacy: I recently engaged with MBRRACE to see whether they can enhance some of the data we have. We have looked at stillbirths since they started collecting data in 2013. I have asked if we can look at some of those vulnerabilities, including whether women are single parents, how long they have been in the country, whether they needed translation services and if they got them, whether there was domestic abuse, or whether there was alcohol abuse. I want to see all the data in front of me to try to read the signals to see where we need to look. I am waiting for that data to come back. Hopefully, it will give us a bit more direction.

Sam Pretlove: That is quite a complex research question, and it is difficult to tease out the difference between association and causation. In our work, using the data from our LMNS, ethnicity has seemed to function as an independent variable to social deprivation. In our cohort,

social deprivation does not account for all the preterm births and poor outcomes.

Q219 **Baroness Blackstone:** Do you find that the attendance at prenatal clinics varies according to socioeconomic groups? In other words, is there some resistance from groups where there is extreme poverty and a lot of social problems that women are trying to cope with? If that is the case, how are you addressing this to try to ensure that they are getting the treatment that they probably need?

Sam Pretlove: In our black African population, we are struggling to get early booking. Fewer than 50% book before 10 weeks, and many book markedly later than that. That is a real problem, because you then lose the ability to do your preterm birth interventions, which start at 16 weeks. We are in the community and listening to them. That has not yet resulted in changes in how they book their pregnancy care with us.

Baroness Blackstone: Catherine, do you have the same problem?

Catherine McClennan: Yes, certainly with bookings and in the work that we are doing on those communities. On deprivation, the feedback we get from women is that it is a choice between feeding their children that day and whether they can afford their bus fare to get to some of those appointments. That is why we are looking at how we take those services and that level of care out to the community and understand some of those barriers. During Covid, we had initiatives in Liverpool like Taxi to the Vaxi, and payments were made to ensure that people got access to some of that care and treatment. It is a genuine and real issue. Those socioeconomic factors play out when it comes to preterm birth and that risk factor.

Q220 **Baroness Seccombe:** Good afternoon. How does your ICB ensure consistent delivery of national guidance relating to preterm birth and the recommendations in the Saving Babies' Lives Care Bundle?

Catherine McClennan: We definitely take a system approach to national guidance. We have eight providers of maternity and neonatal services in Cheshire and Merseyside. As a result of the work of the local maternity and neonatal system, the operational delivery network for the neonatal network and other collaborative forums, we take national guidance and look at how it can be implemented systematically across all providers, obviously with some local nuances but coming together as a system to look at that and take it forward. We meet with each of our providers individually to understand some of the potential challenges to that national guidance. We then look for common themes if there are challenges, but also key opportunities to learn across different providers and resource.

On the Saving Babies' Lives Care Bundle and the work we have been doing with our trusts, they have worked really hard and we have worked really hard with them. We have a very small, dedicated team that works with the teams in trusts to focus on the key priorities. I am pleased to

say that all our providers have met the threshold for MIS year 5 and for SBL this year, but it has been with intense work on Saving Babies' Lives.

For other national guidance, it is about working in that collaborative forum. It is not necessarily always easy, because you need to look at staff, skills, equipment and resources, but it is about working through as a system. If there is something that we are finding difficult as a region or a local area, we would look at how to feed that back nationally, via either our networks or our regional NHSE colleagues.

Caroline Lacy: We are thrilled with the new implementation tool for Saving Babies' Lives. That has really helped us and the providers. We are big fans. From an ICB point of view, we are asking for a very structured approach, in that we are quite clear on deadlines for when evidence needs to be uploaded from the providers. That gives us time to look through the evidence and get assurance. We then plan the meetings with the providers so that we can go through them together. Touch wood, that will all fall in line with the trust board and the ICB.

There is a really clear pathway. I am fairly new in post and this is a new structure, but it feels much more comfortable. We are also very pleased to see that the new MIS year 6 allows trusts and providers to look at overall progress rather than the tiny detail, which some providers may struggle with over others. That is great.

Is it all right to talk about some of the challenges?

Baroness Seccombe: Somebody else might be coming on to that.

Caroline Lacy: I shall not jump in, then, because I have a long list of challenges.

Sam Pretlove: I can give very similar answers. We use our LMNS to assess the quality of the evidence the providers give and then go through the rigour to ensure that it is being implemented appropriately. The LMNS then gives an output to the ICB quality.

Baroness Seccombe: I note that the ICBs are not yet two years old, so they have to be implemented, but do they get a thumbs up from you?

The Chair: You will get your chance to discuss challenges now, Caroline, because Viscount Colville would like to come in.

Q221 **Viscount Colville of Culross:** That sounds very encouraging about the implementation—looking at evidence and how you put it into practice. We have had evidence saying that there is a lack of investment in testing to understand how best the latest research can be put into practice. Sam, you talked about working with your academic colleagues to try to ensure you get the latest evidence and that you can put it into practice. Do you think there could be an improvement in the way the implementation is rolled out and tested?

Sam Pretlove: When we have done our best work across the LMNS, education and ongoing education have been extremely helpful. Whenever you implement something, you need to make sure that everybody understands and speaks the same language. With preterm birth, the best example is risk assessment. We had a period when we knew that new risk factors, such as having a loop excision of their cervix, were coming in that were really important for preterm birth, but when women mentioned them to their community midwife it did not trip the right things to get them referred early to the preterm birth clinics.

When you have an intervention that you know can make a difference, its implementation is really important, as is how you educate your staff to work alongside one another. Some of these things, such as the PERIPrem bundle, are complex. We work in very complex team structures in maternity, with sometimes difficult cultures. How these things are implemented, and investment in them, is very much worth it.

Viscount Colville of Culross: Catherine, you talked about the challenge of national guidance and how pleased you were with how you had been able to roll it out. Do you also feel that more work could be done and more investment made in ensuring that you test how this latest best practice is implemented?

Catherine McClennan: I have spoken really positively about our approach to that, but it does not come without its challenges. The timeliness of that national guidance does not always fit. You can need to change something mid-year, or there is an expectation that people will change their practice, what they do. That definitely needs working through.

Our preterm birth network works very closely with our research teams at the universities, so there is that ongoing research, but investment in how it plays out and evaluation of how it works and how much better it is would definitely be welcome, as well as provider trusts being expected to do this. It can be incredibly hard, especially when they are so stretched and focused on getting the job done, which is to keep our women and babies as safe as we can. They might mean well, but they could be quite disruptive, and I guess it is about how we plan that better and in a more timely way.

Viscount Colville of Culross: Caroline, do you think the way the best practice is rolled out and fed down to the units could be improved? Could there be more flexibility, as Catherine has just said?

Caroline Lacy: Definitely. There is simply no time to stop and reinvent the wheel when you are in the machine trying to keep it going. PERIPrem is a good example of an initiative that has worked using QI methodology. It has engaged with the innovation agency, previously known as the academic health science network. I think the south-west got £250,000, which meant that each unit could put in a lead.

One of the big challenges is that job plans do not keep pace with the guidance that is coming through. So none of the specialist roles, whether midwifery, obstetric or neonatal, can keep up with protecting the time needed to do the job. People do much of it out of good will, and a few years down the line you realise that you have not business-cased that role, and you end up in a pickle, with people being stretched and burnout affecting your workforce. That has a knock-on effect.

Funding is vital. Let the teams that are really good at that work do it. Let us work with our innovation agencies. Let us get our LMNSs set up with the right teams. I am very fortunate in Somerset that we have a neonatal lead, an obstetric lead and a midwifery lead. We have the time to engage with the innovation agencies. If we then had a suitable network, like the neonatal network, to work with—a fetal medicine network, a maternal medicine network—we could do all that hard work and let the clinicians do what they are best at with the time, not spoon-feeding them with interventions but letting them carry on with the job.

The trouble at the moment is that midwifery has very much taken the lead in all these specialist roles. I feel very done to, and I think neonatal and obstetric colleagues probably feel the same. We are deciding what service provision looks like, but we need to structure the teams away from the acute service so that it is borne out of MDT discussion and cascaded through really effective networks.

Viscount Colville of Culross: What is an MDT?

Caroline Lacy: A multidisciplinary team. When we are deciding what a service looks like, it has to be done with your obstetric, neonatal and midwifery teams, and with anaesthetics, which are very often missed out of the new team that is forming.

Viscount Colville of Culross: Thank you. That is a very full answer.

Q222 **Baroness Hughes of Stretford:** Following on from what Baroness Seccombe said, I think some of us are a bit surprised to hear from some witnesses that it is not at all uncommon for national guidance to be adapted locally and translated into local guidance in each region. We have also heard that some providers might water down the principles of the national guidance because, with their resources, they see that they just cannot meet them. Are you aware of that happening in any of your areas? What do you do about it?

Caroline Lacy: I have seen people make it even more complex than it needs to be. There are various opinions in a provider that want to be heard and recognised in their local guidance. I think the time spent on rewriting national guidance into local policy is terribly wasted. Again, if we had regional networks, let the region translate the national guidance into something that works for the footprint of the region. Let us not allow every provider across the country to rewrite it and, as you say, sometimes water it down but also make it more complex and harder to deliver.

Baroness Hughes of Stretford: The problem is that we have also heard that in places where the provider is able to implement a number of interventions, particularly when a child is born—the preventive method, the not cutting the cord, and all the rest of it—the outcomes for the children are generally better. The worry is that if you allow providers to set themselves lower targets for interventions in the national guidelines, you will affect outcomes for babies.

Caroline Lacy: I think it is more about translating how it is operationally mapped out, rather than changing the parameters of the national guidance. In my experience, people have made it more complex—for example, offering more scans, because that is the direction some of the team want to go in. That is when it becomes tricky.

Catherine McClennan: In the way we work there are obviously challenges, and there will be local challenges. I think it is about the established networks and trust and the ability to call out where our providers are finding it difficult. Then it is about trying to work through some of that. We also work quite closely with our regional colleagues, so wherever possible we can take a regional approach. If we are finding things difficult in Cheshire and Merseyside, we work with our counterparts in Greater Manchester, Lancashire and south Cumbria, from a north-west perspective.

I guess for us, coming together as a maternal medicine network in particular for the really complex births and cases has been incredibly helpful, because we can check in to see whether others are finding it difficult and whether they are changing some of those guidelines to local nuances. As much as possible we try to ensure that we can adhere to them.

Sam Pretlove: I am here representing BSOL ICB, but from my experiences as clinical director in Birmingham Women's and Children's Hospital, I found that for us and our clinical team our Saving Babies' Lives Care Bundle was enormously beneficial. It really worked for us, so we could get those improvements in services that we wanted. In the first few years, and as things were introduced, our clinical teams were able to say that if so much was invested, we would still get the big financial incentive. That was enormously helpful in developing our services. I am a big fan of the Saving Babies' Lives Care Bundle.

Q223 **Baroness Hughes of Stretford:** My proper question relates to the triumvirate of neonatal networks, maternal networks and fetal paediatric networks. Caroline and others may have mentioned this. We have heard from previous witnesses that the maternal and fetal networks offer the potential to reduce variations in outcomes for babies born preterm that is not necessarily being realised at the moment, and that not everywhere is investing as much in the maternal and the fetal paediatric as it is in the neonatal. Caroline hinted at that.

Can ICBs work with NHS England and the neonatal networks to ensure that neonatal care is really integrated with the maternal and the fetal

networks, and that the latter two are supported to develop further? They are more—I will not say that they are embryonic. They have had less attention and less investment. Is that fair?

Caroline Lacy: They are certainly more immature than the neonatal networks. If and when they establish themselves, we might get into a situation where smaller district hospitals are better supported by a fetal medicine network. Some preterm babies are probably delivered sooner because of the fear of stillbirth and the capacity to manage in a smaller unit, whereas if you have that support of a fetal medicine or a maternal medicine network, you might be able to go a bit further or get the mother and baby in the right unit in the first place with a better, communicated network.

Catherine McClennan: Obviously, neonatal networks have been around for a lot longer. They are specialised, commissioned services. That is changing: those services are going into the ICBs. In the north-west region, we work really closely with our neonatal operational delivery network colleagues. We have done a lot of work over the years looking at improvement in pathways and in support, and we can see the outputs as a result, such as babies being born in the right place with the right gestation. We have seen a real improvement in outcomes by doing that.

On fetal medicine networks in Cheshire and Merseyside, we have a fetal medicine centre, but for referrals it is not a commissioned network in the way the neonatal operational delivery networks are. There is definitely work to be done by the ICBs to ensure that the "N" in local maternity and neonatal systems is real and integrated so that it is a key part of that quadrumvirate management team. We certainly encourage that in Cheshire and Merseyside. When we meet with every trust we include our neonatal clinical lead to ensure that they are part and parcel of the work that we do. They are obviously a key partner in our preterm birth network, but we can do more. We have developed a very good relationship in the north-west in the way we work, but I think that is because of personalities and collaboration rather than anything that is officially commissioned.

Sam Pretlove: We have the maternal medicine network and the fetal medicine network, and I would like to see abnormally invasive placenta networked. I would also like preterm birth prevention to be networked, so that women who are at a really high risk of preterm birth—if you have had your cervix removed through cancer, for example, you are at a very high risk of preterm birth—can come into appropriate centres that understand and know how to manage those situations. I very much want us to join together, alongside the neonatal networks, to have an idea of a perinatal network rather than all these different strands. Ideally, I would like to use the maturity of the neonatal network in the West Midlands and for the other areas to follow those established pathways so that women and babies can get the right care.

Baroness Hughes of Stretford: That sounds a good idea. Thank you.

Q224 **Baroness Thornhill:** For my question, we want to home in and get your candid views on the extent and impact of staff shortages. We have had consistent evidence throughout that this is a fact. I do not think anybody is challenging that. In particular, we were shocked to learn from the very latest RCM report this year that—in a phrase that stuck out—there were 100,000 hours of unpaid overtime every week and, as Caroline mentioned, that burnout is widespread. In what way do you genuinely believe it is impacting on the optimisation of care? If that statement is true in your area, how are you trying to deal with it?

Caroline Lacy: Looking at the midwifery workforce, we are overrecruited in Somerset—or that is what it says on paper. I can tell you that if you ask the midwives, that is not how it feels. We are due to have another Birthrate Plus assessment, which I think will show, because of all the challenges that have come up over the last few years and the specialist roles, that we need to be in a very different place.

The neonatal nursing team, as of last week, has six whole-time equivalent vacancies. There has been a rolling advert for months and months that it cannot fill, so it has filled those posts with nurses who are not qualified in specialty. It is looking at probably a two-year programme to get those nurses up to speed and where they need to be. It is the same with our obstetric rota. There are gaps in both. It is incredibly difficult to get the team together to work with that team perinatal groupthink to make these changes and interventions when everybody is stretched so very thin.

Catherine McClennan: It is obviously no surprise that our workforce is incredibly challenged. Burnout is a key factor. In Cheshire and Merseyside, from a midwifery perspective our vacancy rate does not look that bad on paper, but again, if you speak to the workforce, sickness levels are high. The main reason cited for that is stress and mental health issues. Although our retention rates are improving and we are doing a lot to look at that, it is still a key factor.

On how we are looking to support midwifery in particular, there is obviously a range of retention, support and recruitment roles, including international recruitment, to try to help. We are looking to support our maternity support workers to help and support the wider maternity team. We are looking at this as a team, not necessarily just as midwives. In particular, when a new initiative comes it generally falls to the midwives to implement it. For the roles that are seen as specialist, the minute there is an issue with staffing they need to drop that and join rotas.

In Cheshire and Merseyside, we have a weekly gold command call for all our providers to provide mutual support: where are the hotspots, where are the key pressures? We have found that incredibly helpful. Trying to listen and put in initiatives that will help and support our teams is also key. We are working with our ICB and HRD colleagues across the trusts to look at the age profile in supporting a predominantly female workforce in midwifery, so that we can support them with women's health issues,

such as menopause support. We are also looking at retire and return to see how we can keep some of those skills in the system.

This is obviously an ongoing issue for us. We work with our RCM colleagues and others to look at help, support and initiatives, and with our HEIs—higher education institutes—to look at the recruitment pipeline, because we are really concerned about what our future workforce will look like if we cannot attract people into those key roles and support them, right at the point of interest in the professions as well while they are in the workplace, and developing them with those support and promotional opportunities.

We have developed quite a lot of leadership roles and created opportunities to try to support them, but we are seeing the lasting effects of many different factors, such as Covid. Obviously, a lot of reports have come out on staff morale and feeling valued and respected. It is a key challenge that we are working on.

Sam Pretlove: Over the past year in BSOL we have done an incredible amount of work on this. In March 2023, one of our providers had a 30% midwifery vacancy rate and a 20% unqualified vacancy rate. In March 2024, following the work we did, it had a qualified vacancy rate of 5% and an unqualified rate of 11%. We have retention midwives, so if you look like you are unhappy, you are not reaching your potential, or work is difficult, the retention midwife will see you to see what she can do. She might help you move to another area or explore other ways of working that would be more helpful.

We put in a lot of extra support for our newly qualified midwives but found that as soon as they had been through that preceptor programme they started to struggle. So now on every shift in our provider units, there are experienced delivery suite midwives who can go into the room and support you with the care of a woman if you are unsure or things are not going as planned. That has made an enormous difference to our midwifery staff.

We have had to be really proactive and think how we could improve things. People come through the system in very different places these days. There is an ongoing tension with very complex women coming into our provider units for the level-3 NICU and then needing to be on delivery suite for a long time having interventions to try to prevent or to optimise preterm birth, and women who are being induced, for example, who are waiting to come to delivery suite.

That is very difficult. We very much see the importance of these preterm babies coming into us and the impact that has on their survival rate. But we also know from our data that when women wait longer for induction of labour, their outcomes are less good. So we have this ongoing tension in the unit. When we have issues with staffing, that becomes much worse.

Q225 **Baroness Thornhill:** Can I push you on the optimisation of care? From what you have said, something has to fall by the wayside. We are not

superhuman, even at 100,000 extra hours. My question relates to two initiatives in particular: the continuity of midwifery carer, and the preterm birth lead team, which is in the Saving Babies' Lives Care Bundle. Is it having an impact on them? We have heard that they are good things, but are they happening realistically in your area? Is it realistic for all trusts to have a preterm birth lead team, for example?

Sam Pretlove: Our preterm birth team is relatively ring-fenced because of the specialist type of work that it does, so it does not get called in to care on delivery suite. We do use our continuity of care teams and our home birth team as escalation, so we have our team on delivery suite, and if we have more women attending or preterm birth women coming in, our continuity of carer midwives may need to come in and care for a woman who is not part of their continuity of carer case load. So, yes, it does impact them.

Catherine McClennan: When it comes to continuity of carer, obviously staffing levels have been a challenge. Currently in Cheshire and Merseyside, three of our providers are under 13 teams who are offering enhanced continuity of carer. We know that the outcomes and the feedback are better, but obviously it comes with challenges. There has been feedback from some of our midwives about burnout and key pressures, so we are working through those and looking to support them. All our providers have plans in place and building blocks to offer continuity of carer, so we are working with them on that.

Preterm birth specialist roles are fundamental to reducing rates of preterm birth and getting the best possible outcomes. As long as they are job planned and the resource continues, and it is recurrent, they are important. We have seen that our trusts and networks absolutely want those specialist roles to be a key part of our model, and that includes our obstetric roles and obviously our midwives. We have a co-ordinator in our preterm birth network in Cheshire and Merseyside, so where there are issues and pressures, they can raise them. Again, those networks are important for offering help and support across many trusts, which in our case we have.

Caroline Lacy: I do not envy your challenge with that many trusts. In Somerset, because of the PERIPrem work, we have fairly well-established PERIPrem leads. We just need to make sure that those leads work more closely with the preterm birth clinic. We are not quite sure what the neonatology lead looks like in that clinic yet and how that will be rolled out.

With continuity of care, we have all been fairly cautious, following the advice in 2022 to pause on continuity of care while our midwifery workforce is under such pressure. In Somerset, we have a continuity of care rate of, I think, 12.6%, but I would argue that it is probably focusing on the wrong team, on the wrong women and families. It is probably a postcode lottery rather than focused on need. We need to understand our data and shift that resource somewhere where it will hopefully be more beneficial.

Q226 **Baroness Cumberlege:** I want to ask a question about the maternity commissioner. This comes from a report from Members of Parliament, who say that we need a maternity commissioner who would directly report to the Prime Minister. This role aims to improve maternity and postnatal care across the country. Do we need a commissioner?

Caroline Lacy: When you say maternity do you mean perinatal? In that case, yes.

Catherine McClennan: If it covers the whole perinatal journey, then absolutely.

Sam Pretlove: It is really clear when you look at maternity services, the CQC reports and the things that are happening with preterm birth, maternity care, investment in it, and the notice that is taken of it by us as a country, that things massively need to change. I do not mind how you do that.

Baroness Cumberlege: I think we need a champion again and to overhaul our maternity services. Whether a commissioner is the person to do it, I do not know.

Q227 **Baroness Watkins of Tavistock:** I have a straightforward question. I will ask Caroline for a yes or no answer. If we brought back apprenticeships for more mature entrants to midwifery, both men and women, would it help to resolve the staffing crisis?

Caroline Lacy: Yes.

The Chair: The others are nodding, so I think you have three answers.

Q228 **Lord Hampton:** We have heard a lot about what happens after people leave hospital, and we hear a lot from parents about how difficult and challenging they find it. What is your role in co-ordinating follow-up care for preterm babies, and how could this be improved? Also, how can ICBs support health visitors to improve the follow-up care for families?

Caroline Lacy: There is definitely a commitment from public health, local authority, maternity and neonatal services to working together. Health visitors need more support. I do not believe that they have training in preterm birth and the developmental delays that that can bring for families and children. Families are well supported when they are in the neonatal unit with our allied health professionals—physios, OTs, dietetics—and then they go home and there is no support there. There needs to be a real push for allied health support alongside the health visiting team, and then a real focus on parents being empowered to deliver learning through developmental play.

Catherine McClennan: I absolutely believe that the ICB has an ideal opportunity to work as a health and care partnership right across local authorities. I speak from very personal experience: I have had two preterm births myself, and I know how lonely, isolating and difficult it is to navigate that system, so I absolutely agree with my colleague about the role of health visitors, allied healthcare professionals, transitional care

in the community, and family hub development so that people can understand and be able to access those.

The training and development of health visitors and midwives is key, but it would be incredibly helpful all round to flag to families as early as possible that there may be ongoing needs and that support and education is available not just from health but from wider teams.

Lord Hampton: Are you doing anything at the moment on that?

Catherine McClennan: Our incorporation as an ICB is quite new, but I have travelled here today with my colleague from a population health and public health perspective, and we have plans to restart our Starting Well collaborative. That is where we bring together all the key stakeholders required to focus in on this, including the longevity that we talked about through paediatric services. So yes, we have plans in place to do that.

Sam Pretlove: One of the difficulties in Birmingham is that our health visitor pipeline is very fragile and we are carrying a big number of vacancies. The nought to five landscape is incredibly complicated, with many different funding streams, and there needs to be a co-ordinated approach, probably through a combination of public health, the city council and the ICB, to ensure that these children get the follow-up that they need.

Lord Hampton: Are you flagging that?

Sam Pretlove: Yes.

Q229 **The Chair:** Caroline, you talked about health visitors and the need for training in preterm birth. Who would do that, and what would the best version of that look like?

Caroline Lacy: I would lean on the operational neonatal networks to deliver that. They already have a fabulous network of training. That would absolutely be my first place to go.

The Chair: And would you endorse that as a recommendation?

Catherine McClennan: I think so, yes.

The Chair: Thank you. You have covered an enormous amount of ground. You have been incredibly clear and very comprehensive and helpful. All that remains is for me to thank you again.