HOUSE OF LORDS

Preterm Birth Committee

Corrected oral evidence: Preterm Birth

Thursday 5 September 2024

11 am

Watch the meeting

Members present: Lord Patel (The Chair); Baroness Blackstone; Viscount Colville of Culross; Baroness Cumberlege; Lord Hampton; Baroness Hughes of Stretford; Baroness Owen of Alderley Edge; Baroness Seccombe; Baroness Watkins of Tavistock; Lord Winston; Baroness Wyld.

Evidence Session No. 20 Heard in Public Questions 254 - 265

Witnesses

I: Professor Lucy Chappell, Chief Executive Officer, National Institute for Health and Care Research, and Chief Scientific Adviser, Department of Health and Social Care; Baroness Merron, Minister for Patient Safety, Women's Health and Mental Health , Department of Health and Social Care; Fiona Walshe, Director of Mental Health, Disabilities and Maternity, Department of Health and Social Care.

Examination of witnesses

Professor Lucy Chappell, Baroness Merron and Fiona Walshe.

Q254 **The Chair:** Welcome. Thank you, particularly the Minister but all three of you, for coming to help us at our last evidence session. Before we start, for the record, I would be grateful if you would introduce yourself and your designation from my left, and then I will move on.

Fiona Walshe: Hello. I am the director for maternity, women's health, mental health and disabilities in the Department of Health and Social Care.

Baroness Merron: Good morning. I am Minister for Patient Safety, Women's Health and Mental Health.

Professor Lucy Chappell: Good morning. I am chief scientific adviser at the Department of Health and Social Care. I am chief executive of the National Institute for Health and Care Research. I also hold an ongoing role as a professor of obstetrics at King's College London, and I am a practising consultant obstetrician at Guy's and St Thomas' just over there.

The Chair: Thank you very much. Thank you all for coming today. As a preamble, let me say this, Minister. All the questions might be addressed to you, Minister, but you can pass them on to your colleagues as you wish.

Baroness Merron: You are most kind.

The Chair: With the change in government, we feel there is a great opportunity to address some of the issues that have been raised in evidence to this committee in relation to preterm births. From the point of view of parents generally and families, but particularly mothers, the issue has been what is available to them at a challenging and traumatic time in their life, which is the birth of a preterm baby, and particularly very preterm babies; and I know you are aware of that. We also heard in other evidence about facilities, manpower and workforce that deliver appropriate care. We also heard about where it is clear that care that will result in a better outcome is not always available or not delivered—issues that we have discussed about unwarranted variations in care.

On the whole of the evidence that we have heard, some of which has been quite emotive, what really concerns us is that from parents about the care of the neonates, the preterm babies. Our questions are therefore designed around that evidence. I hope that, with a new look, with a new Minister and a new Government, particularly developing 10-year plans for the care of children and babies, our evidence will help to do that, particularly the evidence that focuses on better outcomes for babies and parents.

On that basis, I move straight on to questions rather than ask you to make any statements and I will start with Baroness Seccombe.

Q255 **Baroness Seccombe:** Good morning, Minister, to you and your assistants. It is a great pleasure to have you here. Thank you for making the time to spend with the committee. It looks as though we will not get to the level of 6% that we wanted to by 2025. Do you believe that is likely and, if so, why is that?

Baroness Merron: Thank you for inviting us today. As Lord Patel rightly said, this is my first opportunity to come before a committee. This is a particularly important area in my brief. I would like to say how much I welcome the input of the committee, because I believe it will help me in the job that I have to do. Thank you also in advance for all welcomes.

I see that this ambition is not going to be met. I understand that it has provided a focus, but a focus is not only what we need; we need to achieve. As has been rightly said, what matters is outcomes.

Why has it not been met? After I have completed my comments, I will refer to colleagues who have been working on this for some years.

With regard to the 8% rate that will not be met, I have asked the question—and I am sure the committee will have a view on this—about whether it is a sensitive enough target. I say that for this reason. What struck me is that there are, of course, circumstances in which preterm birth is the right thing to use. It feels a bit of a blunt instrument for measurement. When we go to the next situation, when we look at what our next ambition is, I will be keen to make sure it is what I would call a more sensitive ambition to realise.

While I speak about those areas where preterm birth, because of various conditions, may be the right outcome in that situation for that birth, our focus also has to be on the conditions that led to the reasons why preterm birth is a better outcome for that particular woman.

On the particular question, I will turn to colleagues to amplify on their experience over the years. I will also add that the committee will be well aware that we as a Government are absolutely committed to closing the black and Asian maternal mortality gap, and we also very much recognise the inequalities in this area. That will also be something that I will want to look at when we look at our next ambition.

Fiona Walshe: I will talk a little bit about some of the difficulties that we have had, and then I will pass on to Lucy for the clinical observations. If I can take the context of improving safety and maternity, you have heard from our NHS colleagues on the steps that they have taken about the three-year delivery plan to improve maternity services and to make sure that, if a woman goes into labour, everything is there to be as safe as possible for a safe delivery.

As to how women are presenting and some of the issues that they raised about age, BMI and so on, one of the key things that this Government have in their manifesto is a focus on prevention and good health for women throughout a life course approach, and that is very true in the whole approach that has been taken to women's health as well. The

Minister has that responsibility, and I do in my policy world as well. There is more of a focus to improve the population health and the health of women so that even before they become pregnant they have healthy lifestyles. There are also advances in medical technology, which Lucy will talk about, which mean that people are having babies when previously they were told not to, and women are also being given more choice and control about how and when they decide to have babies.

It is taking a while for the data to come through to really understand what is working and what more we need to do; and getting better-quality data in a timelier way is one of our key issues and focuses as well. So there are a lot of things. Sometimes we do not know when things are working as quickly as they could, and sometimes population health takes time. That gives a bit of a context about the world that we are trying to work in at the moment. I will hand over to Lucy for any other clinical comments.

Professor Lucy Chappell: Thank you. I will start with what matters—what matters to women and what matters to families. The Chair very eloquently described what you have heard about the experiences of women and their families who go through a preterm birth. It is what I see every week when I am in antenatal clinic. I do a clinic for women with hypertension and kidney disease, and a really high proportion of those women have preterm births in this pregnancy or have had previous preterm births.

That leads us to ask: what is the right ambition, and should it be based on a flat percentage, or should it be based on outcomes? If you ask the women, they want to know, "How do I get the best outcome?" Our national data from a recently published paper says that about half of the preterm births are after spontaneous labour. Often they may be driven by infection.

Lord Winston: I am sorry, I did not hear that.

Professor Lucy Chappell: Data from the National Maternity and Perinatal Audit, the NMPA, published last year shows that about half of our births are from spontaneous preterm birth—for example, following something like infection—and half are what we call iatrogenic, which means that an obstetrician like me has recommended early birth, for example, after pre-eclampsia, which is the more complicated high blood pressure in pregnancy, or fetal growth restriction.

That is the scenario that the Minister described, which is: what is the outcome that actually matters? If you try to keep a baby in when it is growth restricted, she has horrible pre-eclampsia or she has an infection, you will not improve the outcome for the baby.

We need to look again at what metric would best sum up how to drive better outcomes, and then say that sometimes that is about the care that we provide here and now. That is what we can do. I know that in the last session you talked about unwanted variance. What can we do here and

now to tackle unwanted variance, and where do we need scientific advances into understanding those conditions that drive preterm birth so that we can tackle the upstream measures?

I completely welcome the perspective, because preterm birth is not just the now; it is the lifelong impact both for the woman and for the baby, and that is why I agree that tackling this as a topic is so important.

Q256 **Baroness Seccombe:** Will the Government set revised targets for after 2025?

Baroness Merron: As we have introduced today, we are already working towards looking at the reasons why the original target is not likely to be met and the challenges that we have, which colleagues have emphasised. I am sure this has come up many times in committee hearings about the complexity of people's lives and the impact of socioeconomic factors, smoking in pregnancy, rising age for pregnancy, et cetera. We will certainly be looking at a new ambition, but I am really keen, as you have heard, to make sure it is workable and one that focuses on prevention and outcome, and really reflects a bit more reality, perhaps.

I say that not to try to manipulate whatever we come to but to make it realistic and something that we can use to improve the situation, because clearly having an ambition of 8% has not delivered in the broadest sense. It is not just whether 8% has been improved; we know that this whole area needs a lot of work doing on it, and that is why I want to focus.

Yes, we will indeed be revisiting what should be the ambition and what should be the shape of the ambition, and that is where I hope the committee's work will help.

The Chair: Thank you.

Baroness Merron: I am so sorry. May I correct myself? It is absolutely right. The ambition is 6%, but we are not at 6%; we are at 8%. My apologies. I got mixed up there.

The Chair: No problem, Minister. You corrected yourself, so that is okay.

Q257 **Baroness Blackstone:** Can I begin by declaring an interest? I chair the trustees for the Royal College of Obstetricians and Gynaecologists.

I want to come on to the question of prevention, which you have just touched on. What are the Government planning to do, or are already doing for that matter, to try to reduce what you call the unwanted variance, the number of preterm births that are probably not desirable because it is the best outcome for the mother and the baby and perhaps could be prevented? Could you tell us a bit about what your policies are in this respect and what your plans for improvements are in reducing the number of preterm births that could be prevented?

Baroness Merron: Perhaps I could just start with a word on prevention. I know the committee will be very well aware that prevention is where we as a new Government want to be positioning healthcare, and that will

inevitably help us in this area. I have been very keen that we should look at what I would call being fit for pregnancy and that the health of women is optimised before we get to pregnancy. We should have an emphasis, which has not happened so far, on supporting women to live healthier lives—and I want to add—regardless of whether they want to go on to have children, because I think that is key.

I asked officials how we could build that in, and we talked about even a simple question at a point of contact: "How would you feel about being pregnant in the next 12 months?" That would open up a discussion not just about fitness for pregnancy and pregnancy but about contraception and periods. In all these areas, the conversation and the services need considerable improvement. I am quite keen that while we are here talking about pregnancy, and key though that is, we understand that that may not be where a woman is going or may not be where she is going now, but there is still relevance there.

I am also keen, and have raised this with officials, that we need to make sure that services are where people are—where women are. When I say "where women are", I do not just mean in a physical sense community-wise, but where they are in themselves. That is why those kinds of conversations at points of contact and taking advantage of every interaction will be important.

There are a number of challenges, and I might ask colleagues to talk about these more. We already have a number of interventions, I understand, which I know the committee will have heard about, that are already in place, such as the Saving Babies' Lives bundle, the maternal medicine networks, and the work that goes on if a woman presents when pregnant and she smokes, and she is supported to give up smoking. The role of research will be absolutely key, and I have already mentioned tackling inequalities. Of course, just to add to it, we will have to tackle the workforce and get the right people in place.

I am also very keen that we build in prevention where women are already making contact and, where they are not making contact, why they are not and bringing them in. Some of those points are generic, but I feel they can be particularly helpful when we talk about preterm birth and health of women who either seek to be pregnant or are pregnant. Perhaps I can bring in colleagues to amplify some points.

Professor Lucy Chappell: We need to see a shift—and we are in some areas—from waiting for a pregnant woman to turn up in labour to a completely different way of seeing it. This is everybody's business, and we should think about responsibility across the system. From the pre-pregnancy point of view, prevention starts long before she is pregnant with the sort of approaches that you have heard from the Minister, and that is seeing it in the holistic way of providing the support to women, as you hear, where they are for some of the lifestyle areas such as smoking and the introduction of the maternal medicine networks. From my point of view, we should make it every doctor's or every clinical nurse specialist's business if you have epilepsy or renal disease, as we are

suggesting, to have those conversations. If you think about women accessing contraception services or abortion services, how do we make that a normal part of care?

You then have the work in pregnancy. The introduction of the specialist preterm surveillance clinics and networks is a game-changer. We have seen some such as the Guy's and St Thomas' one that started in 2004 and the Manchester preterm surveillance clinic. They have won awards for what they are doing, and that is now being rolled out. Again, you are not dealing with it at the point where a woman turns up in labour; you are taking a much more proactive and pre-emptive approach.

Then there is the post pregnancy, and you touched on that in the last session. When a woman has had a preterm birth, that is a really crucial opportunity to engage with a woman about what she can do before the next time, and that goes not just for preterm birth but so many other opportunities in a woman's life. Donald Peebles touched on the fact that one view is that pregnancy is a stress test for life, so when you have had diabetes or hypertension in pregnancy you can offer interventions.

If we see the join-up from primary care, then other specialist physicians and other services in the community through pregnancy and then post pregnancy can say, "From a system point of view, how do we see this opportunity to make a difference to women and their babies that will have lifelong implications?" The new Government's focus on going from treatment to prevention, hospital to home, and analogue to digital, are the shifts that we need to continue and accelerate that can have an impact on preterm birth. That relates to policy work that Fiona might want to talk about.

Fiona Walshe: Can I also touch on some of the inequalities that we know happen? If English is not your first language or you live in a community that might be mistrustful of NHS services and so you present late, that brings all the complications that that can have as well. All local areas now have equity and equality action plans. That is important, but what is really important is to make sure that local areas are working and co-producing as much as they possibly can with the women and the families in their area.

There are examples of good practice, but they can be rolled out a little more widely. In Birmingham and Solihull, some of the maternity link support workers speak six languages and they understand the culture and religious demands. All of that is important for encouraging women to come forward as well. They are seeing increased uptake of vitamin D, folic acid, et cetera. Focusing on what works in local communities, with that national oversight on what is absolutely fundamental for knowing that at a population level we are doing right by women and babies, and then making sure that we have what works locally for the local population, will be really key. That will be one of the challenges and the rewards of some of the policy-making and the direction we want to go in over the next few years.

Q258 **Baroness Blackstone:** The socioeconomic differences that are absolutely apparent here are, of course, partly due to wider societal inequality. At the same time, I just wonder whether the health service can find a way of focusing some of the resources—and there will always be a resource constraint on all this—on the kind of women who need additional help and support, and not just in ethnic minorities but among poor white women, too, rather than just having it spread very widely over everybody, some of whom need much less support than others in these groups. Is this something that is being considered and thought about and becoming a national priority, rather than, "They do it well in Birmingham", or wherever?

Baroness Merron: It is a very good observation about how we should be going forward. My feeling is that one size does not fit all, as we see so clearly. While there is a level of service that we should be providing, we have to focus services and care in the areas that, first, need them more—and they can collide very often—and, secondly, access them less. I will be looking for improvements that enable us to do this, because we will just stay stuck where we are and the consequences of that are considerable, not just for the person, the family and the community, but for the wider health service as well. There is not a win in ignoring the point that you have made, Baroness Blackstone, in my view.

Professor Lucy Chappell: Could I just add about Core20PLUS5? NHS England, under Professor Bola Owolabi, launched Core20PLUS5 as an area reflecting what you are saying, which is that you have commonalities about what drives inequalities. The "PLUS" bit of it is where you recognise that there are particular local factors where local, regional communities should address what is on their doorstep. There are five areas that she and her team have picked out. As it happens, the National Institute for Health and Care Research recognised that this is a priority, and we chose to work with NHS England. The first of our NIHR challenges was launched recently and is going through commissioning at the moment. We are seeking to put £50 million over five years into tackling maternity inequalities because we saw it as an area that had not been adequately recognised.

It is interesting that we are seeing new groups from across the country coming forward to do this very much as you describe. Rather than it just being patchy and local, how do you actually understand where you can reduce the unwanted variance on a national basis while still empowering those at a local level to deliver it? There is a balance to be had between that national versus local and regional implementation, and that uptake of evidence.

The Chair: Thank you.

Q259 **Baroness Watkins of Tavistock:** I want to ask about what have been described as significant staffing shortages that have impacted care and the implementation in some areas of the guidelines. I want to know whether the Government can confirm plans for the next stage of the workforce planning tool in obstetrics project and whether they will

continue to be committed to reaching the staffing levels in midwifery units that are believed to be required to significantly improve outcomes, recognising that outcomes is our focus.

Baroness Merron: We will not be delivering without the workforce in place. I know that the committee will be aware of the fact that we have workforce shortages in this area. I spoke on one of my recent visits to a retention midwife, which I thought was a helpful initiative. There are helpful initiatives, and I know that colleagues will talk about what has been done and what is working or working better. We have as a Government committed to training more midwives and health visitors but also incentivising continuity of care, and focusing the workforce, to go to the earlier question about tackling inequalities.

When I look at the figures, I am told that there are increases. Again, perhaps I will ask colleagues to amplify on that. The thing that we do know is that we are still incredibly short. I noted that there was funding approved for three years from 2022-23 to expand training places in obstetrics and gynaecology by 40 per year. My question is: what impact will that make and where do we need to go? We certainly see that the vacancy rates for obstetric consultants slightly decreased, but there is a variance in that across the country, and it remains higher than where it was.

I know that as committee members you are very alive to this, but there are a lot of red flags about the workforce. I have a particular concern about the conditions that staff work in. When I say "conditions", I have been shocked to hear about the amount of racism that staff experience. If we are to recruit and retain people, and they are to work at the right level, they cannot work in that environment. One of the things that I have asked for us to be upping our game on is how we are going to tackle that. Some of that will be about culture, some will be about practice and some will be about action. But there is a role for national leadership—and that is political as well as staff leadership—to say what is acceptable and unacceptable, and it cannot be acceptable.

I just mention that, because I feel that inequalities are a huge issue for preterm birth. It is in the staffing, as it is when we think about the women and their families, too. I will perhaps ask colleagues to amplify on what we feel has been working better in terms of the workforce and what our challenges might be.

Fiona Walshe: I will not add very much to what the Minister said because she touched on all the areas. Obviously, you heard from colleagues in NHS England as well. Making sure that we have a workforce that is fit for how women's needs are changing and how they present will be absolutely key. If women are presenting with more complex cases sometimes, and rightly we are giving them more choice, we will need to have a workforce that reflects that choice. That might mean training some people slightly differently and having slightly different mixtures of people in the areas that need them. That is one of the important things we will do and look at. That is why real-time or as near real-time data as

we can get is so helpful for proper workforce planning at a local level as well.

We are recruiting and training more midwives. We have more in post than before, which is great. We are looking at the different types of professions that can be there to support, which Lucy is definitely more qualified to talk about than I am, so I will hand over to her if that is okay.

Professor Lucy Chappell: We should see maternity and neonatal care as truly multidisciplinary and an area where we really ensure that we are addressing the needs of women and their families through a very holistic approach, and, as Fiona says, with that forward look. What will our women of the next five or 10 years need? We are already seeing some of those shifts through the maternal medicine networks where there is investment in physicians specialising in the medicine of pregnancy and asking what that looks like. There is similar provision in the neonatology area to make sure that we are addressing the needs of women and their babies.

Baroness Watkins of Tavistock: Could I just come back on the issue of the mixed midwifery team? Kate from NHS England was pretty clear—I think you were in the room—that there are advantages to having more apprenticeship structures and some nurses becoming midwives. You are talking about a change in cohort of women having children, and that will become increasingly important. Somebody perhaps with learning disability knowledge might make a brilliant midwife. Could you just give some indication about whether you are committed to relooking at that? It is a slightly more expensive way of preparing somebody, but I think the outcomes are often much better.

Fiona Walshe: Yes, and it should be fine for somebody to slightly change what they want to focus on throughout their career, as lots of you will have done. Yes, we will look at that. I really value the points you made throughout about how it is this whole-life approach from birth, and the points you made, which we will respond to, about the two and four-year checks. I have the policy responsibility for disabilities as well, so I was listening with particular interest to that. You raised some important points that we should consider, and, as you rightly reflected, we probably have not done so as much in the past as we should. You are right; this starts from birth. So often you see children at school who just needed that additional oversight or support, or at least acknowledgement of what had happened at birth, and then impacts throughout their lives.

Q260 **Baroness Cumberlege:** Just thinking about the effect of midwife-led continuity of care for preterm birth, it shows that it has great emphasis in reducing by 24% those most likely to experience preterm birth. What emphasis is being given to that particular area? It seems to me important, if the results are as I have suggested from the research, because they are 24% less likely to experience preterm birth. Perhaps the panel could advise me on how we could reduce this whole problem for a lot of women who are experiencing this. If they are allocated a midwife-led continuity of carer—that seems to me a special emphasis of the

workforce—would that actually make a difference?

Baroness Merron: I agree with you about the importance of continuity of care. The benefits of having the same team working with you throughout the pregnancy are quite clear. My concern, which I will be following up, is that, of course, in some areas, as the committee will know, where safe staffing levels are in place it is being delivered better with the kinds of outcomes to which you referred, Baroness Cumberlege. It cannot be acceptable that it is only in some areas. Again, it really worries me. We are talking about where there are safe staffing levels. That is obviously where we should be throughout. Without the right workforce in place, we are not. The truth is that the right amount and fairness of availability of continuity of care is not happening at present, and, certainly, I would want to assure the committee of my focus on wanting to make that the case.

It is probably worth saying, though, that where safe staffing is in place enhanced midwifery continuity of carer teams are providing support for women who live in the 10% most deprived areas of England, which takes us back to the point we discussed earlier about where the concentration of resources is. It is an area where clearly it makes a difference. It is not happening everywhere. The emphasis of the 10% areas is helpful. Yes, more needs to be done, but it would be very helpful to hear from colleagues.

Professor Lucy Chappell: I agree, Minister.

Fiona Walshe: I agree.

Baroness Merron: That is good news.

The Chair: I will move on. Lord Winston.

Q261 **Lord Winston:** Thank you, Lord Chairman, and it is very good to see you at this session. I fear the questions I am going to ask you will be a bit less pleasant. I suppose I have to declare an interest. I am chairman of the Genesis Research Trust, which has raised well over £40 million, all spent on research in mostly parturition of various kinds, including building the Institute of Reproductive and Developmental Biology at Imperial, which is a six-storey building with a lot of scientists in it. The fact remains that there is very poor research money available for it, and I wonder what you feel about that. The science of parturition is undoubtedly neglected.

Baroness Merron: I will turn to Lucy. We discussed earlier about research.

Professor Lucy Chappell: I will start with some facts and figures and address your question directly. The National Institute for Health and Care Research is the leading funder for pregnancy research in the UK, but obviously we work closely with our partners such as the Medical Research Council, Innovate UK and a good number of charities, including the one to which you have such close ties.

We fund research through four routes. We fund underpinning research infrastructure across the country—and we are very clear on our geographical distribution of it, such as our world-leading biomedical research centres. You will be familiar with the Imperial BRC. The second way we fund is through our research programmes where we fund projects to evaluate new treatments or patient care pathways, as we have heard. The third is research capacity building, because unless we fund the researchers of the future we will not have that. The fourth way is research delivery support. We fund what I like to think of as an army of research nurses and many other health and care professionals across the NHS.

Over the last five financial years, NIHR has invested in 77 research awards. Across their full duration, it is £93 million of funding and, of those, 42 are currently active, with a total investment of about £64 million. They range across a whole portfolio. We have discussed a number of these areas. For example, there is preventing or treating preterm birth, so areas such as a trial to look at putting a stitch into the cervix in the emergency setting. There is treatment—and we have touched on this—and care for babies born preterm. We work with, and fund, our neonatology colleagues.

Lord Winston: Forgive me, I am interested in parturition, not the babies afterwards, and I want a fairly short answer because obviously it is really quite an important issue. What we can see is that UKRI has reduced its funding. It is quite significant; we have seen that. Indeed, I think the MRC has now decided to remove its funding for specialised units.

Professor Lucy Chappell: Yes.

Lord Winston: That is a very serious blow because that will mean that the universities that support those units that have to do research will be either in default or those people will be lost. So, generally, across the whole area, there is a serious concern about basic research.

With due respect to you, Minister—and I mean no harm about this—you cannot prevent something if you do not know what the cause of it is. The fact of the matter is that what we are doing at the moment is treating women without a clear idea of what the basic reason for the miscarriage is. So many of the things are missing here. I do not want to go on because I am not supposed to be giving evidence; I want to get evidence from you, obviously.

For example, if you take in vitro fertilisation and leave out multiple pregnancy, there is still a very high miscarriage rate. Trying to get a research licence from the authority that runs this, the HFEA, is extraordinarily difficult, and many scientists are not prepared to work in the area because they think their work will be held up. That is the sort of thing that is going on, which reduces funding, of course, and makes it more difficult. Could you comment on that?

Baroness Merron: Certainly. One of the things that we have become aware of is exactly as you described, Lord Winston, which is about blocks in the way of progress. I know that it has been discussed already with officials, but certainly we are looking at what I call the unnecessary obstacles. As you have described, if something is extraordinarily difficult, why will anybody go down that road? We are looking across the piece about where there are unnecessary obstacles—this is before we talk about funding, of course—that can be addressed. That work is going on.

As to funding for research, I would just make a general point. I know the committee is very aware of the current financial pressures and the work that is going on for the spending review for 2025-26. All those points about research more generically—I know we are talking very specifically—are currently being made. I absolutely agree with you, Lord Winston: how on earth can one treat if one does not know why? Also, research supports prevention in a different way.

Lord Winston: All our witnesses talk about the risk factors, but it is very difficult to believe that evidence. Take smoking, which has clearly changed massively in the last 10 to 20 years: there is quite a lot of evidence that smoking does not make much difference when you come to take a cohort of patients, which we have done. I will write to you sometime about this because it is something that I think is of interest. Those risk factors are extraordinarily broad. It is very clear that deprivation is important, but the basis of the deprivation—what is in the deprivation, which is important—is not something we understand, and we need to get that information. That will need research.

Q262 **The Chair:** Can we go back to where Lord Winston started? Professor Chappell, you were about to say, and he was asking why. This is what we found in our evidence sessions. Lots of research was being done in the areas of preterm prevention and preterm recognition of risk, et cetera, but it was not focused in any way to find the fundamental reasons and causes.

Professor Lucy Chappell: We need research across the whole of the translational pipeline or cycle, and we are working increasingly with the Medical Research Council. I know that you heard evidence directly from an MRC representative earlier in the committee hearings. I would agree. If I focused on five barriers, one is the funding itself. We have to acknowledge that we are up against competing demands such as cancer and dementia. This same committee might be having a hearing in a few months' time about what we are doing about cancer.

In fact, the RAND report from January 2020 into pregnancy funding called out the disproportionate underfunding in pregnancy research; 1p of every pound spent on pregnancy care is spent on research as opposed to something like cancer, which is 12p for every pound spent, which is why at the NIHR we are taking steps to address this. So the first is the funding of that.

The second is research capacity, which I touched on. You have to fund both across the discovery scientists and across the pull-through into practice, which we have heard about. You have to fund that research capacity.

The third one is about whether women are willing to take part. There is a bit of a myth about whether pregnant women take part. We have numbers from our reproductive health and childbirth portfolio. In 2018 and 2019, when I used to be an R&D lead, we recruited about 97,000 to 98,000 women in that specialty, which covers every area of reproductive health. In the last year, 237,000 women took part.

We should acknowledge, as Baroness Cumberlege has called out, where you must have a really robust ethical framework, and there is much more we can do in the regulatory area. But this is not women not coming forward to take part, and that really speaks to the support that NIHR should continue to give to all those studies. Those ethical and regulatory issues need further examining, as we have heard, whether it is HFEA or MHRA.

The final and fifth one is uptake of evidence. We have to demonstrate that if you generate high-quality evidence it has to pull through into practice because that is how it will make a difference. We have to think about that discovery science, what we call bench to bedside, or campus to clinic, and background, to ask the questions that Lord Winston describes. Both Patrick Chinnery at the Medical Research Council and I are really committed to working together to try to address the blocks that you are describing.

Lord Winston: I think that we are putting scientists away out of the area at the moment, and there is evidence. It is interesting that in the unit I work in most of our senior staff, including the professors, are female, not male. They have a strong passion to do the work, but some have felt that they have been so badgered by their applications to the HFEA in the past that they have in some cases even had depression and given up this work and done other stuff. That is a very serious criticism. It is obviously anecdotal, but surely the work of a research scientist is hard enough without making unnecessary barriers to getting important research done. It is not a question of the ethics. Most ethical issues can be resolved very quickly.

The Chair: Thank you. Professor Chappell, we took the evidence. As I said, there is a lot of research going on in the areas of obstetrics, not just preterm, but you did not seem to be very focused. The neonatal side has issues, but at least there is some focus about trying to do something in the areas that cause the greatest damage in care for neonates—for instance, intraventricular bleeds.

Professor Lucy Chappell: We look at focus through two ways. One is: how do we set priorities and who should be setting those priorities?

The Chair: Correct.

Professor Lucy Chappell: The NIHR funds the James Lind Alliance for priority setting partnerships, which takes a very systematic and robust way in deciding who chooses those priorities, and other funders put money towards addressing those priorities, which I think is the right way. We also do a combination of commissioned calls and researcher-led calls. There are areas where we should clearly drive that prioritisation and that focus, but we should not constrain the best of our world-leading scientists who may also see links or may come up with their own ideas, and we should always leave space for those. We, like many funders, and like the MRC, try to use a balance of those two. That then speaks to saying you must address the priorities that come particularly from users, which you heard about in the last session, but you must also allow new work and innovative thinking to come through, and that is how we aim to manage our portfolio.

Q263 **The Chair:** I know it is not absolutely in your remit as NIHR director, but working with particularly MRC and UKRI, the point that is made—and it came through in the evidence, too—is that obstetrics, or the reproduction side, suffers from not enough research money going into what I would call basic science research, discovery science research. There is a lot of research money going into comparative practices—and you mentioned one—such as whether emergency cerclage is effective or not, in those kinds of areas, but not fundamentally into discovery science, which is likely to lead to much bigger gains if we can crack the nut.

Professor Lucy Chappell: That speaks to the need for strategic co-ordination of health research across not just this area but many areas, particularly where there are similar challenges in bureaucracy. Through the Office for Strategic Coordination of Health Research, OSCHR, which is chaired by Lord Kakkar, we seek to drive that join-up that you are describing and try to see it from the system perspective, which is how we ensure that we have that upstream discovery and that we are enabling the links for the discovery scientists to get the most promising research. In fact, I have spoken to Innovate UK about this very point. It wants to see signals from researchers like NIHR and very strongly from the NHS. This is also very true for life sciences companies, which have traditionally often stayed away from pregnancy areas, but we are seeing much greater interest in pregnancy research. We need to stimulate across life sciences both industry-led and academic research of the type that you describe.

The Chair: Thank you.

Q264 **Baroness Wyld:** Good morning. Welcome to your new role, Minister.

Baroness Merron: Thank you.

Baroness Wyld: I want to return to the experience of families and their babies. There are three parts to my question, so I will set them all out; I think that is easiest. Between you, you have already mentioned each of them, I think, so that is really good to hear.

The first part is about accommodation on neonatal units so that we are

not separating mothers from these babies when they are very small and ensuring that families have the option to stay overnight. I would be grateful if you could set out, Minister, your ambition for that and, if possible, a timeline.

Fiona, you mentioned the developmental checks, and I think you listened to the previous session on the two-year and four-year developmental checks. You will understand how concerned the committee is about this. Perhaps you can help us, therefore, with some of the data and why it is the case, as far as we understand it, that only 75% of babies see the two-year check. I understand there are different criteria for a four-year check, but the numbers on that are tiny. Is there a reason for that? Can we defend those figures, or does it look like something is going wrong? So can we talk about that? Minister, obviously your comments would be very helpful.

Related to that on health visitor training—and you have highlighted this as part of the new Government's priorities—it would be very helpful to hear a bit more specifically in relation to the experience of preterm babies and their families, and what you intend to do there.

Baroness Merron: Okay, thank you for those. I will start on accommodation and then turn to Fiona to start on the second part, and I will come back to the third.

I am glad you have raised accommodation. I looked at the figures that showed that something like less than a third of neonatal intensive care units meet the standard for overnight accommodation for parents. I also looked at the survey that Bliss did, which I am sure committee members will be familiar with, that showed that 13% of babies can have both parents stay overnight in the unit. This is not a technical answer to you, Baroness Wyld, but that is not enough. It is not a "nice to"; it is a "needs to". I feel very sympathetic about the point and I have concerns about the maternity and neonatal estate.

NHS England has conducted a survey, and apparently it was the first time that such a survey had been conducted. What is important is what is next. So what next? The analysis will point out gaps compared to the health building note standards, and it will inform spending review planning, so it is something that we and I will be returning to, but I am grateful to you for shining a light on it.

Fiona Walshe: The short answer is that I do not have the data; I am not going to be able to answer your questions today. Can I go back and speak to my colleagues who also look at the development of children, and we will get back to you with a better answer?

Baroness Wyld: Absolutely. You will understand the frustration we have over this. It is not a criticism of you personally. What we cannot seem to uncover is who is gripping this. We would be very grateful for that. Thank you.

Fiona Walshe: It is a reasonable question. I will come back to you.

Baroness Wyld: Thank you.

Baroness Merron: Perhaps I can just say a few words about the third question that you asked, Baroness Wyld, and answer any additional points. I know variation in service has been a big issue for the committee, and it is right that the committee focuses on that. There is variation very much in providing neonatal outreach services, for sure. Again, I understand NHS England has developed a proposal to inform the spending review about establishing a standard model of neonatal outreach within the 10 networks across England. I will be interested to look further at that proposal.

As the committee will know, we are keen to see more health visitors in post. That will be part of the workforce plan and part of the mix that Baroness Watkins referred to earlier. I just want to refer to specialist services such as the family nurse partnership programme, which is supporting young parents who are at higher risk of premature delivery in order to reduce that risk. That, as all these things do, takes us back to the point that Baroness Blackstone raised about some groups and some people having higher levels of risk, and we have to be staffed up and attentive to provide that and not ignore it. Perhaps, Fiona, you could amplify.

Fiona Walshe: I do not have much more to add to that, because the Minister covered what I was about to say. This Government also have an ambition to have the healthiest generation of children ever, and this has to be part of it. One thing that we are doing is scrutinising spending review bids that are coming forward to make sure they are actually holistic in their approach, and this should be a lens through which we view it as well.

Professor Lucy Chappell: I have just one other point. We should recognise the evolution of how we provide care such as more transitional care where the baby may stay with the mother on the postnatal ward, where care in my day used to be delivered and the baby would be taken away just to receive intravenous antibiotics. That represents a more holistic view across maternity and neonatal. It may also put a bit more stretch on the postnatal ward, but it is the right thing for the woman and the baby. It is about seeing those two things in the round and saying where the best place for care is, and asking how we can continue to evolve those practices—for example, seeing the support of women and babies in the community. Some of these women having preterm babies have other children at home. They may not want or be able to stay overnight. They may want different models of care. Rather than seeing it in a static way, it is just saying how we evolve that.

Baroness Wyld: I agree with that, but the point I would make, as Lord Patel said at the beginning, is that we took very harrowing evidence from some mothers. They were very brave and very dignified in the way that they came forward. I agree with your point that they will have different circumstances, but how do we make sure, therefore, that they are being listened to and that their experience is being taken on board as services

are planning?

Professor Lucy Chappell: We have championed the maternity voices for the maternity side. Similar arrangements happen on the neonatal side. You are right; for a long time we have often based our system of healthcare around the professional's need, and we need to rethink it and say, "How do you start with the woman's journey?" There has been a programme across maternity called Whose Shoes, which literally walks in a woman's shoes to understand what attending multiple appointments might be like or how we get it right for a whole range of women. There is no stereotypical woman. I do not see any. I see women who have individual needs, and it is just reminding us of it. So many maternity professionals do, but we need to say, "How does the system recognise so many needs and within reasonable demands?" We talked about the estate. How do you understand how to address that?

Baroness Wyld: Thank you. That was a really powerful answer.

Q265 **Baroness Watkins of Tavistock:** Could I just come back on the health visitor issue? I really applaud the fact that we are going to train more health visitors, but the way the public health budget was allocated down to local authorities means that many health visitors on completing their training in the last five years have not been able to find jobs as health visitors. I would just ask you to comment on that and whether we can try to ensure that the health visitors are there to deliver what you are implying we need.

Fiona Walshe: You are right about how public health budgets have been allocated, and it is the same for so many different things. I speak on a personal level here. Ring-fencing can be really helpful. However, if you are managing large budgets and trying to do what is best in your own area, ring-fencing might not be the answer. I do not have a direct answer to your question, but we will absolutely take it away and look at what the spending review brings us and how that can be best allocated.

Baroness Watkins of Tavistock: Thank you very much. I really wanted to put that issue on record.

Professor Lucy Chappell: Can I just add that we can see it as an economic case? The health case is made, and everyone on this committee agrees, but if we look at the economic case for that investment we amplify that message about why we would choose to invest. That is the case that we have to make in the spending review.

The Chair: Thank you very much indeed, Minister, Fiona Walshe and Lucy Chappell for coming today. We appreciate it very much. This is our last session, and I hope our report will be very helpful in taking things forward. We clearly understand that there are lots of constraints, not just financial constraints, to do everything that it is possible to do, but some issues are more important than others and should be done, and I hope at least we will get some focus through this report of helping you to do that. Thank you.