HOUSE OF LORDS

Liaison Committee

Corrected oral evidence: Special inquiry committee proposal – Preterm birth

Tuesday 14 November 2023

11.35 am

Members present: Lord Gardiner of Kimble (The Chair); Lord Bach; Lord Bichard; Lord Blencathra; Lord Collins of Highbury; Lord Haskel; Earl Howe; The Earl of Kinnoull; Baroness Scott of Needham Market; Lord Taylor of Holbeach; Baroness Walmsley.

Evidence Session No. 8 Heard in Private Questions 40 - 43

Witness

I: Baroness Bertin.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence.

Examination of witness

Baroness Bertin.

Q40 **The Chair:** Good morning, Lady Bertin. We are looking forward to having a presentation from you on the prevention of preterm birth. It will be a presentation of about three minutes, followed by approximately five minutes for questions.

Baroness Bertin: First, thank you very much for shortlisting the inquiry on preterm birth prevention. It means a great deal to the sector. It is a hugely important issue with a very high human and economic cost attached to it. I do not believe it is spoken about nearly enough. I will not repeat the statistics that you had in the submission, except to emphasise that they are very high, and unfortunately they are going in the wrong direction.

My proposal for this committee would be to have three very tight workstreams to ensure that the inquiry did not run over, the first being on how to best reduce preterm birth rates today in a clinical setting. It would be very important for the inquiry to properly interrogate whether a screen-and-treat package of care could be effective at the 12-week and 20-week scans. High-risk pregnancy units who already do this procedure see very encouraging results, but of course it would be vital to understand properly what the cost implications would be versus the long-term savings. I have to admit a slight bias. I would hope that the inquiry would try to encourage the Government to roll out a significant pilot in order to justify a more significant rollout across the country.

The second workstream should focus on the societal and holistic impact of preterm birth, and the deepening ethnic disparity and inequality associated with this issue. This is not just a medical issue. We know that roughly 6,000 premature babies are left with a disability, but there are very few statistics or data about the life outcomes of these children and families.

There is significant trauma to the mother. Very often, if you have one preterm birth, you may have several. The family dynamic can change enormously, and there are much higher rates of postnatal depression. Even those without a registered disability are far more likely to have behavioural problems or special educational needs. None of this has ever really been looked at in any depth or with any whole-systems approach.

The deepening ethnic disparity in health inequality is very troubling. Babies from black and Asian ethnic groups are the most at risk, and the figures on preterm births have gone up much more in these groups than other groups in the last year. These kinds of statistics cannot be allowed to go on unchecked and not understood. I believe the inquiry would be a natural follow-on from the Commons Women and Equalities Committee on black maternal health.

The final workstream would focus on R&D in pregnancy, highlighting that obstetrics is one of the most underresourced areas of medicine. It is failing to keep pace with progress in other areas. In a sense, nothing much has changed in 50 years. My mother's treatment would have been pretty much

the same as my treatment. Universities have pivoted to growing areas of research, such as cardiology and cancer, because there is such huge pharmaceutical industry support. Sadly, the academic departments of obstetrics and gynaecology have declined across this country.

In the 1970s, just to give an example, obstetrics and cardiology were level pegging, but since then the divergence in progress has been very stark. There are only eight available drugs licensed to be used in pregnancy, and the compendium of drugs for cardiology runs to several volumes. A very crude but perhaps effective reminder is that, in obstetrics, the most commonly used instrument remains the forceps, invented in 1630.

I would finally add that I am confident that the House of Lords would do enormous justice to an inquiry of this kind. A committee made up of medical expertise sitting alongside Members who are passionate about the societal impacts and implications of proving these outcomes would make for a very powerful but also progressive committee. I have reached out to Lord Patel, who would want to sit on it if it was successful. Baroness Watkins likewise made the specific point that we do not know what is happening to these babies, particularly those born at 22 weeks. Of course, we read the headlines just this week that the survival rates are threefold, but we do not know what the life chances are.

Q41 **Earl Howe:** I was looking for, and you gave us, reasons why this inquiry, if it was set up, would stray beyond the territory of the Department of Health and Social Care and the medical world. You mentioned the societal impacts, which are clearly very relevant. If there is a lack of data on the societal impact, as you said, how do you think a committee could reach meaningful conclusions beyond reporting what would amount to anecdote?

Baroness Bertin: Sometimes these committees serve to highlight the issue and the fact that there is a big gap in data. There is a big gap in data across huge swathes of public policy, but that is no reason not to interrogate it and to expose that fact. We may not have millions and millions of pieces of data, but we still have enough to transpose and to lift and shift to say, "If we threw this out on a national level, perhaps this could mean that".

The other point I would make, drawing from other committees that I have sat on, is that we potentially do not look enough into the information that we may already have. For example, many children have education and care plans, at what seems like at a worryingly increasing rate. Do we follow those children properly? I have a son myself who has some minor learning difficulties. I am asked endlessly about the pregnancy and whether it was premature. Those answers go nowhere, as far as I can see, but if we were a little more strategic about following the children we know who have these learning difficulties, whether they were premature and where they then go to in their lives, we could start to build up an effective picture.

Q42 **Lord Collins of Highbury:** In the paper, we have the reference to the maternity care policy published by NHS England in March, and the establishment of the maternity and neonatal care national oversight group.

What is your view of that work and how that will impact? Is it not a good idea to see what that does?

Baroness Bertin: I am not an obstetrician, but I have spoken to Professor Mark Johnson, who would be a very valuable witness. He is probably the most well researched in this area. His argument about these neonatal policies is that, even if you were to meet every target and do everything you should do, ticking every box that the strategy sets out, you would still only reduce the preterm births by 0.5%, which will never get you down to the 6% target.

It goes back to the first point that I made. You have effective moments in a woman's pregnancy where you can see where it might go wrong. If you are not going to intervene at those moments, you are just, in a sense, waiting for the woman to have a preterm birth and potentially lose the baby, and that is when they go into a high-risk pregnancy unit. Until that point, 85% of women do not show any predisposition to have a pre-term birth. Clinicians who know a great deal about this would say that that strategy is probably not going to get you to the place you need to get to.

Q43 **Baroness Walmsley:** Am I right in thinking that the inquiry is less likely to focus on any kind of pharmaceutical interventions, and more on diagnosis, screening, treatment, prevention and follow-up? Is that the scope?

Baroness Bertin: I know quite a bit about this, having had three children. I was surprised that there is almost no pharmaceutical intervention whatsoever. When you think that it makes up 66% of health research, the industry is doing the research because it wants ultimately to sell drugs, I guess. I am not suggesting that suddenly lots of pregnant women are going to want to take drugs, but we should know that there are literally only eight licensed drugs for us to take, should we have this predisposition. That seems wrong to me. That seems very lacking in progress.

I am not trying to boil the ocean. One has to be proportionate about what one can achieve, particularly in 10 months, but given the huge amount of money that is in the baby industry, it does not seem right that there is so little money going into pregnancy research. I do not know whether I have answered your question there.

Baroness Walmsley: Clinical trials may be a problem, of course.

Baroness Bertin: The trials are a problem, but there are still many women who have perhaps lost eight babies. They are desperate, so you could find a cohort of people who would be, frankly, quite willing to take part in trials.

The Chair: Lady Bertin, thank you very much for the presentation. We are grateful.