Report to Health Scrutiny Committee

Infant Mortality – Update

Portfolio Holder:
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Purpose of the Report

The Health Scrutiny Committee has requested an update report on infant mortality in Oldham and our actions to reduce these deaths.

Summary of the issue:

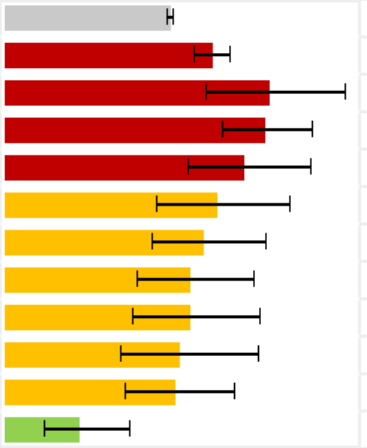
This report provides an overview of the work to reduce infant mortality in Oldham, and focuses on the work on reducing smoking in pregnancy, and advice on safe sleeping.

1. Background to Infant Mortality in Oldham

1.1 Infant mortality has a devastating impact on the lives of the families of Oldham. Infant mortality is defined as the death of a child aged under 1 year. The highest priority for the long-term health of the population is to ensure that children are given the best start in life.

1.2 Oldham's infant mortality rate has been higher than the North West and England rates consistently for over a decade. Oldham's most recent rate for 2018 - 2020 was 6.2 per 1,000, making it significantly higher than the national figure of 3.9 per 1,000. This is a key priority to improve the health of Oldham

Area	Recent Trend	Count	Value
England	–	7,111	3.9
CA-Greater Manchester	–	497	4.9
Oldham	–	58	6.2
Manchester	–	131	6.1
Bolton	–	61	5.6
Rochdale	–	42	5.0
Salford	–	49	4.7
Stockport	–	41	4.3
Tameside	–	35	4.3
Bury	–	27	4.1
Wigan	–	40	4.0
Trafford	–	13	1.7



Source: Office for National Statistics (ONS)

Figure 1: Greater Manchester Infant Mortality Rates 2018-2020, crude rate per 1,000

1.3 Oldham ranks 19th most deprived out of 317 local authorities in 2019 Indices of Deprivation (IMD) data. National research has demonstrated that there is a correlation between child poverty and the rates of deaths in children, including infants. The report on this issue from the National Child Mortality Database[1], which is based on data for children who died between April 2019 and March 2020 in England, finds a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer).

1.4 Key contributing causes of death locally and nationally include congenital abnormalities, babies that are small for gestational age, and extreme preterm births. To reduce the prevalence of these, public health approaches should focus on those women living in the poorest areas, and work to reduce smoking, unplanned pregnancies, maternal obesity and better engagement with those with maternal disorders such as diabetes. In addition, wider determinants of health were found to be factors identified in deaths of children who live in poverty including overcrowded housing, lack of access to interpreting services, and poor maternal health in pregnancy.

[1] https://www.ncmd.info/wp-content/uploads/2021/05/NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf

2. Current Data in Oldham

2.1 The Child Death Overview Panel (CDOP) for Oldham, Bury and Rochdale (ORB), is one of the four CDOPs in Greater Manchester (GM). The CDOP reviews all child deaths under 18 years, but not including still births, late foetal loss or termination of pregnancy. The panel do not determine the cause of death but instead explores all the factors surrounding the death of the child. This learning enables required actions to be taken to protect the welfare of children and prevent future deaths.

2.2 Every year, each CDOP collates information on the cases that have been reviewed in the last 12 months in order to identify themes. This enables each area to identify any lessons learnt and recognise where population level interventions are required to reduce future child deaths.

2.3 In 2020/2021 there were 47 notified cases and 29 reviewed cases. The duration of the review process can vary meaning that not all cases are closed in the same year that they are notified.

2.4 55% of children were within a hospital setting when the fatal event occurred, with home setting being the second most common location. Males were overrepresented in closed cases at 59%, this is consistent with GM and national findings year on year, the reason for this is unclear.

2.5 Children are at the highest risk of death in the first year of life, and this is identified within the ORB data, 41% of cases were in the neonatal period and 55% in the first year of life. Across ORB, the leading cause of child death was chromosomal/ genetic/ congenital abnormalities equating to 31% of the closed cases. The second most common cause of death was perinatal/neonatal event which was the category of 21% deaths.

2.6 Modifiable risk factors are areas which may contribute to an increased risk of child death, and if addressed at a population level can reduce the risk of future child deaths. 48% of closed cases had modifiable risk factors identified. Modifiable factors that were identified in ORB cases included hospital and clinical factors, domestic violence, consanguinity, and parental smoking.

2.7 Preterm delivery and the associated complications are the leading cause of infant mortality. Preterm delivery is defined as any birth before 37 weeks of pregnancy and can be subdivided depending upon gestational age. The earlier the gestation at which a baby is born, the higher the risk of infant death[2]. Preterm delivery is associated with risk factors such as poverty and maternal smoking [3]. 88% of all deaths in children under 1 year were born prematurely across ORB.

3. Update on activities in Oldham to reduce infant mortality

3.1 A key element of the Oldham approach is taking a strengths-based and person-centred approach to understand what matters to people rather than being led by service priorities to build a system which works for residents.

3.2 Taking this approach has enabled us to implement approaches such as Family Nurse Partnership (FNP), Right Start Services (0-5s), and Social Prescribing which are able to work whole system and whole person to really understand the wider

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014

[3] https://www.rcpch.ac.uk/sites/default/files/2018-10/child_health_in_2030_in_england_-report_2018-10.pdf

determinants of presenting needs and respond accordingly drawing on assets both within public services and the wider community.

3.3 There are key programmes of work that aim to reduce the risk of infant deaths across Oldham. Below are the updates on 1) smoking cessation in pregnancy, 2) genetic outreach 3) safer sleeping 4) maternity services

4. Smoking in Pregnancy

4.1 Smoking and exposure to second hand smoke during pregnancy is responsible for an increased rate of stillbirths, miscarriages and birth defects.

4.2 Encourage pregnant smokers to stop smoking is one of the most effective ways we can reduce infant mortality and still births. Stopping smoking will not only benefit women who smoke and are planning a pregnancy, are already pregnant or have an infant aged under 12 months but will also benefit the unborn child of a woman who smokes, any infants and children she may have, her partner and others in her household who smoke.

4.3 The ambition of the Smoking in Pregnancy programme is to reduce smoking in pregnancy across GM through a standardised smoke free pregnancy pathway with investment in workforce development, equipment, and a targeted intervention aimed at our highest risk population. Initially, the programme aimed for a reduction in smoking status at time of delivery (SATOD) in GM to the England average (10.5%) with an ambition to be better than the England average by the end of 2021 and ultimately for no woman to smoke during her pregnancy.

4.4 Oldham has a Specialist Midwife and two dedicated Maternity Support Workers based at The Royal Oldham Hospital. Nicotine Replacement Therapy (NRT) is now available via direct supply on antenatal clinic and ward, labour ward and postnatal ward and progress being made to move towards offering NRT via the community team too

4.5 CO monitoring is being undertaken by personal use monitors, supported/funded by GM. This is important as a validation method of smoking status. Midwives are encouraged to refer all women smoking at booking to face to face appointments with the Smoking in Pregnancy team. In addition, midwives are encouraged to refer all women regardless of smoking status with a raised CO of 4 and above.

4.6 The Smoking in Pregnancy Team offer training for all midwives/maternity staff as well as e-learning so that all maternity staff are clear of importance of smoking cessation in pregnancy.

4.7 Work is also ongoing on smoke free homes. As well as in person advice, a Smoke Free Homes leaflet is included in all packs for women who smoke in pregnancy.

4.8 The Smoking in Pregnancy Team work with the Community Stop Smoking Service (as part of Your Health Oldham) to strengthen pathways to support partners and others in the household who smoke by providing clear advice about the danger that other people's tobacco smoke poses to the pregnant woman and to the baby – before and after birth – and offers help to stop smoking by using evidence-based multi-component interventions and pharmacotherapy.

4.9 Following the introduction of the Smoking in Pregnancy service, Oldham has seen reductions in the rates of women smoking when they are pregnant, from 12.6% in 2017/18 to 9.8% (2020/21 – Oldham CCG data). This means 945 more babies were born smoke free in Oldham.

4.10 The current four week quit rate is 63% (Q3 21/22) with 100% of women who achieved a four-week quit remaining quit at the time of the birth of their baby

4.11 Shisha remains an issue and midwives are encouraged to ask women about its use. New display boards in antenatal clinic to raise awareness of the dangers.

4.12 No Smoking Day Campaign 9th March 2022 was used as an opportunity to build conversations across the hospital and community sites. Stalls were set up at Royal Oldham Hospital to increase awareness of dangers of smoking and the support available. There was also activity on social media within the trust to continue to highlight the service to staff members.

4.13 Development of the Smoke free Digital Platform is continuing – this will provide more options around virtual appointments, where appropriate, with the platform being able to accept MSTeams meetings and WhatsApp video calls.

5. Genetic Outreach

5.1 All the cases reviewed by the Oldham Bury and Rochdale CDOP last year that related to chromosomal, genetic and congenital abnormalities were children of Black, Asian or minority ethnicity. In addition, overall, there were higher rates of child deaths in Black, Asian or minority ethnicity groups across Oldham. This was consistent across GM and it is important that this inequality is addressed.

5.2 Consanguinity is a known risk factor for congenital abnormalities and therefore an important risk factor when addressing child deaths.

5.3 As a response to this, Oldham Council has commissioned a genetic outreach service since 2015. The service aims to raise genetic literacy and awareness in affected communities in Oldham in order to support informed marriage and reproductive choices. The service was recommissioned last year and is provided by HomeStart. The service also aims to raise awareness of:

- The impact of genetic disorders on infant and childhood mortality locally
- Knowledge of genetic and cultural issues related to consanguineous marriage
- The health services that people can be referred to for further help/information
- How to initiate conversations appropriately in the community

5.4 A key delivery mechanism for this service is via building culturally appropriate conversations about genetics, and consanguinity via existing community groups. These have been held in a variety of settings including local mosques, community centres, and multifaith groups. One example was an Arabic teacher training event at the Ghosia Mosque where the service engaged 26 female teachers in discussions about genetic risk, and awareness of how to support discussions in the community. The focus was on ensuring that the discussions are appropriate to cultural norms, and religious beliefs.

6. Safer Sleeping Programme

6.1 Following the completion of a local case review on the sudden and unexpected death of a baby in Oldham the Children's Safeguarding Partnership agreed to undertake a piece of work relating to safer sleep. This work was later reinforced following the publication of the National Child Safeguarding Practice Review of Sudden and Unexpected Deaths in Infancy (SUDI). Both local and national reviews identified challenges relating to the application of safe sleep guidance in the home.

6.2 A multi-agency task and finish group led this work in Oldham and identified that whilst safe sleep messages are provided regularly and consistently by midwifery and health visiting services, they are not always being followed by family members.

6.3 The group carried out an engagement exercise last year with the aim of speaking with new parents and family members about safe sleep, the advice given and any potential barriers to the advice being followed. This engagement exercise has been used to inform the ways in which risks are communicated and so reduce the risks of sudden and unexpected deaths relating to unsafe sleeping arrangements.

6.4 Early Help services have now been supported to share information with their families in relation to safe sleeping.

7. Maternity Improvement Programme,

7.1 As highlighted above, preterm delivery and the associated complications are a significant risk factor in relation to infant mortality. A healthy pregnancy, and good maternity care are key to reducing mortality rates

7.2 A Maternity Improvement Programme has been established by the Northern Care Alliance (NCA), which operates the Royal Oldham Hospital, in order to ensure that Maternity services in Oldham meet national maternity standards, including the recommendations of the Ockenden Review, and other national guidance.

7.3 Included within this programme is a focus on addressing poor outcomes experienced by some, for example higher still birth rates in Pakistani and Bangladeshi patients. While we have highlighted a number of the risks factors, there is evidence to suggest that there are changes within the control of the maternity services which can be made to improve outcomes.

7.4 The programme has established a 'Listening to our Communities' workstream to hear the views and experiences of women and families who have used maternity services to inform the improvement work. This approach will be targeted based upon key communities and groups in Oldham and Rochdale who both experience poorer outcomes, but who are less likely to make complaints, and are often under-represented in traditional surveys and patient groups.

7.5 We already know from national and local research a number of areas that will improve care, and therefore infant mortality, by improving communication and trust between patient and the clinical team;

- Access to and quality of interpretation support throughout the patient pathway
- Culturally appropriate support and advice
- Trust and perception of health professional, including why some women access ante-natal care late or not at all, meaning problems with the baby are detected late

7.6 Alongside the engagement work described, the maternity service is also acting on immediate improvements which can be made such as 'improving flow' to ensure theatre availability for patients requiring emergency caesarean sections.

8. Recommendations

8.1 The Health Scrutiny committee are asked to note the data on infant mortality and support the ongoing actions to reduce infant mortality across the borough.