Appendix B: Infant Mortality Report

Lancashire Infant Mortality Report
Director of Public Health

January 2020

www.lancashire.gov.uk

Lancashire County Council

1. Introduction

1.1 This report provides information about infant mortality and outlines our proposed plan to reduce the number of infant deaths in Lancashire.

1.2 Infant mortality is an indicator of the overall health of a population. It reflects the relationship between the causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

1.3 Reducing infant mortality is an important part of the Population Health Plan First 1000 Days priority.

1.4 Infant mortality is also a key priority area for the Children, Young People and Families Partnership Board as part of a broader approach in the Early Years Strategy (see Appendix 1).

1.5 Infant mortality has been highlighted as a key part of the Director of Public Health report and is also a major part of the ICS work.

2. Definitions

2.1 Infant mortality is defined as deaths that occur in the first year of a child's life.

2.2 The infant mortality rate is the number of deaths at ages under 1 per 1,000 live births. Stillbirths are not normally counted as infant deaths and are not included in the calculation of the infant mortality rate. Some of the factors that contribute to a stillbirth may also be contributing factors in infant deaths.

2.3 Infant deaths can be divided into three broad stages, each with a different set of risk factors and determinants:

- Deaths under 7 days of life (perinatal mortality)
- Deaths to infants aged under 28 days (neonatal mortality)
- Deaths to infants aged 28 days to 1 year (post-neonatal mortality)

3. Data sources and limitations

3.1 There are three main sources of data and information on infant deaths in the UK:

3.1.1 Vital Statistics i.e. information supplied when infant deaths are certified and registered as part of the civil registration process. This is a legal requirement and the information that is collected is prescribed in the relevant legislation. The data collected through this process is managed by the Office for National Statistics (ONS) and is usually reported based on the local authority within which the deceased was usually resident at the time of death.

3.1.2 Child Death Overview Panels (CDOP) collect and review information about each child death in a local area in order to build a picture of emerging themes and patterns and inform local strategic planning on how to best safeguard and reduce harm and promote better outcomes for children in the future. Each CDOP collects data in a common format and also submits information to the Department for Education on an annual basis to inform the national picture.

3.1.3 Surveillance reporting systems, notably the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) system. MBRRACE is part of the national Maternal, Newborn and Infant Clinical

Outcome Review Programme, the aim of which is to provide robust national information about the causes of maternal deaths, stillbirths and infant deaths.

3.2 The information collected by each of these sources is different. For example, the restrictions on the data collected as part of the deaths registration process means that the ONS dataset contains limited information on key risk factors, such as ethnic group, mother's country of birth, maternal lifestyles and family circumstances.

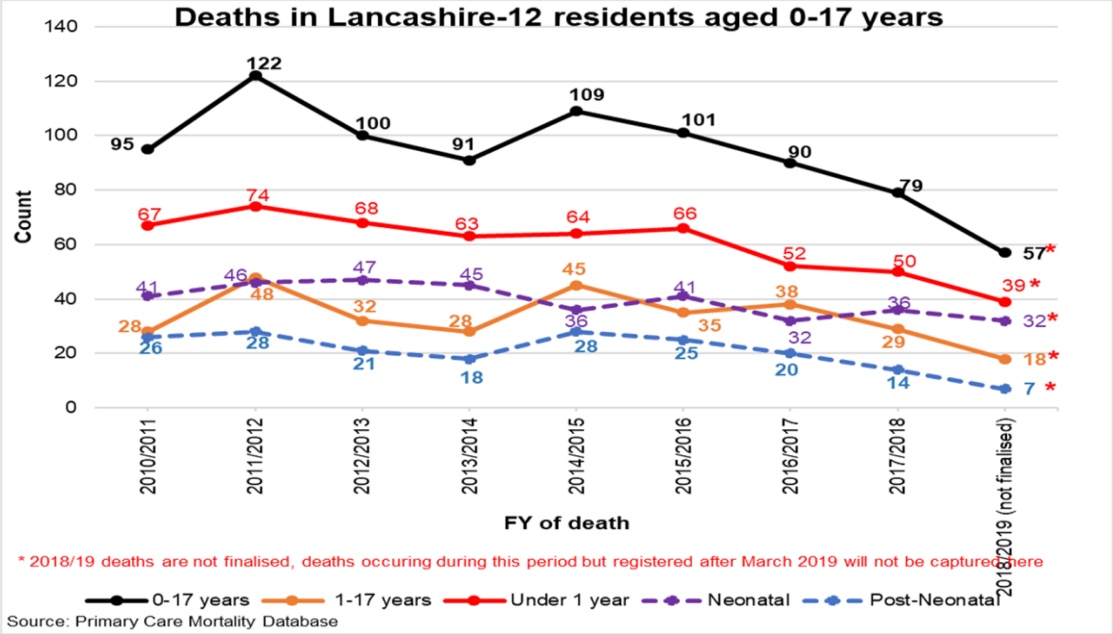
However, data on some of these factors is collected as part of the CDOP process. Used together, the ONS and CDOP data provide a rich and powerful picture of infant deaths in Lancashire.

3.3 The CDOP Annual Report for Lancashire is also produced on an annual basis and supports the context for this report and the action plan.

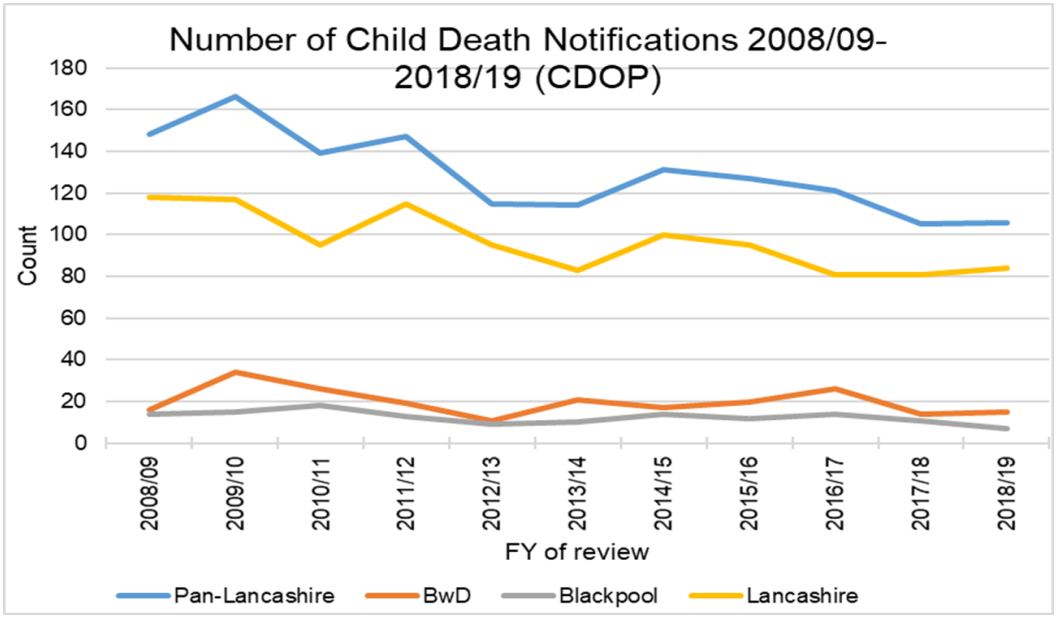
4. Trends and patterns of infant deaths in Lancashire

4.1 Infant Mortality rates

- The overall child mortality rate (age 0-17) in Lancashire has been falling as can be seen below. However child mortality remains significantly worse than the England rate (coverage over the period 2010-12 to 2015-17).
- According to recent published figures (2015-17) infant mortality and post-neonatal mortality remain worse than the England rate (2010-12 to 2015-17).
- Neonatal mortality has been similar to the England rate (coverage between 2012-2014 and 2015-2017).



4.2 According to Child death notifications from 2008/9 to 2018/19, there are inequalities between geographical areas where Lancashire has the highest number of deaths compared to Blackburn and Darwen and Blackpool.



4.3 The infant mortality rate for Lancashire is 4.7 per 1,000 compared to 3.9 per 1,000 England 2015-17. Lancashire after Staffordshire is ranked worst compared to its neighbours.

4.01 - Infant mortality New data 2015 - 17 Crude rate - per 1000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	7,734	3.9	3.8	4.0
Neighbours average	–	-	1,623	3.7*	-	-
Staffordshire	–	2	141	5.5	4.6	6.5
Lancashire	–	-	185	4.7	4.1	5.5
Northamptonshire	–	6	122	4.5	3.7	5.4
Warwickshire	–	7	75	4.2	3.3	5.2
Worcestershire	–	9	74	4.1	3.2	5.2
Nottinghamshire	–	1	104	4.0	3.3	4.8
Kent	–	8	199	3.8	3.3	4.4
Derbyshire	–	5	86	3.7	3.0	4.6
Leicestershire	–	15	77	3.7	2.9	4.6
Lincolnshire	–	10	75	3.3	2.6	4.1
Cumbria	–	12	46	3.3	2.4	4.3
Gloucestershire	–	4	65	3.3	2.5	4.1
Norfolk	–	13	86	3.2	2.6	4.0
Essex	–	3	153	3.1	2.6	3.6
West Sussex	–	14	72	2.7	2.1	3.4
Suffolk	–	11	63	2.7	2.1	3.4

Source: Office for National Statistics (ONS)

4.4 There are also local variations and inequalities in infant deaths within areas of residence in Lancashire. As can be seen in the period 2015-2017 Burnley stands out as having the highest number of deaths, followed by Pendle, Wyre, Fylde, Chorley and Hyndburn. Ribble Valley and Lancaster have lowest number of deaths.

Infant mortality (2015 - 17), crude rate per 1,000 live births

Area	Count	Rate per 1,000	95% Lower CI	95% Upper CI
England	**7,734**	**3.9**	**3.8**	**4**
Lancashire	**185**	**4.7**	**4.1**	**5.5**
Burnley	28	7.8	5.2	11.2
Chorley	19	5.1	3.1	8
Fylde	10	5.3	2.6	9.8
Hyndburn	16	5	2.9	8.1
Lancaster	11	2.6	1.3	4.6
Pendle	21	5.7	3.5	8.7
Preston	26	4.7	3	6.8
Ribble Valley	3	2.2	0.4	6.3
Rossendale	8	3.4	1.5	6.7
South Ribble	14	3.9	2.2	6.6
West Lancashire	13	4.2	2.2	7.1
Wyre	16	5.5	3.2	9

4.5 There are clear links between socioeconomically deprived areas and infant mortality. When broken down into deprivation using IMD, the infant mortality rate is highest in most deprived areas compared to least deprived areas.

IMD Decile	Count of infant deaths	IMR	
1	218	6.7	-0.90
2	91	5.5	
3	63	4.2	
4	51	4.1	
5	33	3.9	
6	45	4.1	
7	37	3.1	
8	39	3.3	
9	27	2.7	
10	19	2.9	

4.6 As can be seen from the table below the majority of the births occur in the most deprived quintile includes Hyndburn, Burnley and Pendle.

Births in 2017						
District	**IMD 2015 Quintile (1=20% most deprived, nationally) - % of total births**					
	1	**2**	**3**	**4**	**5**	**Total**
Burnley	**58.8%**	**24.8%**	5.6%	7.5%	3.3%	100.0%
Chorley	13.5%	25.7%	16.3%	26.6%	17.9%	100.0%
Fylde	4.4%	10.2%	30.6%	34.1%	20.7%	100.0%
Hyndburn	**62.6%**	**16.8%**	6.7%	12.0%	1.9%	100.0%
Lancaster	30.0%	19.6%	19.7%	21.5%	9.1%	100.0%
Pendle	**50.1%**	**22.0%**	14.7%	10.7%	2.5%	100.0%
Preston	44.2%	24.4%	10.6%	9.7%	11.0%	100.0%
Ribble Valley	0.0%	3.1%	28.9%	30.0%	38.0%	100.0%
Rossendale	15.4%	43.3%	17.6%	15.5%	8.2%	100.0%

South Ribble	5.1%	10.6%	35.4%	23.6%	25.4%	100.0%
West Lancashire	31.8%	13.9%	20.9%	14.8%	18.7%	100.0%
Wyre	22.6%	10.1%	28.1%	24.6%	14.6%	100.0%
Lancashire	32.1%	19.7%	18.0%	17.6%	12.6%	100.0%

4.7 There are also links with low birth weight and areas of deprivation. The following table shows the areas with highest IMD scores also have the highest rates of low birth weight babies. Burnley, Hyndburn, Pendle and Preston are worse when compared to England Average.

Low birth weight of term babies, five year aggregate, 2011-2015 (same period as ward data)						
District	%	Lower CI 95.0 limit	Upper CI 95.0 limit	Count	Denominator	Compared to England value
Burnley	3.8	3.3	4.3	204	5412	Worse
Chorley	2.4	2.0	2.8	137	5677	Similar
Fylde	2.0	1.6	2.6	59	2944	Better
Hyndburn	3.4	2.9	3.9	174	5108	Worse
Lancaster	2.6	2.2	3.0	181	6999	Similar
Pendle	3.3	2.9	3.8	193	5882	Worse
Preston	3.6	3.3	4.1	314	8615	Worse
Ribble Valley	2.5	1.9	3.3	51	2043	Similar
Rossendale	2.8	2.3	3.4	104	3741	Similar
South Ribble	2.1	1.8	2.6	120	5593	Better
West Lancashire	2.4	2.0	2.8	121	5061	Similar
Wyre	1.9	1.5	2.4	83	4342	Better

5. Causes and underlying factors of infant deaths

5.1 National data shows a correlation between deaths and deprivation, and as can be seen from the table analysis of local data highlights an obvious correlation locally between IMD and the infant mortality rate.

5.2 National data shows that of babies with known gestational age, babies born in the White Other ethnic group (White Irish and any other White background) had the lowest infant mortality rate. In contrast, Pakistani and Black African babies had the highest infant mortality rates. Further analysis is required on ethnicity locally.

5.3 There are a range of factors that contribute to infant mortality. These are low birth weight, Under 18 conceptions, smoking in pregnancy and breast feeding initiation.

5.4 In Lancashire various modifiable factors have been identified which contribute to the infant mortality rate. This can increase the risk of prematurity, meaning the infant will not be born in the best possible condition, or make sudden infant death more likely.

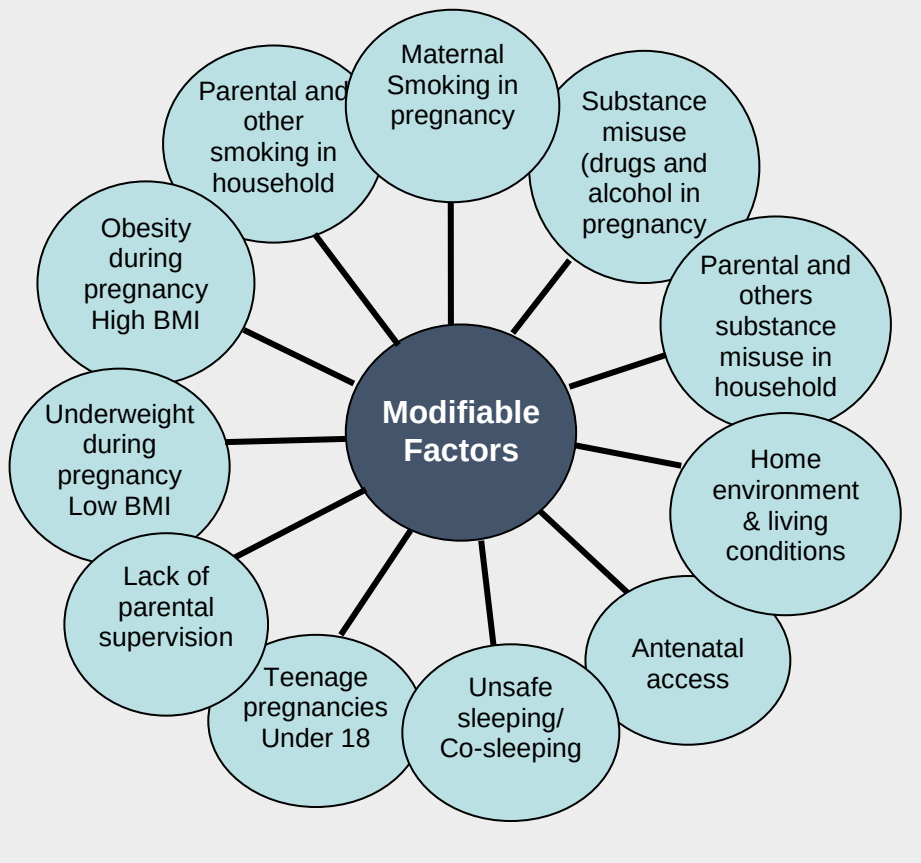
5.5 Modifiable factors act as a multiplier effect. Where there are two or more factors present, the vulnerability of the child increases. The modifiable factors that occur most frequently, and therefore where most impact can be made, include maternal smoking in pregnancy, maternal obesity in pregnancy and Parental/household smoking and substance misuse.

5.6 In part, this can be linked to the fact that the prevalence of some lifestyle factors known to increase the risk of infant mortality are higher in certain ethnic groups. For example, the prevalence of obesity is known to be higher among some South Asian communities.

5.7 Maternal obesity during pregnancy can lead to increased health risks for mother and baby.

5.8 Smoking in pregnancy is the single biggest risk factor for infant mortality.

5.9 Those modifiable factors identified in the CDOP for Lancashire are highlighted in the diagram below.



5.10 As well as these modifiable factors there are a number of protective factors against infant deaths. These include vaccinations including flu vaccination for pregnant women, breastfeeding and safe sleeping practices.

6. What is the data telling us about these factors and the associated risks in Lancashire?

6.1 The following table highlights the risk factors and the associated risk, with data on numbers in Lancashire.

Risk Factor	Local data for Lancashire (2016)	%/Number
How maternal age is associated with increased risk	The risks of birth complications, congenital anomalies and stillbirth increase with age. Multiple births are also more common in older women, particularly as the result of assisted conception. However, the exact age at which these risks increase is uncertain and co-existence of additional risk factors such as smoking will increase the chance of adverse birth outcomes.	In this area, **17.4%** of women giving birth in 2016/17 were aged 35 years or above: **2,227 women**
How teenage pregnancy is associated with higher risk	In 2016 babies born to mothers under 20 years had a **24% higher rate of stillbirth** and a **56% higher rate of infant mortality.** Teenage pregnancy is associated with a higher risk of smoking, of late booking antenatally, lower birth weight babies, stillbirth and infant mortality	In this area, **1.0%** of women giving birth in 2016/17 were aged under 18 years: **132 women**
Low birth weight of <u>all</u> babies	Babies born with a low birth weight are almost **9 times more likely to die in infancy**. Smoking is linked to low birth weight. Evidence suggests reducing and quitting smoking is associated with increased birth weight. Babies which are part of a multiple birth are also more likely to have a low birth weight	In this area, **7.9%** of babies (including pre-term) were born with a low birth weight in 2016: **1,038 babies**
Low birth weight of <u>term</u> babies	This indicator is included in the Public Health Outcomes Framework and looks at the number of babies born live with a low birth weight at full term (37 weeks or more) as a percentage of all babies born at full term. At a population level, a higher percentage for this indicator might suggest that women's lifestyles during pregnancy could be improved	In this area, **2.8%** of term babies were born with a low birth weight in 2016: **338 babies**

6.2 What is the data telling us about Lancashire locally and what do we need to do to make a difference?

The following summary provides information on where we are currently in relation to the areas identified and provides a benchmark against England and Regional data. This will help to prioritise areas of need and inform action planning in order to make a difference in reducing infant mortality from baseline data so we either improve compared to a regional or national benchmark. The data is taken from a toolkit by PHE.

Factor	Outcome of risk factor	England	Region
Stillbirths	In 2014-2016, there were on average 58 stillbirths per year, with a rate of 4.4 stillbirths for every 1,000 live births and stillbirths		
Infant Mortality	In 2014-2016, there were on average 59 infant deaths per year, with a rate of 4.5 infant deaths for every 1,000 live births.		

Smoking	In 2017/18, 13.9% of women in this area smoked when pregnant: **1,619 women**. Approximately **130** fewer women smoking during pregnancy in this area could reduce infant mortality rate to match the North West average. ❖ Reducing smoking during pregnancy alone to 0% would not be enough to reduce the stillbirth rate to be among the 25% best performing local authorities ❖ Any reduction in smoking during pregnancy will have a positive impact on health and help to reduce stillbirth rates. You should consider taking action on other factors as well.		
Obesity	**51.0%** of women in this area in 2017 were obese in early pregnancy: 6,190 women. Approximately **181 fewer women obese in pregnancy** in this area could reduce your infant mortality rate to match the North West average. ❖ Approximately 2,593 fewer women obese in pregnancy in this area could reduce your stillbirth rate to be among the 25% best performing local authorities ❖ Achieving these reductions in the short term may be challenging but at an individual level having a normal weight during pregnancy is beneficial for mother and baby. ❖ Over time year-on-year reductions in maternal obesity should be reflected in reduced stillbirth and infant mortality rates		
Immunisations	In 2017/18, **86.1%** of children in this area were vaccinated against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio at age 1.		
Low birth weight	In 2016, 7.9% of babies (including pre-term) were born in this area with a low birth weight: 1,038 babies		
	In 2016, 2.8% of term babies were born in this area with a low birth weight: 338 babies		
Mothers aged under 18	In 2016/17, 1.0% of women giving birth in this area were aged under 18 years: 132 women		
Mothers aged 35+	In 2016/17, 17.4% of women giving birth in this area were aged 35 years or above: 2,227 women.		

7. What are the key priority areas for action in Lancashire?

7.1 Given the inequalities mentioned above, the public health intelligence data, CDOP findings and serious case reviews, to make a difference in reducing infant mortality we need to take action on the following priority areas:

Key Priority Area	Objective
1. Wider determinants	❖ To address the wider determinants such as poverty, poor housing, overcrowding knowing there is a link between infant mortality and socioeconomic status and a factor on affecting sleeping habits in the home, as well as other risks such as low birth weight.
2. Sudden infant deaths	❖ To reduce the number of sudden infant deaths caused by co-sleeping in unsafe situations
3. Access to services	❖ To ensure equal access to all aspects of pre-conception, maternal and infant health care
4. Social and emotional support	❖ To improve social and emotional support for vulnerable parents, especially those living in areas of social disadvantage, including maternal mental health and wellbeing and attachment
5. Smoking in pregnancy	❖ To reduce the numbers of women (and partners/families) smoking during pregnancy
6. Substance misuse	❖ To reduce the numbers of women with high levels of use of alcohol and/or non-prescribed drugs in pregnancy
7. Women, infant nutrition and breastfeeding	❖ To improve the health and nutrition of pregnant women, babies and infants by promoting a healthy food culture, and tackling obesity
8. Performance, data and intelligence	❖ To ensure appropriate performance and data intelligence to monitor infant mortality
9. Communications	❖ To ensure effective communication so these plans are implemented and shared widely with individuals, communities and professionals

A proposed draft of the action plan can be found in Appendix 2.

8. About the Infant Mortality Plan

8.1 Implementation and delivery

8.1.1 It is proposed the Reducing Infant Mortality Action plan will be over three years from 2020 to 2023 to allow time for outcomes to be realised.

8.1.2 A Strategic Partnership Group will be developed with key internal and external partners who will have a key role in the monitoring and implementation of the plan.

8.1.3 There is already a strong network of organisations and programmes in Lancashire that are supporting healthy pregnancy and the first years of a baby's life.

8.1.4 The approach therefore will be to map and embed priorities in the provision of existing services so they target areas of inequality and develop work programmes and new approaches to improve the health and wellbeing of mothers and infants based on areas of greatest need.

Key thematic groups will be established to oversee the delivery of these priority areas.

8.2 Performance and outcomes

8.2.1 Performance will be measured against the strategic outcomes identified in the Early Years Strategy and the Children and Young Peoples Plan (Appendix 1)

8.2.2 This will be benchmarked against the Public Health outcomes framework (PHOF) which will provide all the indicators and the most recent data that is recorded (https://fingertips.phe.org.uk/profile/public-health-outcomes-framework)

8.2.3 We will be ambitious in setting our targets so that we improve health outcomes overall but using public health intelligence to target areas identified as deprived or achieving below the regional and national average outcomes.

8.2.4 The service will be monitored against the outcomes highlighted for children, young people and families and will be submitted quarterly demonstrating activity against these outcome areas as highlighted in Appendix 3.

8.3 Governance and Reporting

8.3.1 Delivering and measuring progress against this plan will be through the establishment of a Best Start Strategic Group who will monitor progress as part of the wider Early Years Strategy highlighted in Appendix 1.

8.3.2 The Health and Wellbeing Board will have oversight of the Strategic Plan as part of a collaborative and shared leadership approach.

8.3.3 Progress towards achieving the outcomes will be reported through the Children and Young People's and Families Partnership Board, chaired by the Executive Director of Education and Children's Services.

8.3.4 This strategy will link and support as appropriate other wider plans such as the Early Help Strategy; Safeguarding; SEND Strategy; Managing Behaviour Strategy and Emotional Wellbeing and Mental Health Transformation Plan.

8.3.5 The plans will deliver and support key national and local plans in relation to the priority areas identified within the NHS Plan and the Integrated Care Partnership.

9. Next steps

9.1 To establish a Strategic Partnership Group comprising of key partners to oversee the implementation of the Plan.

9.2 To consult, engage and agree with key partners so a robust action plan and performance framework is developed under the key priority areas proposed.

9.3 A detailed Infant Mortality Action plan to be launched in March with regular updates to the Children, Young people and Families Partnership Board and Health and Wellbeing Board.

10. Conclusion and recommendations

- To acknowledge the report
- To approve the Key Priority areas being proposed

APPENDIX 1: Early Years Strategy Plan on a page

Integrated Care System (ICS) | **Health & Wellbeing Board**

CHILDREN, YOUNG PEOPLE & FAMILIES PARTNERSHIP BOARD

Strategic Best Start in Life Partnership Group

VISION:
Children, young people and their families are safe, healthy and achieve their full potential.

INTEGRATED EARLY YEARS STRATEGY - KEY PRIORITY AREAS

Best start in life	School readiness	Improve health and wellbeing	Reduce health inequalities
OBJECTIVES			
To ensure better **maternal and child outcomes** throughout **pregnancy, birth and beyond**	To ensure children families and communities are **school ready** and schools ready for children	To ensure improved health and wellbeing outcomes through the **Healthy child programme** framework	To target **inequalities** and **improve health and wellbeing outcomes** in priority areas
OUTCOMES AND PERFORMANCE			
• Reduce Infant Mortality • Reduce Low birth weight of term babies 37 weeks • Reduce smoking status at time of delivery • Reduce under 18s conception rate	▪ Increase % of reception children achieving CLL and a GLD to national norms ▪ Increase the % of disadvantaged reception children achieving CLL and a GLD to national norms	• Improve oral health • Reduce hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4) • Reduce childhood obesity in reception • Early identification of children with	▪ To achieve a measurable improvement in areas of greatest need ▪ Ensure a targeted approach to reducing inequalities in areas highlighted as priority
KEY ACTIONS			
▪ Develop Infant Mortality Action Plan ▪ Deliver Better births Action Plan ▪ Deliver 1001 critical days action plan	▪ Develop pathways to support early detection of speech delay ▪ Implementation of a Lancashire speech, language and communication plan ▪ Promote Home Learning Environment ▪ Develop parenting Strategy	▪ Develop an Integrated care pathway ▪ Delivery of high impact areas ▪ An integrated workforce development plan ▪ Ensure all families receive mandated developmental reviews	▪ Ensure a clear reporting and governance structure ▪ Develop a Lancashire outcomes framework for CYP ▪ Develop a performance dashboard

Safeguarding, Leadership, Evidence Base-Practice, Accountability

APPENDIX 2: Draft Infant Mortality Reduction Plan

Key Priority Area	Objectives	Actions
1. Addressing the wider determinants to health	1.1 To support efforts to reduce poverty in families	• To ensure we raise awareness of the links between child poverty and infant mortality targeting services in areas of greatest need based on deprivation and infant mortality data
	1.2 To tackle child poverty as a priority	• To consider the development of a child poverty strategy and action plan/embed the importance of this as a priority across everything we do
	1.3 To improve the availability of good quality and affordable housing	• To work with housing services to ensure the needs of pregnant mothers, babies and children are prioritised so we address inequality in housing through improved living conditions and assessment of need and risk of overcrowding
	1.4 Take ensure take up of benefits in most deprived areas	• To support and advise individuals and communities at risk who are eligible for welfare benefits and support with their family and child's needs
	1.5 To establish links with Health and Social care so we target vulnerable Families	• To work with early help, safeguarding and Health and Social care services so we target vulnerable communities at risk
	1.6 To target anti-social behaviour, violence and domestic abuse in pregnant women and families with babies and infants	• To ensure safeguarding of vulnerable women, babies and families by using a partnership approach to address some of these wider determinants linking with youth services, anti-social behaviour and safeguarding teams
2. To reduce the number of deaths caused by co-sleeping in unsafe situations (see case Review Recs)	2.1 To improve professional advice about co-sleeping in unsafe situations and reduce SIDs	• To develop and implement an individualised safer sleep assessment tool as part of the 6 safer sleep steps programme.
		• To strengthen and clarify the safer sleep messages for parents as well as the criminal consequence should they ignore professionals' advice.
		• To continue with the Train the Trainer Sessions so members of the health/ social care/ education professions receive training.
	2.2 To improve public awareness of infant death	• Public campaign on the risks of co-sleeping in line with the Pan-Lancashire safer sleep guidance including a broader approach to reducing SIDS using social media, marketing and a communications plan as well as the development of a workforce development plan.
		• Training carers and parents in rescue and resuscitation techniques to minimise the severity of outcomes from.

	2.3 To raise awareness of deaths and life limiting injuries sustained through shaking an infant and causing Abusive Head Trauma (AHT)	• To implement the ICON (Abusive head Trauma) Campaign as set out in Hampshire's ICON Campaign with additions from UNICEF BFI and signed off by CDOP: • To consider Phase 2 of the ICON campaign • Links with schools/GPs/Digital Screens and the use of the full length film.
	2.4 To ensure adequate support to affected parents and families	• To support families who have been bereaved and ensure appropriate care of next infant (CONI)
3 To ensure equal access to all aspects of pre-conception, maternal and infant health care	3.1 To ensure engagement with antenatal services and promote the benefits of preconception, antenatal care	• To ensure equal access to midwifery services so that every woman receives the appropriate level of antenatal care, assessment and targeted support where needed
		• To develop an integrated care pathway from birth to ensure consistency and evidence based approach across Lancashire so maternity services are engaged and there are clear pathways and a streamlined approach to maternity and other services such as health visiting and early year's services.
		• To align public health and early years services with the Better Births Programme Action Plan
	3.2 To deliver core offer of Health Visiting mandated services	• To ensure all women are offered the mandated visits as part of the core health visiting offer and an assessment of need is carried out at all visits especially the antenatal and birth visit
	3.3 To focus prevention programmes on families most at risk	• To prioritise the needs of those with social circumstances that expose infants to more risk and promote parental behaviour change, including more vulnerable and at risk women and families such as for teenage mothers
		• Communications and raising awareness with so called hard to reach groups - Consider targeted health promotion messages (e.g. ESOL classes, family and neighbourhood centres, nurseries, schools)
	3.4 To ensure timely and complete immunisations and vaccinations	• To increase access to immunisations and vaccinations for pregnant mothers (pertussis, flu) and babies and children (DTaP/IPV/Hib/ HepB, Pneumococcal conjugate vaccination (PCV), MenB, gastroenteritis Rotavirus
		• To ensure screening tests during pregnancy including for infectious diseases, Sickle cell and thalassaemia, Down's syndrome, Edwards' syndrome and Patau's syndrome, 20-week scan and Newborn screening
	3.4 To provide genetic counselling/genetic literacy for	• To ensure clear pathways for genetic counselling when family history is identified or where families have been affected by genetically inherited conditions

	individuals and communities with a need	• To provide training for midwives and obstetricians to improve knowledge of genetics and consanguinity • To raise community awareness of genetics
4 Improve social and emotional support for vulnerable parents	4.1 To improve social and emotional support for vulnerable parents, especially those living in areas of social disadvantage	• Early identification of women and appropriate pathways in place for vulnerable women including younger (teenage mothers) and vulnerable mothers addressing issues such as domestic violence, antisocial behaviour or abuse in families
		• To ensure fathers/partners are provided with appropriate support where social and emotional support is required
		• To provide an enhanced Health Visiting service to vulnerable women with additional visits as well as the core offer which will identify and support women at risk who need more targeted support
	4.1 To ensure early identification of women with perinatal and post-natal depression through universal mood assessment	• To ensure maternal mood and emotional health and wellbeing issues are assessed through antenatal access and maternal mood assessments by Health visitors, including monitoring of referrals and follow up
5 To reduce the numbers of women (and families) smoking during pregnancy (and after	5.1 To ensure commissioning and delivery of Public Health Harm reduction services include a focus on smoking in pregnancy	• To ensure commissioning and delivery of Public Health Harm reduction and other services recognise the importance of the impact smoking on pregnancy has on infant mortality and stillbirths and to include this as part of specifications
	5.2 To ensure all women are offered CO monitoring at their antenatal appointments	• To ensure all midwives have accessed training to use CO monitors and that all women are CO monitored at booking appointments with support to identify and refer women as necessary
		• To ensure smoking cessation clinics for women attending ante-natal ‘high risk’ obstetric clinics and ongoing improvements to CO monitor use, referral system and CO levels recorded
	5.3 To ensure reducing smoking in pregnancy is a core part of the Children and family centres	• To ensure reducing smoking in pregnancy is part of the core offer for Children/family/neighbourhood centres and have trained advisers and brief intervention training on-going with early year's staff with targeted interventions where there is highest need
	5.4 To use public health intelligence data to identify trends and hot spots	• Need to consider the hot spots for smoking using public health data and intelligence as well as linking into key partnerships such as the ICP
	5.5 To reduce smoking in pregnancy and parents and	• Promote smoke free homes and support staff with the training and skills to have conversations about smoke-free homes, with clear, constructive and supportive

	exposure to tobacco smoke in the home and cars	messages and communications.
6. To reduce the numbers of women with high levels of use of alcohol and/or non-prescribed drugs in pregnancy	6.1 To raise awareness of the risks associated with substance misuse in pregnancy	• To ensure that available alcohol and substance-misuse services are communicated more effectively to health professionals and other relevant agencies
		• To ensure that health professionals are aware of the safeguarding risks associated with drug and alcohol use
		• To raise awareness of Foetal alcohol syndrome and the impact of alcohol on the developing foetus, and how children are affected at different ages
	6.2 To ensure referral pathways are up to date and effective	• To ensure existing pathways target pregnant women who have issues with substance misuse and poor mental health as a result
	6.3 To identify substance misuse in pregnancy	• To ensure all women receive the Audit C screening to identify women and signpost to appropriate services and treatment.
		• To consider specialist Substance Misuse Midwife and champions in centres
		• To ensure social workers understand the vital role in their daily practice - effective working with and parenting affected children
	6.3 To ensure appropriate training and resources	• To ensure basic Awareness through Alcohol and Drug courses and consider on-line e-learning Basic Awareness Course
		• To promote this through Every Contact Count so that we embed alcohol screening, smoking cessation and sexual health awareness
7. To improve the health and nutrition of pregnant women, babies and infants	7.1 To reduce maternal obesity and improve nutrition in pregnancy and before	• To raise awareness of the importance of healthy weight for a healthy pregnancy and work with partners to consider maternal obesity that focuses on prevention and earlier intervention
		• To train more health professionals to confidently identify, provide consistent advice, and refer where required.
	7.2 To ensure obesity pathways in place	• To revisit what pathways we have for obesity and faltering growth and ensure that maternal obesity is treated as a priority and that referrals to appropriate services take place as early as possible (family-planning and booking stages).
		• To ensure links are established between Women and Infants Nutrition and Child Poverty so priority areas are targeted as appropriate
	7.3 To develop and policies and guidelines for maternal and early years nutrition	• To ensure we have a strategy on maternal and Early Years nutrition which is developed with key partners
		• To develop guidelines and training on nutrition for maternal and infant health

		including weaning
		• To consider the development of a model food policy for children's centres to use to quality check their provision of food activity including a Food and nutrition toolkit for early year's settings.
	7.4 Community awareness and training	• Consider nutrition training programme for 2020
		• Healthy Start Programme – increase community awareness and uptake of vitamin D supplements • Development and production of a guide to weaning in appropriately culturally sensitive languages
	7.5 To encourage and support breastfeeding	• To take a collaborative approach to breastfeeding and nutrition, ensuring the benefits of breastfeeding and maternal Body Mass Index (BMI) are understood • To ensure consistent advice provided by all health professionals to ensure women are able to make an informed choice • To explore options for increasing the provision of peer support delivering evidence based care • To increase in the number of GPs accessing breastfeeding training • To consider Breastfeeding Champions being in Children/community Centres • UNICEF Baby Friendly Initiative adopting across the area and increase in the number of Organisations working towards Baby Friendly initiative standards
8. Performance, Data and Intelligence	8.1 To ensure appropriate performance and data intelligence is used to monitor infant mortality.	• To ensure work is systematically being undertaken and monitored to reduce local area infant mortality rates. • To improve the focus and understanding of infant mortality rates in the local area • To measure inequalities and progress in areas of greatest need • To ensure relevant performance data is available in the areas identified so we can monitor progress
		• To work closely with CDOP to inform planning and monitoring of infant mortality • To ensure this clear governance and accountability through the CYP and families partnership board, health and wellbeing board and ICS where appropriate
	8.2 To develop a dashboard for infant mortality	• To develop a dashboard as part of the Early Years strategy with a key focus on infant mortality so this can be monitored and benchmarked according to national and regional targets.

9	**Communication plan**	To ensure these plans are shared widely and understood by communities, professionals across Lancashire	▪ To ensure communities are better informed ▪ To develop a website (review what we have) ▪ To ensure Infant mortality is embedded within midwifery, health visiting and early years through development and dissemination of an integrated care pathway. ▪ To ensure consultation and engagement with communities via CCG maternity service user groups ▪ To use social media to raise awareness of modifiable factors mentioned above

APPENDIX 3: OUTCOMES AND PERFROMANCE FRAMEWORK (Example – to be agreed)		
Priority 1: Best Start in Life		
Objective	**Performance Measure**	**Indicator ref**
1.1 Reduce Infant mortality	1.1.1 Rate of infant mortality	
1.2 Reduce Low birth weight of term babies 37 weeks	1.2.1 Low birth weight of term babies 37 weeks gestational age at birth	2.01
1.2 Increase breastfeeding rates	1.2.1. Breastfeeding initiation All ages	2.02i
	1.2.2 Breastfeeding prevalence at 6-8 weeks after birth - current method	2.02ii
1.3 Reduce smoking status at time of delivery	1.3.1 Smoking status at time of delivery All ages	2.03
1.5 Reduce under 18s conception rate	1.5.1 Under 18s conception rate / 1,000 <18 yrs.	2.04
	1.5.2 Under 16s conception rate / 1,000 <16 yrs.	2.04

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