HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	8th December 2022
Subject:	Infant Mortality Strategy Refresh
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Summary:

Please note: This paper covers the topic of early child death including cot death. Whilst it contains no graphic or individual case detail, some readers may find the topic distressing.

The existing infant mortality strategy was written in 2014, shared with the CCG and STH and owned by SCC. We have continued to systematically reduce our infant mortality rates in Sheffield, exceeding the target set out in that strategy and bringing our rates below both the Yorkshire and Humber and England average.

However infant mortality is directly associated with poverty and the current cost-of-living crisis brings a direct threat to our positive progress.

This paper brings the situation to the Board's attention and sets out the approach we are taking to refreshing the strategy for the Board's consideration and opinion.

This approach includes reviewing the evidence relating to the 8 risk factors, engaging with partners, stakeholders and collating service users' feedback to inform a refreshed strategy.

Early recommendations are building on the trusted relationships families have with wider services and organisations, maximising opportunistic contacts to identify risks, and ensuring poverty becomes a theme that runs throughout our strategy as opposed to being a single risk factor in itself.

Questions for the Health and Wellbeing Board:

How can the Board help raise awareness of infant mortality strategy and help incorporate actions to address the risk factors in their sphere of influence.

We ask if the board can raise awareness of the risk to infant mortality progress in Sheffield due to the current cost-of-living and energy crisis.

Recommendations for the Health and Wellbeing Board:

To recognise the good progress on infant mortality since the inception of the last strategy

To acknowledge the risk to infant mortality progress in relation to the current cost-of-living crisis.

To raise awareness of infant mortality risk factors and incorporate actions to address these in their field of influence

To endorse the approach to the current Infant Mortality Strategy refresh

Background Papers:

2014 Infant Mortality Strategy available here

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

Ambition 1 - Every child achieves a level of development in their early year for the best start in life.

Ambition 4 - Everyone has access to a home that supports their health.

Who has contributed to this paper?

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Infant Mortality Strategy Refresh 2022

1.0 SUMMARY

1.1 The existing infant mortality strategy was written in 2014, owned by SCC and shared with the CCG and STH. It is broken down by 8 evidence-based themes relating to broadly preventable risk factors. Thanks to a whole-systems, multi-disciplinary approach we have consistently managed to reduce the infant mortality rate within Sheffield and are now below the England Yorkshire average.

1.2 Data on infant mortality rates show that we have also managed to reduce the inequality gap between the most affluent and most deprived groups in Sheffield since 2014.

1.3 Infant mortality is directly associated with poverty. The current situation with cost-of-living, the energy crisis and families moving into poverty for the first time means that the refresh of the strategy is needed in order to negate as far as possible any reverse in our positive progress to date.

1.4 The infant mortality strategy offers excellent value for money, focusing on partnership working, communication, training and awareness and has very little dedicated spend attached to it.

1.5 The approach to refreshing the strategy is to engage with stakeholders and understand families' experiences to identify improvements. We will also consult latest evidence and review our data.

1.6 Poverty needs to be a theme that runs throughout the strategy. We need to maximise contact points across SCC where trusted relationships with families have been established to impact on risk factors.

2.0 The Infant Mortality Strategy

2.1 Infant mortality is defined as the death of a baby between 24 weeks' gestation and under 1 year of age.

2.2 The current strategy for infant mortality was written in 2014 and was shared between the CCG, Sheffield Teaching Hospitals and owned by Sheffield City Council. Since this strategy was adopted, and particularly within the last 2 years, we have had a significant change in the context in which we (Sheffield City Council) are working and the climate in which our population is living with the effects of the cost-of-living crisis moving many of our families, pregnant people, and mothers into poverty.

2.3 Infant mortality is directly associated with poverty therefore the current context requires that the existing strategy is reviewed and updated to negate as far as possible any loss in progress Sheffield has made in this space.

2.4 Infant mortality rates are an important marker of the overall health of society and used as a key indicator by the UN and UNICEF as a proxy measure. Whilst largely

preventable, the risk factors are directly linked to poverty via maternal health and the wider social and environmental conditions. This means the most disadvantaged in society suffering the highest rates of infant death and subsequent impacts.

2.5 The impact of an infant death is devastating for parents, families, and the wider community. Coping with loss and bereavement significantly impacts on the individuals and family's health and wellbeing which in turn impacts on widening inequalities, and indirectly impacting economy and productivity.

Where are we now?

2.6 The current strategy has been successful in continuing to systematically reduce infant mortality rates since 2001 and accelerate those reductions to below the England average. We have exceeded the target set out in the 2014 strategy and this is with very little dedicated money attributed to the strategy.

2.7 In England infant mortality rates have fallen by 20%, from 4.9 per 1000 births in 2005 to 3.9 per 1000 births in 2020.

2.8 During the same period in Sheffield our infant mortality rate has fallen by 42% from 6.0 per 1000 live births to 3.5 per 1000 births, placing us below the England average rate. The most recent data currently equates to around 21 infant deaths per year in Sheffield.

2.9 We are now ranked 4th of 16 Local Authorities making up our CIPFA nearest neighbours and sit well below the Yorkshire and Humber average of 4.2 (2021) per 1000 births.

2.10 Infant death disproportionately affects the most disadvantaged in society, with most risk factors being linked directly or indirectly to deprivation. This gap in rates between the poorest and most affluent in Sheffield has also continued to narrow as our rates here have fallen but a significant inequality gap still remains.

2.11 Despite significant reductions in the past decade, rates in England (and Sheffield) remain high in comparison to many European counterparts and we still have much progress to make.

2.12 Whilst the England reduction in infant mortality rates have mostly stalled since 2014 in Sheffield we have continued to make progress in reducing our rates. We believe our continued progress is attributable to taking a multi-disciplinary and whole systems approach, like our recent tobacco strategies which have also seen good progress versus our 'nearest neighbours' and England rates.

2.13 The existing strategy is broken down by 8 themes that are recognised in evidence as key risk factors for infant mortality. This currently includes 1) maternal weight, 2) smoking in pregnancy, 3) safer sleep, 4) teenage conceptions, 5) housing and poverty, 6) consanguinity and genetic recessive conditions, 7) breast feeding and 8) early access to maternal care.

2.14 We have had notable success in several theme areas in the existing strategy, such as such as reductions in smoking in pregnancy which has fallen by 35% in 7 years, from

15.1% of mothers smoking at time of delivery (SATOD) in 2014 to 9.8% SATOD in 2021, just a touch above the England figure of 9.6%. The Yorkshire and Humber average rate still sits at 13.1%, again a testament to our whole systems and multidisciplinary approaches to both tobacco and infant mortality especially where little budget is attributed.

2.15 Breastfeeding is another area of notable success with Sheffield achieving 71.7% breast feeding initiation rates, higher than both the England (67.4%) and Yorkshire and Humber (56.4%) averages. Our maternity and health visiting services have also achieved UNICEF Breast Feeding Initiative Gold Status and intend to apply for Beacon Status soon.

2.16 Some themes need additional attention however particularly considering changes to services since COVID-19 and the imminent winter in combination with the energy and cost-of-living crisis. This includes safer sleep, poverty and housing, maternal weight, and teenage conception.

2.17 One example of how this worsening situation may impact directly on infant mortality rates is via safer sleep practices. As families reduce heating usage in their homes and make changes to keep warm there is a risk of parents increasing bedding, blankets and swaddling around their baby, or be tempted to sleep with their babies in their own beds to ensure warmth. These changes to sleeping practices significantly increase the risk of Sudden Infant Death Syndrome (SIDS), more commonly known as 'cot death'.

2.18 This potential for a reversal in rates in a number of our risk factor areas means the urgency to refresh and double down our effort on infant mortality is pressing.

What is the approach for the infant mortality strategy refresh?

2.19 The overall approach to refreshing the strategy consists of reviewing the 8 themes according to;

- Recent national and academic evidence and should any additional risk factors be identified as a theme.
- Seeking professional's and stakeholder's views on current provision and services to highlight gaps or modification
- Seeking views of service users and target audiences to identify gaps and modification of existing services or missing services.
- Working collaboratively with partnerships and organisations who gather insight and learning eg.
- Healthwatch, Maternity Voices Partnership to inform services provision and training.
- Run multi-disciplinary stakeholder workshops on themes requiring more attention
- Review value for money of SCC commissioned projects and services relating to each them such as the community genetic literacy project.

- Review our data and intelligence in relation to each theme, aiming to fill gaps in knowledge and understanding. Examples include working with STH to improve data sharing on births to provide timely information on health inequities.

2.20 This approach is already yielding learning and early recommendations for the strategy. So far maternal weight, safer sleep and teenage conception along with early access to maternal care have been identified as areas for specific workshops and focused review.

2.21 Poverty also needs to be a theme that runs throughout the strategy as it's inherently linked to most risk factors identified within the strategy.

2.22 Access for some teenage conception services and support for teenage parents has also been identified as a particular issue. This also extends to young parents as many pre-existing services have now gone.

2.23 The additional funding for Start for Life/Family Hubs and the opportunity this offers to deliver more targeted prevention and early support particularly in deprived communities will be developed further as the programme of spend takes shape.

2.24 Additional work during the ante-natal and post-natal period to identify vulnerabilities during this early period working with parents to be and families to signpost them to community based support.

2.25 Very little spend is currently attached to infant mortality, outside of breast feeding, genetic recessive conditions and the volunteer Doula programme. We will review this spend to ensure best value for money in terms of impacts and outcomes.

2.26 A key finding developing is the role of contact points and trusted relationships that exist between mothers, families and SCC services. These contact points have the potential to impact on risk factors and we will recommend maximising training and awareness of infant mortality risk factors with multi-disciplinary contacts within the Council beyond those in a professional maternal and child health role such as midwifery and health visiting.

3.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE IN THIS AREA?

3.1 It should first be acknowledged that Sheffield has made great progress in reducing infant mortality rates with very limited budget as set out in the data presented above. However, a very real potential risk to that positive progress exists due to infant mortality being directly associated with poverty and the current situation for families and parents in terms of costs-of-living.

3.2 In order to make a difference we need to focus on areas of the 8 risk factors that have room for gains and improvements and will involve running more focused workshops on some of these factors and extending the range of partners involved in developing the strategy's action plans.

3.3 The approach to this is talking to stakeholders and assessing evidence to identify where improvements need and can be made. So far we intend to hold focused workshops on maternal weight, safer sleep and an additional area that will be identified, potentially poverty, early access to maternal care or teenage conception.

3.4 One early finding of this refresh approach is the importance of the trusted relationship over the professional relationship as well as opportunistic contacts with at-risk families, parents or babies. For example some women and families, and particularly those moving into poverty for the first time may feel stigma or shame about their circumstances and not reveal the full extent of problems to a professional such as a midwife or health visitor. They may however be more likely to disclose their situation to a nursery setting staff member, volunteer doula or community group or faith group leader.

3.5 Opportunities also exist with those staff and professionals who may be entering households for other reasons, such as housing officers, maintenance staff or wider organisations such as VCF, Police and Fire and Rescue.

3.6 Seeking opportunities to engage with, train and upskill these groups in infant mortality risk factors will bring additional opportunities to identify and intervene early with at-risk families or individuals.

4.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

4.1 As infant mortality is inherently associated with poverty is has a direct impact on health inequalities.

4.2 The refreshed strategy will recommend focusing on areas with the greatest gains to make. This will be a combination of areas with the greatest rates of infant mortality, communities and disadvantaged population groups experiencing the greatest risk factors and also be informed by wider SCC reactive poverty work taking place to forecast those communities most at risk of cost-of-living impacts.

5.0 QUESTIONS FOR THE BOARD

5.1 How can the board help raise awareness of infant mortality strategy and actions to address the risk factors in their sphere of influence.

5.2 We ask if the board can raise awareness of the risk to infant mortality progress in Sheffield due to the current cost-of-living and energy crisis.

5.3 How will the board take on some of the actions raised within this paper?

6.0 RECOMMENDATIONS

Our initial developing recommendations include the following;

- To produce a refreshed Infant Mortality Strategy for Spring 2023

- That the strategy remains anchored within and owned by SCC due to the role of wider determinants in infant mortality.
- Engage with the ICB and STH to adopt the strategy in relation to commissioned maternity services
- Engage with the ICB to identify system improvements which could help to reduce risks (eg better data sharing to identify vulnerable parents and respond to their needs) and other activity which will help to accelerate local progress work such as SY funded smoking in pregnancy incentive schemes.
- To build upon the success of the current model but plug gaps identified as part of the process.
- Set out intention for changes in commissioning according to value for money and influence those services commissioned by others.
- Poverty to be highlighted as thread that runs throughout the strategy
- Maximise training and awareness of infant mortality risk factors with multi-disciplinary contacts within the Council - trusted individuals and relationships beyond those in a professional role such as midwifery and health visiting, for example housing and welfare support teams.
- Engage with H&WB Board partner organisations to identify and maximise contact points and training opportunities for infant mortality risks. E.g. Police, early years settings, multi academy trusts, VCF etc.
- Implement and act on recommendations identified as part of multi-disciplinary stakeholder theme workshops
- Improve data including ethnicity data, births data and information received from the Child Death Overview Panel in order to further inform health inequities.
- Explore more options and approaches to maternal weight, safer sleep and other risk-factors with improvements to gain.