Implementation Plan for Reducing Health Inequalities in Infant Mortality:
A Good Practice Guide

Review of the health inequalities infant mortality PSA target

In partnership with

DH Department of Health
department for children, schools and families
Communities and Local Government
Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide

Review of the health inequalities infant mortality PSA target

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Foreword

The death of an infant is a tragedy for the family, a loss to the community and a challenge to us all. We are publishing this plan to help meet this challenge. It underlines our determination to end the loss of infant life in this country and mitigate the disability of those babies who survive into childhood and adult life.

The review report that preceded this plan shows how the distribution of infant deaths is shaped by social and ethnic differences. It showed that the infant mortality rate (IMR) in Birmingham was more than six times greater than in Eastleigh in Hampshire, and that the IMR in babies of mothers born in Pakistan was double the national average.

These differences are not acceptable and that is why we have announced a comprehensive strategy for reducing health inequalities which will challenge the NHS, as one of several key players, to live up to its founding and enduring values of universality and fairness. This strategy review will build on the work of the Programme for Action and the national health inequalities target. We have reaffirmed the Government’s commitment to this target in the recent Comprehensive Spending Review settlement. The target remains a national target within the new health and well-being Public Service Agreement (PSA). The infant mortality aspect of the target will also contribute to the health and well-being of children and young people PSA and the Children’s Plan recently published by the Department for Children, Schools and Families.

Reducing health inequalities in infant mortality will contribute to our aim of reducing health inequalities in life expectancy and to meeting our commitment to a long-term, sustainable reduction in health inequalities. It will require reaching out beyond the target group to other disadvantaged groups and aligning action alongside improvements in child health. This ambition will require change across the generations; it means working together with a range of partners to address the wider, social determinants of health, including working with colleagues from other departments and organisations that have helped develop this plan.

This plan focuses on what can be done to reduce these inequalities in infant mortality at local level, by building on the good practice that already exists and the opportunities to take this work further. Local delivery can be sharpened through greater awareness of the target, systematically applying the key interventions and developing effective partnership working between acute trusts, primary care trusts, local authorities, voluntary organisations and Sure Start Children’s Centres. Local government also has a key part to
play through Local Area Agreements and in tackling the wider determinants of health inequalities such as poor housing. All of these organisations, as well as healthcare and other professionals who work with them and the users they serve, have a part to play in setting the direction for action. Many of the tools are already in place, including service improvements as set out in Maternity Matters.

The review report identified 43 local areas with a relatively high number of infant deaths in the target routine and manual socioeconomic group. Effective action in these areas will make a substantial contribution to meeting the 2010 target, but all areas of the country should be looking at how they can contribute to the wider ambition of the target and the national health inequalities strategy. This means taking account of local need and working with all disadvantaged groups in their area alongside the target group, including black and minority ethnic groups, teenage mothers and single parents, to deliver change. This approach will pay dividends in terms of improving maternal, infant and child health and in narrowing the health inequalities gap in both the short and long term.

We all need to work together if we are to succeed in delivering on the target. Much good work has already been done locally and we hope that this plan will provide a further spur to action.

Rt Hon Dawn Primarolo MP
Minister for Public Health

Rt Hon Beverley Hughes MP
Minister for Children, Young People and Families

Ann Keen MP
Parliamentary Under Secretary for Health Services

Rt Hon Yvette Cooper MP
Minister for Housing
Every year in England, about 3,000 babies do not live to celebrate their first birthday and many more are stillborn or have long-term disabilities. The death of a baby is a devastating loss for a family, and we need to do all that we can to prevent this.

Although the number of babies who die in England is at an all-time low, and falling, there are still unacceptable health inequalities in infant mortality, where babies of families from certain groups are more likely to die than others before their first birthday.

The Government has made tackling health inequalities a priority. In 2002, a national health inequalities Public Service Agreement (PSA) target was set:

- to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth.

This target is underpinned by the following objective on reducing infant mortality:

Starting with children, under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.

The Review of the Health Inequalities Infant Mortality PSA Target was published in February 2007. It was a cross-government, cross-agency review, which aimed to show how the Department of Health (DH), working with its partners, could help deliver the infant mortality health inequalities target.

The review made significant progress in understanding the causes of health inequalities in infant mortality, identifying local delivery challenges and quantifying the impact of evidence-based interventions that would help deliver the target.

This plan, Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide, shows what can be done at local level to help reduce health inequalities in infant mortality and to achieve the 2010 PSA target. The plan sets out to:
• update national progress in reducing health inequalities in infant mortality;
• illustrate progress on implementing the recommendations from the review;
• develop practical guidance to aid local implementation of the review’s recommendations.

Progress in meeting the infant mortality PSA target

8. There were 9,741 infant deaths overall in England and Wales in the period 2004–06, giving an infant mortality rate (IMR) of 5.0 deaths per 1,000 live births. Of those with a valid socioeconomic group (8,674), the rate was 4.8 deaths per 1,000. Of the 8,674 deaths in this category, 43% (3,751) were in the routine and manual (R&M) group, a rate of 5.6 deaths per 1,000.

9. The IMR among the R&M group was 17% higher than in the total population in 2004–06, compared with 18% in 2003–04. This compares with 13% higher in the baseline period of 1997–99.

10. While these developments are encouraging the target to narrow the gap by 10% by 2010 remains challenging.

Implementing the recommendations from the review

11. There are two recommended approaches based on the findings of the review that at a local level will help achieve the target, by drawing on:
   • relevant policies across government, including at local, regional and national level, as outlined in Annex 1;
   • specific actions, including work on service delivery through Maternity Matters and on factors around ethnicity and teenage pregnancy.

12. Although the target is expressed in terms of difference between socioeconomic groups, an area-based focus has been used to facilitate delivery of the target.

13. The review identified the 43 local authority areas that had the highest burden of infant mortality in the R&M group. These were areas with 20 or more infant deaths in the R&M group over the three-year period of 2002–04 (Annex 2). The review estimated that a reduction of 50% of deaths in the R&M group in these areas would achieve the target. These 43 areas will be key to narrowing the gap and delivering the target; however, NHS and other organisations in all areas have a role...
Evidence-based interventions that will help deliver the target

14. Modelling has identified seven interventions that will contribute to reducing the gap by 11.4 percentage points and help meet the target. The interventions are:

• reducing the prevalence of obesity in the R&M group by 23% to the current levels in the population as a whole;

• meeting the national target to reduce smoking in pregnancy from 23% to 15% and meeting this target in the R&M group;

• reducing sudden unexpected death in infancy (SUDI) by persuading 1 in 10 women in the R&M group to avoid sharing a bed with their baby or putting their baby to sleep prone (on its front);

• achieving the teenage pregnancy strategy to reduce the under-18 conception rate in the R&M group by 50% compared with 1998 levels;

• meeting the child poverty target to halve the number of children in relative low-income households between 1998–99 and 2010–11, by increasing the income in the R&M group by an average of 18%;

• reducing housing overcrowding in the R&M group through the effect on reducing SUDI.

15. Promoting early antenatal booking among disadvantaged groups will also help deliver the target.

16. Other interventions will also contribute to the target. The National Perinatal Epidemiology Unit (NPEU) has been commissioned to develop a series of systematic reviews of the research evidence to identify and promote the key interventions that are most likely to contribute to meeting the 2010 target and, in the longer term, to improving maternal and child health and achieving a sustainable reduction in health inequalities.
Practical guidance for implementation

17. This plan describes how commissioners and service providers can develop local services to help reduce health inequalities in infant mortality through:
   - promoting joined-up delivery of the target with *Maternity Matters* and *Teenage Parents Next Steps*. This includes improving access to maternity care;
   - improving services for black and minority ethnic (BME) groups;
   - encouraging ownership of the target through effective performance management;
   - raising awareness of health inequalities in infant mortality and child health;
   - gathering and reporting routine data, including specific maternity and paediatric activity;
   - undertaking joint strategic needs assessment to identify local priorities around health inequalities in maternity and infant mortality;
   - giving priority to evidence-based interventions that will help ensure delivery of the target.

18. It emphasises the importance of partnership working; outlines the role of government departments, strategic health authorities (SHAs), primary care trusts (PCTs), local authorities and Sure Start Children’s Centres; and gives examples of what can be done to help meet the target.
Acknowledgements

The Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide was coordinated by the Health Inequalities Unit and was supported by a number of teams and individuals within DH and across government. We gratefully acknowledge assistance from the following departments:

- Communities and Local Government (CLG);
- Department for Children, Schools and Families (DCSF);
- Department for Work and Pensions (DWP);
- London Health Observatory (LHO);
- Office for National Statistics (ONS).
# Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
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<tr>
<td>BMI</td>
<td>Body mass index</td>
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<td>CEMACH</td>
<td>Confidential Enquiry into Maternal and Child Health</td>
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<tr>
<td>CLG</td>
<td>Department for Communities and Local Government</td>
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<tr>
<td>CONI</td>
<td>Care of Next Infant (Scheme)</td>
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<td>CPHVA</td>
<td>Community Practitioners and Health Visitors Association</td>
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<td>CSR</td>
<td>Comprehensive Spending Review</td>
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<td>DCSF</td>
<td>Department for Children, Schools and Families</td>
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<td>DfES</td>
<td>Department for Education and Skills (now DCSF)</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DWP</td>
<td>Department for Work and Pensions</td>
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<td>FNP</td>
<td>Family Nurse Partnership</td>
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<tr>
<td>HMT</td>
<td>Her Majesty’s Treasury</td>
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<td>IMR</td>
<td>Infant mortality rate</td>
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<td>LAA</td>
<td>Local Area Agreement</td>
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<td>LHO</td>
<td>London Health Observatory</td>
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<td>LSP</td>
<td>Local Strategic Partnership</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>NPEU</td>
<td>National Perinatal Epidemiology Unit</td>
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</table>
1. Introduction

1.1 Every year in England, about 3,000 babies do not live to celebrate their first birthday and many more are stillborn or have long-term disabilities. Each death is a devastating loss for the family and we need to do all we can to prevent these tragic losses.

1.2 Infant mortality is a sensitive measure of the overall health of a population, providing an important measure of the well-being of infants, children and pregnant women. Although infant mortality in England is at an all-time low and falling, significant inequalities persist.

1.3 The Government made tackling health inequalities a priority by setting up the Acheson Inquiry in 1997. The appointment of the Inquiry reflected a longstanding concern with the widening health gap between social groups since the 1970s. A national health inequalities PSA target was set in 2001 ‘to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth’. It remains a key national target within the new PSA 18 on promoting health and well-being for all.

1.4 It is underpinned with objectives on reducing infant mortality and increasing life expectancy:

   Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.

   Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth* and the population as a whole.

1.5 This is a challenging target and developments are monitored regularly. *Tackling Health Inequalities: A Status Report on the Programme for Action* showed that the long-term trend towards widening inequalities in infant mortality and life expectancy at birth has continued, with the gap widening since the target baseline. Reviews of both aspects of the target were set up with the aim of sharpening local delivery to narrow the gap and meet the target.

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* The areas covered by the life expectancy target are known as the spearhead areas, the 70 local authority areas with the worst health and deprivation indicators.
1.6 The Review of the Health Inequalities Infant Mortality PSA Target was published in February 2007. It was a cross-government, cross-agency review, developed with expert advice that aimed to show how DH and its national and local partners could help deliver the infant mortality aspect of the health inequalities target.

1.7 The review made significant progress in:
- highlighting the contribution of specific causes of death to health inequalities in infant mortality;
- identifying local delivery challenges;
- quantifying the impact of effective, evidence-based interventions, which would help deliver the target and tackle the root causes of poverty, low educational achievement and low aspirations.

1.8 The review team developed five recommendations for rapid implementation:
- develop and promote action that will help deliver the target;
- promote joined-up delivery of services to the target group, with Maternity Matters;
- encourage ownership of the target through effective performance management;
- sharpen and raise awareness of the target;
- improve data quality and strengthen the evidence base.

1.9 The review identified that IMRs* in some particularly disadvantaged groups are higher than those in the R&M target group. These include:
- sole registrations (births registered by mothers alone), which includes a higher proportion of teenage mothers;
- babies with fathers in the NS-SEC ‘other’ category. This diverse group includes students, the long-term unemployed and those who have never worked;
- BME populations.

It gave a commitment to monitor and improve rates among these disadvantaged groups alongside the R&M group. The actions set out in this plan will help reduce infant mortality in these groups as well as that of the target group.

*IMR is defined as the number of deaths under the age of one year per 1,000 live births.
1.10 This plan is not about telling local areas how they should deliver the target but provides the evidence and good practice on which effective action can be based. The plan sets out to:

- update national progress in reducing health inequalities in infant mortality;
- illustrate progress on implementing the recommendations from the review;
- develop practical guidance to aid local implementation of the review's recommendations.

1.11 The impact of the wider, social determinants of health is also identified through the impact of poverty, housing and overcrowding. This sets the context for action where persistent inequalities blight people's lives, opportunities and health.

1.12 Effective implementation of these recommendations is part of a wider cross-government agenda to reduce health inequalities, improve maternity and children's services, and improve child health to ensure that every child has the very best possible start in life and fulfils their potential. These measures will have an impact up to and beyond the 2010 target date. Continued progress will depend on a commitment at all levels to tackle health inequalities, promote child health and develop tailored services that will align with those of the *National Service Framework for Children, Young People and Maternity Services*, *Maternity Matters* and the teenage pregnancy strategy to help deliver the target (Figure 1).
Effective implementation will be achieved through a combination of NHS interventions and actions on the wider social determinants of health across government throughout preconception, pregnancy, birth and infancy. This will help achieve the target and, importantly, will:

- contribute to substantial improvements in maternal and child health services in the NHS and community;
- improve the health and well-being of mothers and children;
- potentially have a positive impact on the health and well-being of subsequent generations.

Figure 2 demonstrates the actions through which this may be achieved and the organisations responsible for enabling this.

Action on the wider social determinants will require effective partnership at local level. This will take place within the context of the new local government performance framework, which offers local areas more freedom to develop local priorities.
### Figure 2: Delivery of interventions to reduce health inequalities in infant mortality

<table>
<thead>
<tr>
<th>ACTIONS ON WIDER SOCIAL DETERMINANTS</th>
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<tr>
<td><strong>DWP/DH</strong></td>
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<td><strong>CLG</strong></td>
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<td><strong>DCSF</strong></td>
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<td><strong>DH/NHS</strong></td>
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#### NHS ACTIONS

- **Birth**
- **One year**
- **Childhood**
- **Adolescence**
- **Preconception**
- **Pregnancy**
- **Birth**

#### Provision of high-quality primary care, midwifery, obstetric, neonatal and health visitor care

- **Support to breastfeed**
- **Infant screening**
- **Immunisations**
- **Proactive identification of at-risk women**
- **Identifying high-risk women and targeting resources to deliver evidence-based interventions**
- **Neonatal screening**

- **Support for women with pre-existing conditions**
- **Provision of maternity care in community centres**
- **Provision of genetic counselling services**
- **Promotion of early access to maternity care**
- **Antenatal screening**
- **Help with nutrition for women on low incomes (Healthy Start)**
2. Update on national progress in reducing health inequalities in infant mortality

2.1 Reducing health inequalities is not just about saving lives in the R&M target group, but also about improving life chances for disadvantaged families and communities. The review estimated that a reduction of around 800–900 deaths in the period 2009–11 compared with 2002–04 might reduce infant mortality sufficiently in the R&M group to achieve the target. It was not possible to model the impact of interventions on other disadvantaged groups or in morbidity and long-term conditions. However, improvements in maternity and neonatal care that are needed to help deliver the target are likely to have a significant impact on these groups and conditions.

Progress in meeting the infant mortality PSA target

2.2 There were 9,741 infant deaths overall in England and Wales in the period 2004–06, giving an IMR of 5.0 deaths per 1,000 live births. Of those with a valid socioeconomic group (8,674 deaths), the rate was 4.8 deaths per 1,000. Of the 8,674 deaths in this category, 43% (3,751) were in the R&M group, a rate of 5.6 deaths per 1,000.

2.3 The IMR among the R&M group was 17% higher than in the total population in 2004–06, compared with 18% higher than in the total population in 2003–05 and 19% higher than in 2002–04. This compares with 13% higher in the baseline period of 1997–99.

2.4 While these developments are encouraging, the target to narrow the gap by 10% by 2010 remains challenging.
Figure 3: Infant mortality rates in England and Wales from 1994 to 2006 by socioeconomic group with projection to 2010 target

- **Rate per 1,000 live births**
  - **“R&M” socioeconomic groups**
    - 6.3
  - 5.6
  - 4.8
  - 3.6
  - 5.6
  - 4.8
  - 3.6

- **Health inequality target baseline**
  - 4.8
  - 5.6
  - 6.3
  - 7.0

- **Target**
  - 10% minimum reduction in relative gap, from 13% in 1997-99 to 12% in 2009-11

- **Projection (based on 2001-2006)** of infant mortality in R&M group
- **Projection (based on 2001-2006)** of infant mortality against all* deaths
- **Relative difference in rate**
- **(Ratio of R&M deaths to all deaths)**

1 Projection of data for the six years 2001-2006, since NS-SEC 2001 was introduced.

* All* relate to inside marriage and joint registrations outside marriage if the father does not attend the registration of the baby’s birth.

Source: Office for National Statistics
3. Implementing the recommendations from the review

3.1 There are two recommended approaches based on the findings of the review that at a local level will help achieve the target, by drawing on:

- relevant policies across government, including at local, regional and national level, as outlined in Annex 1;
- specific actions that will have a direct impact on the target, including work on service delivery through Maternity Matters and on factors around ethnicity and teenage pregnancy.

Both aspects are crucial if the infant mortality gap is to be narrowed between the R&M group and the rest of the population and the target met.

3.2 Over the past few months, some of the key building blocks for delivering the 2010 target have been put in place. This chapter describes the work that DH is carrying out, in partnership with other government departments and agencies, to address the review's recommendations and outlines key actions to support implementation.

3.3 Different areas will require different solutions. As set out in the local government White Paper, Strong and Prosperous Communities, priorities for local areas will be set out in their Local Area Agreements (LAAs). The national indicator set, which will be used as a basis for agreeing targets on the set 35 priorities, contains several indicators related to the wider determinants of infant mortality. These include breastfeeding, obesity and smoking. DH will be working with Government Offices for the Regions to ensure that these themes are properly taken account of within LAA negotiations.

Addressing the review’s recommendations

3.4 Although the target is expressed in terms of the differences between socioeconomic groups, implementation on the ground has an area-based focus. This will enable efforts to be targeted and resources mobilised where the need is greatest. In order to reduce health inequalities in infant mortality, all local areas should review what can be done to reduce the risks of infant deaths in disadvantaged populations. However, disproportionate action to reduce infant mortality in certain areas will have a larger effect on reducing infant mortality and contributing to the target.
3.5 The review identified the 43 local authority areas with the highest burden of infant mortality in the target R&M target group. These were areas with 20 or more infant deaths in the R&M group over the three-year period 2002–04 (Annex 2). Twenty-seven of these 43 areas are also spearhead areas. The review estimated that a reduction of 50% of infant deaths in the R&M group in these areas would achieve the target. These 43 areas will be the key to narrowing the gap and delivering the target; however, all local authorities need to reduce the gap to improve child health and help deliver the target.

3.6 The following sections explore further developments in modelling the target, the links with service delivery, ethnicity factors, performance management, improving data and strengthening the evidence base.

(a) Developing and promoting action that will help deliver the target

3.7 Initial modelling showed that four interventions would contribute to narrowing the gap by 7 percentage points. These were:

- reducing the prevalence of obesity in the R&M group by 23% to the current levels in the population as a whole;
- meeting the national target to reduce smoking in pregnancy from 23% to 15% and meeting this target in the R&M group;
- reducing SUDI by persuading 1 in 10 women in the R&M group to avoid sharing a bed with their baby or putting their baby to sleep prone (on its front);
- achieving the teenage pregnancy strategy to reduce the under-18 conception rate by 50% compared with 1998 levels in the R&M group.

3.8 Further modelling has found that:

- meeting the child poverty target – ‘to halve the number of children in relative low-income households between 1998–99 and 2010–11, on the way to eradicating child poverty by 2020’ – by increasing the income in the R&M group by an average of 18%, would narrow the gap by about 3%;
- reducing overcrowding in the R&M group may contribute to narrowing the gap by 1.4 percentage points, through the effect of reducing SUDI.

3.9 Together, these interventions will meet the target if implemented in full, but there are other steps that will also contribute, notably the promotion of early antenatal booking among disadvantaged groups.
Chapter 4 outlines specific actions based on good practice to provide a focus for this work at local level.

**Figure 4: Identifiable actions to reduce the 2002–04 gap in infant mortality**

<table>
<thead>
<tr>
<th>What would work</th>
<th>Impact on 2002–04 gap (percentage points)</th>
<th>Actions/interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing conceptions in under-18s in the R&amp;M group by 44% to meet the 2010 target</td>
<td>1.0</td>
<td>Targeted prevention work with at-risk teenagers and targeted support for pregnant teenagers and teenage parents</td>
</tr>
<tr>
<td>Reducing overcrowding in the R&amp;M group, through its effect on SUDI</td>
<td>1.4</td>
<td>Increase the supply of new social housing; pilot innovative approaches to making temporary social stock permanent; encourage better use of housing stock</td>
</tr>
<tr>
<td>Targeted interventions to prevent SUDI by 10% in the R&amp;M group</td>
<td>1.4</td>
<td>Maintain current information given to mothers and target the Back to Sleep campaign and key messages to the target group</td>
</tr>
<tr>
<td>Reducing rate of smoking in pregnancy by 2 percentage points by 2010</td>
<td>2.0</td>
<td>Smoking cessation as an integral part of service delivery for the whole family during and after pregnancy</td>
</tr>
<tr>
<td>Reducing the prevalence of obesity in the R&amp;M group to 23%</td>
<td>2.8</td>
<td>Support the contribution LAAs can make to tackling obesity Develop plans to implement NICE obesity guidance with a focus on disadvantaged groups</td>
</tr>
<tr>
<td>Meeting the child poverty strategy</td>
<td>3.0</td>
<td>Develop plans to help women with a BMI of over 30 to lose weight by providing a structured programme of support</td>
</tr>
</tbody>
</table>

- **Immediate actions**
  - Optimising preconception care
  - Early booking
  - Access to culturally sensitive healthcare
  - Reducing infant and maternal infections

- **Long-term actions**
  - Improving infant nutrition
  - Improving maternal educational attainment

- **Actions/interventions**
  - Provide comprehensive preconception services
  - Provide advice/support for at-risk groups within the target group e.g. BME groups
  - Increase direct access to community midwives
  - Provide 24/7 maternity direct line for advice and access
  - Implement NICE antenatal and postnatal guidelines
  - Health equity audit of women booked by 12 weeks and more than 22 weeks gestation
  - Commissioners and maternity service providers agree improvement plans in contract
  - Improve uptake of immunisations in deprived populations
  - Implement Baby Friendly standard

3.10 This work is being further developed and future modelling will look at the impact on the gap of maternal educational attainment and reducing infections and accidents.

(b) **Promoting joined-up delivery of the target, with Maternity Matters**

3.11 The priority of maternity services is to provide a choice of safe, high-quality care for all women and their partners. *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* was published in April 2007.³ It set out the government’s commitment for modern NHS maternity services and provided practical guidance for local implementation. It highlighted the role that maternity services have to play to help deliver the infant mortality target, in particular:

- provision of comprehensive preconception services;
• development of maternity, perinatal and neonatal networks of clinical care;
• development of maternity services in easily accessible and visible community settings such as Sure Start Children’s Centres, including provision of effective outreach services for socially excluded groups;
• continuity of midwifery care;
• provision of safe, high-quality and effective maternity services;
• the pilot of Family Nurse Partnerships (FNPs), a joint DH/DCSF project involving intensive, health-led home visiting in 10 PCTs in England working in partnership with local authorities to identify what interventions work best in supporting vulnerable first-time parents. The pilot sites running the programme are Barnsley, Derby City, County Durham and Darlington, Manchester, Slough, Somerset, Southend, Southwark, Tower Hamlets and Walsall. Some £30 million has been announced from the Comprehensive Spending Review (CSR) 2007 to support the Prime Minister’s commitment to expand the programme. Annex 3 sets out the FNP experience in Derby supporting teenage parents.

3.12 Commissioners and providers should develop maternity and paediatric services that provide quality services tailored to the needs of local communities. PCTs and others will make their own judgements about what action is needed within the overall framework of national guidance. The table below shows what can be done at local level to improve service delivery based on good practice. SHAs have a key role in providing strategic leadership and support.
NEXT STEPS FOR IMPROVING SERVICE DELIVERY

The local response: what you can do

SHAs can:
- provide strategic leadership to assist PCTs in the development of the local vision for local maternity and neonatal services, the development of networks and of user involvement;
- hold PCTs to account for commissioning comprehensive maternity services;
- oversee and contribute to the development of the workforce strategy, workforce modernisation and workforce development;
- ensure that local supervisory authority standards and activities promote safe, high-quality care for women and their babies, and monitor standards of midwifery practice and core outcomes for women and babies in their jurisdiction. This should include smoking cessation rates and breastfeeding initiation rates.

PCTs/acute trusts/local authorities can:
- develop a strategy to implement Maternity Matters, including a health equity audit of women booked by 12 weeks and at more than 22 weeks gestation aimed at improving outcomes for vulnerable and disadvantaged families e.g. BME groups, with agreed common data;
- implement Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts (DH/DCSF 2007);6
- carry out joint strategic needs assessment to identify local priorities.

(c) Improving services for BME groups

3.13 The review highlighted inequalities in infant deaths among women in BME groups and noted that reducing infant mortality in BME groups could have an important impact on the target group. This is because some BME groups are at particular risk of poverty and socioeconomic disadvantage, including Pakistani, Bangladeshi, black Caribbean and black African families. Residence patterns reflect these patterns of disadvantage, with the result that there is a disproportionate preponderance of BME groups in the 43 key areas.
3.14 Interpreting ethnic patterns of infant health is not straightforward. Country of birth has traditionally been used to measure ethnic origin and, although Hospital Episode Statistics now record mothers’ ethnic origin, coverage is not complete, with around 75% of delivery records containing information on mother's ethnic group in 2003–04.7

3.15 Tackling disadvantage among BME groups with higher rates of infant mortality is a major challenge for delivery of the target. Evidence from the Family Resources Survey makes clear that, compared with children in households in which the head of the household is white, children in BME households are much more likely to be in the lowest income quintile.8 In the Millennium Cohort Study, white and Indian mothers were at much lower risk of living in disadvantaged circumstances than mothers from other ethnic groups.9 The link between ethnicity and socioeconomic disadvantage is particularly strong for Bangladeshi and Pakistani mothers and their partners who have migrated relatively recently to the UK.

3.16 An ethnicity workshop was held in June 2007 to develop strategies to meet the needs of BME groups and identify how health inequalities in infant mortality in BME groups could be tackled. Participants included key policy makers, front-line staff and voluntary organisations. Two main challenges were identified in providing services for BME groups.

Access and service delivery issues

3.17 It is important to provide services that take account of the different circumstances of mothers, for example between women and their partners from well-established communities and women who have recently migrated to the UK. The majority of Bangladeshi and Pakistani women seeking antenatal and maternity care were born outside the UK, which means that their pregnancy is likely to be their first experience of the NHS. A minority of Bangladeshi and Pakistani mothers are not able to communicate in English, which is a major barrier to access and use of maternity and child health services.10 The workshop noted that women from BME groups may be more likely to book late (more than 20 weeks gestation) and so may miss antenatal screening tests and early opportunities for the provision of maternity care.11 Furthermore, women who are refugees or asylum seekers may have difficulty accessing maternity care and may be more reluctant to do so due to concerns about their citizenship status.

3.18 Rapid changes in population mobility can mean that risk factors in new populations may be picked up slowly in existing data and surveillance
3.19 Establishing the needs of mothers and their families is important in order to establish equal access to preconception, maternal and infant healthcare. This includes communication in community languages and meeting the needs of people with different levels of literacy. Where needed, it will involve targeting of health and social services, for example the provision of advocacy services, interpreting services and community support services.

**Congenital anomalies**

3.20 Congenital anomalies and conditions are an important cause of infant mortality and childhood morbidity and, along with other forms of disability, can have significant impact on their families, the health and social services and wider society. They are conditions or malformations present before or at the time of birth and include structural malformations, genetic and chromosomal defects, congenital infections and inborn errors of metabolism. Most congenital anomalies are detected antenatally or in the neonatal period.

3.21 Congenital anomalies are more common in communities that favour consanguinity (cousins marrying), such as the Pakistani and Bangladeshi communities. Recent research suggests that, although there is community awareness that disability is linked to consanguinity, there is confusion about the basis of that link. Improving the provision of, and access to, genetic counselling and preconception services is important in enabling women and their partners to make informed choices and ensure that appropriate services are in place for these families.

3.22 Community involvement is key to developing genetic services that are sensitive to the needs of these families. Annex 3 shows how Bradford and Blackburn have engaged local BME communities and sought to respond to their needs.

3.23 Consanguinity is, however, only one of a range of risk factors which contributes to high rates of infant mortality among mothers born in Pakistan. Economic disadvantage is the main factor: when Pakistani-born mothers are compared with white mothers living in the same deprived income quintiles, there is little difference in IMRs.
NEXT STEPS FOR IMPROVING SERVICES FOR BME COMMUNITIES

The local response: what you can do

SHAs can:
• provide strategic leadership to assist PCTs in developing services for BME groups;
• hold PCTs to account for commissioning maternity and paediatric services that cater to the needs of BME groups.

PCTs/acute trusts/local authorities can:
• undertake a joint strategic needs assessment, including community involvement, which could include:
  – identifying BME groups with the highest IMR;
  – informing commissioning decisions;
  – developing protocols for partnership working with BME groups, recognising them as equal partners;
  – identifying a clear strategy for the development of services to support the needs of BME groups.

(d) Encouraging ownership of the target through effective performance management

3.24 Reducing health inequalities is an NHS priority. While the life expectancy element of the target provides a core focus, infant mortality is also important, both as a factor in improving life expectancy in disadvantaged groups and as a marker for deprivation.

3.25 Reducing health inequalities is also a priority for local government, with health and well-being a key dimension of the ‘place-shaping’ role of local authorities and at the heart of LAAs. Through the CSR, central government has identified and agreed its national priorities for local delivery in the national indicator set. These indicators cover all those functions for which local authorities, working alone or in partnership, are responsible for delivering. Current LAA indicators with a health inequalities dimension relate to breastfeeding, obesity, access to maternity services, teenage pregnancy and smoking.

3.26 Effective local performance management of the infant mortality aspect of the health inequalities target will help deliver better outcomes to mothers and their families by identifying which areas of care are most
in need of improvement and aligning capacity and resources to local population need. This will only be achieved through improved collection and recording of data.

3.27 The Confidential Enquiry into Maternal and Child Health (CEMACH) produces perinatal mortality data by neonatal network and by individual NHS trust. CEMACH is hoping to extend this to include variation by type of provider and to compare each trust’s mortality data with an expected level adjusted for case mix.

3.28 The accurate assessment of progress on reducing IMR, overall and in the target (and other disadvantaged) groups, is difficult at a local level due to the relatively small number of infant deaths in individual localities. A key part of planning and delivering reductions in infant mortality is to look at infant deaths in the context of other measures. Table 1 includes some useful routine data items to enable the local monitoring of progress in maternal and infant health. This table is intended to show how local knowledge can be improved by drawing on existing data collections. Some of these indicators are also included in the local basket of indicators developed by the LHO (www.lho.org.uk).
Table 1: Useful routine data items to enable local monitoring of progress in infant and maternal health

<table>
<thead>
<tr>
<th>TYPE OF DATA</th>
<th>SOURCE OF DATA</th>
<th>AVAILABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Deprivation</td>
<td>PHO</td>
<td>Yes</td>
</tr>
<tr>
<td>– Ethnicity</td>
<td>Trust</td>
<td>Yes</td>
</tr>
<tr>
<td>– Maternal age at birth</td>
<td>Trust/ONS</td>
<td>Yes</td>
</tr>
<tr>
<td>– Child poverty rates</td>
<td>Regional/DWP*</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Health service data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Maternal BMI at booking</td>
<td>Trust</td>
<td>Yes</td>
</tr>
<tr>
<td>– Maternal smoking status at booking, by age</td>
<td>Trust and quarterly report sent to PCT</td>
<td>Yes</td>
</tr>
<tr>
<td>– Teenage conception rates (under 18)</td>
<td>ONS</td>
<td>Yes</td>
</tr>
<tr>
<td>– Percentage of women who have received a health and social care needs assessment by the 12th week of pregnancy</td>
<td>Trust</td>
<td>Yes</td>
</tr>
<tr>
<td>– Antenatal screening uptake</td>
<td>Trust (Clinical Negligence (Scheme for Trusts (CNST) level 2) and PCT</td>
<td>Yes</td>
</tr>
<tr>
<td>– Breastfeeding initiation and continuation rates</td>
<td>(1) Quarterly report by PCT at trust level (2) Only ones who have baby-friendly commitment at trust level</td>
<td>(1) Yes (2) Yes for some trusts</td>
</tr>
<tr>
<td>– Infant immunisation uptake</td>
<td>PCT</td>
<td>Yes</td>
</tr>
<tr>
<td>– Infant deaths as a consequence of a serious untoward incident</td>
<td>Trust (National Patient Safety Agency), CEMACH</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Outcome data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Proportion of births that are very low birthweight (less than 1,500 g)</td>
<td>ONS</td>
<td>Yes</td>
</tr>
<tr>
<td>– Proportion of births that are low birthweight (less than 2,500 g)</td>
<td>ONS</td>
<td>Yes</td>
</tr>
<tr>
<td>– Proportion of babies born before 37 completed weeks</td>
<td>Child health system in trust</td>
<td>Yes</td>
</tr>
<tr>
<td>– Proportion of births to mothers aged under 20</td>
<td>ONS</td>
<td>Yes</td>
</tr>
<tr>
<td>– Proportion of babies who have a safeguarding plan for protection</td>
<td>Safeguarding board</td>
<td>Yes</td>
</tr>
<tr>
<td>– Overall IMR and IMR in disadvantaged groups</td>
<td>PHO</td>
<td>Yes</td>
</tr>
<tr>
<td>– Neonatal and post neonatal mortality rates</td>
<td>ONS</td>
<td>Yes</td>
</tr>
<tr>
<td>– Cause of death</td>
<td>Trust</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Households Below Average Income (HBAI) publication available on the DWP website at www.dwp.gov.uk/asd/hbai.asp
3.29 Improving the quality of local data, such as those on smoking in pregnancy and breastfeeding, will go a long way to:

- improving understanding of key health indicators for mothers and infants and providing the evidence base for delivering even better services;
- providing an opportunity for NHS and local government services to develop a common approach to this work.

3.30 Public health observatories (PHOs) have an important role in analysing and interpreting routine data to help identify local priorities for action. Yorkshire and the Humber PHO has produced a study on infant mortality and child health which explores some of these issues and identifies 22 indicators.14

3.31 The LHO publication, Born Equal? A Briefing on Inequalities in Infant Mortality in London, explores the factors that contribute to infant mortality in London and ways in which commissioners might identify more accurately where improvements will benefit outcomes and data recording.15

3.32 Health inequalities have been identified as an NHS priority as part of the wider performance framework. Although the life expectancy element of the target is the focus for this work using the all-age, all-cause mortality measure, infant mortality is also important. SHAs will hold PCTs to account for delivering the 2010 health inequalities target. Every SHA has some interest in health inequalities as each SHA includes at least one PCT in the life expectancy spearhead group or the 43 infant mortality areas.

3.33 Improving health and reducing health inequalities is included in the national indicator set and the new local performance framework (www.communities.gov.uk/publications/localgovernment/nationalindicator). Performance against each of the 198 indicators, including the all-age, all-cause mortality measure and those relating to breastfeeding, obesity, access to maternity services, teenage pregnancy and smoking, will be reported for every Local Strategic Partnership (LSP).

(e) Sharpening and raising awareness of the target

3.34 The review highlighted that many local areas did not identify the infant mortality target and the widening health inequalities gap in infant mortality as a priority. Raising the profile of the target is a crucial first step in engaging the support of key players to work towards meeting the target.
3.35 The profile of the target is being raised through a number of national and local initiatives, including:

- working closely within DH and with other government departments to underline the links between different policy agendas;
- raising professional awareness through presentations at conferences, meeting with key professional groups and effective working with the medical/specialist press;
- working with the National Support Team (NST) for health inequalities to identify local issues and make recommendations;
- providing support to develop local strategies to equip leaders from health, local government and the voluntary and community sector with the right skills and knowledge to reduce health inequalities in infant mortality;
- working with the Improvement and Development Agency to develop the capacity of local government for achieving health improvements and reducing health inequalities.
3.36 The NST for health inequalities has visited spearhead areas that face some of the biggest challenges in reducing health inequalities. Some support has been provided through the development of a detailed workshop model on infant mortality to explore partnership, leadership and strategy, the strengths and weaknesses of local services and community structures, engagement, support and development. The NST visits have emphasised that delivering interventions systematically and on the appropriate scale is crucial to success. Lessons from the NST visits include:

- **knowing the target, knowing your gap:**
  - recognising the issue through reference to local data;
  - prioritising health inequalities in infant mortality;

- **making the target part of everyday business:**
  - developing integrated service commissioning;
  - establishing professional and other networks across organisational boundaries;

- **taking responsibility and engaging communities:**
  - providing interpreting services for BME groups;
  - involving users in service developments;

- **matching resources to need:**
  - improving the accessibility of maternity services, including through outreach;
  - developing service models that are targeted to the needs of disadvantaged and vulnerable women;

- **focusing on what can be done:**
  - identifying champions to promote this agenda;
  - ensuring appropriate staffing levels to ensure a safe service and provide for staff development and training;
  - developing a commitment to the Baby Friendly initiative;
  - creating an IT infrastructure that supports data collection and analysis to enable local priorities to be identified.

3.37 Social marketing techniques can identify approaches to help change behaviour and can be used by the NHS and others to reach people in disadvantaged groups and areas. They can help understand where people are in their own lives and help them to build their own strategies for change. Annex 3 sets out how a social marketing approach was used to help women stop smoking in pregnancy in Sunderland.
NEXT STEPS IN RAISING AWARENESS

The local response: what you can do

SHAs can:
- provide strategic leadership to assist PCTs in the development of the local vision for maternity and paediatric services, highlighting issues around health inequalities and infant mortality.

PCTs/acute trusts/local authorities can:
- work together with key professionals and other partners to develop action on awareness on health inequalities, including on infant mortality and child health;
- review current programmes on smoking and obesity to focus on disadvantaged groups and areas.

(f) Improving data quality and strengthening the evidence base

Improving data quality

3.38 Improving the quality of, and identifying gaps in, routinely collected data is fundamental to improving the understanding of key health indicators for mothers and infants, and essential if necessary service redesign and improvements are to be identified and monitored. This was highlighted in the Chief Medical Officer’s 2006 Annual Report, Dirty Hands... The Human Cost. This section describes national initiatives that make best use of available data.

3.39 DH is working with the NHS Connecting for Health and the Information Centre to develop a maternity dataset and is planning to begin implementation towards the end of 2009. This dataset will help planning and commissioning of patient care and will be derived from information already, or anticipated to be, captured in the electronic care record (a primary source of data). This data will flow to the Secondary Uses Service to enable analysis.

3.40 Immaturity-related conditions are one of the most common causes of infant mortality. However, it has not been possible to look at national survival rates of infants according to gestational age, as this information is not collected at birth or death registration. ONS has been given access to information on gestational age and ethnicity, as part of a subset of the data collected by the Central Issuing System, which issues NHS numbers at birth. These records have now been
linked to the 2005 birth registration records, and further linked to registration records for infant deaths. In August 2007, national gestation-specific infant mortality data were published for the first time by ONS. These showed that:

- eight per cent of live births in England and Wales were born preterm (less than 37 weeks’ gestation);
- the percentage of preterm births was highest among babies with fathers in the R&M group;
- infant mortality was higher in the R&M group at all gestational ages.

3.41 These new data will help improve our understanding of the risk factors associated with preterm delivery and survival, in particular in disadvantaged groups such as BME groups and teenage mothers, and will help develop further interventions and research questions that may help deliver the target.

3.42 Variations in IMR by ethnicity will be published by ONS for the first time in 2008.

**Strengthening the evidence base**

3.43 Although knowledge about trends in infant mortality and the causal factors associated with them is growing, there is still a paucity of evidence about the impact of different interventions on reducing health inequalities in infant mortality. This was highlighted by the review, which recommended that the evidence base should be strengthened.

3.44 If an impact is to be achieved in the short to medium term, making best use of existing research evidence to identify effective interventions is crucial. An evidence-based workshop was held in May 2007 to explore these issues. Participants included experts in the field, data analysts, policy leads and clinicians, and the workshop considered how the existing research evidence could be put into practice and gaps filled in the current research evidence.

3.45 It found that there is more scope to use the existing research evidence base in everyday practice. This will help provide a systematic approach to provision of maternal and paediatric care through the development of best practice and evidence-based guidance. In order to facilitate this, better collection and use of routine data and more information about BME groups and teenage mothers are needed. It suggested that local partnerships should be developed to address these issues.
3.46 A clear understanding about the strength of the available evidence and gaps in the evidence is necessary in shaping future plans. Demonstrating what works is vital if the engagement of national and local players is to be sustained. Gaps in the existing evidence base to reduce health inequalities in infant mortality included the need for:

- systematic data collection and better recording of inequalities measures;
- using and collecting morbidity data, as survival does not necessarily equate with well-being;
- understanding the causes of poor perinatal outcomes;
- identifying avoidable deaths;
- cost-effectiveness studies of primary, secondary and tertiary interventions.

3.47 The NPEU has been commissioned to develop a series of systematic reviews of the research evidence to identify and promote the key interventions that are most likely to contribute to meeting the 2010 target and, in the longer term, to improving maternal and child health and achieving a sustainable reduction in health inequalities. Building on the work already done by the review, these reviews will also help to prioritise where there is a need for new research to address significant gaps in the evidence base.

3.48 Work is also in hand with a range of international partners to help understand different priorities and policies around health inequalities, infant mortality and child health, and to identify relevant evidence to help inform and show us what works. This highlighted the importance of using all available evidence to encourage action in this area, including case studies and examples of good practice. This work culminated in an international think tank meeting in September 2007 to support national efforts and contribute to the World Health Organization Commission on the Social Determinants of Health. Meeting information is available at www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Healthinequalities/DH_077951

3.49 Annex 4 describes quality criteria developed as part of the EuroHealthNet project that may be included in interventions to reduce health inequalities.
NEXT STEPS IN IMPROVING DATA QUALITY AND STRENGTHENING THE EVIDENCE BASE

The local response: what you can do

SHAs can:
• support PCTs and acute trusts in planning and monitoring maternity and paediatric care.

PCTs/acute trusts/local authorities can:
• gather and report routine data, including specific maternity and paediatric activity as required in accordance with best practice and agreed datasets once published;
• evaluate the effectiveness of new activity.
4. Practical guidance for local implementation

4.1 Reducing health inequalities in infant mortality, delivering the target and improving maternity and paediatric care services requires a seamless provision of preconception, antenatal, intrapartum and postnatal services. This chapter sets out some practical guidance to support the effective local delivery of key, evidence-based interventions – such as for reducing smoking and teenage pregnancy – to help give local organisations and professionals a sense of what they might deliver.

4.2 From 1 April 2008, all PCTs and local authorities will have to undertake a joint strategic needs assessment to identify the current and future health and social care needs of their local population. Joint strategic needs assessment is the foundation of effective commissioning and will be carried out by the directors of public health, children’s services and adult social services, working closely with directors of commissioning. Joint strategic needs assessment will enable PCTs, hospital trusts and local authorities to:

- describe the health and well-being of their local population;
- identify where inequalities in infant mortality and child health exist;
- identify inequity in service provision;
- identify ‘differences in outcomes’ in different population groups to inform targeting of resources;
- use local community views and evidence of the effectiveness of interventions to shape the future investment and disinvestment of services;
- consider joint commissioning from pooled budgets and resources;
- develop the workforce to support delivery;
- underpin the LAA, children and young people’s plan and the choice of local outcomes and targets.

Further information about data to inform joint strategic needs assessment is available at www.yhpho.org.uk/commissioning_JSNA.aspx
4.3 The review identified a number of key interventions that:

- would have a demonstrable impact on the gap;
- were likely to impact on the gap even without all the evidence;
- were likely to reduce infant mortality overall.

4.4 This section sets out practical guidance for commissioners, service providers and local authorities on the key elements that can be put in place to ensure effective delivery of these interventions. A further set of more detailed examples of local implementation based on good practice are appended in Annex 3.

**Interventions that have a demonstrable impact on the infant mortality gap**

**Reducing teenage pregnancies**

4.5 Health outcomes for babies born to teenage mothers are worse than for babies born to older mothers. In particular, IMRs are 60% higher for teenage mothers than mothers aged 20–39 and there is a 25% greater likelihood of prematurity/low birthweight among teenage mothers compared with older mothers.\(^2\) The main contributory factors to these poor health outcomes are: young mothers are more likely to attend late for antenatal care, more likely to smoke during pregnancy, less likely to breastfeed, and have poorer diets during pregnancy.

4.6 The DCSF is the lead department responsible for the teenage pregnancy strategy, which aims to ‘reduce England’s under-18 conception rate by 50% by 2010’. The target is jointly held with DH.

4.7 Achieving the teenage pregnancy strategy target in the R&M group would contribute an estimated one percentage point of the 10% needed to narrow the gap and meet the target. This will be achieved through reducing teenage pregnancies and providing better coordinated support for teenage mothers and young fathers, including help to reduce second conceptions. Around 20% of births conceived by under-18s are to young women who are already teenage mothers.

4.8 Engagement of all the key mainstream delivery partners – health, education, social services, youth support services and the voluntary sector – is essential to reduce teenage conceptions and improve support services for teenage parents.
4.9 Teenage pregnancy rates are falling steadily. Between 1998 – baseline year of the teenage pregnancy strategy – and 2005, the under-18 conception rate fell by 11.4%, to its lowest level for over 20 years.

4.10 While there has been steady progress nationally, there is huge variation in performance between local areas. The best local authority has seen a reduction of over 40%, whereas in some areas rates have increased – in some cases significantly.

4.11 To understand the difference in progress, an in-depth review was carried out in statistically similar areas with contrasting success in reducing under-18 conception rates. The key ingredients of success are set out in Table 2. Annex 3 shows how these key ingredients were used to develop a cross-agency programme to reduce teenage pregnancies in Knowsley and Wigan.

4.12 Detailed guidance, Teenage Pregnancy Next Steps: Guidance for Local Authorities and PCTs on Effective Delivery of Services, has been sent to all local authorities and PCTs asking them to review and revise their local strategies against these key factors. All areas have been provided with a self-assessment toolkit, to identify strengths and address any weaknesses in children and young people’s plans. Government Offices with SHAs are performance managing progress of all areas, with a particular focus on areas with high and increasing rates and those significantly off trajectory for meeting their 2010 target.

4.13 Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts has also been issued to local authorities and PCTs on improving outcomes for teenage parents and their children including: the poor child health outcomes, including the 60% higher rates of infant mortality; the poor emotional health of teenage mothers; and the poor economic well-being of young parents and their children.

4.14 It makes clear that the solution to improved outcomes for teenage parents and their children does not rest with one agency, but with a range of services – health, education, social care, youth support services and the voluntary sector – working together. The guidance asks LAs and PCTs to identify teenage parents in the antenatal period and provide a package of support to tackle problems early. The support, coordinated by a lead adviser, should bring in specialist advice on issues like smoking cessation, maternal nutrition and breastfeeding, parenting skills and education and training, and continue until young parents are ready – emotionally, educationally and economically – to manage independently.
4.15 The guidance also highlights the importance of helping young parents prevent second conceptions by providing comprehensive contraceptive advice – including long-acting methods – in the antenatal period with proactive follow-up postnatally to ensure effective use of the chosen method.

4.16 The DCSF will be working with youth support services, Sure Start Children's Centres and local parenting strategies to ensure that teenage parents are identified as a priority group. They will also be:

- promoting the You’re Welcome service standards to drive action to make services more young people friendly – including work to develop a ‘kite mark’ scheme for services that meet the You’re Welcome criteria;
- developing communication aids for young parents about the risks of repeat pregnancy and the range of contraception services available;
- identifying effective practice in supporting young parents to avoid repeat pregnancies;
- ensuring that the educational needs of school-age parents are met and those aged over 16 have tailored advice and support to reduce their risk of being not in education, employment or training;
- exploring the establishment of a sustainable funding route for positive parenting courses aimed at young mums-to-be;
- ensuring the continuation of Care to Learn childcare funding for parents aged under 20 in learning.
Table 2: Key ingredients of successful local teenage pregnancy strategies

<table>
<thead>
<tr>
<th>Key component</th>
<th>Examples of what works</th>
</tr>
</thead>
</table>
| **Strategic** | • Clear accountability for delivery of the under-18 conception target  
• A high level champion for the teenage pregnancy strategy in the LSP or local authority/PCT who leads in driving the local strategy  
• Key actions to prevent teenage pregnancies/support teenage parents are included in the area's children and young people's plan and monitored regularly |
| **Data** | • Protocols are in place for collection, analysis and use of data from a variety of sources (e.g. live births, terminations) across sectors to contribute to planning and performance management  
• Where the BME population of a local area is significant, census categories are further broken down to enable effective targeting to communities most at risk |
| **Communication** | • Effective communication among all partners on issues relating to teenage pregnancy  
• Proactive publicising of local services to young people most at risk  
• A media/communications strategy (developed through engagement with young people/parents) to manage proactive and reactive media work |
Table 2: Key ingredients of successful local teenage pregnancy strategies (continued)

<table>
<thead>
<tr>
<th>Key component</th>
<th>Examples of what works</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementation: programme elements</strong></td>
<td></td>
</tr>
<tr>
<td>Provision of young people-focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them</td>
<td>• Young people’s contraception/sexual health services are part of mainstream provision/funded from mainstream resources</td>
</tr>
<tr>
<td></td>
<td>• Clear referral systems for other service providers</td>
</tr>
<tr>
<td>Strong delivery of sex and relationship education (SRE), personal, social and health education (PSHE) by schools</td>
<td>• Systematic delivery of PSHE across primary and secondary schools, in line with DfES (now DCSF) Sex and Relationship Education Guidance, and tailored to meet specific need (e.g. boys, BME communities)</td>
</tr>
<tr>
<td></td>
<td>• Dedicated PSHE coordinator/specialist PSHE teachers in post, with all teachers having basic training</td>
</tr>
<tr>
<td>Targeted work with at-risk groups of young people, in particular looked-after children and care leavers</td>
<td>• Local data are used to identify young people at risk</td>
</tr>
<tr>
<td></td>
<td>• Interventions are tailored to suit specific needs of at-risk children and young people (e.g. looked-after children and care leavers, young men, BME communities, refugees and asylum seekers, young offenders) and include work on aspiration, relationships and safe sex</td>
</tr>
<tr>
<td>Raising aspirations</td>
<td>• Raising aspirations is seen as integral to all other interventions and programmes of action</td>
</tr>
<tr>
<td>Work with parents</td>
<td>• Investment in community-based programmes that seek to engage hard-to-reach families (e.g. through Sure Start Children’s Centres)</td>
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</table>
NEXT STEPS FOR TEENAGE PREGNANCY

The local response: what you can do

SHAs can:

- support PCTs and acute trusts in commissioning and developing services for young families including:
  - specialist maternity care or a lead midwife for teenage parents;
  - the provision of accessible antenatal and postnatal care at times and in locations which are accessible to young parents;
  - information sharing in the antenatal period, between maternity services and local support services provided through targeted youth services and Sure Start Children’s Centres;
  - monitoring the incidence of repeat pregnancies to teenage mothers.

PCTs/acute trusts/Sure Start Children’s Centres can:

- develop common processes for assessing need and joint protocols for information sharing between agencies;
- develop strategies to encourage young women to access antenatal services earlier and sustain uptake of antenatal care;
- provide multi-agency support, coordinated by a lead professional who acts as the main point of contact for the young person, coordinating referrals to specialist support services as necessary;
- actively involve young fathers as part of support for teenage mothers;
- provide specific services that promote smoking cessation, support young mothers to stop drinking alcohol or using drugs as early as possible in the pregnancy, address poor emotional health of teenage mothers and encourage breastfeeding in line with National Institute for Health and Clinical Excellence (NICE) guidance on postnatal care.
Reducing sudden unexpected death in infancy

4.17 Sudden unexpected death in infancy (SUDI) is a significant cause of infant mortality, normally occurring within eight months of life. The risk is higher for males, preterm and low birthweight babies and those sleeping in non-supine (on their front or side) positions. SUDI occurs in all socioeconomic groups but is more common in disadvantaged populations.

4.18 Although the incidence of SUDI has fallen sharply in recent years, this decline is not shared by all groups. The target (and other disadvantaged) groups have persistently higher levels.\textsuperscript{20,21} The public health messages responsible for the decline need to be more widely understood among the target and other disadvantaged groups.

4.19 The review report highlighted:

- a number of effective evidence-based interventions to prevent SUDI, including:
  - ensuring that infants sleep in the supine position – ‘back to sleep’;
  - keeping the baby’s head uncovered by placing the baby in the ‘feet to foot’ position;
  - ensuring that infants sleep in a separate cot, especially if the parents smoke, have been drinking alcohol or have taken drugs;
  - ensuring that infants sleep in the same room as their parents;
  - reducing parental smoking;
- that these messages have not been taken up by the R&M group;
- a 1.4 percentage point reduction of the 10% gap could be achieved if 1 in 10 R&M mothers currently sharing a bed with their baby or putting it down to sleep prone could be persuaded to avoid doing so.\textsuperscript{2}

4.20 In order to ensure that parents receive consistent messages about SUDI risk and prevention, work is in hand to:

- update the \textit{Reduce the risk of cot death} leaflet in partnership with the Foundation for the Study of Infant Deaths. The updated leaflet is given to all women as part of their antenatal care and is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123625;
• explore why disadvantaged families are not taking up the SUDI prevention messages in the same way as other social groups. The Foundation for the Study of Infant Deaths has been commissioned to undertake a survey of the target (and other disadvantaged) group’s attitude to SUDI risk.

NEXT STEPS IN REDUCING SUDDEN UNEXPECTED DEATH IN INFANCY

The local response: what you can do

SHAs can:
• provide strategic leadership to PCTs and acute trusts in developing services to prevent SUDI, including the Care of the Next Infant (CONI) programme.

PCTs/acute trusts/local authorities can:
• recognise the links between SUDI, smoking and overcrowding;
• provide training for healthcare and other professionals about SUDI risks and advice and support for parents;
• provide advice to families about reducing SUDI risks in line with DH and NICE guidance;
• provide support for at-risk families, particularly where there has been a previous SUDI.

Reducing maternal smoking

4.21 Smoking in pregnancy is harmful to the mother and baby. Babies born to mothers who smoke during pregnancy are more likely to die during the first weeks of life than babies of mothers who do not smoke. Smoking in pregnancy increases infant mortality by about 40%. Smoking in pregnancy is 1.5 times higher in women in the R&M group than the population as a whole and nearly three times higher among mothers under 20 compared with rates for all pregnant women.

4.22 Modelling suggests that if the national target on smoking in pregnancy ‘to reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010’ could be achieved in the R&M group, this would reduce the gap by two percentage points.

4.23 Since NHS Stop Smoking Services began operating in 1999, local services have had a particular focus on helping pregnant women who smoke to give up. However, many healthcare professionals are wary of discussing the issue of smoking with women, who may not wish to disclose the existence/extent of their smoking.
4.24 From 2005-06, action on smoking in pregnancy has been delivered as part of the work of PCTs in partnership with local authorities. This is underpinned by a commitment to reduce by one percentage point a year the proportion of women continuing to smoke throughout pregnancy from 23% to 18% by 2005 and to 15% by 2010. The framework focuses especially on smokers from disadvantaged groups as a contribution to the infant mortality target.

4.25 The introduction of Smokefree England from 1 July 2007 created a new context for this work and a spur for further action. The NST on tobacco control, which aims to disseminate best practice across all areas, provides support to those areas that need it and will enable reductions of smoking in disadvantaged populations.

4.26 Key lessons from the NST about reducing smoking in pregnancy in disadvantaged populations include the following:

- Formalise opportunities to embed stop smoking support within midwifery and health visiting structures – both training and an organisational expectation that it will be systematically used are important.
- Where a stop smoking pregnancy specialist post exists, this will be best used in most settings as a primarily coordinating role, enabling the management of a network of suitably trained advisers in appropriate locations, albeit with some client contact where more intensive support is needed.
- Develop the wider network of staff to provide tailored support in pregnancy, for example family support workers, health trainers.
- Seek and develop opportunities within community settings, for example Sure Start Children's Centres and voluntary sector projects, to ensure a presence at every potential contact point with clients.
- Explore social marketing approaches to engage potential clients and improve readiness for and uptake of professional stop smoking interventions.

4.27 Planning steps to achieve this are likely to include:

- identifying risk groups;
- identifying all opportunities to carry out brief interventions and refer throughout the pathway;
- reviewing the weight given to maternal smoking in the booking risk assessment and subsequent activity;
- exploring the potential of a specialist assertive outreach model;
- continuing into the postnatal period with involvement of health visitor support.
NEXT STEPS ON SMOKING IN PREGNANCY

The local response: what you can do

SHAs can:

• provide strategic leadership to PCTs and acute trusts in developing smoking cessation services for pregnant women;
• ensure that smoking cessation services for pregnant women reflect local needs, for example high-risk groups, including teenage mothers.

PCTs/acute trusts/local authorities can assess current models of service delivery to ensure that:

• all pregnant women and their partners who smoke are offered smoking cessation advice and support tailored to their needs;
• there is a clear referral pathway and guidelines for pregnant women who wish to stop smoking, including the use of nicotine replacement therapy, carbon monoxide monitoring and postnatal support;
• there is a named specialist who supports smoking cessation advice;
• professionals are trained to enable them to raise the issue and make appropriate referrals;
• professionals are trained to offer brief smoking cessation interventions at every antenatal appointment with women who reported they smoked at booking and chose not to be referred;
• there is easy access to smoking cessation services through, for example, Sure Start Children’s Centres or a home-based service;
• robust data collection is in place to inform service planning and performance management;
• standards are developed to ensure service quality;
• local targets on reducing smoking in pregnancy are achieved, with a particular focus on high-risk groups, including teenage mothers.
Optimising maternal and infant nutrition

4.28 Optimising maternal nutrition preconceptionally, throughout pregnancy and in the postnatal period is important for maternal and infant health. Antenatal classes help women understand the importance of maintaining a healthy weight through pregnancy and to lose weight after birth. The Infant Feeding Survey showed that women in the R&M group were less likely to attend antenatal classes.23

4.29 Several steps have been taken to optimise maternal and infant nutrition including:

- introducing the Healthy Start scheme, which provides vouchers for pregnant women and those with children younger than four to spend on milk, fruit and vegetables. Women who receive certain benefits or are pregnant and aged under 18 qualify for the vouchers. The scheme also provides vitamin supplements including folic acid to all pregnant and breastfeeding mothers. The Infant Feeding Survey showed that mothers from lower social groups were less likely to take folic acid supplements as recommended to protect against neural tube defects.23 More information is available at www.healthystart.nhs.uk/index.asp;

- developing a 5 A DAY communications programme, which aims to increase awareness of the health benefits of fruit and vegetables, particularly targeting those groups with the lowest intakes.

Maternal obesity

4.30 Body Mass Index (BMI) is a tool used to classify whether a person is a healthy weight for their height. It is calculated by dividing weight in kilograms by the square of height in metres (BMI = weight (kg)/height (m)²). Normal BMI ranges between 18.5 and 24.9.

4.31 The prevalence of obesity has trebled since the 1980s and well over half of all adults are either overweight or obese. Women in disadvantaged groups are more likely to be obese than women in affluent groups.2 Neonatal deaths are more common in women who are underweight, overweight or obese before they conceive.24,25

4.32 In 2004, the Government set a national obesity target to halt ‘the year-on-year rise in obesity among children under 11 by 2010 in the broader strategy to tackle obesity in the population as a whole’. This target is shared jointly by DH, DCSF and the Department for Culture, Media and Sport in recognition that delivery will depend upon a concerted, joined-up effort across government and at local level.
4.33 There is not a specific target for reducing the percentage of obesity in adults. However, if the prevalence of obesity in women in the R&M group were to fall by 23% to the current levels of obesity in the population as a whole, this would be a 2.8 percentage points contribution to the target of 10%.2

4.34 NICE published guidelines on the management of obesity in December 2006.26 It highlighted that multicomponent (including more than one therapy) interventions are the treatment of choice and set out a strategy for PCTs, primary and secondary care settings and local authorities. NICE is currently producing guidance on maternal and infant nutrition, which recommends that women with a BMI above 30 should be encouraged to reduce it before becoming pregnant and/or after pregnancy.

4.35 CEMACH has just started an obesity project. This project seeks to gain an overview of current service provision for obese women – those with a BMI of 35 or over – in pregnancy and to identify any gaps that may exist in the provision of care to obese women.27 A primary output of the project will be the production of a set of recommendations for healthcare providers, commissioners and policy makers on ways to improve the management of pregnant women with obesity and hence the outcomes for these women and their babies.

Breastfeeding

4.36 Breastfeeding provides clear health gains for mother and baby. Breastfed babies are less likely to become obese adults, which in turn will improve health outcomes for the individual and reduce infant mortality in their children. There are significant health inequalities in breastfeeding rates.23 Maternity units should be encouraged to implement an externally evaluated, structured programme for breastfeeding using the UNICEF UK Baby Friendly Initiative, as good practice (www.babyfriendly.org.uk). This approach will be supported by developing positive images of breastfeeding mothers in GP surgeries and Sure Start Children’s Centres. Annex 3 shows how this can be done through a cross-agency programme to improve breastfeeding initiation and duration in Gateshead.

4.37 The prevalence of breastfeeding at 6–8 weeks is one of five key measures for the new PSA on improving the health and well-being of children and young people (PSA 12). PCTs and other primary and community health services will have a key role in delivering against this measure.

LifeCheck

4.38 As part of the Choosing Health White Paper, LifeChecks were announced which are designed to support people to make healthy choices at key times of life.28
4.39 An online early years NHS LifeCheck is being developed and tested for parents with babies around six months old. The aim is to provide access to information and guidance, especially for disadvantaged parents. The guidance covers topics such as language and development, healthy eating and safety.

NEXT STEPS ON MATERNAL AND INFANT NUTRITION
The local response: what you can do

SHAs can:

• provide strategic leadership to PCTs and acute trusts to develop comprehensive care pathways for obesity covering both prevention and treatment and taking into account NICE guidance;
• oversee data collection for the breastfeeding PSA indicator.

PCTs/acute trusts/local authorities can:

• improve work across the delivery chain to ensure alignment of systems at local level, including performance management and supporting the contribution LAAs can make to tackling obesity;
• develop local delivery plans to implement NICE obesity guidance with a focus on disadvantaged groups;
• develop plans to help women with a BMI above 30 to lose weight by informing them of the risks and providing a structured programme of support that can be tailored to the needs of the individual and combines advice on healthy eating with regular, moderate physical activity;
• maternity units should also consider:
  – implementing the UNICEF UK Baby Friendly Initiative;
  – providing breastfeeding education and support, targeting women in the R&M group and other disadvantaged groups and improving data collection about breastfeeding.

To encourage breastfeeding, PCTs should:

• ensure action through the child health promotion programme;
• provide adequate training to the primary care workforce to give consistent advice and support to mothers;
• ensure data collection for the target indicator (6–8 weeks for all mothers).
Improving housing quality and reducing overcrowding

4.40 There have been significant improvements in housing quality over the last few years. The Status Report on the Programme for Action – 2006 Update of Headline Indicators shows that, between 1996 and 2004, the proportion of vulnerable private sector households and social sector tenants living in non-decent housing decreased, with a narrowing in inequalities between these groups and non-vulnerable private sector households in both absolute and relative terms. However, overcrowding remains a concern for some groups.

4.41 Overcrowding can make life intolerable for families. Overcrowded living conditions are associated with health problems such as stress and depression, poor educational achievement by children and family breakdown.

4.42 One definition commonly used to define overcrowding is the ‘bedroom standard’. This determines the notional number of bedrooms the household needs, taking into account the age, gender and relationship of all the household members. A household is said to be overcrowded if it has fewer bedrooms than the notional number.

4.43 In England, there were an estimated 526,000 overcrowded households in 2005–06, about 2.5% of all households. Based on the 2005–06 Survey of English Housing, there were about 535,000 households with an infant aged under one – and 13.5% of these households were overcrowded. Looking at the social rented sector, the overall overcrowding rate was 6% but almost 30% among those with an infant.

4.44 Overcrowding appears to have an impact on mortality through its effect on SUDI, although the mechanisms are unknown. Reducing overcrowding in the R&M group may reduce the gap in the target by 1.4 percentage points through reducing SUDI and will have an impact on other disadvantaged groups.

4.45 Communities and Local Government (CLG) highlighted the issue of overcrowding in its 2006 discussion paper Tackling Overcrowding in England which aimed to develop practical actions to reduce overcrowding.
In order to improve housing for disadvantaged families, there needs to be a coordinated approach between local authorities, housing associations and others. Local authorities have a statutory responsibility for tackling overcrowding and a number of central government initiatives (set out below) are likely to help reduce overcrowding. Annex 3 shows how overcrowding is being tackled in Hackney.

NEXT STEPS IN TACKLING OVERCROWDING

What next? Action by CLG

CLG is:

- providing £15 million of funding for the next Spending Review period to tackle overcrowding, starting in 2008–09 with funding for 38 pathfinders;
- increasing the supply of new social housing;
- piloting innovative approaches in making temporary social stock permanent;
- encouraging better use of stock through dealing with under-occupation, increasing mobility and empty properties.

CLG has produced an action plan setting out next steps on overcrowding in more detail, which is available at www.communities.gov.uk/housing
Reducing child poverty

4.47 The Government has succeeded in arresting and reversing the rising long-term trend in child poverty. In 1997, there were 3.4 million children in poverty, or one in three children. By 2005–06, there were 600,000 fewer children in relative low income households than in 1998–99. Despite progress, persistent high levels of child poverty remain.\(^3\)

4.48 From 2004–05, the Government is measuring progress on child poverty using three indicators:

- absolute low income (60% of 1998–99 median income uprated to take account of inflation);
- relative low income (60% of current median income);
- relative low income and material deprivation combined (70% of current median income and materially deprived).

4.49 Modelling suggests that meeting the child poverty target – to halve the number of children in relative low-income households between 1998–99 and 2010–11 – would narrow the gap by three percentage points.

4.50 DWP has played a key role in reducing child poverty. To date, DWP’s strategy has focused on increasing employment levels for parents, with most policy focus on lone parents and increasing financial support through the tax credit system.

4.51 Although there has been a reduction in the number of children in relative poverty over the last decade, the Government missed its interim target to reduce child poverty by a quarter between 1998–99 and 2004–05. To make further progress towards reaching the 2010 target, DWP is taking a number of steps to:

- improve the Welfare to Work support programmes;
- help single earners to progress in work;
- support non-working partners of single earners (potential second earners) to move into work.

4.52 These changes will not be sufficient on their own to enable the Government to reach its child poverty targets. The Government will need to provide adequate financial support for families as well as help to support parents into work. Tax credit measures announced in the 2007 Budget and the recent Pre-Budget Report will lift a further 300,000 children out of poverty from April 2008.
4.53 A joint Child Poverty Unit has recently been established to ensure a clear cross-government approach to tackling child poverty. The unit will bring together the expertise of officials from DWP and DCSF and will work closely with HM Treasury and key stakeholders to drive forward the child poverty agenda.

4.54 In addition, the Government needs to work in partnership with local authorities, the private and voluntary sector, and civil society more widely and, most importantly, with parents.

**NEXT STEPS IN REDUCING CHILD POVERTY**

*What next? Action by DWP*

On 2 March 2007, DWP published *Working for Children*, which set out the additional measures DWP will undertake to contribute to the eradication of child poverty by 2020. Further measures were also announced in the welfare reform Green Paper *In Work, Better Off*, which was published on 18 July 2007.

The Government is concentrating its efforts to those at greatest risk – primarily children in workless households, ethnic minority families and children with disabled parents.

The Government continues to believe that work is the best way out of poverty and continuing to get parents into employment sits at the heart of the Government’s strategy.

To make further progress towards reaching the 2010 and 2020 targets, DWP’s strategy will include the following steps:

- help lone parents into work;
- ensure people stay in work and progress in their jobs;
- develop a family focus in the Department’s work with all parents.

**Interventions that are likely to impact on the infant mortality gap**

*Improving access to maternity care*

4.55 Emerging knowledge of fetal and infant development is highlighting the importance of offering early intervention and prevention in pregnancy. In addition, maternal deaths are higher in women who book late. Around 16% of all pregnant women, including many of those under 18 years of age delay seeking maternity care until they are five or more months pregnant.
4.56 Maternity Matters and the PSA maternity indicator highlight the importance of early booking. The indicator is set at a full health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy. Where such a standard is met, it will give all pregnant women in an area the full benefit of personalised care and improve outcomes and experiences for mother and baby. Reducing the percentage of women who access maternity services late through targeted outreach work for vulnerable and socially excluded groups will provide a focus on reducing the health inequalities these groups face and will support them in making well-informed decisions about their care throughout pregnancy, birth and postnatally.

4.57 Commissioners need to understand why these women do not seek early care and overcome these barriers by providing more flexible services at times and places that meet the needs of these women. Integrating maternity services into Sure Start Children’s Centres is an essential means of improving local access to maternity services, along with raising awareness on early booking among health professionals and partner organisations.

4.58 Early booking is an issue of particular concern among pregnant teenagers. DH and DCSF are shortly publishing a revised version of Teenage Parents: Who Cares?: A guide to commissioning and delivering maternity services for young people. Understanding the factors influencing early booking is key and examples of action on early booking are set out in Annex 3.
NEXT STEPS IN IMPROVING ACCESS TO MATERNITY CARE

The local response: what you can do

SHAs can:

• provide strategic leadership for PCTs and acute trusts to develop services to enable women to access maternity care and complete a needs assessment by 12 weeks’ gestation.

PCTs/acute trusts/local authorities can:

• carry out a needs assessment to identify the percentage of women who book for maternity care after 12 weeks of pregnancy and develop a strategy to reduce this, such as integrating maternity care into Sure Start Children’s Centres and provision of an effective outreach service;

• provide maternity services in locations and times that are accessible to vulnerable groups, for example BME groups and teenage parents;

• develop and implement protocols for information sharing by teenage mothers with local services to ensure a coordinated package of support in line with multi-agency working to support teenage parents;

• ensure that maternity services are welcoming and user friendly for young fathers.

Interventions that will reduce infant mortality overall

Quality of healthcare

4.59 Infant mortality is influenced by the quality of healthcare provided.

4.60 Ensuring that mothers and babies receive high-quality care is the cornerstone of maternity and neonatal care and is the overarching maternity standard of the National Service Framework for Children, Young People and Maternity Services. The standard is for women to have easy access to supportive, high-quality maternity services, designed around their individual needs and those of their babies.
4.61 The review identified that immaturity-related conditions are one of the most common causes of infant death. Prevention of deaths from immaturity-related conditions involves taking a two-pronged approach:

- preventing preterm births; however, accurate prediction of women at risk of preterm birth remains elusive;\(^3^4\)
- ensuring that babies who are born prematurely receive high-quality healthcare.

4.62 The Project 27/28 Inquiry into the quality of neonatal care and its effect on survival of babies who were born at 27 and 28 weeks’ gestation in England, Wales and Northern Ireland found deficiencies in all aspects of neonatal care consistently more frequent in babies who died, even adjusting for initial illness.\(^3^5\) However, there is no evidence to suggest that the quality of care babies receive is socially patterned and the impact on the target is low.

4.63 Networks of care for maternity and neonatal services can help improve the quality of care provided and provide access to the appropriate neonatal unit and a seamless pathway of care.

4.64 In order to continue to ensure high-quality maternity and neonatal services:

- PCTs will want to monitor quality and performance of maternity and neonatal providers;
- PCTs and acute trusts should ensure that there is an appropriately skilled maternity and neonatal workforce who receive regular continuing professional development;
- Local Safeguarding Children’s Boards will take up the function of carrying out child death reviews on all child deaths from birth to 18 years in April 2008. These reviews will focus on identifying preventable and avoidable factors for child deaths. Further information is available at www.cemach.org.uk.

**Screening**

4.65 Antenatal and newborn screening may prevent infant deaths by detecting certain congenital anomalies that may cause infant deaths or long-term illness, for example congenital heart disease and medium-chain acyl-coA dehydrogenase (MCADD) deficiency.
4.66 There are ethnic inequalities in the uptake of antenatal screening; more research is needed to establish whether there are social inequalities. Neonatal screening is universal.

4.67 The review concluded that:

- addressing inequalities in antenatal screening may have an impact on the gap by enabling women to be offered appropriate screening tests;
- newborn screening is unlikely to contribute very much to reducing inequalities in infant mortality, although it will prevent infant deaths.

4.68 PCTs and acute trusts will want to consider developing plans to address inequalities in screening through enabling women to access antenatal care before 12 weeks’ gestation and developing services for disadvantaged groups, for example BME groups.

4.69 Further information about antenatal and neonatal screening programmes is available at www.screening.nhs.uk/an/index.htm

Immunisation uptake

4.70 Immunisation protects children against diseases that can kill or cause serious long-term ill health. Babies routinely receive seven vaccines in their first year of life (www.immunisation.nhs.uk). Inequalities in immunisation practice are persistent and result in lower coverage for poorer families.

4.71 The number of infants who die due to vaccine-preventable infections is too low to have an impact on the health inequalities infant mortality gap. While recognising that improving immunisation uptake is important, the contribution to the target is low. However, the number of children who suffer illness and long-term disabilities due to vaccine-preventable illnesses makes a considerable impact on their families and the NHS and other local services.

4.72 PCTs need to examine immunisation uptake rates and plan to prioritise actions to improve immunisation uptake for those most in need.
5. Conclusion

5.1 The death of a baby is a devastating loss for a family. There are unacceptable health inequalities in infant mortality; although infant mortality affects all population groups, babies of families from certain groups are more likely to die before their first birthday.

5.2 Ensuring that avoidable infant deaths are prevented through the provision of high-quality preconception, maternity, neonatal and paediatric care and targeted interventions to at-risk groups is essential.

5.3 This implementation plan shows what can be done at local level to help reduce health inequalities in infant mortality and achieve the 2010 target. It highlights the importance of cross-government working at a national level and cross-agency working at a local level and the importance of both NHS actions and actions on wider social determinants to reduce the gap.

5.4 The Secretary of State for Health has announced his intention to develop a comprehensive strategy building on the target and looking beyond 2010 to continue to reduce health inequalities. The results of this work will be announced in 2008.
6. References


Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide


Annex 1: Relevant policies that will help deliver the infant mortality health inequalities target

This section highlights the relevant government initiatives that will drive change and support delivery of the 2010 target.

  
  
  This 10-year programme set national standards for children’s health and social care, which promote high quality women and child-centred services that meet the needs of parents, children and their families.
  
  Key standards require the NHS to: ensure that pregnant women receive high-quality care throughout their pregnancy; improve access to services; and tackle health inequalities, addressing the particular needs of communities, children and their families who are likely to achieve poor outcomes.

  
  www.everychildmatters.gov.uk/_files/F9E3F941DC8D4580539EE4C743E9371D.pdf
  
  This document set out the national programme for local change programmes to build services around the needs of children and young people in order to maximise opportunity and minimise risk.
  
  It highlighted that improving access to services is a priority for reducing health inequalities. The Government has established more than 1,000 Sure Start Children’s Centres in disadvantaged communities, with plans for 3,500 to be in place by 2010. These offer integrated early years education, family and parenting support and health support.
• **Our health, our care, our say: a new direction for community services** (2006)


  This White Paper promised to help people to stay healthy and independent, to give people choice in their care services, to deliver care closer to home in the community and to tackle health inequalities. It highlighted ways of achieving this through, for example, local health and social care commissioners working together to understand and address local inequalities, in order to ensure that people get the services they need through joint commissioning between primary care trusts (PCTs) and local authorities.

• **Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies** (2006)


  This guidance sets out what is known about effective delivery of local teenage pregnancy strategies, based on in-depth reviews carried out in a number of areas with differing levels of success in reducing under-18 conception rates. It also includes new analysis on the underlying factors that affect young people’s sexual behaviour and subsequent outcomes, to help areas to target their strategies on the young people who are at greatest risk of early pregnancy.

  The guidance asks local areas to review their strategies in the light of the review findings and new analysis, and reflect them in their plans. It also sets out what support will be provided nationally to support local delivery.

• **Commissioning Framework for Health and Well-Being** (March 2007)


  This set out practical proposals for the commissioning services that promote health and well-being, proactively prevent ill health and work in partnership to reduce health inequalities.

  It describes the process of more effective commissioning through focusing on choice and access to good information; understanding the needs of populations and individuals through joint strategic needs assessment; sharing and using information more effectively and assuring high-quality providers for all services.
• **Maternity Matters: Choice, Access and Continuity of Care in a Safe Service** (April 2007)


  This sets out the Government’s commitment to modernising NHS maternity services and provides practical guidance for local implementation. It focuses on the key areas of delivering the choice policy through improving access to maternity services, and providing continuing support and safe maternity services for all women. *Maternity Matters* highlighted the role that maternity services have to play to help deliver the infant mortality target.

• **Common Themes: Local Strategic Partnerships and Teenage Pregnancy** (May 2007)

  www.neighbourhood.gov.uk/publications.asp?did=1912

  This highlights how effective programmes to tackle teenage pregnancy can contribute to Local Strategic Partnerships (LSPs) achieving their key priorities and outcomes. It asks LSPs to consider how they could assist partnership working in their area to help tackle teenage pregnancy.

• **Delivering Health Services through Sure Start Children’s Centres** (June 2007)


  Integrating health services into Sure Start Children’s Centres is an essential means of reducing health inequalities. This guidance sets out the benefits of integrating health services into Sure Start Children’s Centres through building effective, sustainable partnerships between health services and local authorities.

• **Multi-agency Working to Support Pregnant Teenagers: A Midwifery Guide to Partnership Working with Connexions and Other Agencies** (April 2007)

  www.everychildmatters.gov.uk/resources-and-practice/IG00211

  This guide aims to improve the outcomes of pregnant teenagers and new teenage parents. It highlights the importance of midwifery services working in partnership with other agencies to meet the complex needs of teenagers.
Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts (July 2007)

www.everychildmatters.gov.uk/resources-and-practice/IG00250

This publication complements 2006 guidance on accelerating reductions in under-18 conceptions, and provides a refreshed strategy designed to improve outcomes for teenage parents and their children.

The strategy provides guidance for local authorities and PCTs on the integrated services that we want each local area to provide. It also gives details about the support that will be provided nationally to assist local delivery. It aims to improve outcomes in three broad areas:

- child health;
- poor emotional health of teenage mothers;
- poor economic situation of teenage parents.
Annex 2: Local authority areas with 20 or more infant deaths in the routine and manual group from 2002 to 2004

Birmingham*
Blackburn with Darwen*
Bolton*
Bradford*
Brent
Bristol
Calderdale
Coventry*
Croydon
Derby
Doncaster*
Dudley
Ealing
East Riding of Yorkshire
Greenwich*
Hackney*
Haringey*
Kingston upon Hull*
Kirklees
Lambeth*
Leeds
Leicester*
Liverpool*
Luton
Manchester*
Medway Towns
Milton Keynes
Newham*
Northampton
Nottingham*
Oldham*
Portsmouth
Preston*
Rotherham*
Sandwell*
Sheffield
Southwark*
Stoke-on-Trent*
Sunderland*
Tower Hamlets*
Wakefield*
Walsall*
Wolverhampton*

Spearhead areas are denoted by an asterisk (*)
Annex 3: Actions to implement change by tackling health inequalities and reducing infant mortality

Addressing black and minority ethnic (BME) issues
- Building an advocacy service in Tower Hamlets
- Improving knowledge about genetics in Bradford
- Providing appropriate genetic services and support in Blackburn.

Supporting pregnant women and new parents
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- Health-led parenting in Derby
- Supporting parents through Sure Start Children’s Centres in Portsmouth and Southwark.

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Making better use of data
- Public health observatory support to focus local action using key data in London
- Developing a fuller picture of what is happening in Bradford
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- Matching resources to need in Milton Keynes.

Tackling Overcrowding
- New ways of tackling overcrowding in Hackney.
Addressing BME issues

There is a strong association between ethnicity, disadvantage and health inequalities. Reaching out to BME groups, and securing the engagement of these groups with infant and maternal health services, is a priority.

Poverty and deprivation are central factors in the worse health outcomes for many of these groups.

(1) Building an advocacy service in Tower Hamlets

Tower Hamlets is one of the most deprived communities in England and it has a large Bangladeshi community. Its rates of infant mortality are, however, around average. A number of factors are likely to contribute to this relatively low rate, including the low incidence of smoking in pregnancy and of teenage pregnancy in the Bangladeshi community and high rates of breastfeeding. Early booking is encouraged and family support provided through a bilingual advocacy service.

The service seeks to promote the interests of service users by empowering them to make the best use of services and support. Bilingual health advocates help by:

- providing information and advice to enable informed choices;
- facilitating communication by using language support/interpreting to increase positive consultation outcomes;
- acting as an interpreter, e.g. if a medical practitioner is giving a diagnosis or prescribing medication;
- registering providers with primary care services;
- working with other agencies, including referrals and liaison with the Department for Work and Pensions, housing services, social services, environmental health, solicitors etc;
- providing health promotion activities and training provision (delivering new healthcare initiatives to the hard-to-reach groups), including:
  - individual and community needs assessments;
  - outreach, home and hospital visits;
  - complaints mediation.

This range of services highlights that language is not the only factor hindering the Bangladeshi community’s access to services and advocates will continue to work with the patient outside of the services.
Advocates also provide basic support and evidence-based information and advice in such areas as healthy eating and exercise during pregnancy, obesity, breastfeeding and stopping smoking as well as providing assistance with benefits and welfare claims.

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(2) Improving knowledge about genetics in Bradford

Bradford has the second-highest number of infant deaths in England, and 15% of its population is of Pakistani origin, of which 70% are in consanguineous (or blood-related) marriages.

Figure 5: Ethnicity of the population of Bradford (2001 census data)

A study was launched and at-risk groups identified to explore the knowledge and experiences of family, community and health professionals in addressing the issues within Bradford, Blackburn and Derby, all areas with high concentrations of families of Pakistani origin.

The objectives of the study were to examine by interview and focus group discussions:

- family and community perceptions, knowledge and experiences of genetics and the links between cousin marriage, disability and genetics;
- factors and dynamics that prohibit or facilitate communication within extended families and between families and health professionals;
- the educational tools required to improve communication.
Preliminary findings from the study show that there is general community awareness that cousin marriage has been, and is still, linked to increased childhood disability. The link appears illogical to, and causes confusion among, community and at-risk family members, because they know many people who are married to first cousins who have healthy children, as well as white families who do not marry their cousins and have children with disabilities. Community members have little knowledge of carrier testing and no knowledge of recessive inheritance, while few at-risk family members have a sufficient grasp of recessive inheritance to understand the implications of genetic risk for family members. Both community members and at-risk families want access to accurate information and suggested that there should be outreach work with communities.

The emerging recommendations are around the need to develop:

- tools to enable accurate transmission and retention of information about familial genetic risk between health professionals and families and between members of extended families;
- outreach work for communities practising cousin marriage to counteract misinformation about the causal role of cousin marriage in childhood disability and promote accurate information; promote debate about genetic testing and reproductive technologies associated with genetics; and promote greater understanding of maternal, child health and genetic services.

Families, community and health professionals each have a need for information and knowledge. This is a prerequisite for developing strategies (e.g. on early booking) that integrate their needs. The study findings will feed into the design, commissioning and implementation of genetics services in areas with a high proportion of people of Pakistani origin.

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### (3) Providing appropriate genetic services and support in Blackburn

Blackburn is an ethnically mixed community with a 20% south Asian population, within which there is a high level of autosomal recessive disorders. The incidence of these disorders in Blackburn is 12 times higher in the south Asian groups than in the white population. Some 95% of south Asian parents were related by blood prior to marriage, and the death rate resulting from autosomal recessive disorders is almost 50% higher in south Asians than in the population as a whole.

A dedicated genetic nurse counsellor, supported by the regional genetics centre, was appointed to help identify approaches that would assist in tackling this issue. The aim of this Department of Health-funded project...
was to ascertain whether families in Blackburn would take up the offer of genetic services if these were offered in a culturally sensitive manner with no language barriers. The approach of the project was to target, through local paediatricians, extended families identified by the presence of a child with one of a number of inherited disorders, and then to provide explanation of genetic risk and the impact of consanguinity. Carrier testing and prenatal diagnosis risk-assessment and advice were then offered.

The service was effective and well received by families. In particular:

- gaps in knowledge were addressed – several families made requests for additional genetic testing and services, such as pre-implantation genetic diagnosis, showing that they do use the information;
- providing a professional from a similar cultural background was crucial to the acceptability of services and to addressing the language barrier;
- at-risk families recognise that they are now able to take genetic risk into consideration when making marriage plans.

Effective joint partnership working between the regional genetics centre, local paediatricians and the PCT provided the basis for success as well as the employment of a bilingual, Asian-speaking health visitor. The project also generated a good deal of interest among families within the local Asian community.

The approach was demonstrated to be cost-effective in terms of care and other services. The PCT’s decision to implement this approach as a mainstream service showed that it had been successful.

Other PCTs with significant ethnic minority groups are looking into establishing similar services.

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**Supporting pregnant women and new parents**

(4) **Pregnancy outreach worker programme in Birmingham**

Reaching pregnant women in the target and other disadvantaged groups in order to provide advice and support can be a key challenge. In Birmingham, the Health and Well-being Partnership has commissioned a social enterprise to deliver a programme to reach these women and help tackle health inequalities in some of the most deprived parts of Birmingham. The service run by Gateway family service was launched in August with 28 pregnancy outreach workers (POWs).
POWs provide social and emotional support to women during pregnancy, tackling some of the key indicators that increase the risk of infant mortality. They encourage women to book early and attend their antenatal appointments, and to improve their lifestyle by stopping smoking, eating healthily and taking exercise. POWs work alongside midwives in clinics and in various community settings; they have found that women require a range of support services – from help with domestic violence, housing and benefits to reducing isolation and stress. Women have continuing contact with the POW until the baby is born, when they link them with their local Sure Start Children’s Centre family support service.

Many of the POWs speak community languages, and have a good understanding of the barriers faced in communities that prevent some women accessing and utilising statutory services. This has proved useful since there has been a significant demand from women who are newly arrived and are seeking asylum. Many women who experience domestic violence are encouraged to access the support they need.

An important factor in the success of this service is that it complements the service provided by midwives, and has staff with ‘real life’ experience coupled with skills, training and – most importantly – time, to ensure that women feel that they can use a service they understand and trust.

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(5) Health-led parenting in Derby

Babies born to mothers under the age of 20 have a 60% higher infant mortality than those born to mothers aged 20 to 39. In addition, girls from the poorest backgrounds are ten times more likely to be teenage mothers. In Derby, infant mortality is above the national average and the teenage pregnancy rate is 54.8 conceptions per 1,000 women aged 15 to 17, compared to England’s rate of 41.1 conceptions per 1,000 women aged 15 to 17.
Derby signed up to the Family Nurse Partnership (FNP) pilot programme, working with teenage mothers. Building on a successful evidence-based programme in the United States, it is being tested in 10 sites across England, and the programme seeks to:

- improve pregnancy outcomes by engaging women in good health practices;
- improve child health, development, future readiness and achievement by helping parents to provide responsible and competent care;
- improve parents’ economic self-sufficiency by helping them to develop a vision for their own future, plan for future pregnancies, continue their education and find work.

Intensive home visiting is being provided to 100 of the most vulnerable first-time mothers under the age of 20 from the fourteenth week of pregnancy until the child is two years old. Families and family support systems are often included in the visits and help to assess the needs of the family. The PCT has recruited four family nurses and a supervisor for the project, with backgrounds in health visiting and midwifery. The programme includes subjects such as attachment and bonding, building therapeutic relationships, motivational interviewing, perinatal mental health and training in the use of the FNP materials and guidelines. The programme is a joint PCT and local authority project with one year’s initial funding from the Department for Children, Schools and Families (DCSF).
While it is too early to assess long-term outcomes, early indicators suggest:

- that the project is well accepted by teenage parents with very few drop-outs so far;
- an increase in the number of young parents who stop smoking in pregnancy;
- an increase in the self-esteem of young parents on the programme;
- involvement from young fathers and other family members in the programme;
- a willingness to develop a long-term therapeutic relationship with the family nurse and to learn about and try breast feeding;
- a willingness to learn about the development of babies and health-related issues.

The FNP programme’s long-term aims are improved antenatal health, fewer unplanned pregnancies, an increase in breastfeeding rates, better school readiness and a reduction in child abuse and neglect. After seven months, 90% of the families offered FNP have accepted and enrolled on the programme, helped by the excellent working relationship between health visiting and midwifery services.

The experience in Derby will help serve as a catalyst for change and play a key role in renewing and reshaping health-led child and family support services to reflect the needs and aspirations of local families.

Further information about the pilot can be found at www.everychildmatters.gov.uk/parents/healthledsupport

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(6) Supporting parents through Sure Start Children’s Centres in Portsmouth and Southwark

Sure Start Children’s Centres act as a focal point for families, providing a range of integrated services such as access to health and parenting support services, advice and information about healthy lifestyles and access to high-quality childcare and early years education. They also have an important role to play in helping parents who are seeking to return to training or work. In many disadvantaged areas, services are co-located to ensure better integration of services and enable those families with additional needs to receive an appropriate level of support.
Children’s Centres can also provide a focus for reconfiguration of services. Many PCTs are in the process of reorganising health visitor and midwifery services to provide a clearer focus on the needs of vulnerable and socially excluded members of the community.

_In Portsmouth_

Portsmouth is one of the 43 areas with the highest number of deaths in the R&M group. Community outreach is an important way of delivering services to where there is greatest need. In Sure Start areas, the maternity outreach worker visits all newly pregnant families at home early in pregnancy. They provide information on local services and offer support and parenting education, information about ‘bumps and babies’ groups, infant feeding and referrals to appropriate agencies such as the smoking cessation service and infant mental health team. All families are offered a further visit just before the baby is due and just after birth. All teenage mothers in Portsmouth are allocated a maternity outreach worker wherever they live in the city.

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_In Southwark_

Southwark has a diverse population with a high turnover and many new families arriving each year. 1st Place Children and Parents’ Centre is one of many centres that provide support for families through a wide range of services, working with voluntary, statutory and private sector providers in the local area. The family outreach programme provides support for the families that are new to the area and gives information on what services and support are on offer locally, as well as advice on the activities and services most likely to suit the family. A parents’ room provides face-to-face information and opportunities to access a computer for training and employment searches – with the offer of crèche support to allow parents to follow up any of these opportunities as they arise.

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More information can be found at: www.1stplace.uk.com
Reconfiguring services using LAAs

(7) Delivering antenatal services through Sure Start Children’s Centres

In 2006, Birmingham PCT, in partnership with the City Council, submitted a floor target action plan for the reduction of infant mortality. The action plan included the redesign of maternity services and proposed the relocation of community antenatal services from GP practices into Sure Start Children’s Centres. The Sure Start Children’s Centre setting enables community midwives to work as part of an integrated multi-agency team that offers education, childcare, family support and health services.

Currently, through the Birmingham Health and Well-being Partnership, 10 Sure Start Children’s Centres are running mainstream antenatal services within the 13 priority wards. The aim is to have 18 centres delivering services by June 2008.

The transfer of community maternity services to Children’s Centres has received extremely positive feedback from service users and providers. Midwives also report that they are accessing women earlier and experiencing a reduction in clinic defaulters. The Birmingham Health and Well-being Partnership is currently working to quantify these encouraging observations.

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(8) Using LAAs to reduce infant mortality in Hackney

Although the problem of infant mortality has long been recognised in Hackney, the Local Strategic Partnership (LSP) has used the LAA process to raise its profile (Using Local Area Agreements to reduce health inequalities, www.renewal.net) and commission interventions to make a targeted impact. An assessment of the data highlighted the need for action among disadvantaged groups. It showed that infant mortality rates were three times higher for children of black African women and black Caribbean women than white mothers.

Partnership working is crucial if LAAs are to be developed effectively, and it was on the initiative of the LSP that a comprehensive review was established to determine how these health inequalities could be tackled more effectively. It was agreed to include the reduction in infant mortality as one of the LAA’s stretch targets and by commissioning the LAA grants to fund appropriate interventions.

A series of targeted interventions aimed at black African and Caribbean women, women not accessing maternity care at all (including hidden
communities such as asylum seekers) and young women were recommended. Work was piloted to test:

- a community empowerment and neighbourhood approach to reducing infant mortality for all expectant mothers and their families;
- more supportive and targeted ways of working with women at greater risk of experiencing infant mortality.

The plan is to roll out the learning from the pilots to other areas, with the aim of having a Hackney-wide approach by 2010. Key lessons include:

- engaging all the key agencies encourages them to commit to the infant mortality target by working together to develop joint strategies and by aligning their delivery plans, targets and budgets;
- the LAA is enabling a more targeted approach, with local solutions being applied to local circumstances. This strategy is ensuring that those groups most at risk of infant mortality are being targeted at neighbourhood level and that the interventions are designed to be accessible to those who are hardest to reach;
- by taking an area-based approach, initial action has been concentrated in those neighbourhoods with the highest numbers of infant deaths;
- reflecting the target in the joint commissioning of services by the NHS and local authorities, e.g. by developing maternity services in Children’s Centres to improve their accessibility.

Further information can be found at www.teamhackney.org/rim_interim_report_october_2007_final_version_with_pictures.pdf

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Tackling smoking and promoting breastfeeding

(9) Reducing smoking rates during pregnancy in Sunderland

Women who smoke during pregnancy are more likely to have babies born prematurely, twice as likely to have babies with low birth weights and up to three times more likely to have a baby die from SUDI. Some 29% of women in R&M groups in England continue to smoke during pregnancy, compared with 7% from managerial and professional groups.

Sunderland, with higher than average smoking rates, employed a midwife to set up smoking cessation services for pregnant women and their families, using social marketing research to develop an effective user-friendly service. In 2004, as a result of joint working, Sure Start agreed to fund a further specialist adviser to work intensively within the Sunderland Sure Start areas. They received training through the Smoking Cessation Treatment and Research Programme (Maudsley training) and update on a regular basis.

The service focuses on providing brief advice training to all staff who come into contact with pregnant women and parents of young children, to encourage appropriate referrals and increase client recruitment. Following referral, an initial assessment is made, the client is assisted to develop a quit plan and a quit date is established. Weekly support sessions are organised for 12 weeks with nicotine replacement therapy provided.

Most visits are home based to target the whole family group. The client is also supported monthly throughout her pregnancy and given intensive postnatal support to help prevent relapse at this difficult time.

Sunderland has increased the number of pregnant women not smoking from 62.1% (2004–05) to 76.7% (2006–07). Dedicated ongoing support addresses a major barrier for pregnant women (gleaned from the initial social marketing), which is the lack of enthusiasm and empathy from healthcare workers.

The elements of success are:

- delivery of intensive ongoing support sessions by a small number of dedicated clinicians;
- promoting brief advice training to help staff understand the target population and enable them to effectively motivate/encourage pregnant women interested in quitting to access the dedicated specialist services for ongoing support;
- organising/encouraging referrals by midwives/other healthcare professionals, multi-agency working is essential;
• engaging clients so they are responsive to the services;
• offering nicotine replacement therapy in conjunction with support services and easily accessible means of obtaining prescriptions;
• providing home visits/family support.

In 2003–04 Sunderland Stop Smoking Services recorded 267 pregnant smokers setting a quit date, with 99 successful quitters at the four-week mark.

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(10) Improving breastfeeding rates in Gateshead

Evidence has linked breastfeeding to improved health outcomes for infants and important benefits for mothers. Despite this, rates in England are low compared with the rest of the world. Gateshead, a spearhead area, had some of the lowest breastfeeding rates in England.

In 2003, Gateshead Council and the local Social Care Partnership secured funding to raise awareness and promote breastfeeding through the Department of Health’s Communities for Health programme.

The following actions were put into place:

• a breastfeeding coordinator was appointed to work across Gateshead to develop breastfeeding management and provide advice to health professionals;
• a campaign to raise breastfeeding awareness was developed with television and radio advertising, and a breastfeeding booklet (Off to a Good Start) was given to all new mothers on discharge from the maternity unit.

The following programmes were also established in areas where breastfeeding rates were low:

• bosom Buddies Gateshead;
• gateshead Breastfeeding Friendly Scheme;
• a breastfeeding in public accreditation scheme for Gateshead businesses developed by mums, with local NHS and council support to make businesses more baby friendly;
• a breastfeeding management and support group run by local mothers, backed by peer counsellor training, with weekly ‘drop in’ at four Sure Start Children’s Centres.
Figure 7: Breastfeeding initiation rates in Gateshead

Measured against the local Public Service Agreement (PSA) target of increasing breastfeeding rates by 2 percentage points a year, there is evidence of success (see Figure 7). Breastfeeding initiation rates rose by 20 percentage points (from 31% to 51%) in the year 2004–05 to 2006–07. Breastfeeding continuation rates at 6–8 weeks have increased by 4 percentage points (from 18% to 22%) over the same period.

Gateshead has now exceeded the local PSA target and continues to improve on maternal and child health through increasing breastfeeding rates as a result of local partnership working and engagement with the local community.

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Promoting early booking

(11) Identifying barriers to early booking in Wolverhampton

Wolverhampton has high infant and perinatal mortality rates compared with the rest of England. An audit of services in 2004 by the PCT showed that fewer than 4 in 10 women booked within 10 weeks, with the same proportion booking late. Women from BME groups are significantly less likely to book an appointment within this period.

A small research project explored the factors influencing the timing of booking appointments with a community midwife. Data were collected using a questionnaire and interviews with pregnant women and professionals at antenatal clinics with a high proportion of late bookers.

The project confirmed that late bookers tended to be from BME groups, women who are single and unsupported and women who are more socially deprived. The lack of social networks was identified as important and it was suggested that any action needs to build social networks and support, rather than limiting scope to issues of ethnicity.

The report identified a number of possible ways to promote early booking. These included:

- direct booking access to a community midwife;
- use drop-in clinics for greater flexibility of antenatal appointments;
- review scope for a targeted approach for home booking;
- increase profile of community midwives in disadvantaged communities;
- improve communications by:
  - using a wider range of languages in letters and key documents;
  - including maps with letters inviting women to parent-craft classes;
  - developing an enhanced website for mothers;
  - identifying information gaps between community midwives and GP practices.

The lessons from this study can contribute to raising awareness among health professionals of the importance of early booking and help to identify new ways of engaging pregnant women from at-risk BME and other disadvantaged groups.

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(12) Pregnancy fast-track services in Birmingham

Birmingham has the highest number of infant deaths in the country and has some of the poorest outcomes in infant mortality. A floor target action plan was developed in 2006 and funded by neighbourhood renewal funds to pump-prime targeted innovative practice to improve infant mortality outcomes.

Early antenatal booking is a priority within the plan, supported by NICE guidance and more recently by The New Performance Framework for Local Authorities and Local Authority Partnerships (2007).

To encourage earlier booking, a fast-track, free pregnancy testing programme was developed within local pharmacies. The pharmacist (with the patient’s consent) refers the information to the multilingual midwifery registration call centre. The call centre then fast tracks a referral to the midwife, who is the first point of referral on confirmation of a pregnancy.

The call centre also alerts service users to pregnancy counselling, family planning, pregnancy testing services, safeguarding, smoking cessation and drug and alcohol services.

In September 2007 the service made 139 referrals to midwives. Some 85% of referrals were before 12 weeks’ gestation, compared with a baseline of 39%. Default rates have declined and levels of midwifery-led care have increased.

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(13) An action approach to early booking in Lambeth and Southwark

Effective action on early booking requires knowledge about the local situation – as well as knowledge about the target – as the basis for effective local action. The London boroughs of Lambeth and Southwark have combined their efforts to improve local knowledge as a way of promoting interventions that may improve outcomes.

A recent audit in one local provider showed that less than 10% of women book by 12 weeks. It suggested that the low level of early booking is not down to the characteristics of the diverse local population (given as an anecdotal reason by professionals), but rather down to capacity issues, reflecting the heavy backlog of antenatal bookings. This has prompted a focus on improving access to services in a way that emphasises the whole pathway of care, including the culture and behaviour of professionals, the physical capacity and professional resources available and the expectations of users.
It means using local professional and user knowledge to develop new approaches or scale up existing approaches, such as through provision of active outreach, Sure Start Children’s Centres and other community bases. In addition, pregnant women accessing other hospital services are linked proactively to a midwife who will attend, review and provide direct access to maternity care if not already arranged. Reductions in the number of unbooked women show what can be done through provision of responsive individualised services, assertive follow-up arrangements for non-attended appointments and working in different ways, such as midwives working in the community with different partners and stakeholders.

Top Tips from Lambeth and Southwark for improving local knowledge by using available local data include:

- map the five-year (or two-year) trends of numbers of bookings and numbers of births;
- break down gestation at booking by 12, 20, 28, 36 weeks and unbooked at delivery, for the last one (or two) years to scope potential for improvement;
- map perinatal deaths by postcode, and identify any geographical hotspots linking to current maternity service provision to identify potential prioritisation and improvement strategies;
- analyse the teenage pregnancy rate, the smoking in pregnancy rate, the breastfeeding initiation rate by postcode and the type of maternity care provided for women delivering in the previous two years, and areas where women use maternity less well, to identify the potential for using the MAAP approach.

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Reducing teenage pregnancy

(14) Targeting high rates of teenage pregnancy in Knowsley

North Huyton, in Knowsley, has high levels of poverty, deprivation and disability and low levels of educational achievement, as well as high rates of illnesses such as cancer and heart disease. In 2000–02, teenage conception rates in this area were more than double the national average and those of the rest of the borough. When the North Huyton New Deal for Communities (NDC) area was identified in 2001, several programmes were launched, including teenage pregnancy initiatives in 2002.

The teenage pregnancy programme was developed in line with NDC principles of participation and consultation with the local community and engagement between local agencies.

Specialist youth workers were employed by the local authority's Youth and Play Service to develop the strategy by promoting peer education, mentoring and young people's clinics through outreach youth work. Parents, volunteers and local groups were involved to build local capacity.

Working with NDC partners, the programme used general lessons from an evaluation of a Sure Start Local Programme (the precursor to Children's Centres) project to develop its work. The programme included work on self-esteem, outreach, emergency contraception and peer-led education.

Figure 8: Under-18 conception ratio in Knowsley

The programme worked closely with the drug and alcohol teams, which helped to focus on risk-taking behaviour and relationships and to reach...
a wider audience using a range of mechanisms for disseminating key messages.

Engaging young people and other community members in the programme has enabled young people to make positive decisions about their own sexual and reproductive health.

The Knowsley project reached nearly 4,000 young people between 2003 and 2006 and provided more than 40 training sessions for local people. The numbers of teenage pregnancies were reduced by up to 32% in the area – a greater reduction than in England and the borough as a whole (see Figure 8)

This programme provided the blueprint for three new, jointly funded and area-based sexual health youth workers across the borough in 2006. These workers continue to engage local young people in planning and developing services.

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(15) Reducing repeat pregnancies in teenagers in Wigan

Wigan is a spearhead area with a teenage pregnancy rate in 2005 of 58.5 conceptions per 1,000 females aged 15 to 17, compared with the national average, in 2005, of 41.3 per 1,000. Of the teenagers who gave birth in Wigan during 2006, less than 10% are second or subsequent pregnancies, compared with England’s rate of around 20%. Around 5 per cent had had a previous live birth, while 3 per cent had experienced a previous termination of pregnancy. These statistics only include young women who deliver in the local maternity unit.

As part of the strategy to support young mothers and prevent subsequent unplanned pregnancies, teenagers receive extra support from the teenage pregnancy midwife, who is also a family planning nurse. The teenage pregnancy midwife reviews previous contraceptive use, if any, and discusses future contraception.

Contraception is discussed again whenever the teenage pregnancy midwife sees the young woman during the pregnancy. Time constraints prevent individual postnatal home visits to each young woman; there is therefore a targeted postnatal visit to younger teenagers and those who are deemed more vulnerable. The postnatal visit includes advice about contraception, the provision of condoms and gives information on local young mums’ groups and services.

The teenage pregnancy midwife runs local teenage parent-craft classes. At the contraception session, the midwife leads a discussion and passes around
samples of different contraceptive methods. They advise the young people on how alcohol and drugs can lead to contraceptive failure (e.g. incorrect condom technique), and uses ‘beer goggles’ to illustrate how alcohol affects perception. The contraception session was originally a session on its own, but has been incorporated into a tour of the hospital delivery suite as this has been found to maximise attendance at the sessions.

There is good uptake of contraception, but the teenage pregnancy midwife role may be extended in the future to enable the midwife to issue contraception, including long-acting reversible contraception (LARC), and fit contraceptive implants. This will reduce the consequences of young women not accessing initial contraceptive services appointments.

Currently ward staff are undertaking training in order to dispense condoms to young mothers as part of the local C Card scheme in the early postnatal period.

The development of a business plan to present to the local PCT for a ‘stepping-stone’ contraception service for teenage mothers is currently underway. It is hoped that this will enable one-to-one contraceptive information/advice and contraception initiation, including LARC methods, to all mothers under 18 in the postnatal period, including insertion of contraceptive implants if desired by the mother.

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Making better use of data

(16) Public health observatory support to focus local action using key data in London

In Born Equal: A briefing on inequalities in Infant Mortality in London, the London Health Observatory developed risk summaries (using a ‘traffic light’ colour-coding system) for each London borough based on the prevalence of eight key risk factors for infant mortality. These indicators included:

- proportion of births to couples in R&M (national target) groups;
- proportion of births to sole registered mothers;
- proportion of births to mothers aged under 20;
- proportion of births to mothers born in east and west Africa and the Caribbean;
- proportion of low birth weight babies.

It also measured the impact of interventions known to have an impact on infant mortality that are locally modifiable and can be monitored using routinely available data. These include not smoking in pregnancy, initiation of breastfeeding and early booking of antenatal care.

For example, the report identified early booking of the first antenatal appointment as a good precursor of better health for mother and child and to identify this, gestational age at booking is needed. The results showed that in Tower Hamlets, the proportion of mothers who booked early is ‘green’, showing a high proportion of mothers booking early. A high proportion of deliveries were also coded with gestational age, indicating that the data from Tower Hamlets on early booking can be interpreted with some confidence. However, in South London, data on a number of risk factors were not within electronic records and therefore could not be analysed.

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(17) Developing a fuller picture of what is happening in Bradford

Bradford set up an infant mortality commission out of concern for its high rates of infant mortality, especially among BME populations. This commission drew together health and public service professionals, voluntary organisations, academic experts and bereaved mothers. It asked why proportionately more babies die in their first year of life in Bradford than in England as a whole, what can be done and what more needs to be done. The commission reported in 2006 (www.bdmc.bradford.nhs.uk).
The use of data and statistics played a key role in underpinning the commission’s recommendations. A specific recommendation was to develop further the data collection and monitoring procedures in Bradford. This reflected the commission’s finding that the use of routinely collected data offered only limited insights into the state of maternal and infant health outcomes. To get a fuller picture, it suggestions include:

- a more comprehensive collection and analysis of local data, facilitated in part by an electronic maternity system in the local hospital trust, to include vital information on smoking, maternal health and genetics;
- further continued monitoring of infant health and mortality, linking closely to the Born in Bradford cohort study.

The Born in Bradford study will follow the lives of 10,000 babies born in the city between 2006 and 2008 as they grow into children and eventually into adults. It will find out what makes some of the children and babies born in Bradford ill and what can be done to put things right.

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(18) Using better data to reduce perinatal and infant mortality in Walsall

Walsall is a spearhead area with high levels of deprivation. Data from the West Midlands Perinatal Institute showed that the IMR had more than doubled from 4.6 deaths per 1,000 live births in 2000 to 10.2 in 2005, higher than the national and regional average.

A project was planned by local NHS trusts using local data to explain the increase in mortality rates and develop an action plan. This included reviewing the public health death files from 2001 and a detailed case note review of over 200 notes at local hospitals.

Among the key lessons learned from this project was the need for robust and timely monitoring of local data and the importance of joint working between organisations and departments, with ‘champions’ to take the work forward.

The project will be evaluated through the ongoing monitoring of infant and perinatal mortality in Walsall. Additional outcome measures arising from the project will also be built into the action plan.
As a result of this work, Walsall PCT decided to establish a local health inequalities unit, with a component focusing on infant mortality. It will implement an action plan based on the available data, including targeted work around smoking in pregnancy, the introduction of additional scanning for at-risk mothers and ensuring that a monitoring system is in place to inform planning. Walsall Borough Strategic Partnership will oversee the work of the unit.

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(19) Matching resources to need in Milton Keynes

Milton Keynes is a fast growing, ethnically diverse city with a large young population (40% are aged under 30) and areas of deprivation. The infant mortality rate is consistently slightly higher than the national average.

To assess the health needs of its community and address health inequalities in infant mortality, the PCT has developed an annual health visitor audit to help match resources to need.

This audit gives a better picture of caseloads and geographically based health needs, and helps to distribute the staffing resource equitably across the PCT. It contains GP practice population, age distribution, a range of deprivation factors, health indicators and workload indicators. With the exception of two public health leads to analyse the results, no additional resources are required to carry out the audit, as the collection of data is planned and prioritised into the annual work plans of the health visitor teams.

The audit is scored to give an appropriate health visitor whole-time equivalent establishment. The results of the audit, including trend data, are shared with all staff and used throughout the PCT.

The audit has underpinned decisions on the allocation and planning of health visiting services within the PCT for over 10 years. It is a priority mainstream activity and has maintained core services while being able to provide additional services to disadvantaged groups and families.

The Community Practitioners’ and Health Visitors’ Association has recommended that the audit is adopted as a tool nationally.

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Tackling overcrowding

(20) NEW WAYS OF TACKLING OVERCROWDING IN HACKNEY

Overcrowding appears to have an impact in the health inequalities in infant mortality through its impact on SUDI and in the social rented sector in London overcrowding is serious and worsening. Between 1991 and 2001, severe overcrowding in Hackney increased by 60%. Hackney Council addressed the issue by improving access to 3+ bedroom social housing, reviewing its lettings policy and reconfiguring existing social housing stock, together with a range of other initiatives including

Increasing the level of under-occupancy moves

The 2001 Census survey showed both high levels of overcrowding and significant instances of under-occupancy. An under-occupancy scheme helps unlock this extra capacity for overcrowded families by:

- offering a cash incentive for each bedroom given up for tenants in under-occupied homes;
- decorating the property and undertaking additional works;
- giving a high priority given for a move;
- providing practical support to assist movers.

Using the private sector

A Choose & Move scheme launched in July 2007 helps severely overcrowded households secure alternative suitable accommodation in the private sector by:

- offering a payment of up to £6,000 (inclusive of the deposit and a month’s rent);
- providing practical support given by dedicated officers to assist movers;
- helping the search for other accommodation by providing a list of private landlords in different areas.

Out of London Scheme

The Fresh Start scheme helps families on the waiting list to move out of London into other accommodation by:

- paying all expenses to view properties;
- providing removal payments;
- providing extra support for moves into private sector.

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Annex 4: EuroHealthNet quality criteria

EuroHealthNet has described 11 quality criteria of interventions to reduce health inequalities. To meet its quality criteria, the intervention should fulfil three of the quality elements:

- need assessment;
- low barrier method;
- participation and commitment of the target group;
- empowerment of the target group;
- setting approach;
- collaborative capacity building/partnership;
- snowballing/multiplier/intermediaries concept;
- quality management;
- evaluation;
- proportionality;
- sustainability.

Further information about the EuroHealthNet project is available at www.health-inequalities.org
Annex 5: What next? Considerations for commissioners and local providers

The following list identifies the key features of effective service planning that local commissioners can use to help reduce health inequalities in infant mortality.

Action on infant mortality will also contribute to meeting the life expectancy element of the target.

Key features

Improving service delivery

• Develop a strategy to implement *Maternity Matters*.
• Implement *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts*.
• Carry out a joint strategic needs assessment to identify local priorities.

Improving services for BME groups

• Improve demographic data about local BME groups.
• Consult BME communities about service developments.
• Ensure that the appropriate services are culturally sensitive.
• Allow sufficient numbers of staff to provide translation services.
• Provide provision of outreach services to socially excluded groups.

Raising awareness of the target

• Work together with key professionals and other partners to develop action on awareness of health inequalities, including on infant mortality and child health.
• Review current programmes on smoking and obesity to focus on disadvantaged groups and areas.
**Improving data quality and strengthening the evidence base**

- Develop routine data collection and reporting, including specific maternity and paediatric activity, in accordance with best practice and agreed datasets (once published).

- Ensure that an inequalities element is included in research projects.

**Encouraging ownership of the target through effective performance management**

- Gather and report on data, including specific maternity and paediatric activity, in accordance with best practice and agreed datasets (once published).

**Reducing teenage pregnancies and supporting teenage parents**

- Implement *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts*.

- Develop common processes for assessing need and joint protocols for information sharing between agencies.

- Appoint specialist maternity services or a lead midwife for teenage parents.

- Provide antenatal care services in easily accessible community settings such as Sure Start Children’s Centres.

- Encourage early contact with teenagers by midwives or obstetricians to ensure that they offer a convenient first pregnancy appointment to conduct the standardised risk and needs assessment before the 12th week of pregnancy.

- Identify a lead professional to act as the main point of contact for the young person, co-ordinating support services as necessary.

- Provide community midwifery services in the home or in community settings such as Sure Start Children’s Centres.

- Locate health visiting services in Sure Start Children’s Centres and other community settings which are accessible at convenient times.

- Provide specific services that promote smoking cessation and support young mothers to stop drinking alcohol or using drugs as early as possible in the pregnancy.

- Provide breastfeeding advice and support.
Prevention of SUDI

- Provide all women with the Reduce the risk of cot death leaflet antenatally.
- Train healthcare professionals about the risk factors, prevention advice and management of SUDI.
- Use evidence-based protocol of the management of SUDI, including how health inequalities can be minimised.
- Provide long- and short-term support for parents.
- Consider links with the CONI scheme.

Reducing maternal smoking

- Offer smoking cessation advice and support to all pregnant women and their partners, tailored to their needs.
- Establish a clear referral pathway and guidelines for pregnant women who wish to stop smoking, including the use of nicotine replacement therapy, carbon monoxide monitoring and postnatal support in line with NICE guidance.
- Identify a named specialist who offers smoking cessation advice.
- Provide training for healthcare professionals to enable them to raise the issue and make appropriate referrals, and to offer brief smoking cessation interventions at every antenatal appointment with women who reported that they smoked at booking but chose not to be referred.
- Provide smoking cessation services in easily accessible community settings such as Sure Start Children’s Centres or a home-based service.
- Develop routine data collection and reporting in accordance with best practice and agreed datasets (once published).
- Consider the possible role of local targets for reducing smoking in pregnancy, with a particular focus on high-risk groups, including teenage mothers.

Optimising maternal and infant nutrition

- Provide Healthy Start vouchers to eligible women.
- Train healthcare professionals to provide advice about nutrition and breastfeeding, with a focus on women from disadvantaged groups.
• Develop well-understood, functioning protocols for when, how and where to refer women who are obese for more specialist opinion or care.

• Consider a strategy to implement NICE obesity guidance.

• Develop routine data collection and reporting of maternal obesity rates in accordance with best practice and agreed datasets (once published).

• Agree a commitment to the UNICEF Baby Friendly Initiative.

• Identify a dedicated breastfeeding support professional.

• Ensure that there are sufficient staff, working flexibly across community and hospital settings, to provide breastfeeding advice and support.

• Provide breastfeeding support services in easily accessible community settings, with a focus on women from disadvantaged groups.

• Develop routine data collection about breastfeeding initiation and continuation to six weeks.

**Improving access to maternity care**

• Create the ability to book appointments at times and in places that are convenient to women and their partners.

• Provide midwifery services, including antenatal classes, based in community settings such as Sure Start Children’s Centres which are accessible at convenient times, or provide care at home.

• Deliver effective outreach services for women from disadvantaged groups, including women in the R&M group, sole birth registrations, teenage mothers and women from BME groups.

• Ensure that maternity services are welcoming and friendly to young mothers and fathers.

**Quality of healthcare**

• Develop networks of care for maternity and neonatal services.

• Ensure that there are sufficient staff, working flexibly across hospital and community settings, to provide high-quality maternity and neonatal care.
• Ensure that the maternity and neonatal workforce is appropriately skilled and receives regular continuing professional development.

• Monitor the quality and performance of maternity providers.

Antenatal and newborn screening

• Provide midwifery services in community settings such as Sure Start Children’s Centres to enable women to access care by 10–12 weeks’ gestation.

• Train healthcare professionals to provide information about antenatal and neonatal screening to enable women to make informed choices.

• Develop protocols to implement National Screening Committee antenatal and neonatal screening guidelines, with a focus on women from disadvantaged groups.

• Monitor the quality and performance of antenatal and neonatal screening services in accordance with best practice and agreed datasets (once published).

Immunisation uptake

• Monitor immunisation uptake rates and identify the differences between population groups and geographical areas in terms of completion rates and access to improve equity in provision.

• Design and deliver immunisation services to reach disadvantaged groups.

• Ensure that immunisation services are easily accessible at convenient times, for example by providing immunisations in Sure Start Children’s Centres or opportunistically at home.

• Deliver immunisation to recipients in a setting with which they are culturally comfortable and explain the process in a language they understand.