Health Matters

Report of the Health Matters Working Group

To be presented to Children's Servcies Scrutiny Panel on 29 April, 2014

Walsall Council

Foreword

The rate of infant mortality in Walsall has been concerning for a number of years, each death represents a personal tragedy to the families involved. Consideration needs to be given to the factors that contribute to infant mortality and how to tackle this within our local communities. The Children's and Young People Scrutiny and Performance Panel has a role to play in contributing to the debate. This working group was established to better understand the position within Walsall and has produced this report.

Reducing infant mortality in Walsall will not be an easy task, requiring partnership working and a coordinated approach.

Councillor Cassidy
Lead Member

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Introduction

The Children and Young People's Scrutiny and Performance Panel identified the need to investigate services on offer in relation to 'Health Matters' at its meeting on 17 July, 2013.

The Working Group was supported by Neil Picken, Senior Committee Business and Governance Manager.

Membership

The working group was made up of the following Councillors.

Councillor B. Cassidy

Lead Member

Councillor D. Shires

Councillor P. Lane

Methodology

The Working Group held a number of meetings during its investigations taking into account the views of numerous officers.

Witnesses

The Working Group met and discussed issues or received evidence relating to home educated children with the following witnesses:

Uma Viswanathon	Consultant in Public Health Medicine
Wendy Thompson	Operational Lead - Targeted Youth Support

Report Format

The report sets out the Working Group's findings.

Infant Mortality

Infant mortality is the death of a child less than one year of age and over one week of age. Perinatal mortality is the death of a child less than one week of age. Failure to address poor health in the first year of life can lead to mortality, delayed cognitive development, poor social skills and, and over time, difficulties in accessing learning and reaching potential.Infant mortality is a sensitive indicator of the overall health of a population, providing a measure of the well-being of infants, children and pregnant women. Walsall's infant mortality rate is consistently higher than regional and national rates, reflecting its high level of deprivation.

Both infant and perinatal mortality are strongly associated with deprivation. Reducing health inequalities in infant mortality requires a combination of health interventions and actions on the wider social determinants of health. Actions to reduce infant mortality will require coordinated efforts by a wide range of agencies across health, education and social care.

In Walsall infant mortality has been identified as a concern in the Joint Strategic Needs Assessment and is one of the key priorities in the Joint Health and Well Being Strategy. The reduction of Intrauterine Growth Retardation (restricted growth within the womb) has been identified as a key priority of the Walsall Clinical Commissioning Group. It has also been identified as a priority for the Children and Young People's Plan.

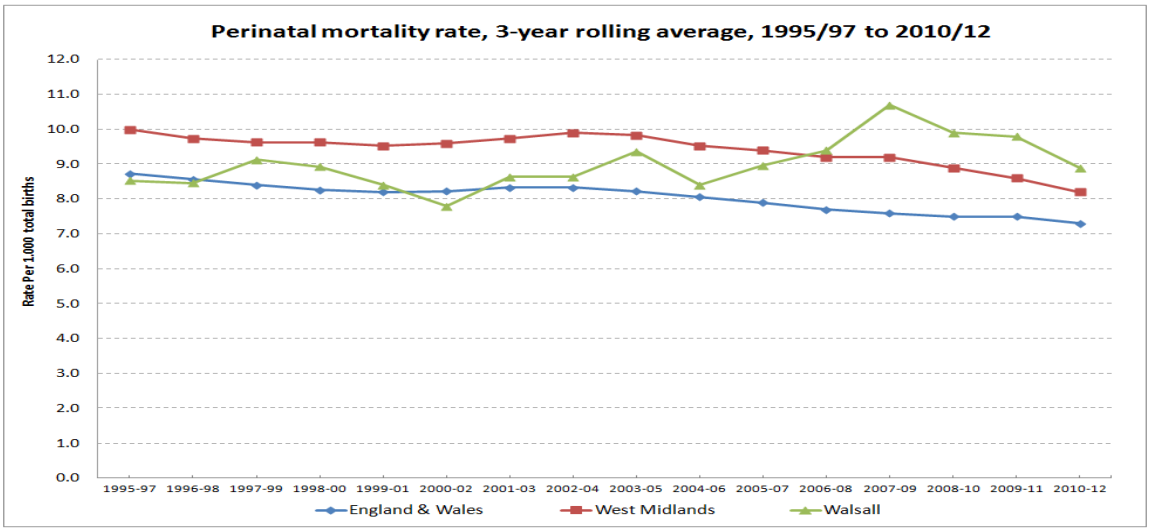
Contributors to infant mortality

- Deprivation
- Smoking in pregnancy
- Low birth weight
- Quality of care during pregnancy
- Maternal Obesity
- Genetic conditions
- Teenage pregnancy
- Substance misuse
- Not breastfeeding
- Sleeping environment
- Poor uptake of immunisation and screening

What is the current situation in Walsall?

In Walsall both infant mortality and perinatal mortality remain consistently higher than regional and national rates. Infant and perinatal mortality are strongly associated with deprivation, with infant mortality rates of less than 5 per 1,000 live births[1] in the least deprived areas compared with rates of 32 per 1,000 in the most deprived areas of Walsall. Reducing health inequalities in infant mortality requires a combination of health interventions and actions on the wider social determinants of health.

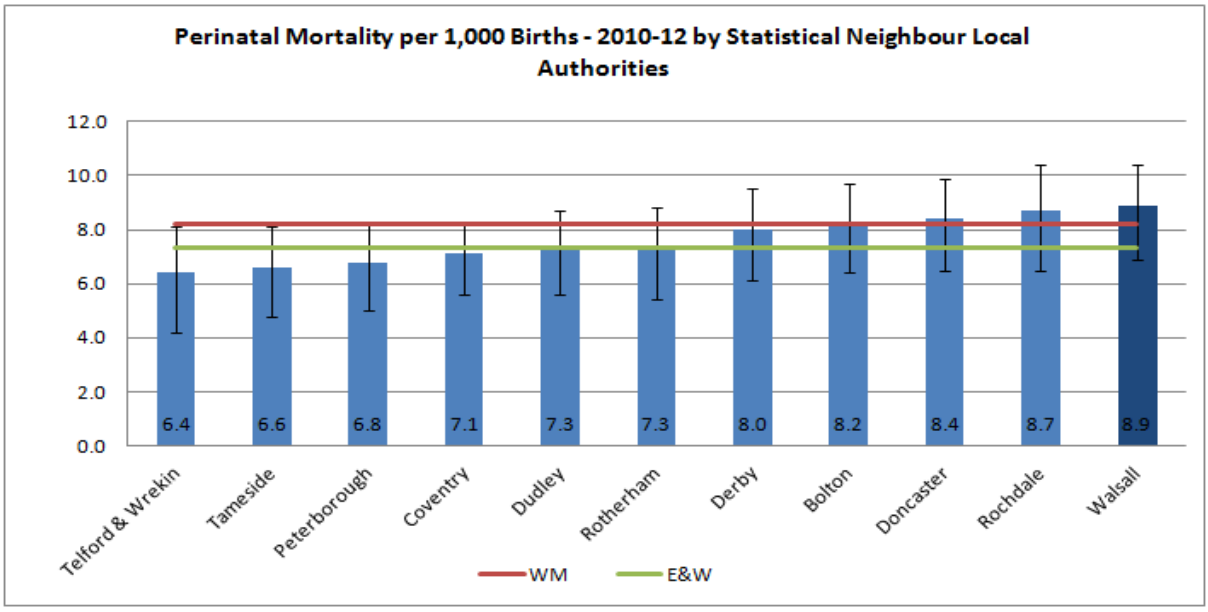
Figure 1 Perinatal Mortality rates, 3 year rolling average, 1995-2012 (Source: ONS)



Perinatal rates for 2010-12 have reduced to 8.9, a reduction from 9.8 the previous year and although they are still above regional and national levels, the gap has reduced.

[1] Walsall Public Health Profiles 2012

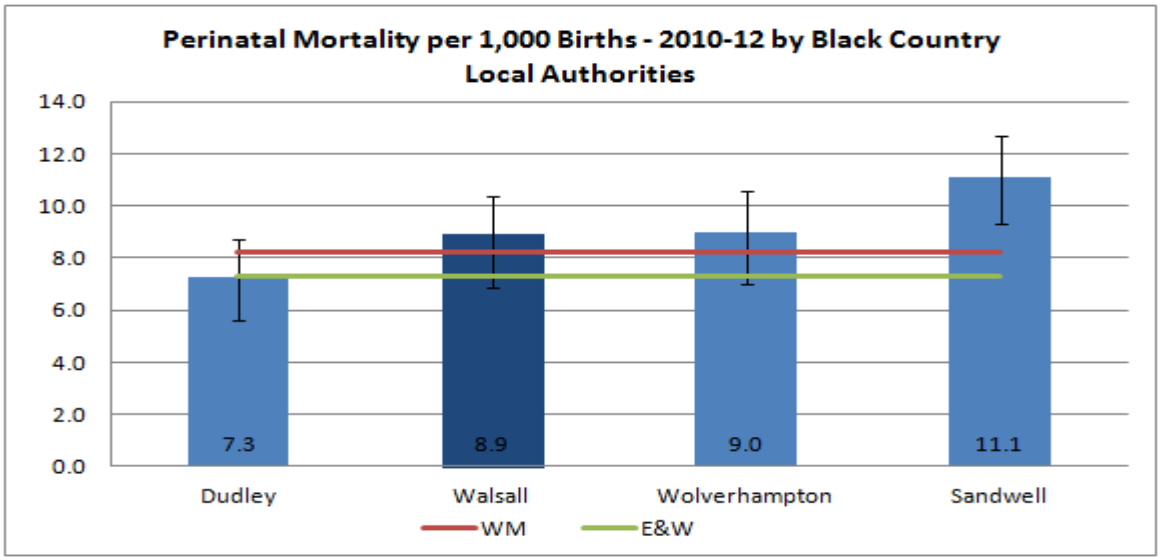
Figure 2 Perinatal Mortality Rates, 3 year rolling average, 2010-12 by Statistical Neighbour Local Authorities (Source: HSCIC)



Even though numbers are small and subject to greater volatility, Figure 2 above shows that Walsall's rate is high when compared to Walsall's statistical neighbours. 3 of the 11 Local Authorities have rates above regional and national levels and 6 of the 11 have rates below both regional and national levels.

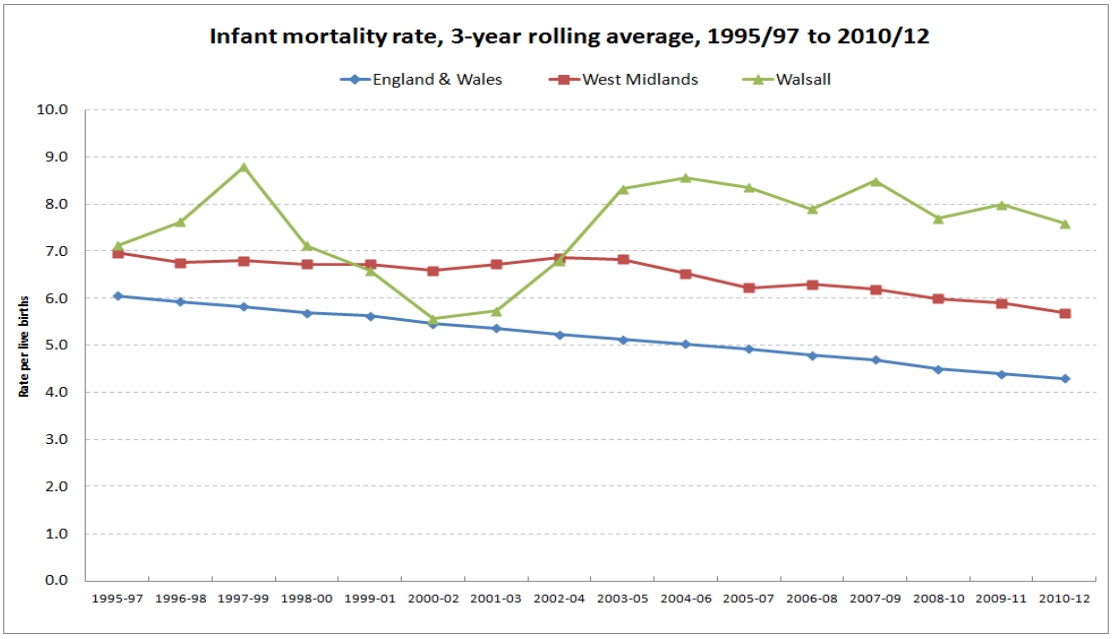
Comparing perinatal mortality to Walsall's Black Country Authorities, (see Figure 3 below), Walsall's 8.9 rate is lower than both Wolverhampton (9.0) and Sandwell (11.1).

Figure 3 Perinatal Mortality Rates, 3 year rolling average, 2010-12 by Black Country Local Authorities (Source: HSCIC)



Rates for 2010-12 for Walsall were 7.6 which is a reduction on the previous year of 8.0. Walsall does appear to be showing signs of reducing, however the gap between Walsall and regional and national rates remains large.

Figure 4 Infant Mortality rates, 3 year rolling average, 1995-2012 (Source: ONS)



As with perinatal mortality, Walsall's infant mortality rate is highest when compared to statistical neighbours (see Figure 5 below). When compared with Walsall's Black Country Local Authorities, Wolverhampton is slightly worse (refer to Figure 6).

Figure 5 Infant Mortality Rates, 3 year rolling average, 2010-12, by Statistical Neighbour Local Authorities (Source: HSCIC)

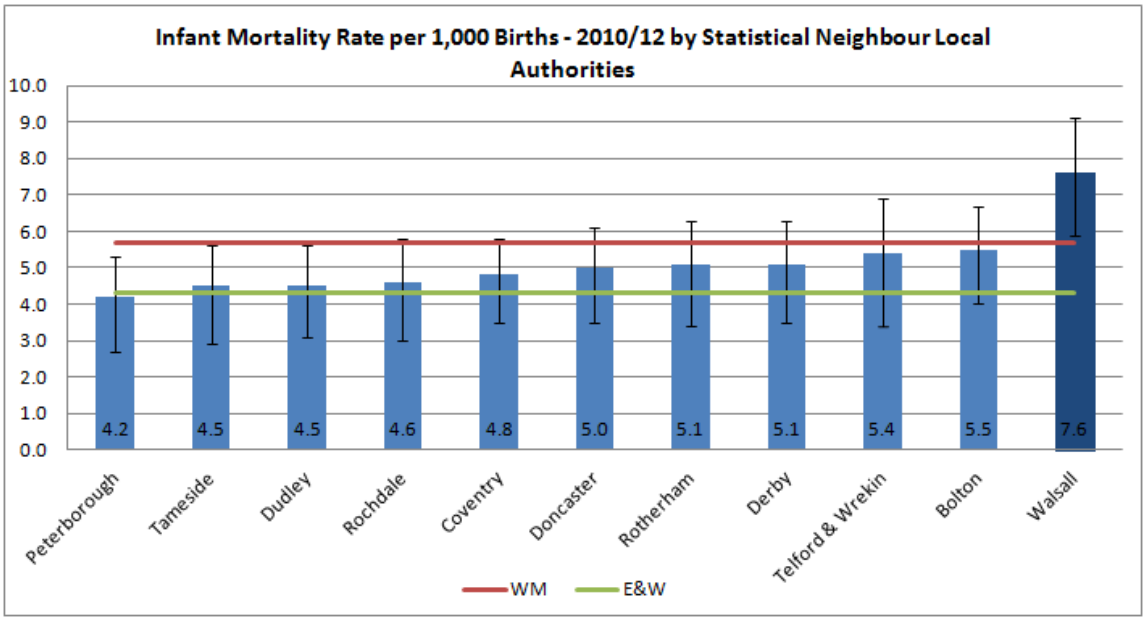
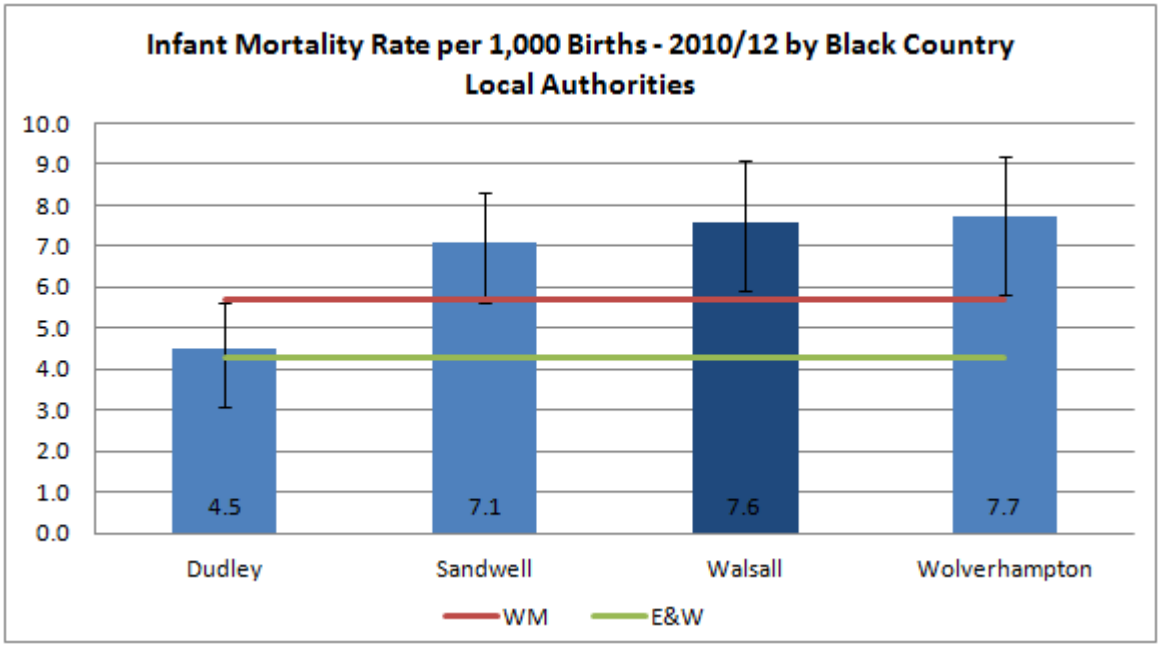


Figure 6 Infant Mortality Rates, 3 year rolling average, 2010-12, by Black Country Local Authorities (Source: HSCIC)



Even though numbers are small and subject to greater volatility a funnel plot analysis of local authority infant mortality rates (See Figure 3) shows that Walsall's level is still high (Walsall shown in red).

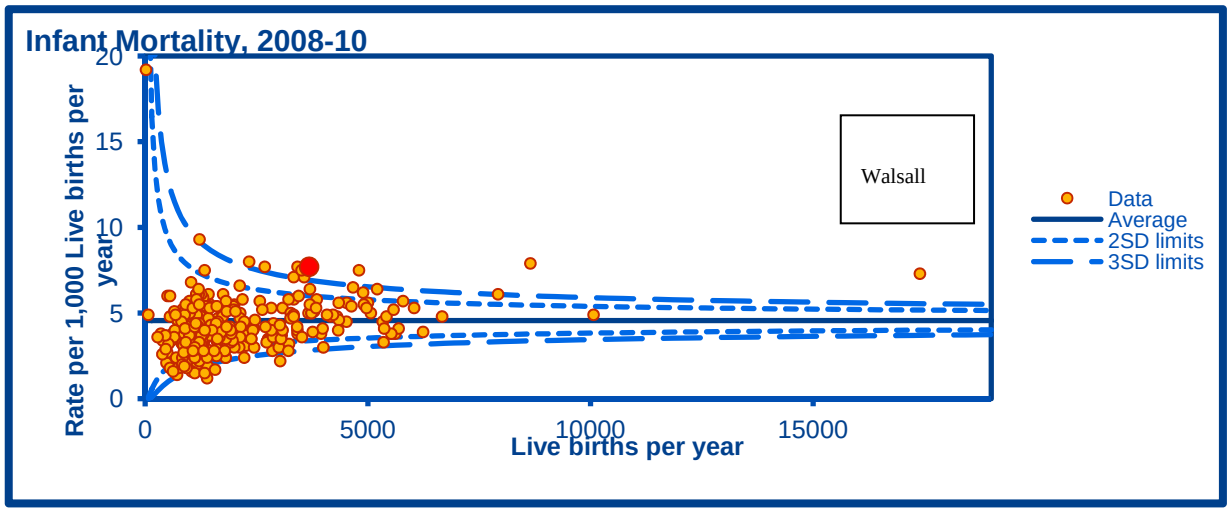


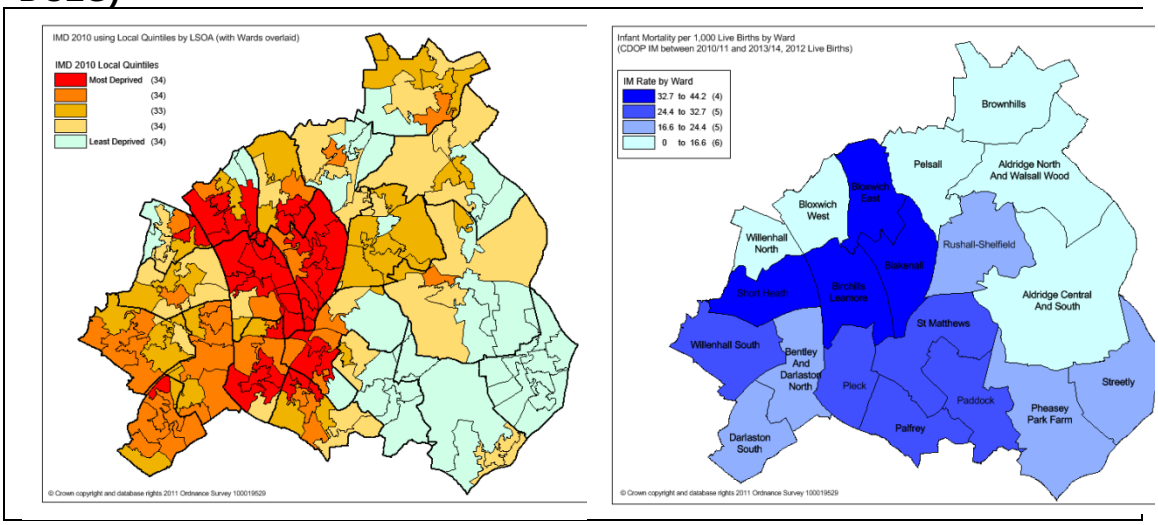
Figure 7 Funnel plot analysis of Infant mortality rates per 1000 live births per year 2008-10, by local authority

Infant Mortality by 2010 Deprivation

Immediately evident is the East / West split – the majority of infant mortalities over that time period occurred to the West of the borough and amidst areas that are highly deprived. There also appears to be a clustering of infant

mortalities to the central and southern areas including St Matthew's, Pleck and Palfrey wards. These areas are highly populated with people from a BME background.

Figure 8 Infant Mortalities mapped by postcode for 2010/11, 2011/12, 2012/13 and 2013/14 as compared to IMD 2010 (Source: CDOP and DCLG)



Infant Mortality by Smoking in Pregnancy

The proportion of women smoking during pregnancy in Walsall is highest within the Blakenall and Bloxwich East wards. Proportions are low to the East and far west of the borough, with the remaining central north to south slice of the borough ranging from 3.9% to 11.7%.

Figure 9 Proportion of women reported to be smoking in pregnancy (Q1,2 & 3 – 2013/14) by Ward (Source: Walsall NHS Hospital Trust)

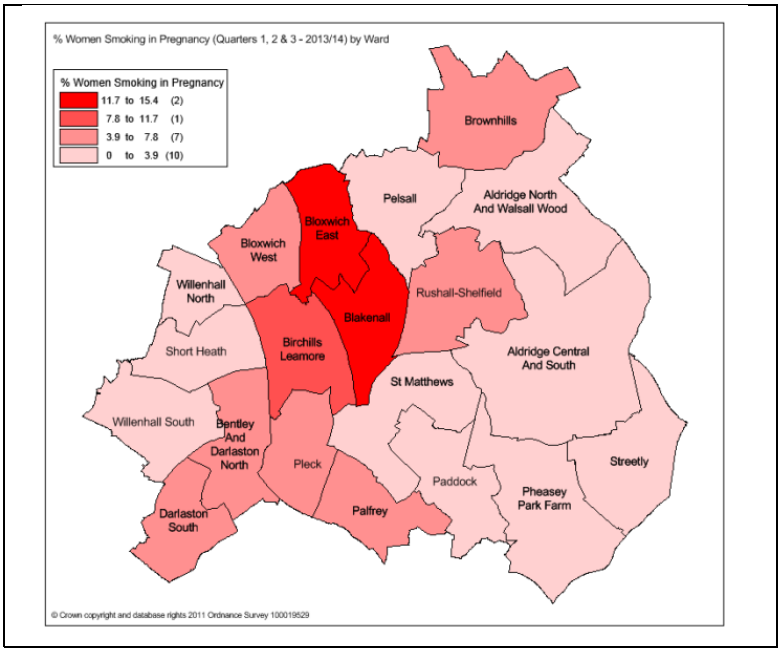
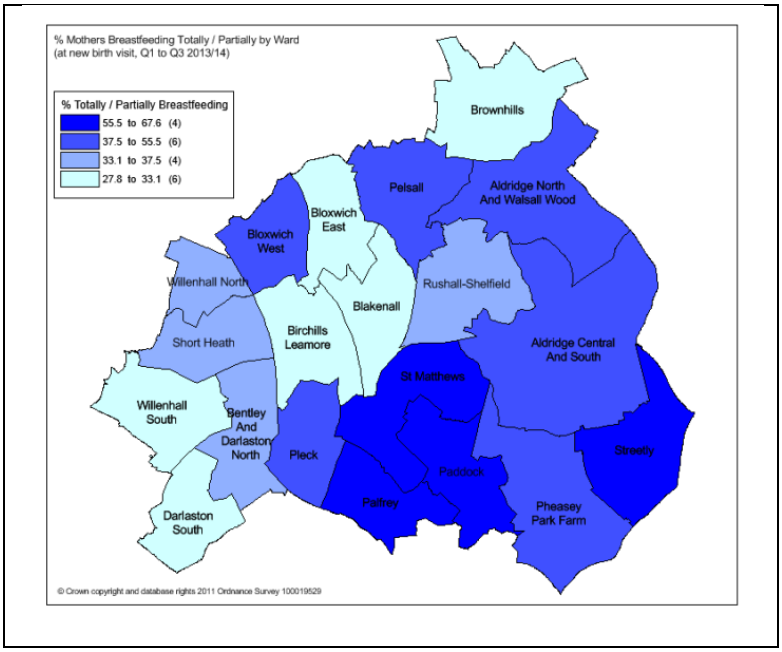


Figure 10 Proportion of women totally / partially breastfeeding at new birth visit for Q1 to Q3 2013/14 (Source: Walsall Hospital Trust)



What are the key actions which will reduce infant mortality?

An audit into infant and perinatal deaths in Walsall completed in 2008 identified four key contributing factors to infant and perinatal deaths in Walsall, namely smoking in pregnancy, consanguinity, maternal obesity and deprivation, which are in turn linked to prematurity and congenital abnormalities.

Some of the key actions to address infant mortality include:

- Improving antenatal care through encouraging early booking for antenatal care, identification and management of social risk factors in pregnancy, continuity of carer through pregnancy and improved detection of intrauterine growth restriction (IUGR).

- Reducing levels of maternal obesity and smoking in pregnancy through projects such as Maternal and Early Years, Smoke Free Homes, improving smoking cessation in pregnancy and working with ethnic communities to reduce the use of ethnic tobacco products

- Maintaining an effective antenatal and newborn screening programme

- Reducing sudden unexpected death in infancy (SUDI) and improving breastfeeding initiation and continuation rates

- Target vulnerable groups through specialised programmes such as the Enhanced Community Genetics service and the Family Nurse Partnership

- Addressing social determinants such as reducing child poverty, improving housing and reducing overcrowding and reducing teenage conceptions, including repeat conceptions are also critical to reducing infant mortality

The Family Nurse Partnership is an intensive support programme for young vulnerable families to guide/support them through pregnancy and first two years of life. Early evidence suggests that this has increased breastfeeding rates and smoking cessation rates amongst participants. Public Health is working with children's services to update the child poverty strategy and action plan. The Children's and Young People's Board has identified child poverty as a key priority.

Robust child death over view and safeguarding structures are in place with a comprehensive work programme to prevent and investigate sudden unexplained death in infancy; training has been offered to maternity and health visitors along with the development of local communication materials**.** There is a comprehensive childhood immunisation programme, in Walsall there is high levels of immunisation uptake.

Walsall Public Health commissions;

- A Maternal and early years service which supports women to maintain a healthy weight in pregnancy
- A smoking cessation services for pregnant women and smoking at delivery has steadily dropped to 13%.
- A breastfeeding peer support service. There has been a steady improvement in breastfeeding uptake at 6-8 weeks of age to current levels of 38%.

Walsall has had an infant mortality reduction plan in place since 2009. Although the infant mortality strategy addresses all the key actions mentioned above, the Infant Mortality Local Implementation Group has further work to do in addressing the wider determinants of infant mortality.

Partnership working - which agencies would need to contribute?

Tackling this combination of disadvantage and its impact on the life chances of children will require many professionals to work together. This will include:

- Maternal and infant health professionals including midwifery, health visiting, Family Nurse Partnership, etc

- Public Health professionals
- Children's centres, nurseries and schools
- Housing
- LA services (including, social workers, Family Support workers, Troubled Family professionals, teenage pregnancy services etc)
- Adult Colleges

Measuring success:

- Reduction in infant and perinatal mortality.
- The following supplementary measures are also used to measure progress in addressing infant mortality.
    - Increase in breastfeeding levels
    - Reduction in smoking in pregnancy
    - Reduction in the proportion of babies who are of a low birth weight
    - Improved access to antenatal screening programmes
    - Reduced admissions of full term babies to neonatal care

Maternity services are currently under review. Key areas of work include:

- Development of a Quality bid to secure the services of a midwifery specialist to undertake a case note audit of alignment to the new PbR pathways and redesigning care pathways to increase efficiency and target the most vulnerable and high risk women;
- Ensuring that the Ante Natal pathway is aligned to the Healthy Child Programme, and targeted for Vulnerable Groups;
- Exploring recent (2012-13/14) SI's, to determine whether there are any key themes emerging;
- Robustly exploring the impact that the MLU has had on quality and outcomes;
- Ensuring safety and quality of services in context of workforce challenges.

Deep dive into Infant Mortality in Walsall

There is an externally commissioned piece of research being undertaken by national experts to identify key factors influencing infant mortality in Walsall and make recommendations as to how these might be tackled.

Congenital anomalies and Consanguineous marriage

Congenital anomalies are also known as birth defects, congenital disorders or congenital malformations. Congenital anomalies can be defined as structural or functional anomalies, including metabolic disorders, which are present at the time of birth.

Congenital anomalies contribute 28% of infant deaths in Walsall (CDOP data 1st April 2010 – March 2014) and contribute to about 1/3 of the extra infant deaths experienced by the 'Routine and Manual' groups as compared with the population as a whole. However congenital anomalies are not universally lethal during pregnancy but they can have a high risk of early death either due to the anomaly itself or the complications of treatment and:-

- are not detectable through screening in pregnancy or
- are detectable through antenatal screening but
- there is poor access to screening or
- low uptake of screening or
- termination of pregnancy tends not to be taken up

The cause of the majority of congenital anomalies is not known although pre-gestational diabetes is associated with a two fold increase in the risk of anomalies and maternal obesity is also associated with congenital anomalies (there is an independent risk from obesity above that associated with diabetes). Consanguinity is a risk factor – overall contribution of consanguinity to congenital anomalies is fairly small but the burden is disproportionately higher in ethnic groups where cousin marriages are the norm. There are also non specific risk factors include maternal age, smoking in pregnancy, alcohol and drug use. There is a four fold higher risk of infant death from congenital anomalies in babies born to mothers of Pakistani origin (remains statistically significant after accounting for levels of deprivation

In Walsall, there are a variety of congenital anomalies contributing to infant deaths, e.g. cardiac anomalies (antenatal detection rates of 35%), diaphragmatic hernia (antenatal detection rates of 64%) and metabolic disorders.

Primary prevention:

High quality universal pre-pregnancy and pregnancy care for women along with optimisation of management before conception for specific women at higher risk of anomalies e.g. diabetes. Availability of genetic services for women with a family or past history of pregnancies affected by congenital anomalies

Secondary prevention:

Prenatal screening and diagnosis followed by offer of termination of pregnancies affected by major anomalies

Walsall PCT commissioned a service from the Women's Hospital in 2009/10 which was decommissioned in 2012/13 for the following reasons:

- Very limited evidence of engagement with the community on genetic literacy
- Very limited uptake of genetics services by the local community
- Some evidence of improved understanding of health professionals but training did not empower health professionals to raise the issue with clients

Teenage Pregnancy

Teenage pregnancy is the pregnancy of females below the age of 20 years old at the time of the end of that pregnancy.

The rate of teenage pregnancy has fallen 30.8% since 1998 from 67.2 per 1,000 to 46.5 per 1,000 in 2012 this compares with a fall of 40.6% nationally from 46.6 per 1,000 in 1998 to 27.6 per 1,000 in 2012 (Q4); The national average has shown to have fallen steadily over the given time period. A similar trend is shown for Walsall up to 2004, however prevalence has increased from March 2007 to March 2009 then has been steadily declining ever since with occasional quarterly increases.

Comparator data

- Nationally Walsall's teenage pregnancy rate of 46.5 in 2012 (Jan-Dec) gives a ranking of 147th out of 149 (3rd highest nationally – Stoke on Trent and Middlesbrough being higher) falling from 143rd in 2011 (Jan-Dec);
- Walsall's rate of reduction of 30.8% since 1998 ranks 104th out of 152 local authorities in England;

Termination data – rate and numbers

In 2011, the abortion rate was 40.3% of under-18 conceptions (91 conceptions). Giving an abortion rate of 18.9 per 1,000 females age 15 to 17 and a maternity rate of 28 per 1,000 females age 15 to 17. This shows an increase from the abortion rate of 17.5 females per 1,000 in 2010 with 36.1% of pregnancies resulting in termination. The maternity rate has decreased from 31.0 per 1,000 in 2011. Walsall shows an abortion rate lower than all three comparator averages and the 5th lowest out of the statistical neighbours: Statistical Neighbours: 42.7% ; West Midlands mets.: 46.5%; England: 49.1%.

Care 2 Learn

Care 2 Learn is funding for childcare provision to enable young parents, predominately mothers, under-20 years to continue their education. The table below shows Walsall to have the highest take up for engagement at under-20 comparatively with its neighbours for 2013/14 (January) ranking 58th nationally. For predominately mothers under-19, Walsall is behind Sandwell and Dudley for mothers under-19 ranking 70th nationally.

	Engaged at 19		Engaged at 20	
LA	**%**	**RANK**	**%**	**RANK**
Birmingham	9.4	104	6.5	112
Solihull	5.7	138	5.6	131
Dudley	13.1	57	8.6	70
Sandwell	12.7	66	8.3	78
Walsall	**12.1**	**70**	**9.2**	**58**
Wolverhampton	8.9	111	7.9	91
Coventry	10.2	92	8.2	81

Mothers under-20 taking up C2L Care to Learn (2013/14 - January)
Source: Education Funding Agency

Walsall to rank 4th highest out of the 8 statistical neighbours [SN Range: 6.6% to 24.9%]; The take up in Walsall of 12.1% is higher than all three comparator averages: Statistical Neighbours (13.7%), West Midlands (10.3%) and England (12.8%);

Work undertaken to address each issue

School Age

In 2013 a part time post was established to support the lead role with school age mums, and to enable Carol to be able to focus on development work alongside her work with school age mums.

Post school age

Teenage Pregnancy part funds a Prospect Personal Advisor role (the other half being funded by IYPSS). The main function of this role is to engage our post school age young mum's in education training or employment. This is a very difficult cohort to engage in EET, partly because they wish to remain at home with their babies, and they do not wish to be separated from their babies or trust provision – no matter how good – to care for them.

Nova training

Nova training are running an accelerate programme aimed at young mum's. Young women are able to attend, receive an allowance and their babies are able to attend an onsite nursery provision. This helps to build young mums confidence, to leave their child at nursery provision.

Teens and Toddlers (Prevention Programme)

Walsall bought the licence to deliver Teens and Toddlers in 2007. The oversight and delivery of this was originally outsourced. However, in 2010 we made the decision to bring it back in-house. Since 2007 we have trained 31 professionals to deliver the Programme. The facilitators come from a range of backgrounds including Targeted Youth Support, Schools, Children's Centres, TLC etc. Of the 31 trained we have 5 who are no longer able to deliver as they have left Walsall employment, 4 have no capacity within their current role to deliver, and 1 is on maternity leave.

The programme runs for 18 weeks (3 hour session), and targets young people at risk of becoming teenage parents. We have targeted our hotspot schools:

- Mirus Academy - 2 programmes per year
- Willenhall E-ACT - 2 programmes per year
- Grace Academy – 2 programmes per year
- 1 Borough wide programme per year which targets young people on alternative provision, LAC, TYS, Care Panel etc.

The young people complete a programme of personal and social development and are matched with a toddler whom they mentor for the duration of the programme. On completion of the Programme they are awarded a National Award in Interpersonal Skills level 1. There are 7-10 young people on each course, 179 young people have started the programme and 97 have completed and gained the full award, 29 are attending programmes which are currently running.

Young people are tracked by Children Our Ultimate Investment UK up to their 19th birthday to see if they become teenage parents. One young person who became pregnant at 16 had completed the programme at 14 years.

National Childbirth Trust

Provide antenatal classes monthly to teenage mum's to be.

Easy SRE website

The Easy SRE website was a launched in June 2013. It is the culmination of several years partnership work between Teenage Pregnancy, Catcher Media, Creative Arts Team, Schools, DV forum, Health and local young people and their parents. This contains all the DVDs which have been produced locally on SRE for all key stages, as well as the 'Is this what you want?' and 'Talk the Talk' DVD's. The website is available and accessible to all professionals working in Walsall for free. The site contains not just the DVDs which are available to download or stream, but lesson plans, and frequently asked questions section and access to professional advice.

The EASY SRE website has been shortlisted as part of the nominations for the UK Sexual Health Awards 2014. We will know the outcome on March 14th 2014.

Brook/School Health

We have recognised that the best way to reach young people regarding SRE is through schools. Schools have been reticent to deliver SRE through PSHE, so to bridge this gap temporarily Public Health commissioned Brook to deliver two sessions of SRE to years 10 and 11, in our hotspot schools Shelfield School, Mirus Academy, Willenhall E-ACT, Grace Academy, Joseph Leckie School and Brownhills School. We also offered sessions to New Leaf, Elmwood, and Castle. The delivery was agreed for academic years 2012-13 and 2013-14. We have also completed an SRE audit of 4 primary schools.

To add sustainability, Brook have now been commissioned to build on this work, by delivering train the trainer to Walsall's School Nurses which means from September 2014 we will be able to deliver the SRE in schools ourselves. They will also:

- Consult with school nursing team on role and requirements for the SRE Toolkit
- Deliver two Traffic Light Training Courses (helps professionals who work with children and young people to identify, assess and respond appropriately to sexual behaviours)
- Develop and produce a SRE Toolkit containing lesson activities and guidance. Topics to include: puberty, relationships, sex, the law and consent, Contraception, STIs, pornography and e-safety. Toolkit will also contain a workshop to be used with parents.

- Produce a template for the school nurse sexual health assessment
- Develop and deliver two two-day train the trainer courses for the implementation of the SRE toolkit(there will be some capacity for a few other professionals working with Children &Young People to access this training possibly TLC Nurse, YPHA,TYS)
- Provide shadowing opportunities between February and April to observe Brook delivery of activities in secondary school.
- The toolkit will be uploaded to the SRE website.

Pathways to prevent second conceptions

The prevention of second pregnancies has always been a concern to Teenage Pregnancy. We have worked closely with Sexual Health, Midwifery, Family Nurse Partnership, and the Manor Hospital. Two pathways have been put in place.

Pathway 1 – all young women will be given contraception advice at 28-32 week appointment, so they can begin to plan what contraception they prefer post natal 'making every contact count'. The packs which they leave hospital with will include condoms. This will then be followed up by YPHA's and Hatherton Centre, to confirm and supply the chosen preventative method.

Pathway 2 – is aimed at our more vulnerable young women such as those who are having their baby removed at birth. Sexual Health and Midwifery are managing this pathway.

Support for terminations

We have a pathway in place which supports those young women who request termination. Walsall Health has agreement in place with Calthorpe Clinic and transport is provided for those accessing via TP.

Additional Information

Migrant population

There have been a significant number of young women from Eastern European countries who are not known within the Authority until they present as pregnant. These young women are not known to Education or Health prior to this, so it is impossible to target for prevention programmes. This is an area that is beginning to be explored with partners to look at how we can identify or reach these young people and their families although we recognise that the issues we are trying to address do not fit with their cultural norms.

Conclusion

It is clear that a great deal of work and effort is undertaken to reduce the level of infant mortality in Walsall. This should be sustained with Partners working together to ensure that every effort is made to reduce instances of infant mortality.

Recommendation

1. **That the Health and Wellbeing Board be invited to consider the 'Health Matters' final report; and;**

2. **That the Chair of the Health and Well Being Board, or a representative, be invited to attend a meeting of the Children's and Young People Scrutiny and Performance Panel in September, 2014 to set out what action is proposed to reduce infant mortality in Walsall.**