	Agenda Item: 15
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22 March 2022**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES - PERI-NATAL AND INFANT MORTALITY TASK FORCE**
Organisation	**Birmingham City Council**
Presenting Officer	**Justin Varney, Marion Gibbon, Sushma Acquilla**

Report Type:	**Information**

1.	**Purpose:**
1.1	The purpose of this report is to update the board of progress made to date by the Birmingham Peri-natal and Infant Mortality Task force. The main report is a video presentation.

2.	**Implications:**	
BHWB Strategy Priorities	Reducing Perinatal and Infant Mortality in Birmingham and Solihull	Y
	Reducing Health Inequalities	Y
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		Y
Health Protection		

3.	**Recommendation**
3.1	The board to note the contents of this report.

4. Background

4.1 A report was prepared for Birmingham Health Overview and Scrutiny in 2020 and a request for an in-depth piece of work to consider the figures for infant mortality in Birmingham and the contributing factors which was presented to HOSC in December 2020.

4.2 A series of recommendations were posed which consisted of:

1. To work with partners to establish a multi-agency 'Reducing Infant Mortality in Birmingham' Task Force to oversee a concerted effort by all relevant agencies to achieve a substantial reduction in infant mortality in the city. The Task Force should include the existing Local Maternity System, Clinical Genetics representation, commissioners and other maternity services such as BCHC, plus BCC Public Health, representatives of the CVS sector and elected Member, with a brief to bring the threads of all related interventions together in a concerted and mutually reinforcing programme. It should also identify and address any factors that may discourage some parents from engaging with their maternity service professionals.

2. To set an ambitious goal to reduce infant mortality by 50% in Birmingham by 2025 (from 2015 figures, matching the national target) but to then go further and eliminate the gap between infant mortality rates in Birmingham and the England average by this date. This should be accompanied by a delivery plan that can plausibly demonstrate how these targets can be met, identifying both the structural and modifiable factors underlying the infant mortality within the City.

3. To develop a strong community awareness strand within the Task Force work programme, led by respected and trusted community groups, local community and faith leaders, and other influencers who are engaged in social media. This should be targeted at improved health behaviours, identifying and supporting families facing material hardship and adverse stressful circumstances, early detection of poor baby growth, and empowering people to make healthy life choices that minimise their infant mortality risk factors. This will include ensuring up to date information is available, including current and likely future trends in consanguineous unions in Birmingham.

4. The work of the Task Force should be tasked to consider and adapt the 'four strands' approach put to us by Professor Salway and access any resource and support available nationally.

5. Progress towards achievement of these recommendations should be reported to the HOSC no later than 30th October 2021. Subsequent progress reports will be scheduled by the Committee thereafter, until all recommendations are implemented.

4.3 A tracking report was provided for HOSC on the progress of each of the recommendations in October 2021 detailing the progress of the recommendations (see **Appendix 1**).

4.4 As part of shaping the approach to creating a positive discussion, regarding both desire and preparation for pregnancy, Birmingham City Council commissioned qualitative research targeting 'seldom heard' communities across Birmingham. The groups included: Bangladeshi and Pakistani, Chinese, Eastern European, Black African and Caribbean and women with particular needs, including learning disabilities. A report was written which captures the findings and recommendations from these conversations. It is currently being finalised.

4.5 In response to Recommendation 1 of the HOSC report, a Task Force was established, and an Independent Chair was appointed by Birmingham City Council on 23rd August 2021. The Task Force has been established for a period of time to take an accelerated evidence-based and data-driven approach with organisational partners and communities to reduce perinatal and infant mortality across the city.

4.6 The membership of the task force was selected and agreed by the Infant Mortality Task and Finish Group that was established to report on Infant Mortality in Birmingham for the HOSC.

4.7 Their first workshop was held on 21st September 2021 involving over 30 stakeholders and representing professionals from 12 different organisations. The first meeting of the task force was held in January 2022 where the terms of reference were agreed and suggestions to expand the membership were discussed and agreed.

4.8 It was agreed that:

- The Task force will work in 3 work streams led by the designated members of the task force, leading each stream. Work stream leaders can choose to include individuals that may not be members of the task force and report progress at the Task force meeting. Following were agreed as the three groups:

- **Research Group: to be established** by Richard Kennedy. It will create research evidence build on previous work and draw on the national and international evidence base. Research questions on belief and attitude should be included**.**

- **Innovation and co-production of possible solutions: to be led by Marion Gibbon.** To draw on lived experience of citizens and professionals to shape its thinking and will connect with a broad base of academic resources across the city from different disciplines.

- **Implementation of Key actions:** in the short, medium and long term, that will reduce the rate of perinatal and infant mortality in Birmingham and will provide advice and monitor implementation of these actions. It will also look at the quality improvement in the existing service and identify gaps.

- In addition to the three agreed workstreams, the appointed chair – Sushma Aquila - decided to have 1 to 1 meetings with the individuals who had experience of the topic and were interested in making a difference. This included not only the members of the task force but also the individuals identified by those who were interested but not the members of the task force.

The findings from these interviews will in turn provide the input for action into three workstreams.

- It has been agreed with the DPH and the members of the Task Force, items that can be implemented in the service as follows:

    1. Ethnicity to be recorded in near 100% maternity patients
    2. Those at risk should be flagged and monitored carefully.
    3. All pregnant women advised re obesity, diabetes and smoking risk factors. To add vaccination as current requirement.
    4. Any women with having a stillbirth / infant loss referred for bereavement and future pregnancy planning at 6-8 weeks and not at 3 months. Ideally this visit should be with partner accompanying the women.
    5. Pre-Pregnancy health/ consanguinity/ genetic test availability should be taught in the school and not wait till later.
    6. Complicated premature delivery should only be done in the level 3 main hospital with good neonatal facility.
    7. Treatment pathway should be developed and followed in the maternity hospitals.
    8. Community facility to be provided where minority women can meet and discuss their issues openly.

- **For constitution of task force** (see **Appendix 2.)**
- **Accountabilities**

    1. The task force will be accountable to the Creating a City without Health Inequalities Forum.
    2. The Task force will help determine, shape and implement key priorities to deliver improved perinatal and infant mortality and reduce inequalities, during the next year

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	This report is to update the board on the progress being made by the Birmingham Perinatal and Infant Mortality Task force set up in September 2021 by the Birmingham Council.

5.2	Management Responsibility
	The task force is accountable to the Health and wellbeing Board through the Director of Public Health.

6.	Risk Analysis		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Lack of engagement from partners	Low	High	Ensure are partners informed and involved throughout
Lack of involvement from women and families	Low	High	Ensure co-production throughout
Task force does not complete actions within agreed time frame	Medium	Medium	Close monitoring of agreed actions by task force and subgroups

Appendices
Appendix 1 - Infant Mortality Tracking Report **Appendix 2** - Membership of the Taskforce **Appendix 3** - Draft Development Plan

The following people have been involved in the preparation of this board paper:

Sushma Acquilla, Marion Gibbon.

Appendix

Appendix 1.

Infant Mortality Tracking Report October 2021.pdf

Appendix 2.

Task Force Membership:

- Independent Chair
- Chair of Child Death Overview Panel
- Birmingham City Council (secretariat)
    - Public Health Children & Young People's Lead
    - Children's Commissioning Lead
- NHS Birmingham & Solihull
    - Children & Maternity Commissioning Lead
    - Local Maternity System
- Maternity & Paediatric Providers
    - Birmingham Women's and Children's NHS Foundation Trust (Obstetrician or foetal medicine Paediatrician)
    - University Hospital Birmingham NHS FT (Obstetrician or Paediatrician)
    - Sandwell and West Birmingham (obstetrician or paediatrician)
    - Genetics department of BWCNFT
    - Midwifery Services Lead
- Birmingham Voluntary & Community Sector
- Academic representatives
- Elected Member
- It has been suggested that Bereavement Nurse/ HV should be invited.

Appendix 3.

Draft Development Plan:

1. Research and innovation
2. Co-production and community engagement
3. Implementation

Priority themes, objectives and actions

1. Quality, safety and access to services

Objectives	Themes from discussion 1:1
Improving access to the system	Best care for women knowing How and what to do Plenty of good guidance is available but problem with implementation of guidance Move towards "Package of care"

Strengthen preconception care services and engagement	Vitamin D and Folic acid deficiency Non invasive prenatal screening. Holistic support and care for next pregnancy Implementation of good practice Reducing preterm births: pre pregnancy Counselling Pre-conception panel genetics Advice re losing weight before next pregnancy / poverty issue Community side of the care is missing sometimes, hence pre-pregnancy/ pre conception advice is not available.
Increase engagement with antenatal services and promote the benefits of antenatal care	Services are better for high alert patients Care drops after 2nd delivery in hospital Risk assessment best done by Fetal medicine nurse /HV Improving access to the system HBA1C needs to be introduced as routine test in pregnancy. Quality standards in antenatal care are important factors.
Increase awareness regarding genetic services	More education is required in school on preventable causes Rare conditions recorded at delivery but may not be seen as problem – prompt referral Difficult to change as 90% of Consanguineous couples may produce normal child
Training of health care workers and clinicians in cultural compassion	Women feel that there is structural racism and lack of trust and respect. There are superstitions and cultural behaviours that do not help Holistic support and care for next pregnancy get a group of women and arrange meeting to educate them and empower women in decision making
Training regarding postpartum contraception	Implementation of good practice Move towards “Package of care” Need to improve maternal post partum care/ postnatal checks.

Appropriate assessment and referral during pregnancy and support during birth	Services are better for high alert patients Care drops after 2nd delivery in hospital Risk assessment best done by Fetal medicine nurse /HV Non invasive prenatal screening. Risk assessment and risk management
Develop excellence in reducing injury in premature Births	Use literature from other areas like Manchester. Plenty of good guidance is available but problem with implementation of guidance Adverse outcome if born in separate local unit without adequate neonatal support. Adverse outcome for hypothermia in babies at the time of resuscitation. Both can be avoided by complicated/ premature deliveries to be done in Level 3 women's hospital and Transthermot heating pack cover the baby and avoid hypothermia. Monitor breathing cycle during "golden hour" Midwives have an important role for those who have had premature delivery before.

2. Maternal and infant wellbeing

Objectives	Theme group
Support women to stop smoking and promote smoke free homes	Smoking cessation Immediate action could be taken on major risk factors in women i.e. Obesity/ smoking/ diabetes/ socio economic factors Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Housing issues: overcrowding
Support maternal mental health and wellbeing	Re establish women's centre for exchange of information/ education Re establish children's/ women's Centres like Sure start get a group of women and arrange meeting to educate them and empower women in decision making
Reduce maternal obesity and improve nutrition	More education is required in school on preventable causes Immediate action could be taken on major risk factors in women i.e. Obesity/ smoking/ diabetes/ socio economic factors Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Housing issues: overcrowding

Encourage and support breastfeeding	
Support families in health and genetic literacy	More education is required in school on preventable causes get a group of women and arrange meeting to educate them and empower women in decision making Service providers need to change attitude Families are now coming forward for tests and new generations are changing. Access to information for young couples Intervention not accepted due to religion and get judged on the decision Adoption and milk bank not accepted in religion Rare conditions recorded at delivery but may not be seen as problem – prompt referral
Alcohol and substance-misuse support during pregnancy and postnatally	

3. Addressing the wider determinants of health

Objectives	Theme group
Support efforts to reduce and mitigate the impact of poverty	Wider public health determinants to be addressed i.e. pollution and Poverty Income poverty and quality standards in antenatal care are important factors.
Housing	Wider public health determinants to be addressed i.e. pollution and Poverty Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Hosing issues: overcrowding
Identify and address poor environments	Wider public health determinants to be addressed i.e. pollution and Poverty
Working with homeless team to support vulnerable mothers and infants	

4. Safeguarding and keeping infants safe from harm

Objectives	Actions
Safe sleeping	More education is required in school on preventable causes
Safe home environments	More education is required in school on preventable causes
Prevention of injuries	More education is required in school on preventable causes
Reduction in domestic abuse during pregnancy and motherhood	More education is required in school on preventable causes "I can cope" not shaking the baby

5. Providing support for those bereaved and affected by baby loss

Objectives	Theme group
A system-wide approach to making things as easy as possible for bereaved families	counselling for those who have lost a baby-(3 months after)
Strengthen pathways to ensure people who have had a loss receive enhanced support for their next pregnancy	Holistic support and care for next pregnancy Timing for postnatal bereavement 5-6 wks Late loss in pregnancy and stillbirths should be one of the research priorities
Increase the skills and confidence of the wider workforce to talk about bereavement	Timing for postnatal bereavement 5-6 wks