CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board
27 April 2016

Report title	Infant Mortality Scrutiny Review Update	
Cabinet member with lead responsibility	Councillor Sandra Samuels Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, People	
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Service Director Public Health and Wellbeing
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Report to be/has been considered by	Public Health Senior Management Team Meeting	4 February 2016
	People Leadership Team	8 February 2016
	Scrutiny Board	1 March 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Consider progress made to implement the recommendations from the Infant Mortality Scrutiny Review that concluded in March 2015.

1.0 Purpose

1.1 The purpose of this report is to update the Board on the implementation of the recommendations of the Infant Mortality Scrutiny Review that was undertaken from July 2014 to March 2015 to gather evidence in relation to the high rate of infant mortality in Wolverhampton.

2.0 Background

2.1 The National Child Health Profiles published in March 2014 indicated that Wolverhampton had the highest rate of infant mortality in England. The average rate of infant mortality between 2010 and 2012 was 7.7 deaths per 1,000 live births compared to the England average of 4.3 deaths per 1,000 live births.

2.2 This high rate of infant mortality raised concerns across health and social care organisations and resulted in the convening of a multi-agency infant mortality working group in May 2014.

2.3 A Health Scrutiny Review commenced in July 2014 to assess the effectiveness of current and future work aimed at addressing modifiable factors that are the main causes of infant mortality in Wolverhampton. The review group met on seven occasions to consider written and verbal evidence from local and regional organisational and professional representatives.

2.4 The detailed consideration of the evidence presented to the Review group resulted in the development of twelve recommendations outlined in the executive report found in appendix one.

2.5 All review recommendations were approved by Cabinet on 22 July 2015 and the Health and Wellbeing Board on 7 October 2015.

3.0 Infant Mortality Scrutiny Review Update February 2016

3.1 There has been good progress on the implementation of the recommendations arising from the Infant Mortality Scrutiny Review. Overall there has been strong multi-agency commitment to delivering the recommendations and collective partnership working to improve outcomes, underpinned by the infant mortality working group.

3.2 The twelve recommendations produced following the infant mortality review are divided into three specific areas:

- The importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton
- A strategic and co-ordinated response to tackle the modifiable causes of infant mortality in Wolverhampton and also respond to the challenges of dealing with the effects of poverty and deprivation

- Changing practices and policies and apply learning based on reliable evidence as to their impact and effectiveness in reducing the rate of infant mortality.

3.3 The concise detail of progress against the recommendations is documented in appendix one. In summary:

3.3.1 *Co-ordinating local efforts*

- Additional carbon monoxide monitors were purchased in December 2015 to support screening in pregnancy at every antenatal visit and at key contacts in early infancy
- 1983 pregnant women were screened between April 2015 and January 2016
- 405 referrals were received by the Healthy Lifestyle Service; this represents 20% of the women screened
- There was a 20% (81) uptake of referrals from the antenatal clinic
- There has been a steady reduction in the proportion of women smoking at the time of delivery over the first two quarters of 2015/16 (16.9 and 16.6 respectively). Previous annual percentage 18.8 (2014/15).
- A postnatal parent education programme, 'Reducing the Risk' commenced in January, funded by Public Health and delivered by the neonatal unit. This programme is for parents with premature infants and other vulnerable mothers in Wolverhampton referred from midwifery services. The aim is to teach parents basic life support skills, promote breast feeding and safe sleeping alongside dietary advice and smoking cessation.

3.3.2 *Dealing with the effects of poverty and deprivation*

A stakeholder event is planned for 14/15 March 2016 to promote safe sleeping practices, supported by the Lullaby Trust. Local risk factors for modifiable causes of infant mortality will be shared at the event alongside progress on delivery of the recommendations of the infant mortality action plan.

3.3.3 *Changing practices and policies*

- Careful consideration is being given to the implementation of a smoke-free site at Royal Wolverhampton NHS Trust hospitals to take into account how a policy can be enforced without compromising staff safety. Further work is required and will be informed by an audit of practice against smoking cessation guidance produced the National Institute of Health and Care Excellence (NICE).
- A specific programme to deliver Making Every Contact Count (MECC) training was developed by the Healthy Lifestyles Service and training disseminated widely within the acute trust setting for individuals working with pregnant women and new mothers.

4.0 Scrutiny Board Recommendation

4.1 The Infant Mortality Scrutiny Review Update for February 2016 was presented to the Scrutiny Board on 1 March 2016. The Board requested that the review was closed subject to receiving an annual update on the implementation of the recommendations.

5.0 Financial implications

5.1 There are no explicit funding implications arising from implementation of the recommendations of the Infant Mortality Scrutiny Review. All costs associated with the Infant Mortality are met from existing budgets within Public Health. [GS/05022016/M].

6.0 Legal implications

6.1 There are no anticipated legal implications associated with the content of this report. RB/0302015/J

7.0 Equalities implications

7.1 An initial equalities analysis screening has not identified any equality issues at this stage. There are no concerns that implementation of the recommendations arising from the Infant Mortality Review could adversely affect people differently or not meet the needs of certain groups. Inequalities were highlighted during the review process and the recommendations were developed to ensure that these inequalities were addressed.

8.0 Environmental implications

8.1 There are no environmental implications related to this report.

9.0 Human resources implications

8.1 There are no anticipated human resource implications related to this report.

10.0 Corporate landlord implications

10.1 This report does not have any implications for the Council's property portfolio.

11.0 Schedule of background papers

11.1 Scrutiny Review of Infant Morality – Final Report, 21 May 2015.

This report was presented to:

- Cabinet on 22 July 2015
- Health and Wellbeing Board 7 October 2015

Appendix 1
Section one: Executive response - Scrutiny Review of Infant Mortality

The importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton

Recommendation 1

1. The Service Director- Public Health and Wellbeing to be responsible for collating a coordinated response from the officers responsible for to the following recommendations listed below. The Service Director to advise Scrutiny by presenting a report to Scrutiny Board with details of progress in implementing all the accepted recommendations and necessary follow up action, as appropriate, where accepted recommendations have not been implemented. The Scrutiny Board report to be presented to the Infant Mortality Working Group for information and comment:

a) Royal Wolverhampton NHS Trust to coordinate a response from the maternity, healthy lifestyles living and health visiting services which details specific actions aimed at increasing the percentage of pregnant women setting a smoking quit date, indicating where the results are either not known or lost to follow up. The report to include details of the take-up rate of nicotine replacement therapy and the number who have set a quit date.

b) Royal Wolverhampton NHS Trust to coordinate a report from maternity, healthy living lifestyles and health visiting services on progress in the use and results of carbon monoxide testing of pregnant women at every contact. The report to include feedback from pregnant women recorded as smoking and subsequently referred, about their experiences of the stop smoking service.

c) Royal Wolverhampton NHS Trust to present a report on a review of effective interventions aimed at reducing the numbers of women smoking during and after pregnancy.

d) The lead officer for infant mortality at Wolverhampton Clinical Commissioning Group (CCG) to report on current commissioning arrangements and the extent to which services for pregnancy and infancy are delivering the right mix of enhanced and targeted interventions for pregnant women, particularly vulnerable women considered to be at risk.

e) A report on the benefits of providing a Pepi-Pod crib or similar alternative cot in Wolverhampton. A report of the potential value of using a mobile phone app for parents and parents-to-be with personalised information and content approved by doctors and midwives that spans from pregnancy right through to the first six months after birth. The schemes, if introduced, should be initially targeted a vulnerable women and the findings published with recommendations about a possible future roll out across the City.

f) The Service Director – Public Health and Wellbeing to work with lead officers from key partners to for infant mortality at Wolverhampton CCG to detail proposals to discuss proposals to make best use of available local intelligence in order to help with the early identification better of identify vulnerable pregnant women mothers and provide appropriate targeted interventions that can support them and contribute to the overall aim of reducing the numbers of infant deaths. The findings to be shared with the Wolverhampton Health and Wellbeing Board, and Wolverhampton CCG Governing Body and the Infant Mortality Working Group.

g) To invite Directors of Public Health across the West Midlands region to share examples of best practice in respect of delivering an effective smoking cessation programme to pregnant women and to discuss further opportunities to promote the adoption of best practice across the region.

h) The Service Director – Public Health and Wellbeing and the Chair of the Child Death Overview Panel (CDOP) to jointly report on progress in recruiting staff to collate current and future statistics. Analysis of comparative data at a regional level to be included in future annual reports.

i) The Chair of the Child Death Overview Panel (CDOP) to publish the annual report for Wolverhampton to be published prominently on the Council's website and also the findings shared with key local agencies to promote good practice and improve the quality of local intelligence.

j) The Service Director- Public Health and Wellbeing to report on outcome of review of the national funding formula for 2016/17. (The formula is used to calculate the number of health visitors that an area needs to deliver safe and effective services.)

Comment		**Timescale/progress so far**	**Officer Responsible**
	1a-c **Accepted** The draft scrutiny report was presented to the Infant Mortality Working Group (IMWG) on Friday 8 May 2015. Representatives across the whole working group were present, including representatives in relation to recommendations 1a – 1c.	1b. CO monitors have been purchased for midwifery and health visiting services and training will be delivered to support delivery. A more detailed response by responsible organisations/services will be required at the Infant Mortality Working Group (IMWG) at the November 2015 meeting.	Ros Jervis, Service Director, Public Health and Wellbeing (SDPHW)

	Everyone is aware of the need to respond collectively to these recommendations regarding quit rates, use of carbon monoxide monitors (CO), nicotine replacement therapy and the use of stop smoking services in general by pregnant women.	**February 2016 Update: 1a-c** • CO monitors are being used by midwifery, health visiting and healthy lifestyles service. Additional monitors were ordered in December 2015. • 1983 women were screened between April 2015 and January 2016 • 405 referrals were received by the Healthy Lifestyle Service; this represents 20% of the women screened • There was a 20% (81) uptake of referrals from the antenatal clinic • More detailed information on stop smoking services in pregnancy is contained with the Healthy Lifestyle Service report in section six.	
	1d **Accepted** The executive nurse (EN) for the CCG alongside the Designated Doctor for Child Deaths (DDCD) will respond in detail to this recommendation. ***Manjeet Garcha*** has provided a detailed response to the recommendation – see section two.	A more detailed response by responsible organisations/individuals will be required at the IMWG at the November 2015 meeting. **February 2016 Update** It is acknowledged that local intelligence can come from many sources; this intelligence should be disseminated across services to ensure appropriate consideration is given to the impact on relevance of the information on care needs along with any additional education required by providers. In addition, General Practitioners are the primary point of access for pregnant women to maternity services. There is guidance in place for GPs and this is being added to the new GP pathway system currently being implemented in Primary Care. Information sharing between the patients GP and midwife has also been discussed with the Practice Manager Lead/Forum and mechanism are in place. A report has been produced by the CCG and is detailed as an update in section four.	Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

	1e **Accepted** Public Health to undertake an evidence review in relation to available information relevant to use of: i. pepi-pod or alternatives ii. phone applications for personalised information Cost effectiveness will be evaluated where possible	A more detailed response will be reported by Public Health to the IMWG at the November 2015 meeting. **February 2016 Update** (i) Pepi-pod: An evidence review of pepi-pod was completed and the key findings were that the pepi-pod is an infant sleep space culturally tailored for the Maori population and delivered as part of a wider programme to support vulnerable families to prevent sudden unexplained deaths in infancy (SUDI) and may not be easily transferable for use within Wolverhampton. There is no published evidence of the effectiveness of the use of the pepi-pod and some evidence of an increased risk of SUDI with the use of other infant sleeping equipment. A randomised control trial is currently in progress in New Zealand comparing the pepi-pod to another sleeping device. The results will be available late 2016 and will be reviewed to assess effectiveness and cost effectiveness within a UK setting (ii) Phone applications: Whilst there has not been a formal evaluation of 'phone applications for pregnancy and infancy, the application produced by Best Beginnings has received multiple endorsements from key professional bodies such as Royal College of Midwives; Royal College of Obstetrics and Gynaecology and the Faculty of Public Health. The application has been produced in collaboration with health care professionals and is actively promoted locally and used by some mothers.	Ros Jervis (SDPHW)
	1f **Accepted** Public health working alongside EN for CCG, maternity and children services will review the vulnerable women's pathway. There is also a proposed task and finish group to discuss and develop a conception to	A more detailed response by responsible organisations/services will be required at the IMWG at the November 2015 meeting. **(Please read in conjunction with recommendation 2)** **February 2016 Update** Detailed report presented at the May 2016 IMWG to include action against the linked recommendations 1f, 2 and 6. This can	Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

	age five pathway which will also address vulnerability) ***Manjeet Garcha*** has provided a detailed response to the recommendation – see section three.	then be reported to either the Health Scrutiny Board or HWBB (or both).	
	1g **Accepted** Public Health to work with Public Health England on a regional basis in terms of gathering and sharing good practice that supports women to stop smoking during pregnancy and to continue not to smoke after delivery.	A more detailed response will be reported by Public Health to the IMWG at the November 2015 meeting. **February 2016 Update** Regional documents to support smoking cessation during and after pregnancy have been produced by Public Health England and circulated to all relevant organisations.	Ros Jervis (SDPHW)
	1h & 1i **Accepted** Public health working alongside the Chair of the Child Death Overview Panel (Joint) to report on the review currently being undertaken which will be completed by end June 2015.	A more detailed response by the Chair of the Child Death Overview Panel will be required at the IMWG at the November 2015 meeting. CDOP agree to publish the annual report through the WSCB. **February 2016 Update** The Annual report from the Child Death Overview panel is due at the end of January/beginning of February 2016 and once available will be forwarded for publication on the Council website	Chair of the Child Death Overview Panel
	1j **Accepted** SDPHW has submitted a response to the consultation on the national funding formula for 2016/17. A national response is awaited.	It is possible that a national response will be published in December 2015. **February 2016 Update** As of 2 February 2016, a national response is still awaited.	Ros Jervis (SDPHW)

Recommendation 2 Wolverhampton Clinical Commissioning Group (CCG) and the Service Director - Public Health and Wellbeing to agree a programme of work that supports enhanced targeted interventions for high risk families or vulnerable mothers with new babies identified by maternity services; including advice on contraception to avoid unplanned early repeat pregnancy, and support pregnancy spacing. This should include post natal support in the first few weeks of life aimed at parent education and support to reduce the risk of infant death after discharge from the neonatal unit/post natal ward.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Public Health working alongside EN for CCG, maternity and children services will review the vulnerable women's pathway. There is also a proposed task and finish group to discuss and develop a conception to age five pathway which will also address vulnerability.	A more detailed response by responsible organisations/services will be required at the IMWG in November 2015. (**This must be read in conjunction with recommendation 1f**) **February 2016 Update** A postnatal parent education programme, 'Reducing the Risk' commenced in January, delivered by the neonatal unit. This programme is for parents with premature infants and other vulnerable mothers in Wolverhampton referred from midwifery services. The aim is to teach parents basic life support skills, promote breast feeding and safe sleeping alongside dietary advice and smoking cessation. Detailed report to be presented at the May 2016 IMWG to include action against the linked recommendations 1f, 2 and 6.	Ros Jervis (SDPHW)

Recommendation 3

The Black Country clinical representative of West Midlands Maternity and Children's Strategic Clinical Network in discussion with representatives of SSBC Newborn and Maternity Networks to jointly present a report to the Infant Mortality Working Group regarding care pathways for anticipated extreme preterm births.

The report to include an update on work towards improving survival rates for this cohort and also progress on the outcome of discussions with West Midlands Ambulance Services about improving care pathways for intrauterine transfers of pregnant women in preterm labour. The overall aim of the policy is for pregnant women in preterm labour to be taken to the most appropriate hospital for the safe delivery and on-going care of their baby.

Comment	Timescale/progress so far	Officer Responsible
Accepted This recommendation will be addressed via the Black Country SCN lead update on infant mortality which will incorporate current discussions on intrauterine transfers across the network.	A final report will be presented to the IMWG in November 2015 with a view to a future joint presentation to the Health Scrutiny Panel. **February 2016 Update** A meeting of the Black Country Strategic Clinical Network was held on 26 January 2016 and the outcome of discussions will be reported at the May 2016 meeting of the Infant Mortality Working Group.	Ros Jervis (SDPHW) alongside either a representative of the SCN or Tilly Pillay, Neonatal Lead, The Royal Wolverhampton NHS Trust (RWT)

Recommendation 4

The review group endorse the recommendations of the Infant Mortality Working Group Action Plan 2015 – 2018. A joint report to be presented by the lead officer for infant mortality at Wolverhampton CCG and Public Health to the Wolverhampton Health and Wellbeing Board on a six monthly basis on progress and achievements against recommendations accepted in the Infant Mortality Action Plan.

The Service Director - Public Health and Wellbeing to ensure the action plan is reviewed and updated to include emerging risks and further services changes. The findings to be shared with all key partner agencies.

Comment	Timescale/progress so far	Officer Responsible
Accepted Update on the IMWG action plan will be presented to the Wolverhampton Health and Wellbeing Board (WHWB).	Update to be completed within two weeks of the May 2015 IMWG and forwarded as an agenda item to be considered for a forthcoming HWBB meeting. Careful consideration needs to be given regarding reporting progress against infant mortality actions (mechanisms and timescales) to various interested parties. **February 2016 Update** The Infant Mortality Action plan is reviewed at each working group meeting and actions updated and circulated to the group. An update was presented to the HWBB on 2 December 2015.	Ros Jervis (SDPHW)

A strategic and co-ordinated response to tackle the modifiable causes of infant mortality in Wolverhampton and also respond to the challenges of dealing with the effects of poverty and deprivation.

Recommendation 5 The findings and progress of the Infant Mortality Working Group to be shared with organisations with a special interest in reducing the number of child deaths, for example, the CDOP, SANDS, BLISS and the Lullaby Trust for comment. Representatives to be invited to comment on progress and invited to share learning locally and nationally on further improvements in the co-ordination of care from a neonatal setting, to home and whether there are any specific recommendations to build on good practice.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A workshop event to be developed at the end of the calendar year and presented in 2016 to allow monitoring of progress and assessment of improvements.	Workshop discussed at IMWG November 2015 meeting with the proposal for the event to be delivered before March 2016. **February 2016 Update** Plans are in place to hold a stakeholder event on 14/15 March 2016 to promote safe sleeping practices (supported by the Lullaby Trust) and share the progress on the Infant Mortality Action Plan recommendations.	Ros Jervis (SDPHW)

Recommendation 6 The Service Director – Public Health and Wellbeing to draft terms of reference and agree membership for a task and finish group to review vulnerable pregnant women's care pathway. Representatives of Wolverhampton Integrated Substance Misuse Service (Recovery Near You) need to participate in a review of the effectiveness of the current working arrangements for supporting women referred to the service; particularly those involving drugs, alcohol, domestic abuse or long term mental health issues. A report of the findings to be reported to the Health and Wellbeing Board and Scrutiny Board.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A task and finish group will be established to address this complex recommendation, with representatives from CCG, Public health, LA Children services and Recovery Near You (and possibly others) This work is a fundamental component of the vulnerable women's pathway and therefore will also link to recommendation 1f and 2. Helen Kilgallon, Recovery Near You, representative of Wolverhampton Integrated Substance Misuse Service, provided a detailed response to the recommendation – see section five.	Detailed report to be presented at the May 2016 IMWG to include action against the linked recommendations 1f, 2 and 6.	Ros Jervis (SDPHW) and Manjeet Garcha Executive Lead for Nursing and Quality Wolverhampton CCG

Changing practices and policies and apply learning based on reliable evidence as to their impact and effectiveness in reducing the rate of infant mortality.

Recommendation 7 Royal Wolverhampton NHS Trust to provide a detailed response to the NICE published guidance that all NHS hospitals and clinics should become completely smoke-free zones and to set out detailed proposals for implementation and a timetable for achieving this to be presented to a meeting of the Health and Wellbeing Board.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Discussions are being held between the Medical Director and the Healthy Lifestyles Service manager regarding progressing this recommendation. Public Health will be presenting the Infant Mortality Action Plan (as approved by HWBB) to the Royal Wolverhampton NHS Trust (RWT) Board on 1 June 2015.	Proposed update at the IMWG meeting in November 2015 **February 2016 Update** The Infant Mortality Action Plan was presented to the RWT Trust Board on 1st June 2015. It was highlighted that a number of Trusts in the West Midlands had implemented a smoke-free site policy. However, following discussion the consensus of the Board was that the implications of such a move for RWT required careful consideration, not least the means of enforcing such a measure without compromising staff safety. No further progress has been made to date, but an audit of the NICE guidance PH 26 Smoking: stopping in pregnancy and after childbirth is proposed for discussion at the May 2016 meeting of the IMWG.	Anne Mcleod, Manager Healthy Lifestyles Service, RWT

Recommendation 8 The lead officer for infant mortality at Wolverhampton CCG to consider the availability of genetic screening and counselling support across Wolverhampton and to raise awareness generally of the service. The findings to be presented to the Health Scrutiny Board**.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Genetic screening and counselling support is commissioned from Birmingham Women's Hospital NHS Trust on a regional basis. We are not aware of any issues with regards to access or availability of these services however we acknowledge the need to ensure good awareness across the public and professionals; including the conditions that would benefit from these services, how to access services and referral mechanisms.	August – October 2015 **February 2016 Update** Genetic screening and counselling support is commissioned from Birmingham Women's Hospital NHS Trust on a regional basis. We are not aware of any issues with regards to access or availability of these services from professionals and would welcome opportunities to raise public awareness.	Manjeet Garcha, Executive Lead for Nursing and Quality Wolverhampton CCG

Recommendation 9

Service Director - Public Health and Wellbeing, to work with partner agencies to create a public resource document similar to Bradford's 'Every Baby Matters' which explains the risk factors and provides practical advice and support that can help reduce the numbers of avoidable deaths of babies.

The resource should be built into any planned public awareness campaigns and include details of the impact of lifestyle behaviours, such as smoking and alcohol that increases the risks of child dying. The document should promote positive health messages and signpost families to sources of available support and useful information.

Comment	Timescale/progress so far	Officer Responsible
Accepted A task and finish group to be established to review developing a resource and the feasibility of delivering Making Every Contact Count (MECC) training to key agencies	Task and finish group to be convened in July 2015 **February 2016 Update** A specific programme was developed by the MECC lead within the Healthy Lifestyles Service to include: • key public health messages, • importance of preventative health in reducing infant mortality rates, • local services and referral pathways. The training has been delivered and is currently being updated and rolled out to community midwives, midwifery support workers & family support workers, sonographers, sonographer support workers, health care assistants and reception staff at RWT.	Ros Jervis (SDPHW)

Recommendation 10 All newly elected Councillors to be given a briefing on the issue of infant mortality in Wolverhampton and the practical advice and information they can give when they meet people as part of their work. This should be presented as briefing of the key health messages and the main risks including sofa/bed-sharing, as well as smoking and alcohol in the lifestyle behaviours.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted	Public Health will update the previous member briefing by the end of February 2016 and arrangements will be made for circulation to Councillors.	Earl Piggott-Smith, Scrutiny Officer

Recommendation 11 Service Director - Public Health and Wellbeing, to report on progress in resolving the issue of getting access to personal confidential health data needed to assess the effectiveness of changes introduced to reduce the infant mortality rate.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Information sharing agreement in progress and proposed infant mortality dashboard content agreed by IMWG	Data should be available by end of July 2015 and populated Infant Mortality dashboard presented at IMWG meeting in November 2015 **February 2016 Update** Maternity data was made available to Public Health via an information sharing agreement in May 2015. The data was used to update the infant mortality briefing and produce an infant mortality dashboard	Ros Jervis (SDPHW)

Recommendation 12 The scrutiny review of infant mortality report to be sent to Wolverhampton CCG, Royal Wolverhampton NHS Trust and CDOP for information and comment and they are invited to give comments on the findings and recommendations. A progress report on those recommendations accepted by the Cabinet is reported to the Wolverhampton Health and Wellbeing Board in 6 months. The report recommendations to be tracked and monitored by Scrutiny Board at the same time.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted	A final report will be sent to representatives when approved. Report sent to all organisations and witnesses who contributed evidence to the review. **February 2016 Update** Director of Public Health presented update report to Health and Wellbeing Board meeting 7 October 2015. An update report to be presented to Scrutiny Board on 1 March 2016.	Earl Piggott-Smith

Section two
Further information: recommendation 1d

Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

Current arrangements

The Royal Wolverhampton NHS Trust is commissioner by Wolverhampton CCG to provide a full and comprehensive maternity service. The service is provided in accordance with all national and local policies in particular NICE guidelines and RCOG standards for maternity care. NHS England's Maternity Pathway payment system is in place which is split into three modules; antenatal, delivery and postnatal. For antenatal and post natal pathways there are three case-mix levels; standard, intermediate and intensive. Intermediate and intensive levels are where women require additional care and or intervention. The delivery element is split by whether or not there are complications and co-morbidities at a level that requires additional care.

Assurance

These pathways are underpinned by NICE guidance and should deliver the appropriate mix of enhanced and targeted interventions. In order to further understand the extent of interventions provided to women across the case-mix levels a multi-disciplinary case note audit is proposed. The aim of the audit will be to provide assurance of appropriate mix of enhanced and targeted interventions as well as provide learning, identify opportunities for training and education, for example.

Initial outline plan

Audit planning – May – June 2015
Undertake audit – July – August 2015
Review outcomes: September 2015
Develop plan: October 2015

Section three
Further information: recommendation 1f

Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

It is acknowledged that local intelligence can come from many sources; this intelligence should be disseminated across services to ensure appropriate consideration is given to the impact on relevance of the information on care needs along with any additional education required by providers. In addition, GPs are the primary point of access for pregnant women to maternity services. There is guidance in place for GPs however; the extent to which this is adhered to is unknown. Further understanding is required of the mechanisms in place across primary care for information sharing between GP and midwife. A survey to gather intelligence followed by education/promotion is opposed.

Survey: June – July 2015
Assess Response: August 2015
Review guidance: September 2015

Section four
February 2016 update: Report on CCG Commissioning Arrangements for Maternity and Child – Infant Mortality

Health Scrutiny Review of Infant Mortality Recommendation 1d
The importance of co-ordinating local efforts to tackle the underlying causes of infant Mortality in Wolverhampton: The lead officer for infant mortality at Wolverhampton Clinical Commissioning Group (CCG) to report on current commissioning arrangements and the extent to which services for pregnancy and infancy are delivering the right mix of enhanced and targeted interventions for pregnant women, particularly vulnerable women considered to be at risk.

Wolverhampton CCG commissions the Royal Wolverhampton NHS Trust (RWT) to provide a full and comprehensive Maternity Service. The service complies will all national and local policies, including NICE guidelines and Royal College of Obstetricians and Gynaecologists (RCOG) Standards for maternity care. The CCG also complies with the NHS England Maternity Pathway Payment system[1] which separates antenatal and postnatal pathways into three case-mix levels; standard, intermediate and intensive. The delivery element is split into two pathways; births where there are not any complications or co-morbidities and those with complications where the pregnant women may require additional care. Pathways attract higher payment tariffs with increased complexity.

All pregnant women are allocated to the appropriate pathway at the antenatal booking appointment, and this is reviewed throughout the pathway to ensure women receive the right level of intervention to meet their needs. Factors considered for allocating women to the intermediate pathway both antenatal and postnatal care, include complex social factors such as age, migrant, refugee, asylum, learning disabilities, safeguarding etc, BMI >=35, or <18 (antenatal only), physical disability, substance misuse including alcohol and medical issues including medical health, hypertension, respiratory, epilepsy, hepatitis and/or previous obstetric history.

Factors considered when allocating women to the intensive pathway include expecting twins, HIV, long-term conditions including Diabetes, chronic heart disease, renal disease and cancer as well as previous fetal congenital anomaly that required specialist medicine.

Each of the Maternity Pathways, developed nationally by RCOG, Department of Health, The Royal College of Midwives and Health Financial Management Association, are expected deliver the appropriate mix of enhanced and targeted interventions.

Current position
The CCG regularly reviews benchmarking information to ascertain the proportion of women in each of the case-mix levels. Patients have, and exercise, choice of where to receive their maternity care and the review includes the local providers that Wolverhampton-registered women choose across the three stages of the pathway; antenatal, intrapartum (delivery) and postnatal. The table below show the activity by risk score (standard, intermediate and intensive) benchmarked against the England average for 2015 and for other trusts (2014).

Table - Maternity PbR pathway - Casemix for Wolverhamption patients 2014 - 2015

Point of Delivery	HRG	National Average %	Commissioners: 06A (WCCG) Sep-15 RL400(RWT)	06A (WCCG) Sept-14 RL400(RWT)	05C Other local Providers RNA00	05Y RBK00	05X RXW00	05N RXW00
Antenatal	INTENSIVE	8.0%	9.3%	7.8%				
	INTERMEDIATE	29.0%	31.1%	33.5%				
	STANDARD	63.0%	59.0%	58.7%				
Postnatal	INTENSIVE	1.0%	0.2%	0.4%				
	INTERMEDIATE	24.0%	15.6%	22.7%				
	STANDARD	75.0%	84.1%	76.9%				
Intrapartum (Delivery)	WITH COMPLICATIONS & COMORBIDITIES	28.6%	22.0%	34.30%				
	WITHOUT COMPLICATIONS AND COMORBITIES	71.4%	78.0%	65.7%				

Key

	In line with national average proportions
	Significantly lower than national average proportions
	Significantly higher than national average proportions

1. www.gov.uk/government/uploads/system/uploads/attachment_data/file/216573/dh_133896.pdf

There have been 1,216 women booked onto the antenatal pathway over the period April to September 2015. The latest data shows that Wolverhampton has a higher proportion of women on antenatal Intensive and intermediate pathways and a lower proportion of standard pathway pregnancies, than the national average. Local factors believed to contribute to this are levels of complex social factors, pregnant women under 20 years, number of women with a BMI >= 35, the level of smokers and the high levels of deprivation in Wolverhampton.

Additional assurance is provided in the form of local and national audits across maternity and neonatal services. RWT undertakes a number of national and local audits both annually and intermittently. National audits such as the Maternal, New and Infant Clinical Outcomes review are completed annually as are the BLISS/neonatal audits, the national Saving Children's lives audit, the latter covers smoking cessation, fetal movement, electronic fetal monitoring and growth charts. It was confirmed that the consultant obstetricians/maternity staff have taken part in local audits on infant mortality and the EMBRACE Confidential enquiry.

Local audits include a postnatal care audit on smoking and pregnancy, RWT follow-up mothers who were smoking at the time of delivery. Original audit was undertaken in November 2014 following the introduction of global CO_2 monitoring. The audit reviewed case files of 40 women as to whether the mother smoked, whether they had received smoking cessation advice during pregnancy and whether they have been offered and taken up CO_2 monitoring. Other forms of audit include the weekly multidisciplinary meetings (Risks assessed) and the monthly Paediatricians meetings with pathologists and other clinicians that discuss any infant deaths and still births.

The CCG is working with RWT to discuss the outcomes and learning from national and local audits, and has the capacity to request additional audit focus should areas of concern be highlighted.

Section five

Helen Kilgallon
Programme Manager
Wolverhampton Substance Misuse Service

In April 2013 a newly commissioned integrated substance misuse service began. This is a partnership with NACRO as prime contractor, Aquarius and BSMHFT as sub-contractors. A recovery model was adapted within the service and a number of posts that were in existence at the previous service were no longer in the new service model. One of the reasons for this was RNY wanted to ensure all staff were skilled to a high level in safeguarding, pregnancy, domestic abuse and mental health and not rely on one particular specialist post.

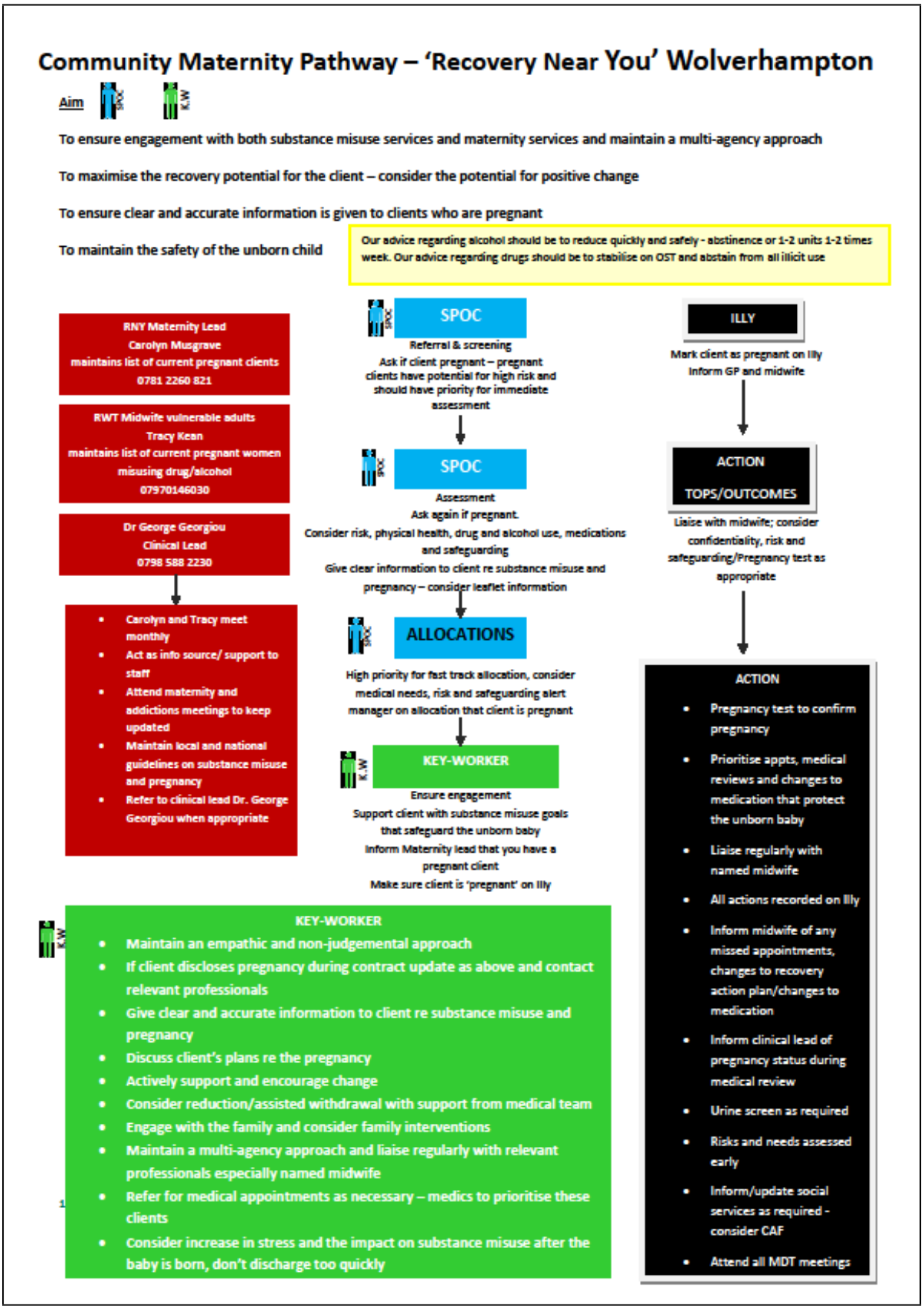
The DALT (drug alcohol liaison team) has been successfully operating within RWT for over 5 yrs. When RNY were awarded the contract leads from DALT and the RNY consultant lead met with maternity as a priority to adapt existing pathways and ensure this particular group of women were given a priority within the service. This pathway has been revisited a number of times to ensure all processes and procedures work smoothly and effectively. I have every confidence that the maternity pathway within RNY and RWT is effective as I know RNY staff sit at maternity meetings, and daily discussions are had with specialist nursing staff within RWT. They can often be seen at meetings at RNY and are a visible presence.

As programme manager I have weekly reports sent to me on all pregnant service users and can view their treatment, attendance and offers of support. I also chair safeguarding meetings where they are discussed. I do not feel that RNY needs to review the process we have currently as they have been working successfully for over 18 months.

I would be more than happy to be part of any processes to look at referral routes into and out of the service i.e. mental health services, and more especially primary care. I feel that this is a particular area where much more work could be done at a very early level as they have access to patients where alcohol screening could be done, offers of smoking cessation, weight management and offers of support for mental health and domestic abuse.

A summary of the community maternity pathway is outlined below:

SPOC- single point of contact
KW- key worker


Community Maternity Pathway – 'Recovery Near You' Wolverhampton
Aim
To ensure engagement with both substance misuse services and maternity services and maintain a multi-agency approach
To maximise the recovery potential for the client – consider the potential for positive change
To ensure clear and accurate information is given to clients who are pregnant
To maintain the safety of the unborn child
Our advice regarding alcohol should be to reduce quickly and safely - abstinence or 1-2 units 1-2 times week. Our advice regarding drugs should be to stabilise on OST and abstain from all illicit use
RNY Maternity Lead
Carolyn Musgrave
maintains list of current pregnant clients
0781 2260 821
RWT Midwife vulnerable adults
Tracy Kean
maintains list of current pregnant women misusing drug/alcohol
07970146030
Dr George Georgiou
Clinical Lead
0798 588 2230
Carolyn and Tracy meet monthly
Act as info source/ support to staff
Attend maternity and addictions meetings to keep updated
Maintain local and national guidelines on substance misuse and pregnancy
Refer to clinical lead Dr. George Georgiou when appropriate
SPOC
Referral & screening
Ask if client pregnant – pregnant clients have potential for high risk and should have priority for immediate assessment
SPOC
Assessment
Ask again if pregnant.
Consider risk, physical health, drug and alcohol use, medications and safeguarding
Give clear information to client re substance misuse and pregnancy – consider leaflet information
ALLOCATIONS
High priority for fast track allocation, consider medical needs, risk and safeguarding alert manager on allocation that client is pregnant
KEY-WORKER
Ensure engagement
Support client with substance misuse goals that safeguard the unborn baby
Inform Maternity lead that you have a pregnant client
Make sure client is 'pregnant' on Illy
ILLY
Mark client as pregnant on Illy
Inform GP and midwife
ACTION
TOPS/OUTCOMES
Liaise with midwife; consider confidentiality, risk and safeguarding/Pregnancy test as appropriate
ACTION
Pregnancy test to confirm pregnancy
Prioritise appts, medical reviews and changes to medication that protect the unborn baby
Liaise regularly with named midwife
All actions recorded on Illy
Inform midwife of any missed appointments, changes to recovery action plan/changes to medication
Inform clinical lead of pregnancy status during medical review
Urine screen as required
Risks and needs assessed early
Inform/update social services as required - consider CAF
Attend all MDT meetings
KEY-WORKER
Maintain an empathic and non-judgemental approach
If client discloses pregnancy during contract update as above and contact relevant professionals
Give clear and accurate information to client re substance misuse and pregnancy
Discuss client's plans re the pregnancy
Actively support and encourage change
Consider reduction/assisted withdrawal with support from medical team
Engage with the family and consider family interventions
Maintain a multi-agency approach and liaise regularly with relevant professionals especially named midwife
Refer for medical appointments as necessary – medics to prioritise these clients
Consider increase in stress and the impact on substance misuse after the baby is born, don't discharge too quickly

Section six

Stopping Smoking in Pregnancy: Health Lifestyle Service report February 2016

The Stop Smoking Service delivers services to the population of Wolverhampton City. Providing they have a GP in Wolverhampton, are receiving health care or live or work in the city.
The service provided to Pregnant Women following the NICE Guidance's below;

- PH26 – Quitting smoking in Pregnancy and child birth.
- PH48 – Smoking Cessation in Secondary Care, Acute, Maternity and Mental Health Services.
- PG45 – Tobacco Harm reduction approaches.

All women in Wolverhampton who book with a midwife and are identified as smoking are referred to the stop smoking service.

- The service will attempt to contact these pregnant women three times, if unable to contact by phone then a letter is sent from the department asking the women to contact the department with information literature included.
- When contact is made, the women is offered a face to face consultation with a trained Stop Smoking Adviser who use motivational interviewing techniques and small goal setting to support the women to set a quit date. (appointments offered in home or community setting)
- Licenced Nicotine Replacement Therapy is then offered and provided to all clients to help reduce the craving to smoke. This is given via a voucher for 2 weeks after which a letter is sent to the clients GP asking then to continue to prescribe the Nicotine Replacement Therapy as advised by the Trained Stop Smoking Adviser.
- Every client is followed up weekly for 6 weeks then every 2 weeks to 12 weeks.
- If they successfully quit smoking they are then contacted monthly by phone or a face to face consultation for the duration of their pregnancy and elapse prevention is offered
- If the client returns back to smoking they are then supported to stop smoking by the above method.
- Relapse prevention is offered at any time.
- The phone number of the adviser is given to all clients; they can be contacted when additional support is required.

Antenatal Service Developments

Staff Training:
Initially it was identified front line staff required training in some key areas relating to improving infant mortality rates;

C0 monitor Training – A Smoking Specialist delivered CO monitor training, including correct use, infection prevention measures, interpreting of results & how to refer into services. This has been delivered to Community Midwives, Midwifery Support Workers & Family Support Workers. CO monitoring at all antenatal visits implemented March 2015 with all pregnant women given printed advice related to the outcome and results recorded in maternity notes.
Smoking Brief Intervention – Smoking specialist has delivered specific smoking cessation brief intervention advice and support to coincide with anyone who uses C0 monitors or discusses lifestyle changes with pregnant women. Anyone who blows over a 4 on the C0 reading gets an opt out referral into the smoking cessation team.

Making every contact count – A specific programme was put together by the MECC lead to include key public health messages, importance of preventative health in reducing infant mortality

rates, local services and referral pathways. This has been delivered and is currently being updated and rolled out to community midwives, midwifery support workers & family support workers, sonographers, sonographer support workers, HCA's & reception staff.

Neonatal Service developments

- Smoking specialist visits Neonatal Unit once weekly. To talk to parents and their families about smoke free homes and offer support to anyone who is interested in attempting a quit attempt.
- Assess smoking status of parents with children on the Neo natal Unit and refer to smoking cessation service. Given advice and support there and then and offered a community referral to follow up.
- Facilitate a weekly informal coffee morning to engage with parents and families.

Table 1: Smoking in Pregnancy Data Quarter 1 2014/15 – Quarter 2 2015/16

	2014/15					2015/16	
	Q1	**Q2**	**Q3**	**Q4**	**Annual**	**Q1**	**Q2**
Set Quit Date	21	33	24	38	**116**	17	38
Quit Smoking	8 (38%)	16 (48%)	11 (46%)	13 (34%)	**48 (41%)**	9 (53%)	14 (37%)
Not Quit Smoking	7 (33%)	9 (27%)	4 (17%)	8 (21%)	**28 (24%)**	2 (12%)	9 (24%)
Loss to Follow-up	6 (29%)	8 (24%)	9 (38%)	17 (45%)	**40 (34%)**	6 (35%)	15 (39%)
Smoking at delivery	19.6%	18.2%	19.6%	19.0%	**18.8%**	16.9%	16.6%