Haringey Infant Mortality Strategy 2007 - 2010

Revised 2009

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The Haringey Infant Mortality Strategy was developed in partnership with colleagues across the NHS and Local Authority. Contributions were gratefully received from:

NHS Haringey

GOSH in Haringey

The Whittington Hospital NHS Trust

The North Middlesex University Hospital Trust

Haringey Council

HARINGEY INFANT MORTALITY STRATEGY – EXECUTIVE SUMMARY

The Infant Mortality Strategy 2007–2010 was agreed at the Children and Young People's Strategic Partnership Board in March 2007. This document, and accompanying action plan, updates the strategy and takes into account recent guidance from the Department of Health and local progress over the last two years.

This report utilises national data to compare Haringey with other boroughs and regions, but also uses local data to describe the differences within Haringey. Combined, the data will be used to inform and develop the implementation of Haringey's Infant Mortality Action Plan.

Local analysis - summary

Over 4,000 babies are born in Haringey every year, most with positive outcomes. However, Haringey has an infant mortality rate of 6.0 per 1,000 live births compared with a rate of 4.9 for England and Wales and 4.8 for London (2005-2007). Although more recent data exists for infant mortality in Haringey, national and local comparative data is only currently available for 2005 to 2007. The 2006 to 2008 data will be available from December 2009. We know however, that in Haringey, there were 21 deaths of infants under the age of one in 2008 and 13 deaths up to July 2009. Recent figures suggest that the infant mortality rate for 2006 to 2008 is likely to be lower than for 2005 to 2007.

- Between 2005 and 2007, there were 75 deaths in infants under one in Haringey. The highest number of deaths were in Tottenham Green (9) and White Hart Lane (9). There were no reported deaths in Alexandra or Bounds Green wards. Analysis over a 3 year period shows that the Infant Mortality rate is higher in wards in the east of Haringey. However, as the numbers are small it is not possible to ascertain a clear pattern across the borough.

- The main causes of infant deaths in Haringey are prematurity related conditions (67%) and congenital anomalies (21%).

- Between 2005 and 2007 there were 41 deaths to children under 7 days in Haringey, 14 between 7 and 28 days and 20 over 28 days. Compared with figures for England, Haringey has a slightly higher proportion of deaths under 7 days and between 7 and 28 days, but a lower proportion over 28 days.

- The main causes of death for neonates (under 7 days) are prematurity related conditions (85%) and congenital anomalies (15%). The main cause of death for those aged between 7 and 28 days is prematurity (71%). In those over 28 days, congenital anomalies are the main causes of death (35%).

- As numbers of deaths are small, there are fluctuations in the rate year on year. Birthweight is therefore often used as a proxy measure for infant mortality. All of the wards in the east of the borough, with the exception of Seven Sisters, had the highest proportion of low birthweight babies (under 2500g) born between 2005 and 2007.

The Department of Health undertook a review of the infant mortality aspect of the life expectancy target during 2006, which aimed to identify the current position and develop a strategy for delivering the target. The review gained a clear understanding of the infant mortality target and the challenges faced in terms of local delivery.

The review identified five key barriers to delivery:

- No recognition of the target or widening gap
- Services not fully delivering to the target group
- Lack of leadership and systems to support delivery
- Lack of knowledge and understanding of the target

- Poor handling and use of data and gaps in the evidence base.

It also identified key principles or "high impact changes" that could achieve change at a local level and help deliver the target. These are listed below:

- Know the target, know your gap
- Make the target part of everyday business – integrate it into commissioning plans and provider contracts
- Take responsibility, engage communities and families in this work
- Match resources to need
- Focus on what can be done

The Department of Health published an Implementation Plan for Reducing Health Inequalities in Infant Mortality at the end of 2007. This offered further guidance for local areas in terms of what works and what would make a difference.

The implementation plan highlighted interventions that will have a demonstrable impact on the gap; likely to have an impact and likely to reduce Infant Mortality overall. These interventions are listed below with further details available on the full report:

Interventions that have a demonstrable impact on the gap:

Reducing teenage pregnancies

Reducing sudden unexpected death in infancy (SUDI)

Reducing maternal smoking

Optimising maternal and infant nutrition

Improving housing quality and reducing overcrowding

Reducing child poverty

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

Improving access to maternity care

Interventions that will reduce infant mortality overall:

Improving the quality of care

Screening

Immunisation uptake

Development and implementation of an action plan to reduce infant mortality

The revised Action Plan to reduce infant mortality in Haringey incorporates recommendations from the Department of Health's Implementation Plan for Reducing Health Inequalities in Infant Mortality. The Infant Mortality Action Plan will also be guided by the implementation of the National Service Framework for Children, Young People and Maternity Services, Maternity Matters, Healthy Lives, Brighter Futures, the strategy for children and young people's health and the Healthy Child Programme, together with relevant NICE Guidance.

The revised 2007-10 plan identifies priority actions to reduce infant mortality in Haringey focussing on:

- Strengthening local delivery
- Teenage Pregnancy
- Smoking Cessation
- Antenatal Care
- Postnatal Care including Breastfeeding
- Improving Housing Quality and Reducing Overcrowding
- Reducing Child Poverty

Implementation of the action plan is guided by the multi-agency Infant Mortality Implementation Group and will be monitored by the Children's Trust Board.

RECOMMENDATIONS

a) The NHS Haringey/Children's Trust Board adopt the Infant Mortality Strategy, subject to any revisions.

b) The Children's Trust Board agree to incorporate monitoring of the Infant Mortality Action Plan through the existing monitoring arrangements for the Children and Young People's Plan.

c) The Infant Mortality Implementation Group will identify stakeholders and leads to deliver the action plan. The detailed monitoring of progress will be carried out by the Infant Mortality Implementation Group which meets quarterly.

September 2009

1. INFANT MORTALITY IN HARINGEY

The Infant Mortality Strategy 2007–2010 was agreed at the Children and Young People's Strategic Partnership Board in March 2007. This document, and accompanying action plan, updates the strategy and takes into account recent guidance from the Department of Health and local progress over the last two years.

WHY FOCUS ON INFANT MORTALITY?[1]

"Infant mortality is a sensitive measure of the overall health of a population. It reflects the apparent association between the causes of infant mortality and other factors that are likely to influence the health status of whole populations, such as their economic development, general living conditions, social well being, rates of illness and the quality of the environment."[2]

While the infant mortality rate for England is at an all time low, rates in Haringey are significantly higher than those for England and London. This report utilises national data to compare Haringey with other boroughs and regions, but also uses local data to describe the differences within Haringey. Combined, the data will be used to inform and develop the implementation of Haringey's Infant Mortality Action Plan.

Table 1 compares the infant mortality rate in Haringey with England and London:

Table 1: Infant mortality rates (2005-2007)

	England	London	Haringey (Rate and number)
Under 1 year (deaths per 1,000 live births)	4.9 (95% CI[3]. =4.8-5)	4.8 (95% CI= 4.6-5.1)	6.1 (75) (95% CI=4.8-7.6)
Neonatal (deaths under 28 days per 1,000 live births)	3.4 (95% CI= 3.3-3.5)	3.3 (95% CI =3.1-3.5)	4.5 (55) (95% CI=3.4-5.8)
Deaths under 7 days (per 1,000 total births)	2.6 (95% CI= 2.5-2.7)	2.5 (95%CI=2.3-2.6)	3.3 (41) (95%CI=2.4-4.5)
Stillbirths	5.3 (95% CI= 5.2-5.4)	6.2 (95%CI=5.9-6.4)	6.1 (76) (95%CI=4.9-7.6)

[1] Infant mortality rates describe the deaths of infants in the first year of life. The rate is the number of live newborns dying under one year per thousand live births

[2] Health Inequalities Unit. Review of the Health Inequalities Infant Mortality PSA Target. Department of Health February 2007

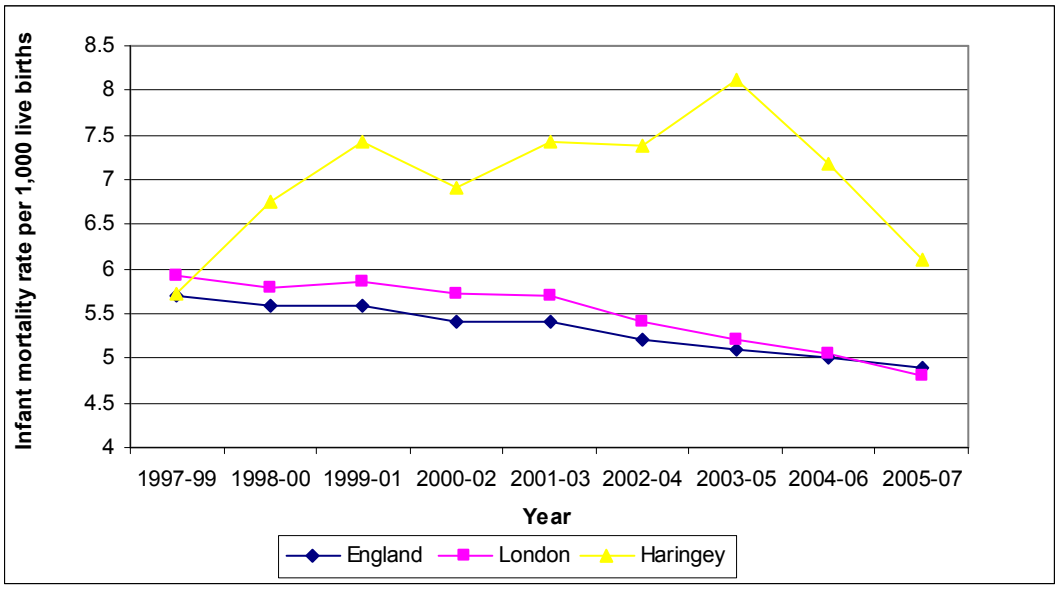
[3] C.I The Confidence Interval describes the upper and lower limits of the rate at a 95% confidence level

Source: NCHOD

Although more recent data exists for infant mortality in Haringey, national and local comparative data is only currently available for 2005 to 2007. The 2006 to 2008 data will be available from December 2009. We know however, that in Haringey, there were 21 deaths to infants under the age of one in 2008 and 13 deaths up to July 2009. Recent figures suggest that the infant mortality rate for 2006 to 2008 is likely to be lower than for 2005 to 2007.

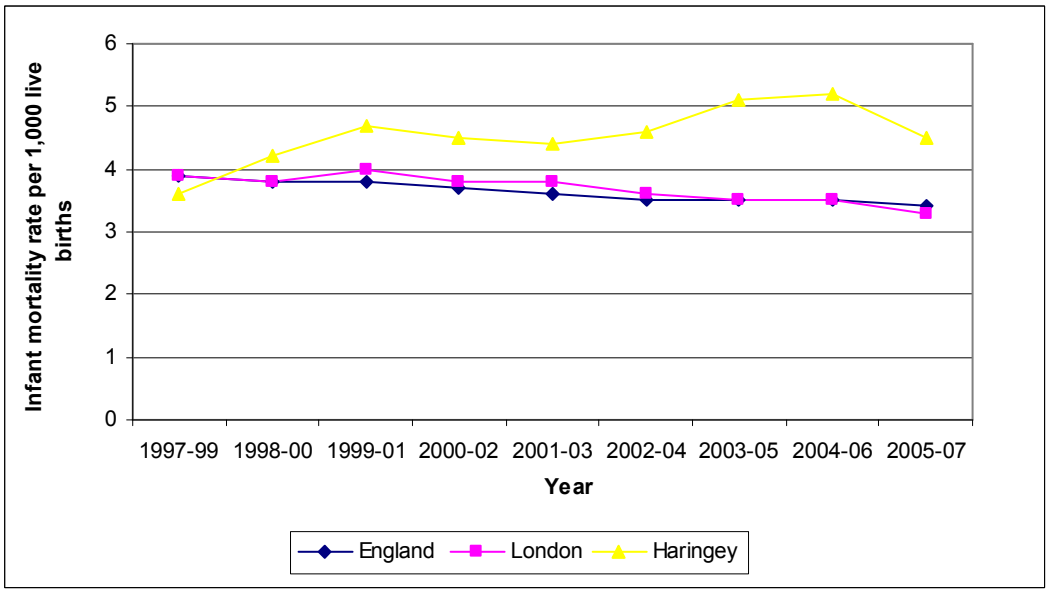
As the numbers for infant mortality are small, it is worth looking at trends and data aggregated to 3 year totals. Figures 1, 2 and 3 show that Haringey's rate remains considerably above London and England, although the gap has closed in recent years.

Figure 1: Infant Mortality, Under 1 year in England, London and Haringey, 3 year rolling average, 1997/99-2005/07



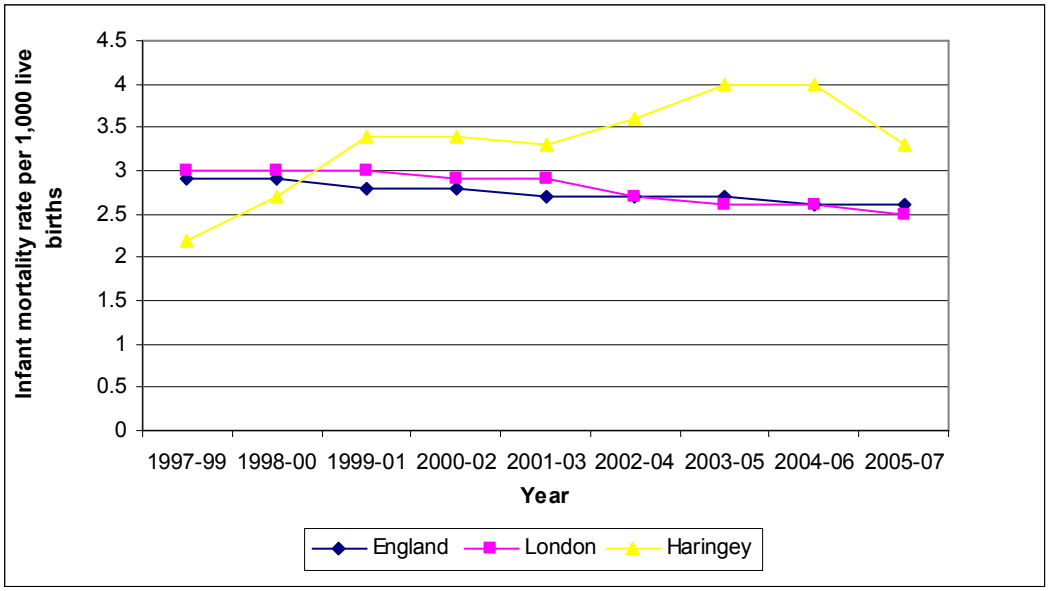
Source: NCHOD

Figure 2: Infant mortality, Under 28 days, 3 year rolling average, 1997/99-2005/07



Source: NCHOD

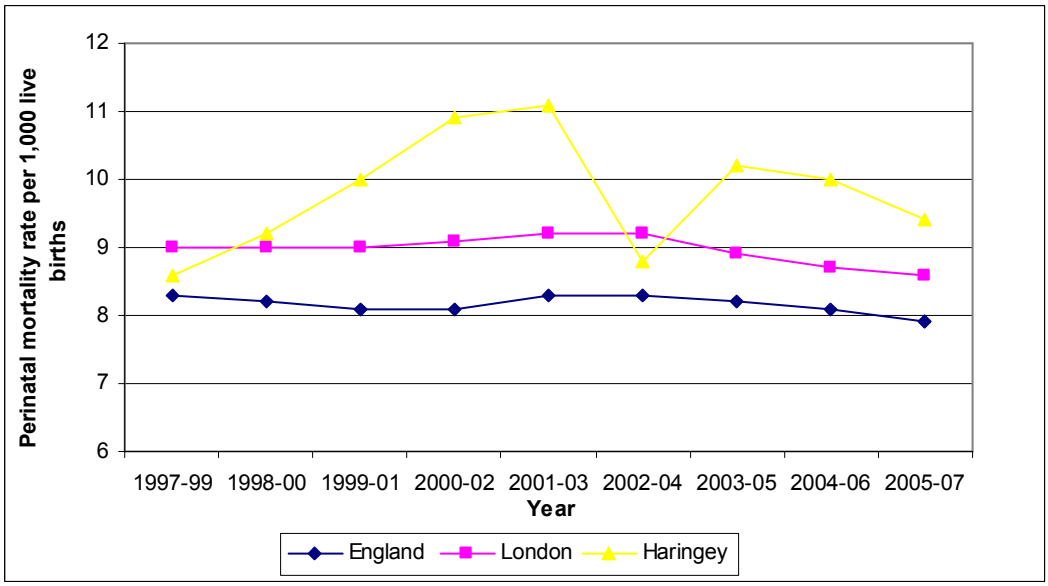
Figure 3: Infant mortality, Under 7 days, 3 years rolling average, 1997/99-2005/07



Source: NCHOD

Figure 4 shows that the perinatal mortality rate which includes stillbirths and deaths under 7 days has also fluctuated but figures are closer to London and England averages. This is due to a slightly lower stillbirth rate in Haringey.

Figure 4: Perinatal mortality, 3 year rolling average, 1997/99-2005/07



Source: NCHOD

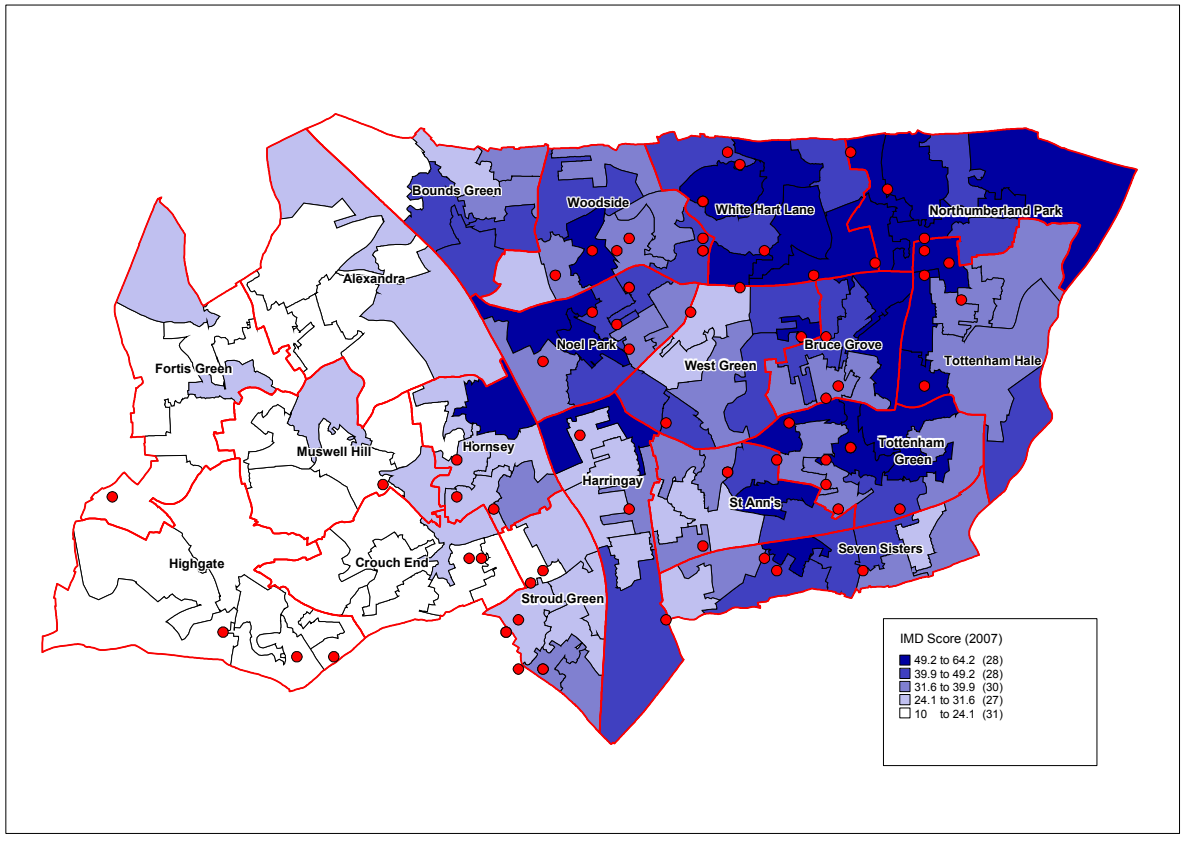
Based on 2003-2005 data, the infant mortality rate for Haringey was 8.1 per 1000 live births, making it the highest in London. Based on the 2005-2007 data, Haringey has the 5th highest rate in London, with Enfield having the highest rate of 6.7. Rates for Haringey's statistical neighbours[4] are listed below:

Southwark	6.4 per 1,000 live births
Lambeth	5.7 per 1,000 live births
Hackney	5.4 per 1,000 live births
Lewisham	4.6 per 1,000 live births

LOCAL ANALYSIS

Between 2005 and 2007, there were 75 deaths in infants under one which are described in the following charts and maps.

Figure 5: Distribution of infant deaths (under 1 year), 2005-2007



Source: Public Health Mortality File (PHMF)

[4] Statistical neighbours are boroughs with similar characteristics including sociodemographic backgrounds, population profile and levels of deprivation which can be used for benchmarking purposes.

Figure 5 and Table 2 describe the distribution of infant deaths between 2005 and 2007. It shows that the highest number of deaths were in Tottenham Green (9) and White Hart Lane (9). There were no reported deaths in Alexandra or Bounds Green wards. Analysis over a 3 year period shows that the Infant Mortality rate is higher in wards in the east of Haringey. However, as the numbers are small it is not possible to ascertain a clear pattern across the borough.

There were a higher proportion of male deaths, 63% (47), which is consistent with national figures.

Table 2: Infant deaths by ward and gender, 2005-2007

	2005			2006			2007			2005-2007		
Ward	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Alexandra										0	0	0
Bounds Green										0	0	0
Bruce Grove					1	1	1	1	2	1	2	3
Crouch End	1	1	2				1		1	2	1	3
Fortis Green	1		1							1	0	1
Harringay	1	1	2							1	1	2
Highgate	3		3							3	0	3
Hornsey				1	1	2	1	1	2	2	2	4
Muswell Hill							1		1	1	0	1
Noel Park	2	1	3	2	1	3				4	2	6
Northumberland Park		1	1	1	1	2		1	1	1	3	4
St Ann's	1		1	1		1	1		1	3	0	3
Seven Sisters	2		2	1	1	2	1		1	4	1	5
Stroud Green	3	2	5	2		2	1		1	6	2	8
Tottenham Green	2	2	4	2	1	3		2	2	4	5	9
Tottenham Hale		2	2		3	3				0	5	5
West Green	1		1		1	1	1		1	2	1	3
White Hart Lane	2		2	3	2	5	1	1	2	6	3	9
Woodside	2		2	1		1	3		3	6	0	6
Haringey	21	10	31	14	12	26	12	6	18	47	28	75

Source: PHMF

The main causes of infant deaths in Haringey are shown below. Prematurity related conditions (67%) and congenital anomalies (21%) account for the highest numbers of deaths.

Table 3 Infant deaths by cause 2005-2007

Cause of Death	Number
Premature	50
Congenital	16
Infection	6
SUDI	3
Total	75

Source: PHMF

Table 4: Comparison of Haringey Infant Mortality with England by age 2005-2007

Age of death	Haringey percentage and (number)	England (percentage)
Under 7 days	54.6% (41)	53%
7-28 days	18.6% (14)	16.1%
Over 28 days and under 1 year	26.6% (20)	30.8%

Source: PHMF/ONS

Between 2005 and 2007 there were 41 deaths in children under 7 days in Haringey, 14 between 7 and 28 days and 20 over 28 days. Compared with figures for England, Haringey has a slightly higher proportion of deaths under 7 days and between 7 and 28 days, but a lower proportion over 28 days.

Table 5 shows cause of death by age. The main causes of death for neonates (under 7 days) are prematurity related conditions (85%) and congenital anomalies (15%). National data suggests that 75% of deaths among neonates are caused by prematurity related conditions and congenital anomalies, suggesting that Haringey has a higher number of deaths from these causes than expected.

The main causes of death for those aged between 7 and 28 days is prematurity (71%). In those over 28 days, congenital anomalies account for the main causes of death (35%).

Table 5: Cause of death by age 2005-2007

	Age of Child at Death			
Cause of Death	**Under 7 Days**	**7 to 28 Days**	**Over 28 Days**	**Total**
Congenital	6	3	7	16
Infection		1	5	6
Premature	35	10	5	50
SUDI			3	3
Total	41	14	20	75

Source: PHMF

Age of mother

The national picture suggests that age of mother is a risk factor for infant mortality, with rates highest among women under 20 and over 40. Nationally, the infant mortality rates for babies born to mothers under the age of 20 are around 60% higher than for babies born to mothers aged 20-39.[5] Of the 75 infant deaths in Haringey

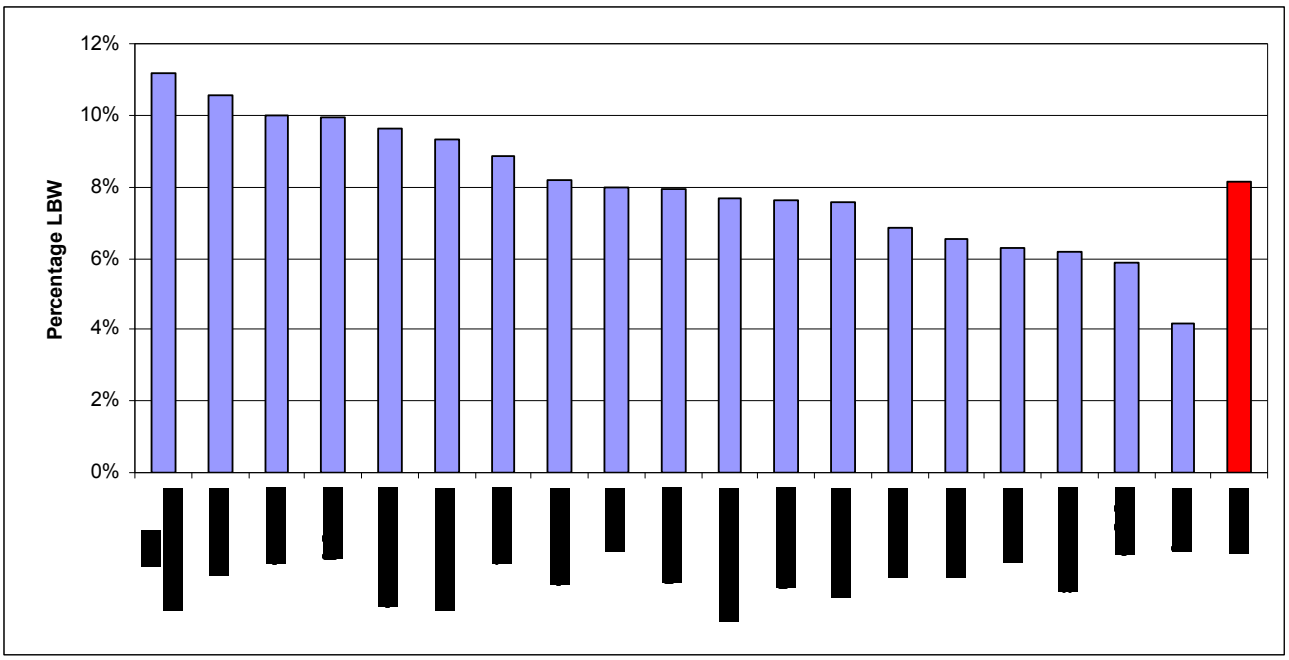
[5] Health Inequalities Unit. Review of the Health Inequalities Infant Mortality PSA Target. Department of Health, February 2007

between 2005 and 2007, the age of mother was obtained for 67 of the cases[6]. 6% of the deaths were to mothers under the age of 20; 88% to mothers aged between 20 and 39 and 6% to mothers over the age of 40. This is a similar proportion for total live births in these age categories in Haringey over the same period.

Local analysis of deaths by ethnicity is underway and will be reported when the information becomes available.

As numbers of deaths are small, there are fluctuations in the rate year on year. Birthweight is therefore often used as a proxy measure for infant mortality.

Figure 6 Low birth weight by ward 2005-2007



Source: Public Health Birth Files PHBF)

Figure 6 describes the difference in low birthweight between wards. All of the wards in the east of the borough, with the exception of Seven Sisters, had the highest proportion of low birthweight babies (under 2500g) born between 2005 and 2007.

Ongoing local analysis of infant deaths will inform priorities within the Action Plan and identify areas for further development.

[6] Age of mother is obtained from the Child Health Surveillance System in Haringey and is not available from the Public Health Mortality File.

POLICY FRAMEWORK TO REDUCE INFANT MORTALITY

The Government has made tackling health inequalities a priority by setting a national health inequalities PSA target, which is underpinned with objectives on reducing infant mortality and increasing life expectancy in disadvantaged populations. The infant mortality element of the target is:

Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group[7] and the population as a whole.

The Department of Health undertook a review of the infant mortality aspect of the life expectancy target during 2006, which aimed to identify the current position and develop a strategy for delivering the target. The review gained a clear understanding of the infant mortality target and the challenges faced in terms of local delivery. It also identified interventions that would help to meet the target through data analysis, fieldwork visits and modelling in order to quantify the effect of identifiable actions to reduce the gap.

The review identified five key barriers to delivery:

- No recognition of the target or widening gap
- Services not fully delivering to the target group
- Lack of leadership and systems to support delivery
- Lack of knowledge and understanding of the target
- Poor handling and use of data and gaps in the evidence base.

It also identified key principles or "high impact changes" that could achieve change at a local level and help deliver the target: These are listed below:

- Know the target, know your gap
- Make the target part of everyday business – integrate it into commissioning plans and provider contracts
- Take responsibility, engage communities and families in this work
- Match resources to need
- Focus on what can be done

These principles, and the learning gained from the review have been incorporated into this local action plan in the "Strengthening Local Delivery" section and will guide the implementation of the plan overall.

An implementation plan for reducing health inequalities in Infant Mortality was published in 2007[8]. This offered further guidance for local areas in terms of what works and what would make a difference.

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[7] The routine and manual group includes those in lower supervisory and technical, semi-routine and routine occupations. Typical examples might be porters, cleaners, bar staff, waiters/waitresses, sales assistants, catering assistants, train drivers, people working call centres, electricians and sewing machinists.

The implementation plan highlighted interventions that will have a demonstrable impact on the gap; likely to have an impact and likely to reduce Infant Mortality overall. These are summarised below and where available, local data will highlight Haringey's current position. For further information on local action to reduce infant mortality see Appendix 1 Haringey's Infant Mortality Action Plan 2007-2010.

Appendix 2 presents an illustration of how different interventions can impact on reducing the gap. The following section describes these interventions in more detail.

2. INTERVENTIONS THAT HAVE A DEMONSTRABLE IMPACT ON THE GAP:

REDUCING TEENAGE PREGNANCIES

Health outcomes for babies born to teenage mothers are worse than for babies born to older mothers. Infant mortality rates are 60% higher for teenage mothers than mothers aged 20-39, with a 25% greater likelihood of prematurity and low birthweight among teenage mothers compared with older mothers. The main contributory factors to poor health outcomes are that young mothers are more likely to attend late for antenatal care; more likely to smoke during pregnancy; are less likely to breastfeed and tend to have poorer diets during pregnancy.

The national teenage pregnancy strategy has a target to reduce England's under 18 conception rate by 50% by 2010. Haringey has a target to reduce under 18 conceptions by 55%. Achieving the teenage pregnancy strategy target in the routine and manual group would contribute an estimated one percentage point of the 10% needed to narrow the gap and meet the infant mortality target.

However, the most recent data available shows that Haringey's conception rate was 70 per 1,000 among 15-17 year olds in 2007[9], which is above the 1998 base rate of 62.3. Reaching a 55% reduction by 2010 is therefore challenging on Haringey. Work to reduce teenage conceptions and support teenage parents is informed by Haringey's Teenage Pregnancy Strategy.[10] Further actions are detailed in Section 2 of the Infant Mortality Action Plan.

REDUCING SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)

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

Effective evidence–based interventions to prevent SUDI include:

- Ensuring that infants sleep in the supine position (on their backs)
- Keeping the baby's head uncovered by placing the baby in the "feet to foot" position

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[8] Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide, Department of Health, December 2007.

[9] Of these conceptions, 65% led to abortion in 2007 with 87 young women becoming teenage mothers

[10] Haringey's Teenage Pregnancy and Parenthood Strategy

- Ensuring that infants sleep in a separate cot, especially if the parents smoke, have been drinking alcohol or have taken drugs
- Ensuring that infants sleep in the same room as their parents
- Reducing parental smoking

However, the Department of Health review of infant mortality highlighted that these messages have not been taken up by those in the R & M group. A 1.4 percentage point reduction of the 10% gap could be achieved if 1 in 10 R & M mothers currently sharing a bed with their baby or putting the baby down to sleep prone could be persuaded to avoid doing so.

In Haringey, from 2005-2007, there were 3 SUDI out of a total of 75 deaths. Information from Haringey's Child Death Overview Panel will be used to analyse potential points for intervention for example, targeted work with particular BME groups; ensuring that links are made between SUDI, smoking and overcrowding; training for professionals and others, in order to try and prevent further deaths.

MATERNAL SMOKING

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

If the national target on smoking in pregnancy – "to reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010" could be achieved in the R&M group, this would reduce the gap by two percentage points.

Lessons from the National Support Team (NST) about reducing smoking in pregnancy in disadvantaged populations include:

- Formalising opportunities to embed stop smoking support within midwifery and health visiting structures
- Develop the wider network of staff to provide tailored support in pregnancy e.g. family support workers etc
- Seek and develop opportunities within community settings, e.g. Children's Centres.

In 2008/09 7.16% of mothers were smoking during pregnancy in Haringey[11]. Section 3 of the Infant Mortality Action Plan highlights interventions to tackle smoking in pregnancy.

OPTIMISING MATERNAL AND INFANT NUTRITION

Optimising maternal nutrition preconceptually, throughout pregnancy and in the postnatal period is important for maternal and infant health. Neonatal deaths are more common in women who are underweight, overweight or obese before they conceive. Although there is not a specific target for reducing obesity in

[11] Information received from North Middlesex Hospital, Whittington Hospital and Chase Farm Hospital.

adults, if the prevalence of obesity in women in the R & M group were to fall by 23% to the current levels of obesity in the population as a whole, this would be a 2.8 percentage points contribution to the target of 10%.

Recent NICE Guidance[12] recommends that women with a BMI above 30 should be encouraged to reduce it before becoming pregnant and /or after pregnancy. Work is underway in Haringey to investigate options for a care pathway for maternal obesity in order to support pregnant women to lose weight.

BREASTFEEDING

Breastfeeding provides clear health gains for mother and baby. Breastfed babies are less likely to become obese adults, which in turn may reduce infant mortality in their children. It is known that there are health inequalities in breastfeeding rates and work will be undertaken in Haringey to identify from maternity records who is and is not initiating and continuing breastfeeding. This will enable more targeted work and lead to increased breastfeeding rates. This will be monitored through the PSA on improving the health and well-being of children and young people which requires PCTs to collect data on the prevalence of breastfeeding at 6-8 weeks.

Maternity units will be encouraged to implement the Baby Friendly initiative as standard practice and this will be supported by promotion of breastfeeding in the community, via Children's Centres and GP surgeries.

IMPROVING HOUSING QUALITY AND REDUCING OVERCROWDING

Overcrowded living conditions are associated with health problems such as stress and depression, poor educational achievement of children and family breakdown. Although the exact mechanisms are unknown, there appears to be a link between overcrowding and SUDI. Reducing overcrowding in the R & M group may reduce the gap in the target by 1.4 percentage points through reducing SUDI. The Local Authority has recently published a ten year housing strategy which highlights actions to reduce overcrowding and improve housing stock.

REDUCING CHILD POVERTY

Although there has been progress in reducing child poverty, persistent levels of child poverty remain. Modelling suggests that meeting the child poverty target – to halve the number of children in relative low-income households between 1998-99 and 2010-2011 – would narrow the gap in inequalities in infant mortality by three percentage points. The Local Authority has produced a Child Poverty Strategy and Action Plan[13] which has been incorporated into the Infant Mortality Action Plan, focusing on increasing employment levels for parents (including teenage parents), increasing financial support through the tax credit system and reducing educational attainment gaps for children in poverty.

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[12] NICE Public Health Guidance 11. Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. March 2008

[13] Action Plan to deliver the Five Objectives of the Child Poverty Strategy, Haringey Council September 2008.

3. INTERVENTIONS THAT ARE LIKELY TO IMPACT ON THE INFANT MORTALITY GAP

IMPROVING ACCESS TO MATERNITY CARE

Maternity Matters and the PSA maternity indicator, for women to have a full health and social care assessment of needs by 12 completed weeks of pregnancy, highlight the importance of early booking. The Department of Health recommends that PCTs conduct a Health Equity Audit of women who book before 12 weeks and after 22 weeks of pregnancy, to highlight reasons for late booking and to enable targeted outreach work with those women that are vulnerable and socially excluded. This piece of work is currently underway in Haringey. NHS Haringey has also recently commissioned a social marketing company to investigate reasons why women do not book in early and the recommendations will feed into the Infant Mortality Action Plan. Work is already ongoing to offer easier access to maternity services in the community, via Children's Centres and also to raise awareness with local professionals about the importance of early booking.

4. INTERVENTIONS THAT WILL REDUCE INFANT MORTALITY OVERALL

IMPROVING THE QUALITY OF CARE

Prematurity related conditions account for the highest number of infant deaths. It is therefore vital that women and babies receive high quality care from maternity and neonatal services. The Department of Health recommends that in order to ensure high quality maternity and neonatal services, PCTs need to:

- Monitor quality and performance of maternity and neonatal providers
- Together with acute trusts, ensure that there is an appropriately skilled maternity and neonatal workforce
- Utilise information from Child Death Reviews to identify preventable and avoidable factors for child deaths.

SCREENING

Antenatal and newborn screening may prevent infant deaths through early identification of certain congenital anomalies. There are ethnic inequalities in the uptake of antenatal screening and further work is necessary at a local level to assess if other inequalities exist and how these can be addressed. Increasing the number of women who access maternity services earlier will also impact on the uptake of antenatal screening.

IMMUNISATION UPTAKE

The number of babies that die due to vaccine preventable infections is too low to impact on the health inequalities infant mortality gap. However, the number of children with life limiting conditions due to vaccine preventable illnesses makes a considerable impact on their families and the NHS. There are inequalities in the uptake of immunisations with a lower coverage for families in more disadvantaged areas. A strategy to address these inequalities is in place in Haringey.

5. DEVELOPMENT AND IMPLEMENTATION OF AN ACTION PLAN TO REDUCE INFANT MORTALITY

The revised Action Plan to reduce infant mortality in Haringey incorporates recommendations from the Department of Health's Implementation Plan for Reducing Health Inequalities in Infant Mortality. The Infant Mortality Action Plan will also be guided by the implementation of the National Service Framework for

Children, Young People and Maternity Services, Maternity Matters, Healthy Lives, Brighter Futures, the strategy for children and young people's health and the Healthy Child Programme, together with relevant NICE Guidance

The 2007-10 plan identifies priority actions to reduce infant mortality in Haringey focussing on:

- Strengthening local delivery
- Teenage Pregnancy
- Smoking Cessation
- Antenatal Care
- Postnatal Care including Breastfeeding
- Improving Housing Quality and Reducing Overcrowding
- Reducing Child Poverty

6. MONITORING OF THE ACTION PLAN

Implementation of this plan will be monitored by the Children's Trust Board.

7. RECOMMENDATIONS

a) The NHS Haringey/Children's Trust Board adopt the Infant Mortality Action Plan, subject to any revisions.

b) The Children's Trust Board agree to incorporate monitoring of the Infant Mortality Action Plan through the existing monitoring arrangements for the Children and Young People's Plan.

c) An Infant Mortality Implementation Group to be established which will identify stakeholders and leads to deliver the action plan. The detailed monitoring of progress will be carried out by the Infant Mortality Implementation Group which meets quarterly.

September 2009

APPENDIX 1

INFANT MORTALITY ACTION PLAN 2007 – 2010 (REVISED JUNE 2009)

1. STRENGTHENING LOCAL DELIVERY

Policy objective	Actions	Area lead/key stakeholder	Resources[14]	Progress measure and key dates
1.1 Improve data quality and strengthen evidence base	Utilise the evidence base in development by the National Perinatal Epidemiology Unit, University of Oxford and the LHO Report "Born Equal" to target interventions appropriately. Develop a list of indicators that impact on Infant Mortality	NHS Haringey Public Health		Development of an evidence base and local profiling to address targets Infant Mortality scorecard developed and in use May 09
1.2 Establish a local understanding of causes of death in those aged under one	Review local causes of death in the under 1s to identify major causes and trends via the Child Death Review panel and analysis of death files to inform potential points for intervention and prevention	NHS Haringey Public Health Child Death Review panel		Analysis of deaths completed and presented to Child Death Overview Panel by December 09.

[14] Unless otherwise stated, from existing resources.

Policy objective	Actions	Area lead/key stakeholder	Resources[14]	Progress measure and key dates
1.3 Improve services for BME Communities	Identify BME groups with highest IMR. Develop protocols for partnership working with BME groups. Identify clear strategy for development of services to support needs of BME groups	Infant Mortality Implementation Group		Development of plan to engage with BME groups by December 09
1.4 Raise awareness of the Infant Mortality target and action plan with key stakeholders	Establish mechanisms to clarify and communicate the target using existing networks to promote the key actions that are most likely to contribute to the target and improve outcomes for mothers and babies; ensure high level partnership support and sign up to the Action Plan. Development of credit card style information containing key messages around infant mortality for health and social care professionals.	NHS Haringey Public Health Department		Revised Action Plan signed off by the Children's Trust Board October 5th 2009 Communication plan in place by November 09. Card developed and distributed by December 09.
	Target areas with highest numbers of low birth weight babies and organise meetings for key staff working at a local level with families to raise awareness of Infant Mortality	NHS Haringey Public Health		5 meetings held during 2009 in wards with highest low birth weight. Increased knowledge of risk factors for Infant Mortality among key staff. Post workshop evaluations to be collated.

Policy objective	Actions	Area lead/key stakeholder	Resources[14]	Progress measure and key dates
1.5 Improved monitoring arrangements to assess progress in reducing infant mortality	Establish Infant Mortality Implementation Group to oversee implementation of Action Plan Review Infant Mortality Action Plan as part of the monitoring of the Children and Young People's Plan. Update the Children's Trust Board regarding progress. Proxy indicators to be reviewed on a quarterly basis to improve upstream picture of Infant Mortality	NHS Haringey Public Health NHS Haringey Planning and Performance Team Haringey Council Performance team		Network established. First meeting July 09 Monitoring arrangements in place and implementation leads agreed by October 09. Update to Children's Trust Board – October 2010.

2. TEENAGE PREGNANCY[15]

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure and key dates

[15] Infant Mortality Rates are 60% higher for teenage mothers than mothers aged 20-39.There is a 25% greater likelihood of prematurity or low birthweight among teenage mothers compared to older mothers. Teenage parents are more likely to smoke, less likely to breastfeed and more likely to book late for antenatal care. It is important that services are responsive to needs of pregnant teenagers and teenage parents. Meeting the targets set out in the Teenage Pregnancy strategy will have a demonstrable impact on reducing Infant Mortality and achieving the Infant Mortality target. For further information see Haringey's Teenage Pregnancy Action Plan.

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure and key dates
2.1 To promote the health of teenage parents	Ensure actions to support young parents are delivered and monitored via the Healthy Child programme. Pilot specialist services for teenage parents e.g. to promote smoking cessation; stop drinking alcohol and using drugs; address the poor emotional health of teenage mothers and to promote breastfeeding in line with DH guidance. Ensure services are welcoming and involve young fathers.	Whittington and North Middlesex Hospitals; Health Visiting Service Children's Networks		Performance management arrangements for the Healthy Child Programme to be agreed by January 2010. Clear framework for delivery in place. Plan for specialist services in place by April 2010.

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure and key dates
2.2 Strengthen information base around teenage parents	Improve data collection and sharing to ensure that services are aware of where teenage parents are to ensure timely and effective support. Monitor mechanisms to highlight teenage parents through Child Health records. Ensure births to teenage mothers and termination data is regularly shared with Teenage Pregnancy Strategic Partnership Board. Ensure all professionals confident with CAF to ensure appropriate referrals Ensure ongoing liaison with Safeguarding Midwife at NMH and dedicated Teenage pregnancy midwives at Whittington	NHS Haringey: Public Health; Child Health Children's Networks North Middlesex Hospital; Whittington Hospital; Teenage Pregnancy Co-ordinator		Data sharing protocols between key agencies established and information used appropriately to target interventions at those most in need by December 09. Clear referral pathways established; Children's Centres aware of teenage parents requiring support in their reach area by December 09.
2.3 Strengthen partnership support for teenage parents	Establish clear lines of accountability with services working with teenage pregnancy and teenage parents to ensure all key stakeholders are aware of roles and responsibilities. Sub groups to report to main partnership group to ensure actions carried out and progress made.	Teenage Pregnancy Co-ordinator NHS Haringey North Middlesex Hospital; Whittington Hospital; Children's Centres		All agencies aware of specific roles and responsibilities around teenage pregnancy and teenage parents – Stakeholder event, 19th November 09.

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure and key dates
2.4 Ensure services meet the needs of teenage parents and are young people friendly	Adoption of You're Welcome standards for key services to ensure they are welcoming, non-judgemental and accessible to teenage parents.	Teenage Pregnancy Co-ordinator; Children's Network Area Leads		50% of key services meeting You're Welcome standard by April 2010.
	Pilot drop ins for teenage parents at identified Children's Centres to encourage networking; reduce social isolation and promote information sharing. Organise 3 Teenage Parents Roadshow a year – 1 in each network to promote services for young parents.	Teenage Pregnancy Co-ordinator Teenage Parents Support Team Children's Centres		Drop ins established April 09; numbers of teenage parents accessing drop ins and perceived satisfaction with services. 3 Roadshows held by April 2010. Numbers of young parents attending and evaluation of events.
2.5 Ensure strong support for breastfeeding	Identify young mothers to be trained as peer breastfeeding supporters and pilot a specific teenage breastfeeding support group. Ensure ongoing support for existing young peer supporters.	Infant Feeding Co-ordinator		Number of young people trained; young mothers breastfeeding groups established by March 2010.

3. SMOKING CESSATION

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure and key dates
3.1 Smoking cessation to be an integral part of service delivery for whole family during and after pregnancy	Ensure appropriate level training is part of • mandatory training programme for appropriate staff in NHS Haringey (i.e. those dealing with (teenage) mothers/parents) • Health Visitor training • Midwives • School nurses • Student health professionals training/education (also approach Royal College to include in curriculum) • Educational services which deal with teenage parents • Children's Centre staff training	Stop Smoking Service Service managers for Midwifery and Health Visiting	Training provided free by Stop Smoking Service	Training strategy in place, which targets staff and students by January 2010. Training of all new Health Visitors and identified Children's Centre staff to Level 1 by March 2010.
	All pregnant women to be asked their smoking status at booking, throughout pregnancy and in post natal period. Status recorded and referrals made to Stop Smoking Service.	Maternity services North Middlesex Hospital; Whittington Hospital; Health Visiting Service Stop Smoking Service Children's Networks		Numbers of pregnant women who attend Stop Smoking Service referred from Hospital Trusts and Health Visiting Service. Monitoring reports presented quarterly to Infant Mortality Implementation Group.

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure and key dates
	Teenage Parents Support Team to monitor levels of smoking in teenage parents and the number of referrals made to the Stop Smoking service	Teenage Pregnancy Co-ordinator Teenage Parent Support Team; Stop Smoking Service		System in place to collect data on smoking in Teenage Parents by December 09
	Improve GP referral rates for pregnant women to the Stop Smoking Service. Maintain good links with Level 2 GPs and encourage other GPs to access training.	Stop Smoking Service; Primary care Facilitators		Every new Practice Nurse to receive at least level 1 training by March 2010. Training delivered to all GP collaboratives by March 2010 Smoking booklet sent to all GPs by January 2010
	Develop referral pathways for pregnant women to Smoking Cessation Service through other sources e.g. Pharmacists, Dentists and Children's Centres. Ensure Children's Centres Information Officers receive regular information from Stop Smoking Service	Stop Smoking Service		Referral pathways in place for other professionals by January 2010.

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure and key dates
3.2 Make the smoking cessation service more accessible and community based	Build on existing work undertaken with pharmacists etc. to monitor usage to assess appropriateness of times of service etc. Update session for Level 2 counsellors every 6 months. Audit to be undertaken of languages spoken by Level 2 Advisors	Stop Smoking Service		Patient satisfaction with stop smoking services.
	Regularly review the roles of the specialist posts within the Stop Smoking Service to ensure that they are meeting the needs of those in greatest need of support.	Stop Smoking Service		Roles adapted to reflect changing needs if necessary.
	Implement recommendations from the Smoking Social Marketing Report	Stop Smoking Service		Quick wins identified and action plan in place to implement recommendations by December 09.

4. ANTENATAL CARE

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
4.1 Maximise opportunities to work with women preconceptually to improve overall health	Develop a protocol with the GP collaboratives to encourage GPs to screen women for sickle cell etc. prior to pregnancy or before 10 weeks of pregnancy. Establish links with Sickle cell clinics; diabetes clinics, sexual health services and family planning clinics to promote the importance of preconceptual care.	NHS Haringey Public Health Strategist, C&YP GP Collaboratives		GPs aware of the need to screen women for sickle cell and protocols established by March 2010.
4.2 Improve access to effective and appropriate antenatal care	Implementation of Healthy Child Programme in line with Healthier Lives, Brighter Futures – The strategy for children and young people's health.	NHS Haringey GOSH		Service specification developed by March 2010.
4.3 Target women in routine and manual groups and other vulnerable groups to ensure earlier booking	Commission a Health Equity Audit of women booked by 12 weeks and after 22 weeks to identify inequalities in early booking and act upon recommendations Utilise findings from social marketing company investigating reasons for late booking	Public Health NHS Haringey Whittington Hospital North Middlesex Hospital		Recommendations made and incorporated into action plan by April 2010. 80% of women booking for antenatal care by 12 weeks 6 days of pregnancy by March 2010

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
	Develop more targeted community-based antenatal and post natal services through the Children's Centres core offer to improve access to deprived and vulnerable communities	Children's Networks; NHS Haringey; North Middlesex Hospital; Whittington Hospital		50% of Children's Centres offering antenatal and post natal care; Health Visitor appointments in line with core offer by March 2010.
4.4 Development of a local referral form for access to antenatal services	Raise awareness of, and accessibility to, antenatal services through: • Advertising more widely routes to care in the community (i.e. with midwives or GPs) and the types of service available (screening, smoking cessation etc) • Increasing venues at which booking can be undertaken in community (i.e. children's centres; Saturday sessions in hospitals etc) • Self referral forms on Whittington and North Middlesex Hospitals websites	NHS Haringey; Whittington Hospital; North Middlesex Hospital; Children's Networks		Yearly review of any changes Service user feedback. Increase in number of women accessing antenatal care prior to 12 weeks 6 days of pregnancy by March 2010.
4.5 Implementation of NICE Guidance on Antenatal Care	Ensure practice is guided by evidence of best practice.	North Middlesex Hospital; Whittington Hospital; NHS Haringey; Children's Networks		Guidelines implemented and progress against guidance reviewed by April 2010.

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
4.6 Implementation of NICE guidance on antenatal and postnatal mental health	Recognise mental health problems during pregnancy and in the first year after giving birth and ensure systems in place to provide: • care and treatment (including drugs and psychological treatments) of women who develop a mental health problem during pregnancy or in the first year after giving birth, and women who have a higher chance of developing a problem at this time • care and treatment (including drugs and psychological treatments) of women who already had a mental health problem before becoming pregnant • how families and carers may be able to support women with mental health problems and get support for themselves Roll out use of Whooley questions to screen women. Roll out training to all midwives. Establish Perinatal Mental Health Network across sector to promote effective joint working across all agencies.	North Middlesex Hospital Whittington Hospital Perinatal mental health team		Midwives trained in using screening tool by April 2010. Mental Health Teams engaging with women at earlier stage in pregnancy. Develop Perinatal Mental Health pathway by July 2010.

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
4.7 Promotion of ante natal screening to identify potential problems at an earlier stage	Utilise annual screening audits to identify if inequalities exist in those accessing screening Engage with GPs to encourage early screening for sickle cell (ideally by 10 weeks of pregnancy or prior to considering a pregnancy). Liaise with Screening midwife to identify any emerging patterns in those who do not access screening. (Links to encouraging early antenatal booking to ensure women have access to screening)	Public Health NHS Haringey; North Middlesex Hospital; Whittington Hospital		Information obtained from screening audits used to improve screening uptake by April 2010. GPs undertaking screening for sickle cell etc. by March 2010.
4.8 Revision of antenatal risk assessment form	In partnership with the acute trusts, review referrals for risk factors relating to domestic violence; safeguarding children; substance misuse; mental health etc. with a view to improving liaison with other agencies through CAF (Common Assessment Framework).	North Middlesex Hospital Whittington Hospital NHS Haringey		Monitor referrals and follow up individual Trusts by April 2010.

5. POSTNATAL CARE

Policy objective	Actions	Area lead/key stakeholder	Resources[16]	Progress measure and key dates
5.1 Implementation of NICE Guidance on Postnatal Care.	Ensure practice is guided by evidence of best practice. Ensure communication of new and forthcoming relevant NICE guidance	North Middlesex Hospital; Whittington Hospital; NHS Haringey; Children's Networks		Guidelines implemented and progress against guidance continually reviewed
5.2 Promotion and effective targeting of neonatal screening to improve outcomes	Clearly communicate to parents the purpose and benefits of neonatal screening e.g. physical examination at birth and at 6 weeks and newborn bloodspot screening and how these tests improve outcomes for babies.	North Middlesex Hospital; Whittington Hospital; NHS Haringey; Health Visiting Service; GPs; GOSH		Monitoring uptake of screening tests among targeted groups by April 2010.

[16] Unless otherwise stated, from existing resources.

Policy objective	Actions	Area lead/key stakeholder	Resources[16]	Progress measure and key dates
5.3 Implementation of NICE guidance on Effective Actions on initiation and duration of breastfeeding	Ensure practice is guided by evidence of best practice. Ensure communication of new and forthcoming relevant NICE guidance	North Middlesex Hospital; Whittington Hospital; NHS Haringey; Children's Networks		Guidelines implemented and progress against guidance continually reviewed

Policy objective	Actions	Area lead/key stakeholder	Resources[16]	Progress measure and key dates
5.4 Increase exclusive breast-feeding rates (e.g. first 6 months)	Implementation of local breastfeeding policy; ongoing training for staff to promote best practice Ensure health visitors, midwives and other interested parties receive training based on the UNICEF UK Baby Ten Steps to improve breastfeeding maintenance Breastfeeding policy to be displayed in settings accessed by parents of 0-5 year olds Ensure NHS Haringey and Local Authority maternity policies make support for breastfeeding more explicit Produce parent friendly version of Breastfeeding policy to be displayed at GP surgeries, Children's Centres Utilise breastfeeding policy to ensure that all pregnant women are given information about the benefits of breastfeeding and how to initiate breastfeeding Ensure all pregnant women from 28 weeks have received From bump to breastfeeding DVD – (UNICEF identified that this should be given as part of audit). Utilise peer breastfeeding supporters when trained- to work alongside midwives antenatally to promote DVD and breastfeeding. Women are given information about where to access breastfeeding support in their local area Monitor action to promote breastfeeding via the Healthy Child programme Identify Breastfeeding lead for North Middlesex Hospital	NHS Haringey Infant feeding Co-ordinator Health Visiting Service; North Middlesex Hospital; Whittington Hospital		Increase in breastfeeding initiation and maintenance rates. Quarterly performance reports from Performance Team, NHS Haringey. All health visitors and midwives receive regular training and is included as part of a package of training for new Health Visitors and midwives – ongoing.

Policy objective	Actions	Area lead/key stakeholder	Resources[16]	Progress measure and key dates
5.5 Improve data collection and information on rates of breastfeeding	Build on existing system for collating and analysing breastfeeding data using hospital computerised records and data collated from parent-held child health record i.e. at new birth visit; 6-8 week check and every other contact. Use RIO to determine who is and is not breastfeeding and develop actions accordingly.	NHS Haringey Child Health Surveillance Team; Performance Team; Public Health; North Middlesex Hospital; Whittington Hospital		Improved intelligence on breastfeeding initiation and maintenance System introduced to analyse data and provide baseline for national target by April 2010.
5.6 Implement Baby Friendly in acute trusts.	Establish senior level strategy group to oversee implementation of Baby Friendly in Haringey. Acute trusts to work towards registering for the Baby Friendly certificate of commitment. Identify funding stream to commence Baby Friendly in Haringey, to include funding to release midwives for training.	North Middlesex Hospital Whittington Hospital NHS Haringey Infant Feeding Co-ordinator Public Health, NHS Haringey	Cost associated with applying and achieving Baby Friendly Accreditation	Hospitals register intent by March 2010

Policy objective	Actions	Area lead/key stakeholder	Resources[16]	Progress measure and key dates
5.7 Improve Maternal and Infant nutrition	Implement recommendations from Improving the nutrition of pregnant and breastfeeding mothers and children in low income households NICE Public Health Guidance 11 March 2008. Develop local delivery plans to implement NICE obesity guidance with a focus on disadvantaged groups. Develop plans to help women with a BMI above 30 to lose weight by informing them of the risks and providing a structured programme of support that can be tailored to the needs of the individual and combines advice on healthy eating with regular, moderate physical activity. Development of referral pathway for obese pregnant women. Promotion of Healthy Start and other healthy weight programmes to be targeted in disadvantaged communities via Children's Centres; GPs etc. Ensure action through the Healthy Child Programme.	NHS Haringey Obesity lead Whittington and North Middlesex Hospitals	Funding needs to be identified to support referral pathway.	Referral pathway developed by April 2010. Services in place to support obese pregnant women by April 2010. Uptake of Healthy Start vouchers

Policy objective	Actions	Area lead/key stakeholder	Resources[16]	Progress measure and key dates
5.8 Ensure health promotion messages are being targeted to the most vulnerable groups to achieve greatest impact in reducing infant mortality	Midwives and health visitors to reinforce and target 'Back to Sleep' campaign to reduce Sudden Unexpected Deaths in Infancy. Analyse Child death Review where SUDI recorded to identify potential points for action. Information to be made available in Children's Centres and other places where people with young families attend. In particular, advice needs to be targeted to those in the Routine and Manual groups and other vulnerable groups to achieve greatest reduction in infant deaths. Develop pictoral information on sleeping position etc. for those who do not speak/read English. Ensure links made between SUDI, smoking and overcrowding – develop relationships with housing providers for those most in need. Regular training for all relevant staff on SUDI risks and advice – link to Healthy Child programme. More high profile campaign to raise awareness of SUDI risks e.g. bed sharing; smoking etc.	NHS Haringey Health Visiting Service/CONI (Care of Next Infant Co-ordinator); North Middlesex Hospital; Whittington Hospital; Children's Networks; GPs		Sleeping position is recorded as part of new birth visit. Action plan developed to target at risk groups (using information from Child Death Review panels) by December 2009.

Policy objective	Actions	Area lead/key stakeholder	Resources[16]	Progress measure and key dates
5.9 Increase uptake of Immunisations	Interventions to increase immunisation rates are targeted to those in greatest need. Information is readily available to explain the importance of immunisations through a variety of outlets including Children's Centres; community organisations etc. Develop action plan to address issue of those not registered with a GP and how they can access immunisation services.	NHS Haringey Public Health Health Visiting Service Children's Networks GPs District Immunisations Co-ordinator Immunisation lead	Cost associated with establishing immunisation clinics	Increase in immunisations Depending on funding – additional immunisation clinics established. (Further information available from Immunisation Action Plan)

6. IMPROVING HOUSING QUALITY AND REDUCING OVERCROWDING[17]

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
6.1 Establish links with Housing Department to raise awareness of links with Infant Mortality	Presentation to be given to Strategic Housing and Community Service (SCHS) Managers with potential to deliver training to visiting housing officers to raise awareness of risk factors and potential links between housing quality, overcrowding and infant mortality SCHS to develop an underoccupation and overcrowding strategy[18] in 2009-2010 in which the effects of poor housing on infant mortality will be included. NHS Haringey to be invited to be on the strategy development project group.	Public Health, NHS Haringey Haringey Council Housing Department To be lead by SCHS. NHS staff time required		Presentations to senior management teams by December 09. Increase in awareness of Infant Mortality among housing staff. Presentations to visiting housing staff by February 2010 Strategy and action plan developed, agreed and implemented. Monitoring reports on the strategy will be presented to Haringey's Integrated Housing Board (a theme group of the Local Strategic Partnership)
	Ensure Housing Strategy makes explicit links between poor housing and overcrowding and infant mortality	Public Health, NHS Haringey, Haringey		Links explicit in Housing Strategy

[17] Overcrowded living conditions are associated with health problems such as stress and depression, poor educational achievement of children and family breakdown. Although the exact mechanisms are unknown, there appears to be a link between overcrowding and Sudden Unexpected Death in Infancy (SUDI).

[18] This strategy is a sub strategy of the overarching Haringey Housing Strategy 2009-2019. Haringey's Housing Strategy makes the links between the impact poor housing has on vulnerable groups. In respect of infant mortality this will be explored further in the underoccupation and overcrowding strategy

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
		Council, Housing Department		
6.2 Ensure Haringey children have decent and secure homes	(see Local Authority Child Poverty Action Plan Objective 4) This is addressed in Haringey's Housing Strategy 2009-2019			Performance reports on Housing Strategy
	Utilise data on overcrowding in Haringey to target prevention work . (Data will be collated on overcrowding for the forthcoming strategy and used to inform the emerging priorities)	Public Health, NHS Haringey Haringey Council Housing Department		Targeted prevention work based on high quality data
6.3 Housing agencies to prioritise vulnerable families and expand provision of supported housing for teenage parents	Increase the allocation of mother and baby supported housing units in new supported housing scheme The Move-on Strategy currently being developed will address the problem of 'silting-up' of short term supported accommodation and aim to increase the number of units available in such schemes. The audit to support the strategy will identify exactly what the current data is and gather views on the barriers to move on.	Supporting People Haringey Council Housing Department		More supported housing available for teenage parents Move-on Strategy agreed and implemented

7. REDUCING CHILD POVERTY[19]

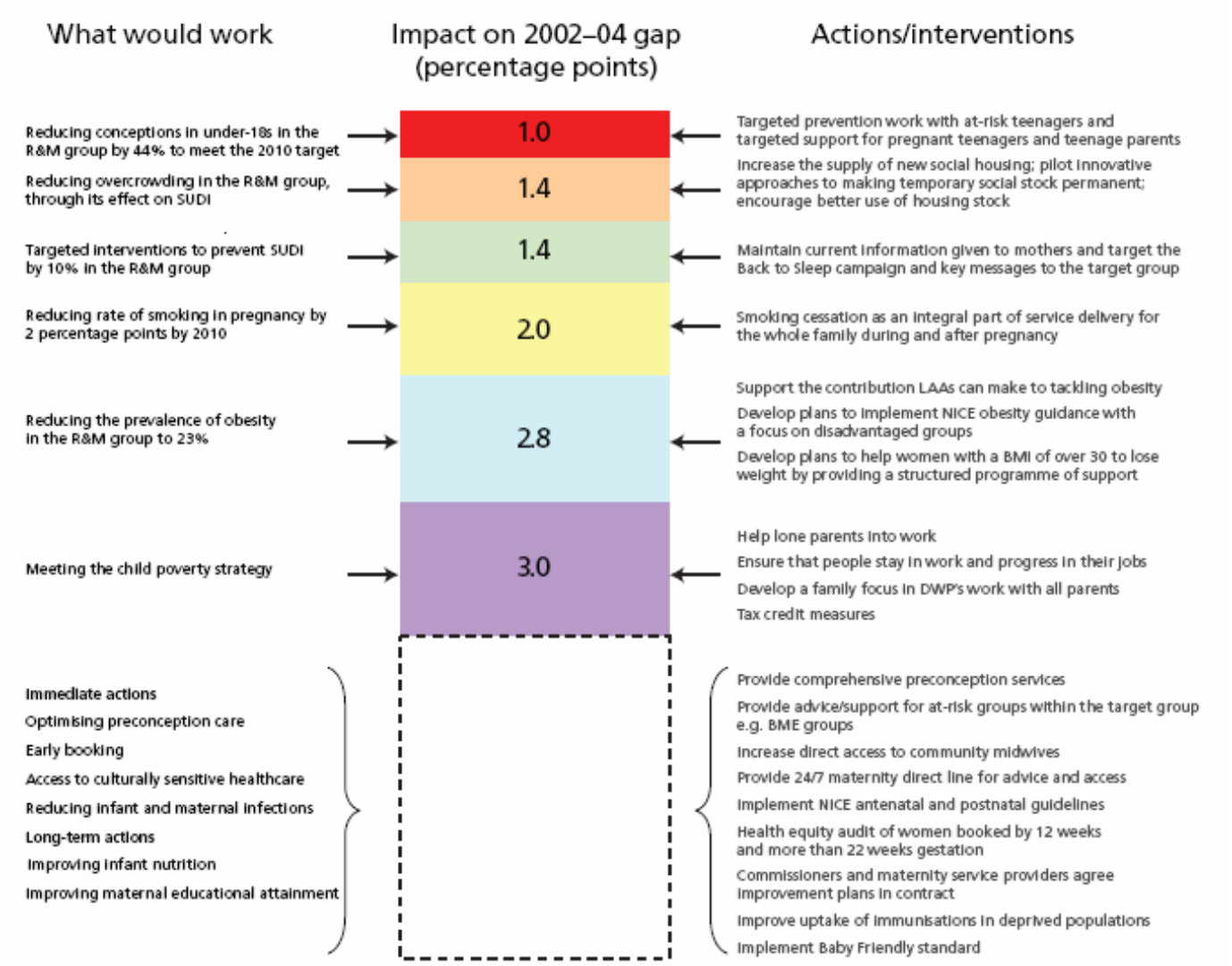
Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
7.1 Increasing parental employment in sustainable jobs: All teenage parents known to Supporting Teenage Parents to have education or employment plans and access to accredited training programmes (objective 1)	Development of accredited training programmes through 14-19 strategy for pregnant teenagers, teenage mothers and teenage fathers	Teenage Pregnancy strategic partnership	Part funded through 14-19 and part LAA	98 % of those known to supporting teenage parents and Connexions by 2010
7.2 Maximising incomes through improving the delivery of benefits and tax credits (objective 2)	Increase financial capability amongst the most disadvantaged communities including support in accessing benefits such as working and family tax credits. Benefits sessions in primary schools and Children's Centres	Haringey Council, Children's Centres, Job Centre Plus, Schools	Haringey Council budgets	To be monitored through Changing Lives
	Ensure that staff in Children's Centres and family support workers are equipped to provide information on an increased range of financial benefits that are available to low income families	Children's Networks, Children's Centres Development Manager		Training rolled out. Increase in number of people claiming benefits

[19] **NB: For further details, see Action Plan to Deliver the Five Objectives of the Child Poverty Strategy (Haringey Council September 2008))**

Policy objective	Action	Area lead/key stakeholder	Resources	Progress measure
7.3 Reducing educational attainment gaps for children in poverty (objective 3)	Increase opportunities in 14-19 vocational training, enterprise education, work related training, work based learning and extend the Step to Employability scheme	The Children and Young People's Service, Haringey Council		Increase in numbers of 14-19 in education, employment or training

APPENDIX 2

IDENTIFIABLE ACTIONS TO REDUCE THE 2002-04 GAP IN INFANT MORTALITY



APPENDIX 3

INFANT MORTALITY IMPLEMENTATION GROUP

TERMS OF REFERENCE

Aim

To implement the Haringey Infant Mortality Action Plan

Objectives

1) Identify leads for key areas of the action plan

2) Agree priorities for action

3) Utilise national policy and translate into local action

4) Identify and update local needs based on available data.

5) Establish reporting mechanisms into Children's Trust Board

6) Prepare for the National Support Team visit

Membership (tbc)

Associate Director Public Health, C&YP (Chair)	Jin Lim
Public Health Strategist, C&YP	Sheena Carr
Head of Strategic Commissioning C&YP Services	Claire Wright
Health, Well-being and Sustainability Manager	Jude Clements
Immunisation Lead	Helen Donovan
Consultant Community Paediatrician/GOSH	David Elliman
Infant Feeding Co-ordinator	Jenny Alexander
Stop Smoking Service Manager	Debbie Morgan
Teenage Pregnancy Co-ordinator	Vivien Hanney
Consultant Midwife in Public Health, Whittington	Rachel Ambler
Consultant Midwife in Public Health, NMH	Kanta Patel
Head of Housing Strategy	Nick Powell
Service Manager Early Years	Pat Loizou
Head of Commissioning North East	Clare Hodgson
Children's Centre Strategy Manager	Ngozi Anuforo
Public Health Strategist, Obesity Lead	Vanessa Bogle

Frequency of meetings – quarterly

APPENDIX 4

List of tables and graphs