Safe and Healthy Beginnings

A plan for working in partnership to reduce infant mortality in Manchester 2024- 2029

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Acknowledgements

Several key organisations and individuals have contributed to the Safe and Healthy Beginnings plan, including colleagues from Manchester City Council's Department of Public Health and Children and Education Services. Manchester Local Care Organisation and Manchester University Foundation Trust (MFT) provided clinical input for the project, including the Vulnerable Babies Service and Health Visiting Service. Additionally, invaluable input was provided by midwifery colleagues from the Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (LMNS), along with those from Saint Mary's Hospital and community midwives. Contributions were also received from Voluntary Community and Social Enterprise organisations such as Home-Start and Community Health Equity Manchester Sounding Boards. This information was supplemented through discussions with parents and expectant mothers and birthing people at various events and venues across the City.

Note on the language

The language we use throughout this document reflects that the majority of pregnant and post -natal people identify as women, therefore in practice we will commonly use the term 'woman' or 'women' in the information we provide. However, we also recognise diverse gender identities and will use gender inclusive language acknowledging that trans and non-binary people do experience high levels of discrimination, which can often limit their access to healthcare.

1. Context

Infant mortality is a sensitive measure of the overall health of a population. It reflects the 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 wellbeing, rates of illness and the quality of the environment.

The **Infant Mortality Rate (IMR)** is defined as the number of deaths under the age of one year, per 1,000 live births. It consists of two components:

- The **neonatal mortality rate**: the number of neonatal deaths (those occurring during the first 28 days of life) per 1,000 live births.
- The **post-neonatal mortality rate**: the number of infants who die between 28 days and less than one year, per 1,000 live births.

Another term often used in maternity services is the **perinatal mortality rate (PMR)**, i.e. the number of still births and deaths within the first seven days of life per 1,000 live and still births. This is a key outcome for new-born care and directly reflects prenatal, intrapartum, and new-born care.

There are several risk factors associated with stillbirths and infant mortality in general including maternal obesity, maternal morbidity such as diabetes, low birth weight, gestational age, ethnicity, age, smoking in pregnancy, deprivation, and access to antenatal care. Improvements to reduce these risk factors should lead to a reduction in infant mortality.

2. Where are we now?

2.1 The National picture

Data from the Office for National Statistics (ONS) shows that the main causes of death among infants in 2022 were congenital malformations, deformations and chromosomal abnormalities. Conditions related to immaturity were responsible for 51.2% of neonatal deaths, while congenital anomalies and infections occurring just before birth together accounted for 41.6%.

Infant mortality rates in 2022 for England and Wales were 3.9 deaths per 1000 live births. This is higher than in 2021 (3.7 deaths per 1000 live births). The UK has some of the highest mortality rates in Europe.

The highest rates of infant mortality were among infants of Black ethnicity, those born to a mother aged under 20 years and those with a birthweight under 2500g. The mortality rate among infants living in the 10% most economically disadvantaged areas in England was almost three times higher than those living in the 10% least disadvantaged areas. This is the widest difference seen at any time over the previous 12 years.

The ONS recently published data on the relationship between neonatal/child mortality and ethnicity. The data also examined the relationship with Socioeconomic Status (SES). The project estimated the risk of death among infants and children, using census figures to develop statistical models. It found that the highest estimated risk of death among infants and children was among those born to mothers from Pakistani and Black African ethnic groups.

In addition, national data from MMBRACE-UK (2024) shows that the maternal death rate of women from Black ethnic backgrounds has decreased slightly from the rate in 2019-21 but Black women remain almost four times more likely to die in childbirth compared to White women. The maternal death rate for women from Asian ethnic backgrounds remains twice that of White women. Women living in the most economically

disadvantaged areas still have a maternal death rate more than twice that of women living in the least disadvantaged areas.

2.2 The Manchester picture

Infant mortality in Manchester in 2022 were almost double the national rate at 6.7 deaths per 1000 live births. Manchester has the highest infant mortality rate across Greater Manchester and is significantly higher than the regional average in the Northwest of England (4.4 per 1000 live births). This is concerning in and of itself but also as it is a proxy for general health across the City. Between 2010 and 2023, there were a total of 640 infant deaths in Manchester. Most deaths occurred in the perinatal period.

In line with national statistics, the most common cause of death in infants between 2010 and 2023 in Manchester was “certain conditions originating in the perinatal period”, followed by “congenital malformations, deformations and chromosomal abnormalities”. In line with the national picture, local data show that the highest rates of infant mortality occurred in the most economically disadvantaged populations when analysed at ward level.

The deaths of children in the area are reviewed through the Child Death Overview Panel (CDOP), for children aged 0-17 years, excluding stillbirths, late fetal losses, and legal terminations. The CDOP examines factors in the family environment, parenting, and services to identify preventive actions to improve child health and safety.

In the five-year period from April 1st 2019 to March 31st 2024, the Manchester CDOP reviewed a total of 122 infant deaths. Of these, 71 infants were aged less than a month and 53 infants were between one month and one year old when they died. Fifty-six infants were female, and 66 were male. In terms of ethnicity, infants were assigned to 5 categories[1]: ‘Asian or Asian British’ (44 infants, the highest death rate being among the Asian – Pakistani community), and ‘White’ (37 infants, the highest death rate being among the White British community), ‘Black or Black British’ (25 infants, the highest death rate being among the Black African community), ‘Mixed ethnicity’ (9 infants), ‘Other Ethnic group’ (7 infants).

In common with other health inequalities, all infant deaths in Manchester in this period were concentrated in the four most socio-economically disadvantaged deciles, according to deprivation data. 70 infants were living in decile 1 i.e. the most socio-economically disadvantaged wards in Manchester, and 28 infants were living in decile 2.

[1] These terms are used by the National Child Mortality Database to categorise the ethnicity of children reviewed at panels

Across the 122 infant deaths, the main contributory factors were maternal smoking (24 infant deaths), father smoking (21 infant deaths), maternal substance misuse (8 infant deaths), father substance misuse (14 infant deaths), known domestic violence (16 infant deaths), maternal mental health (30 infant deaths). Eighty-nine of the infant deaths had a gestation indicating extreme prematurity. Prematurity and consanguinity was present in 17 infant deaths. Modifiable factors were identified in 30 infant deaths, and they include maternal smoking, maternal BMI (over 30+), maternal substance/alcohol misuse, unsafe sleeping arrangements/co-sleeping, late/unbooked pregnancy, domestic violence, consanguinity and delays in assessment.

2.3 The policy context

This plan for Manchester is situated in the context of national polices and strategies aimed at reducing infant mortality and improving health outcomes for pregnant women and people, their babies and families.

In particular, this plan encompasses the actions outlined in the Saving Babies Lives Care Bundle, a national programme which focuses on elements of care such as reducing smoking in pregnancy, improved surveillance of foetal growth, better management of reduced foetal movements, effective foetal monitoring during labour, reducing pre-term births and improving management of pre-existing diabetes in pregnancy.

Other measures, for example digitising maternity care records and CORE20PLUS5[2] measures, including working towards continuity of carer teams throughout pregnancy, birth and the early postnatal period are also under development within maternity services.

In 2021, NHS England published Equity and equality guidance for local maternity systems. The document focuses on actions to reduce disparities for women and babies from Black, Asian, and Mixed ethnic groups and those living in high poverty contexts. NHS England provides funds to support Local Maternity Services to implement these plans. Subsequently, Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS) developed the Equity and Equality action plan that describes the steps required from 2022-2027, to improve maternity outcomes and address inequalities.

The Women's Health Strategy for England, published in August 2022 includes fertility, pregnancy, pregnancy loss and postnatal support as one of the six priority areas. The strategy also mentions funding from the National Institute for Health and Care Research,

[2] A national NHS England approach to inform action to reduce healthcare inequalities at both national and system level

for a policy research unit dedicated to maternal and neonatal health and care research at the University of Oxford.

3. How we developed the Plan?

The development of the new action plan to tackle infant mortality in Manchester involved a number of activities aimed at identifying the main challenges and existing good practice.

3.1 Review of *Reducing Infant Mortality Strategy 2019-2024*

Manchester's *Reducing Infant Mortality Strategy 2019-24* was the City's response to the rising rates of infant mortality identified in 2018. The quality of this strategy has received widespread local and national recognition. Valuable pieces of partnership work were achieved, and lot of work focused on identified modifiable factors contributing to infant deaths such as smoking, maternal obesity, alcohol/substance misuse, unsafe sleeping practices and poor housing.

3.2 A Joint Strategic Needs Assessment (JSNA)

A Joint Strategic Needs Assessment was initiated to provide a summary of the evidence and data regarding the current and anticipated future health needs and wider determinants of health for infants in Manchester. Please see Appendix 1 for the full version of the Infant Mortality Joint Strategic Needs Assessment for Manchester (2024).

3.3 Workshops and Review of the Start Well Consultation (2021)

We conducted a series of workshops with Manchester clinicians and wider partners, including Voluntary, Community, Faith and Social Enterprise (VSFSE) sector and parents, to identify challenges and agree the priorities for action. Throughout the six-month partnership engagement, additional stakeholders were being identified to be included in the development of our refreshed approach. Please see Appendix 2 for the full description of the findings from the engagement.

3.4 Highlights of the Findings

It was widely acknowledged during the development of the plan that there have been many improvements to ante-natal and early years services In Manchester. However, despite the interventions, the last five years have been especially challenging because of contextual factors: the impact of Covid and the cost-of-living crisis, in particular, both of which have disproportionately affected racially minoritised groups, disabled and low-income groups. In addition to these, lack of adequate housing, lack of accessible consistent information (both for families and clinicians), experiences of "top-down and rigid" services and pathways all contributed to a challenging situation.

Another key finding of the engagement process was the recognition of some contradictions in calls for action to reduce infant mortality. For example, there were calls for consistent services/messaging as well as for bespoke, culturally appropriate services/messaging. There were some differences of opinion between professionals and communities as to the success of current approaches to some issues. These differences were most notable for the practice of co-sleeping (which the evidence tells us is a risk factor for infant mortality but which, for some communities, is an embedded cultural practice).

A significant gap was identified in terms of past input from families with young children and of the local voluntary, community and faith sector.

4. *It takes a village*. Our vision and approach

We know that structural racism and discrimination and not having needs listened to and acted upon, can impact on families' abilities to keep their babies safe and well. All the future work will have a stronger focus on equity, specifically around the poorer outcomes impacting racially minoritised groups and those on low-income. We will also emphasise how services could work better together and listen to the diverse communities of Manchester. In so doing, the opportunities will increase for pregnant women and people to have a healthy pregnancy and be supported so that their babies thrive. This vision aligns with Making Manchester Fairer Action Plan.

We recognise that issues such as maternal obesity and smoking in pregnancy are some of the most important modifiable factors of infant mortality and we will continue to address these using equity as our guiding principle. We will work with our partners to interrogate data using equity as a lens and make recommendations about how resources are allocated to address inequity in outcomes. We will work alongside communities on solutions that work for them.

We will continue with what is being delivered in terms of safety and access to services, maternal and infant wellbeing, safeguarding and bereavement. The refreshed plan reflects the strong will within the partnerships to focus on how we deliver services and campaigns and enable the upstream interventions that address the causes of inequity.

More than this, our vision is to support the health and wellbeing of pregnant women and people, their families and the communities that support them including clinicians and other professionals. The actions outlined in this plan aim to be more responsive to a baby's wider context in recognition of the broader social and material factors influencing mothers and their shared environments which influence all their wellbeing. This plan recognises that a baby's health and well-being is reliant upon the health and well-being of their community.

5. *Once you've got the relationships, then the magic happens.* The Safe and Healthy Beginnings Plan

The key finding from the development stage of the plan was the recommendation to focus on how we work, in addition to what we offer. The importance of foregrounding relationships to reduce infant mortality in Manchester cannot be over-stated. Our plan spans 5 years (April 2024- March 2029). In 2027 the implementation group will undertake a full review of the plan to ensure the priorities and outcomes are still relevant, and on target. Below is a summary of priorities and the impact we are hoping to achieve.

PRIORITIES	IMPACT
Create and support multi-systemic partnerships	• shared ownership and accountability • Improved safety for babies in all types of accomodation • Improved acessibility and experience of maternity care to reduce inequalities
Support culturally appropriate, person-centred, relational practice	• Improved understanding and trust between communities and clinicians leading to more equitable outcomes for families
Produce and share accurate, timely data	• Gaps in services and inequalities are better understood and addressed by the partnership
Harness digital technology	• Parents, particularly those who can't read (English), can access and are confident in using technology to access information to make informed choices about their pregnancy and beyond
Develop local best practice	• Reducing the risks attributable to modifiable factors of infant mortality
Partner more with community groups and support place-based communities of practice	• VCSE expertise and communities' voice contributes to the delivery of the Plan

The Safe and Health Beginnings Plan 2024-2029

Priority	Outcomes	Activities leading to outcomes	Impact
Create and support multi-systemic partnerships	Raise the profile of Safe and Healthy Beginnings Plan and ensure strategic buy-in and improved coordination of the work	• Present and link this plan to the Start Well Board for strategic oversight and to the Family Hubs steering group for system ownership. Partners commit to actions. • Launch the new plan to raise awareness amongst stakeholders. • Report to and feedback from Community Health Equity Manchester (CHEM) on yearly basis including issues related to co-sleeping and consanguinity • Include an Integrated Care Board (ICB) Clinical Lead in this work to ensure oversight • Celebrate and amplify good practice, for example, multi-agency training • Create a systematic approach to consultation with pregnant people, parents and carers of babies • Develop and implement a Performance Monitoring Framework for the Plan • Work with providers of midwifery education in Greater Manchester to contribute to learning of the future workforce • Develop an integrated neighbourhood model to deliver place-based maternity and early years support services • Improve commissioning alignment between Public Health and Early Years	There is a shared ownership and accountability
	Contribute to GMEC Equality and Equity plan, and participate in their campaigns including ASAP - As Soon As Possible Early Booking Campaign	• Present and link this plan to GMEC for system ownership of Manchester's strategy • Identify areas of common priority and agree how to maximise resources available in response to need. • Integrate delivery of actions in both plans into services in Manchester	Access to maternity services is improved. Reduction in health inequalities among

			the most disadvantaged groups
	Deliver and embed LMNS Saving Babies' Lives Care Bundle (SBL)	• Work towards Implementation of SBL version 3; achieving 50% implementation as a minimum in each element and working towards achieving stretch targets • All maternity providers will implement the SBL care bundle in full. • Strengthen neonatal links • Build upon the SBL care bundle to introduce other measures such as smoking cessation and offering Omega 3 supplementation for those at high risk of preterm birth; all optimisation measures are offered to babies born early to maximise their potential and give them the best start.	Stillbirths, neonatal deaths, premature births and birth injury are reduced
	Deliver and embed LMNS Personalised Care Planning (PCSP)	• Pilot training and means of offering personalised plans for individuals and taking account of individual circumstances, including needs – both clinical and social needs • Complete pilot and agree final model and roll out across the area • Embed offer of PCSP and supporting conversations in maternity services	Personalised care planning will improve connections to community health and social/VCSE services and take account of the wider determinants other than clinical needs
	Deliver and embed LMNS Midwifery Continuity of Carer (MCoC)	• Establish MCoC among maternity providers where safe staffing is in place to identify potential pathways or groups.	Carer models are offered in an enhanced way and through an equity

			and equality lens, to support those most in need and at risk of poorer outcomes
	Work with housing to ensure the needs of pregnant people and babies are prioritised and their safety ensured, especially in temporary accommodation	• Re-establish strategic and operational relationships • Agree actions with housing providers to prioritise the safety of pregnant women and babies, especially in temporary accommodation • Operationalise ownership of the plan at neighbourhood level (for example midwives have knowledge of local housing providers)	Improved safety for babies in all types of accommodation
Develop local best practice	Continue and develop services that address the modifiable risk factors of infant mortality and enhance collaboration between strategies	• Continue working with the smoking in pregnancy service at MFT to prevent smoking amongst pregnant women and people and their household members, and contribute to Room to Breathe Project so that all babies are protected from exposure to environmental tobacco smoke, especially in their homes • Ensure that Shisha and use of different types of tobacco beyond cigarettes use by pregnant women and people and families is discussed and acted upon • Work with Unintentional Injury Prevention Team to deliver child safety campaigns and training to parents and carers, and professionals and promote social media toolkit once developed • Prioritise healthy weight in pregnancy when Manchester Healthy Weight Strategy is refreshed in 2025, with actions on preconception education package for raised BMI	Reducing the risks attributable to modifiable factors of infant mortality

		• Address the rise and normalisation of cannabis use, and wider substance misuse amongst pregnant women and those who care for the babies, in collaboration with specialist midwives and Change Grow Live commissioned service • Continue to support and develop Teenage Parents service to improve young parents engagement with services	
Produce and share accurate, timely data	Use data to target resources where they are most needed	• Agree data sharing protocols (for example on late bookings in Manchester) • Work with Hospital Foundation Trusts and other partners across the City to ensure accurate and timely data collection and analysis, particularly with regard to ethnicity and post code. This will enable partners to monitor and take action to ensure that services (for example, maternal and child vaccinations) are accessed by people who experience the most health inequalities, poorer health outcomes and life chances. • Map where late bookings are concentrated across Manchester	Gaps in services and inequalities are better understood and addressed by the partnership

		• Work with Child Death Overview Panel and partners to refine data categorisation so more accurate information about children's ethnicity, for example, is available, so we can work together in culturally appropriate ways to support specific issues • Explore, share and promote a smoke free pregnancy platform and LMNS dashboard on Tableau • Produce amalgamated statistical data, dovetailed with neighbourhood level data for a richer statistical picture that would support front line practitioners to have a focussed approach on more vulnerable families for example younger parents who may be more likely to struggle with accommodation	
Partner more with community groups and support place-based communities of practice	Identify community groups, especially those working with racially minoritised parents and invite them to participate in the implementation of the Plan	• Compensate community groups for their time and contribution to Safe and Healthy Beginnings work, with Making Manchester Fairer (MMF) renumeration policy as an example • Facilitate conversations about Safe and Healthy beginnings as early as possible, especially around genetic literacy, impact on mental health and smoking, with youth services and school health and faith groups • Continue the peer support volunteer work in families' homes, engaging those often furthest away from the services • Extend an offer of Safe Sleeping training to upskill community groups • Celebrate the smaller scale examples of collaboration working well, for example, the Thriving Babies programme, and explore how that model and way of working can be replicated.	VCSE expertise and communities' voice contributes to the delivery of the Plan

		• Work with bereavement midwives, nurses and healthcare practitioners to identify at risk patients who have previously suffered a neonatal death to ensure early intervention prior to or during a subsequent pregnancy. This will include linking with the GMEC Perinatal Loss Group and engagement with charities such as SANDs, Caribbean and African Health Network (CAHN), Dad Matters, Finding Rainbows and spoons	
Support culturally appropriate, person-centred, relational practice	Collaborate with Family Hubs to facilitate grassroots and community groups to deliver culturally safe services for racially minoritised parents, especially around mental health	• Pilot and evaluate the approach in at least one Family Hub area • Input into the Early Booking ASAP campaign to ensure it includes targeted messages for different groups	Improved understanding and trust between communities and clinicians leading to more equitable outcomes for families
	Extend training on cultural competency and implementing equitable practice to a wide group of professionals in line with MMF	• Implement the recommendations from Workforce Engagement and Development element of MMF	
	Facilitate dialogue between communities and professionals on issues affecting Safe and Healthy Beginnings such as healthy weight in pregnancy, safe sleeping, genetic literacy	• Establish and run listening events on specific subjects relating to Safe and Healthy Beginnings with groups from whom we seldom hear • Share safe sleeping resources and training with *Umeed* volunteers to enable them to support parents in a culturally competent ways • Understand the additional skills, competencies and knowledge Black and Asian staff bring to services, such as language and cultural understanding to aid individual care and support for families from different cultures	
	Work with specialist midwives, Maternity Action and other VCSE to address the additional needs of	• Create a specialist package of support for pregnant people who are recent arrivals to the UK, considering their language needs, and recognising	

	pregnant asylum seekers and migrants	the differences in approach to maternity in different cultures • Engage with carers beyond the parents (that could include extended family members) • Consider membership of Implementation Group moving forward and involve specialist midwives as required • Increase staff knowledge and awareness of when and how to use interpreting services and report incidents • Improve infrastructure and equipment available for interpreting and improve options for f2f interpreting in antenatal clinics	
	Broaden professional understandings of pregnancy so we acknowledge and include the experience of different cultures and people in bringing up their children	• Contribute to the multi-agency review of safe sleeping guidelines taking place in 2025 • Develop a gender-inclusive approach to addressing the some of the disparities that trans and non-binary people experience due to high levels of discrimination, which may limit their access to healthcare	
Harness digital technology	Utilise and promote online platforms to communicate with pregnant people and new parents ensuring the platforms are inclusive	• Ensure the use of technology for translation and interpreting services is safe and effective • Provide parents with information and support to access online platforms • Join a conversation with Essential Parent platform via GMEC LMNS Partners to ensure it accommodates languages other than English	Parents, particularly those who can't read (English), can access and are confident in using technology to access information to make informed choices about their pregnancy and beyond

6. Examples of good practice

Below are some case studies of organisations working to address the actions within the plan and enact a positive change.

1. Bump 2 Baby course, Sure Start Centres

Across the city, within Sure Start centres, 5-week antenatal programme for mums to be to promote bonding are ran as an important element of baby's development. They aim to help parents to prepare for their baby's arrival and help to build parenting confidence and skills. They also play a key role in supporting parental health and wellbeing, benefits of which are positive for newborns. The classes cover bonding, attachment and baby care and are updated regularly to adhere to the changing advice we often see in pregnancy.

2. Room 2 Breathe Project

Exposure to tobacco smoke is the most prevalent modifiable risk factor for infant mortality. Manchester Foundation Trust, in collaboration with the Public Health Team at MCC, is committed to eliminating smoking during pregnancy. Central to this initiative is the Room 2 Breathe programme, a two-year programme which seeks to minimise the exposure of pregnant women and infants to environmental tobacco smoke. The programme's success will be measured by its goal of reducing adult smoking prevalence in Manchester to below 5% by 2030. Despite this target, significant challenges remain, particularly the inability to accurately measure the number of individuals smoking within homes. To advance this initiative and the Smoke Free Pregnancy Programme, it is crucial to engage a broader range of stakeholders and partners in supporting the project's objectives.

3. Doula Programme/UMEED

Manchester's Department of Public Health have established the Umeed* programme (volunteer peer support programme). Volunteers (Apis'*) will provide healthy pregnancy advice to Pakistani women at the early stages of their pregnancy (5-8 weeks) up to 28 days after delivery, with the aim to promote a healthy pregnancy and improve outcomes for women at increased risk of having a child with a genetic disorder. This project launched in September 2023 focusing on Cheetham Hill and Longsight wards. *'Umeed' is an urdu word meaning Hope. *Api is an Urdu word to describe 'big sister'.

4. Maternity Action is working with the Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System on two maternity health justice partnership (HJP) projects for the GMEC region. One of the HJP is a dedicated free and confidential advice service on entitlements to housing and support for migrant and asylum-seeking women who are pregnant or new mothers. Migrant women may experience specific

challenges which makes addressing the social determinants of health particularly complex, leading to multiple vulnerabilities. These can include: difficulties accessing healthcare (language barriers or previous poor experiences); low levels of asylum support which make it difficult to access a healthy diet or travel to appointments; poor quality housing; dispersal policies within asylum support which move women away from maternity services and networks of support. This HJP project provides advice on entitlements to housing and support as well as support and training for professionals.

5. Home-Start Manchester volunteers work with expectant parents living in hotel homeless accommodation providing emotional support around peri-natal depression and anxiety, and practical help to prepare for a baby in temporary and unsuitable home conditions. Some parents do not have English as first language and come from a variety of cultures and backgrounds, and some plan to co-sleep with their babies. The volunteers can be specifically matched due to similar cultural background and the same language. Home-Start is also able to provide families with some essentials to ensure safe sleeping, such as travel cot and mattress, sleeping bags and cellular blankets and support parents to understand the risks of co-sleeping. Following baby's birth, volunteers also support families to access groups and services, encouraging conversations about mental health and building trust over a long period of time. Families as a result are linked to their local Children's Centre, talking therapies, and infant feeding support.

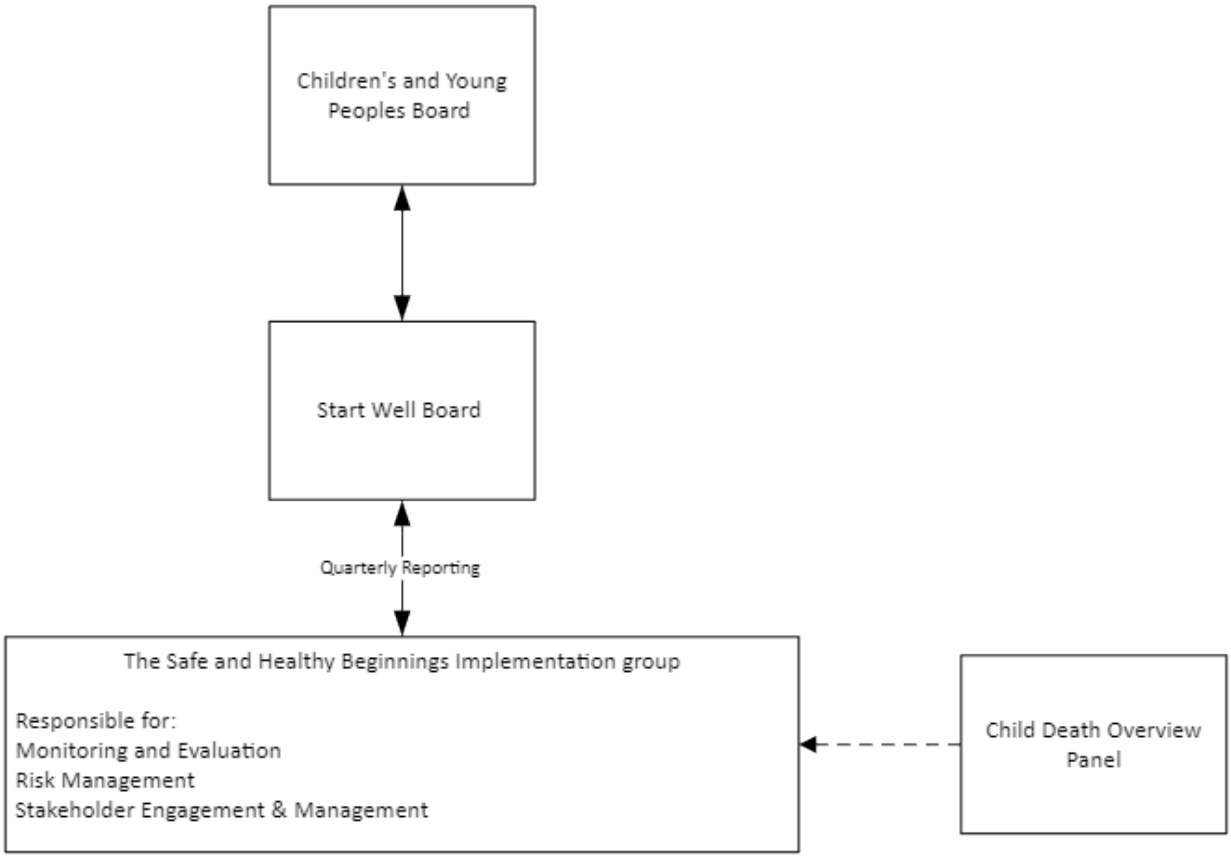
6. Gorton Sacred Heart Family Hub

Gorton Sacred Heart Family Hub was the fourth one to open in Manchester in the spring of 2024. Shortly after opening, a link was made between Caribbean and African Health Network, who were looking for a space to deliver activities linked to their Cultural Wellbeing Hub for Black parents. Gorton Sacred Heart Family Hub was able to offer a permanent desk and a room twice weekly across the Family Hub network to deliver sessions, including at the weekends. The Hub is keen to offer additional desk space once the work is finished for any other partners who want to co-locate at the sites. Linking of community groups who know their population well with spaces where the Council delivers their early years offer could contribute to wider statutory services co-located there listening and learning from experts within the communities. This will contribute to more positive relationships between the early years council and health services and contribute to building trust with communities which is much needed.

7. Governance and monitoring

The Safe and Healthy Beginnings Implementation Group will monitor the delivery of the actions agreed within the plan and report its progress to Start Well Board. Child Death

Overview Panel's data will be brought to the Implementation Group annually for consideration of any trends and the need for any immediate actions. A comprehensive evaluation framework will be developed in the first six months of the implementation of the plan to ensure the partnership can assess how effectively we are addressing the needs of infants and their families.



8. References and Additional Reading

1. 'Joint Strategic Needs Assessment- Gypsy, Roma and Traveler communities' Laura Parker. Action to work with Early Help and families in GRT communities.

2. Manchester's Start for Life Offer Booklet

3. Guide to Pregnancy, Family and Mental Health

Available in following languages: Arabic, Bengali, English, Polish, Punjabi, Urdu

4. Rodney House Specialist Support School: Rodney House provides an outreach service to families and settings of children with SEND aged 0-5 across the city. RHOSEY outreach for families provide support directly to children through individual and group work. The outreach for families teamwork with families who have a child aged between 0-5 years old not in a setting who meet referral criteria. RHOSEY Outreach for Settings role is to work with practitioners from Early Years settings throughout Manchester in an outreach capacity, offering advice and support in their work with children who have been identified as having additional needs.

5. Making Manchester Fairer Plan: The plan is a city wide action plan to address health inequalities across Manchester between 2022-2027 to tackle social determinants of health (i.e. housing, employment, poverty and debt).

6. Start Well Strategy: Vision of the Start Well Board to come together to enable every child in Manchester to have the best possible start in life, as highlighted in the strategy.

7. Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS)Maternity Equity and Equality Action Plan 2022-2027

8. Maternity Action Maternity Rights Advice Service and Maternity Care Access Advice Service

9. Manchester Family Hubs www.mcrfamilyhubs.com

10. Lullaby Trust: The Lullaby Trust raises awareness of sudden infant death syndrome (SIDS), provides expert advice on safer sleep for babies and offers emotional support for bereaved families.

Appendix 1: Infant Mortality Joint Strategic Needs Assessment for Manchester

Appendix 2: Full description of the findings from the engagement

1. Challenges

1.1 Contextual factors

Current and historic occurrences of trauma (experienced by too many women and birthing people) often result in mental health issues. These issues often become compounded with existing medical conditions (for example, sickle cell anaemia) and social isolation, for example. The most difficult issue for families receiving support from clinicians/professionals included the lack of adequate housing. This issue was mentioned repeatedly as problematic for families with a range of challenging consequences. For example, some families need to move away from their communities to access housing, often creating issues around accessing support. These contextual factors were also challenging for clinicians offering support to families. Maternity clinicians described their worries and frustrations about their inability to safely discharge some women following the birth of their babies owing to homelessness, poor/temporary housing with no equipment/ support. This could result in bed blocking in hospitals. Sometimes discharging safely means accommodating women/families in distant places away from support so is potentially unsafe and poses other risks.

1.2 Lack of accessible, consistent information

Many families are fortunate to live in multi-generational households and have extended family who can support in pregnancy and babies' early years. However, this can sometimes lead to contradictory ideas and expectations within the family. Conversely, some mothers do not have strong support mechanisms and sometimes do not know where to go to find support and information, or may feel ashamed to do so. In addition, many newcomers – refugees and migrants are often not aware of the NHS system, and when to book their pregnancy. New entrants will come to the UK with their own cultural norms and practices around pregnancy and childbirth that may not translate to the same practices in the UK.

In addition to these issues is the challenge of women who are cared for by a midwife late into their pregnancy, often referred to as 'late bookings'. There is a high number of women from racialised minority groups who present their pregnancy late to doctors and maternity services. This can impact on many outcomes for babies and their mothers. There is a greater uptake of Vitamin D, for example, when bookings are early. There are many

potential reasons for late bookings. Mothers from different countries may have different understandings of booking times for appointments, potentially contributing significantly to the late bookings seen in new entrant mothers. Information about booking or families being unsure where to go to find information or how to book may also be contributing to the problem. In addition, families can often find themselves facing a range of challenges, not least temporary housing, and this may mean that a potential pregnancy is not prioritised.

1.3 One size fits all?

Many participants described maternity services as “top-down and rigid” with not enough sensitivity to different cultural practices or circumstances or little opportunity for families to discuss their everyday practices. Safe sleeping advice was perhaps the most obvious example as Manchester largely provides one message and warns of the dangers of co-sleeping. However, some houses are limited in space, one room or bed may be shared by several people. Some families’ cultural practice may be to co-sleep. Some told us that messages concerning safe sleeping (or advice around babies in general) has to recognise both the extra challenges faced by some families living in Manchester and the different choices families make. Practice needs to be culturally sensitive so that families can make informed choices about child rearing. The consequences of not doing this is that ‘official guidance’ may be dismissed by some families who know they cannot fulfil that expectation, or hidden from professionals for fear of being judged and potentially discriminated against for now following ‘the rules’. Some professional practice was described as ‘following a given script and rigid guidance’ with little opportunity for a relaxed conversation. This was described as sometimes leading or contributing to a lack of trust between families and professionals. However, maternity practitioners are conscious of giving advice to parents that could possibly have negative outcomes for a child and may fear the risk of being blamed if something were to happen to a baby. Co-sleeping is one of the risk factors for infant mortality.

In addition, many participants described that there’s a fine balance to achieve between implementing culturally appropriate practice and addressing some misconceptions that may be present in communities – thereby supporting parents to make informed choices. So, for example, some participants told us that in some East African communities there is the belief that autism is increasing with the use of vaccinations. Stigma around learning difficulties in some communities is linked to vaccine hesitancy. So too, embarrassment about FGM. However, many clinicians told us that they recognise that one size definitely does not fit all, and that many of the challenges families face are exacerbated by lack of trust in services (described universally as the biggest risk to families with babies).

Professionals recognised that some women feel stigmatised (for example, around being a young mum who smokes and doesn't breastfeed) when smoking/drinking alcohol are sometimes used as coping mechanisms to deal with poverty/poor housing, for example.

1.4 Systemic pressures

Clinicians shared some of the challenges they face to adequately support the families whose care they are committed to support. Not least of these is that, at the time of writing, Manchester's midwifery service had a high vacancy rate. On top of this stretched service, clinicians told us that they often feel inadequately equipped (in terms of knowledge/information) to deal with the complex multiplicity of the wider contextual issues many families experience (for example, the legal complexities of asylum), on top of any medical issues.

Professionals also described their struggles to access interpretation services which makes communication difficult. This can mean that some families may pick up mixed messages about Healthy Start vouchers, for example, with families not knowing they can use them in the shops/greengrocers selling the kind of food they prefer to eat. In addition, services can be so stretched that some maternity clinicians do not know about supplementary support available locally nor even the kind of training that is offered by other professionals.

2. Opportunities

2.1 Introduction

Participants in our consultation told us that front-line practitioners (in particular, midwives and health visitors) plus friends and family are the main sources of information and support for people in the early stages of parenthood. So too, the services and opportunities to connect with other parents that are available in Sure Start Children's Centres and Family Hubs are highly valued for providing holistic support. This front-line practice needs to be valued, supported and strengthened. The following opportunities were suggested as mechanisms to engage all parts of the system to this outcome.

2.2 Create and support multi-systemic partnerships

Develop a strong partnership with Greater Manchester & East Cheshire LMNS and their maternity Equality and Equity Plan to achieve their ambition to reduce inequalities in maternity services. This strongly links with Manchester's ambition to reduce infant

mortality. Opportunities to contribute to and draw resources from this partnership could be explored including work around genetic literacy, late bookings and the Saving Babies Lives bundle.

2.3 Partner more with community groups to support place-based communities of practice

Alongside the essential work of ensuring more representation of racialised minority groups in the maternity profession, we also need to develop and strengthen partnerships with community groups in local areas. These groups can support the dissemination of information, for example about booking times, and advise about culturally competent approaches. This may help to build trust between communities and professionals. Neighbourhood workers could support the work in engaging GRT communities, for example Roma mothers typically present much later to primary care due to the lack of trust in services and cultural understandings of when medical help and support is needed. We could look at the smaller scale examples of collaboration working well - for example, the Thriving Babies programme, and how that model and way of working can be replicated. Working with partner organisations would help to improve accessibility to advice, guidance and support so that families not only have the information but would understand it too. We need a bespoke approach for some communities in Manchester. This approach has the potential to support earlier identification of mental health needs.

Knowledge, skills and experience of supporting families to realise their holistic needs are available in the system as a whole, but professionals, owing to the challenges previously outlined, often work in silos. Participants suggested that professionals also need the means/networks to be supported and to enable sharing of information, not least to avoid duplication. For example, health visiting is a universal service; Health Visitors are informed if a family is homeless and in temporary accommodation. Health Visitors could therefore be the first port of call for midwives to support with this issue.

Sure Start Children's Centres, and Family Hubs in particular, provide opportunities for this ambition to be realised. Family Hub funding has enabled the early help offer in Manchester to develop and strengthen work with targeted groups, for example, trauma experienced cohorts and bespoke projects, for example, the Genetic Literacy project. In addition, excellent work is currently underway for partners to share information at multi-agency 'team huddles' to support families whose circumstances may make them vulnerable; to share information about training (eg Jane McConkey, vulnerable babies training) and to celebrate good practice. These multi-agency networks could be strengthened by the inclusion of the VCSEF sector, including grassroots community groups and the potential for co-production with this sector could be another way of

including all partners within the system for the benefit of pregnant people and families with very young babies. So too, building links with GPs has the potential to ensure pregnant women and birthing people are referred early for gestational diabetes checks, for example. The networks could also be a means of sharing developing local knowledge to use as evidence to escalate concerns – for example with housing providers. There are also opportunities to develop and support 'system champions' at district level whose responsibility it is to create or facilitate networks around priority issues: specialist midwives and housing practitioners to support safe discharge planning, resources to support mental health for pregnant black women, and late bookings, for example.

The family hubs also act as a focus and meeting point for parents who have come through antenatal services to volunteer their expertise-by-experience. Parent volunteers are embedded in the community and have knowledge and connections within the community in which they can encourage new parents to become involved. Training for volunteers is offered and this strengthens the role they provide for the community. An example of this is the Umeed project, which is a volunteer peer support programme supporting pregnant Pakistani women to have a healthy pregnancy and improve outcomes for women at increased risk of having a child born with a genetic disorder. Female volunteers complete 4 weeks of culturally appropriate training and are then suitably matched to expectant women at the early stages of their pregnancy, up to 28 days after delivery. The role of the volunteer is to provide emotional and practical support to their expectant mum.

2.4 Support culturally appropriate, person-centred, relational practice

As conversations with participants demonstrated and this plan reflects, there is much good practice in Manchester to celebrate. But we were also told that it's patchy. Building compassionate, person-centred relationships with expectant parents – especially those most at risk - and not just imparting information, however well-meaning. The risk is that parents can feel judged and stigmatised which is counter-productive.

There was widespread agreement among all participants – clinicians, community groups and families alike of the importance of implementing culturally appropriate, person-centred practice. Participants advised us of the need to embed good maternal/perinatal health in communities (trusted places with trusted people). Good maternal health would then be owned by the community and would filter through to fathers, grandparents and children et al.

2.5 Produce and share accurate, timely data

Produce amalgamated statistical data, not only about late bookings and child deaths, but dovetailed with neighbourhood level data for a richer statistical picture that would support front line practitioners to have a focussed approach on more vulnerable families and could support all professionals working with a family to consider housing conditions, including overcrowding, during assessments. In addition, the data we currently collect about infant mortalities (particularly about the ethnicity of affected families) is much too broad. We need to have more fine-grained statistical data to feedback to community groups so we can work together in culturally appropriate ways to support the specific issues experienced by racialised minority groups.

2.6 Harness digital technology

Online information is often inaccessible to those who do not have access to the internet or who do not speak English. There are opportunities to develop and strengthen work to improve this – for example, through the 'Essential Parents' portal promotion. Bespoke packages of care are provided for parents, tailored to their support needs. Opportunities to adapt the portal so it accommodates languages other than English could be explored.

3. Conclusion

3.1 Supported practitioner, confident family, healthy child

There's a basic contradiction at the heart of this plan: a call for consistent services/messaging as well as a call for bespoke, culturally appropriate services/messaging. Both requests are relevant, and a sophisticated plan needs to work with both approaches, according to circumstances. Above all, the consultation we undertook to develop this plan underlined the need to support maternity professionals who in turn would then be in a better position to support families to have the confidence and resources to make informed choices about their pregnancy, the birth and joy of bringing up their baby in Manchester.