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Safer Sleeping Guideline

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Worcestershire Health and Care NHS Trust

WORCESTERSHIRE SAFER SLEEPING GUIDELINE

Document Type	Guideline
Unique Identifier	CL-126
Document Purpose	This policy sets out the standards for ensuring a consistent message to safer sleeping is adopted throughout Worcestershire for all new born babies. The aim is to reduce the risk of Sudden Infant Death Syndrome (SIDS)
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Target Audience	Midwives Health Visitors Breastfeeding Support Workers Community Nursery Nurses Consultant Paediatricians Neonatal nurses Paediatric Nurses
Responsible Group	Clinical Policies Group
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Version History

Version	Circulation Date	Job Title of Person/Name of Group circulated to	Brief Summary of Change
1	13.02.13	Clinical Policies Administrator	Formatting
2	11.03.13	**WHACT** Children's SDU Leads Quality Governance Manager Director and Deputy Director of Nursing Safeguarding Lead Health Visiting Clinical Lead and team leads Breast Feeding Advisor	**Changes** No changes No changes No changes Minor changes to roles and responsibilities to make more generic to both WHACT and Acute Trusts Additional info on TOG Ratings/ Additional info on twin co sleeping Minor changes to breast feeding information
2	11.03.13	**Worcestershire Acute Trusts** Obstetric and Midwifery Leads/ Matrons Clinical Director for paediatrics and obstetrics Director and Deputy Director of Nursing Head of Clinical Governance and Risk Management Safeguarding Lead Neonatal and Paediatric Leads/ Matrons General Manager for paediatrics and obstetrics	**Changes** Change to conduct ante natal safer sleeping talk to between 31 and 36 weeks, as opposed to 36 weeks. Safer sleeping leaflet not given out at ante natal appointment as given in hospital. Inclusion of pre-term and low birth weight in definitions No changes No changes No changes No changes Minor change to include hospital midwives in roles and responsibilities/ minor change to include babies placed on tummies *whilst monitored* on neonatal unit No changes

2	11.03.13	Medical Director – NHS Worcestershire	No changes
		Deputy Nursing Director-NHS Worcestershire	No changes
		Children's Social Care Operational Manager	No changes
		Child Death Overview Panel Members	No changes
3	02.10.13	Health Visitors and Community Midwives	Additional comment about 'out of county babies', and how they should be risk assessed
		Training and Development Manager	E Learning to be completed every 3 years instead of annually.
4	25.10.13	Nurse Consultant – Infection Prevention and Control	No Changes
		Integrated Safeguarding Team Manager	No Changes
5	31/01/2017	Matron Community Midwives WHAT	No Changes
		Midwifery Infant Feeding Advisor	Comment on training and leaflets used.
		Infant Feeding Advisor WHCT	Additional comments on training and Bednest Crib safety.
		SDU Quality Lead	Removed appendices relating to frequently asked questions and TOG ratings
6	27/03/2017	Team Leader Starting Well 0-19 Public Health Nursing Service	Additional comments on Equality Assessment.
7	30/03/2017	SDU Lead, CYPF	No comments received
		Service Leads CYPF	No comments received
		CSM Starting Well Service	Additional comments on referencing training, and wording on advice to parents.
8	24/04/2017	Integrated Safeguarding Team manager	No changes
		Nurse Consultant-Infection Prevention and Control	No changes
		Deputy Director of Nursing	
		Manager Clinical Audit	No changes
			Additional comments on monitoring

Accessibility

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Training and Development

Worcestershire Health and Care NHS Trust recognise the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

Co-production of Health and Care – Statement of Intent

The Trust expects that all healthcare professionals will provide clinical care in line with best practice. In offering and delivering that care, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with patients, agreeing a plan of care that utilises the abilities and resources of patients and that builds upon these strengths. It is important that patients are offered information on the treatment options being proposed in a way that suits their individual needs, and that the health care professional acts as a facilitator to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises the resources available through colleagues and other organisations that can support patient health.

Contents

1. Introduction

a. There is evidence from many long term studies of Sudden Unexplained Deaths in Infancy (SUDI) that some of the infant deaths associated with bed sharing, co sleeping and other risk factors could have been preventable (See Appendix 1 for references).

b. It is recognised that the factors, which influence the sleeping arrangements of infants and children, are a combination of parental values, socio-economic factors and cultural diversity

c. There are a range of factors that are known to increase the risk of a sudden infant death. Those pertinent in Worcestershire (from analysis of 2008 - 2016 figures) are smoking, co- sleeping, bottle feeding, alcohol consumption, drug taking and sleeping in a car seat. Other known risk factors are sofa sleeping, low birth weight/ pre term babies, young mothers. (See Appendix 1 for references).

d. Community practitioners should offer advice on the relative risks of unexpected infant death for babies and infants sleeping alone or with their parents. They should do so with an understanding of parental expectations and goals, while also taking into account the need to provide a secure physical and emotional sleeping environment for their children.

2. Purpose

a. To minimise the risk of sudden infant death by identifying where babies and infants sleep and maximising the ability of the carers to implement safe infant sleep practices.

b. To reduce the number of babies and infants who are put down to sleep in unsafe sleeping conditions:

   i. By informing families of the risks of bed sharing/co sleeping and other unsafe sleeping practices with babies and infants; and

   ii. By promoting safe sleeping for all babies and infants.

c. To provide staff with evidence based research to support their discussions with parents.

d. It is recognised that parents will take infants into bed and share sofas with them to comfort them, feed them, and promote bonding and skin to skin contact. This guidance does not discourage this but promotes alongside that: the safest place for your baby to sleep is on their back, in a crib, cot or Moses basket and in a room with you for the first 6 months (DH).

3. Scope

a. This policy is applicable to Worcestershire Health and Care NHS Trust (WHCT) and Worcestershire Acute NHS Trust (WAHT). It is applicable to Midwives, Health Visitors, Community Nursery Nurses, Breast Feeding Support Workers, Consultant Paediatricians, neonatal and paediatric nurses and staff working in Maternal Mental Health Services.

b. Children's Centres, Social Workers and General Practitioners should be made aware of this policy so that they can ensure effective inter agency working with health professionals if necessary.

c. All relevant people are responsible to ensure effective inter agency working and communicating issues regarding safer sleeping with each other.

4. Definitions

a. SIDS/Cot Death**:** The sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history. (Krous et al, 2004)

b. Co sleeping is one or more person falling asleep with a baby in any environment (e.g. sofa, bed or sleep surface, any time of day). This maybe a practice that occurs on a regular basis or it may happen occasionally. **A key feature is the baby is asleep**

c. Bed sharing describes babies sharing a parent's bed in hospital or home, to feed them or give comfort. This maybe a practice that occurs on a regular basis or it may happen occasionally. **There is a risk that the carer may fall asleep**

d. Pre- term: Born before 37 weeks gestation

e. Low Birth Weight: Under 2.5kg or below 10th centile

5. Duties

a. Whilst this document lists duties and responsibilities for the organisations that have signed up to it, this section also includes suggestions for other staff in organisations that will come into contact parents with young babies.

b. **Chief Executives** are responsible for ensuring that:

   i. Arrangements are in place so that employees are fully aware of their statutory, organisational and professional responsibilities and that they are fulfilled.

   ii. The arrangements in support of policy/guidelines are fully implemented through inclusion in Service Delivery Unit Performance Reviews.

   iii. In order for this responsibility to be effectively discharged, Executive Directors and senior colleagues will have specific delegated responsibility to support the Chief Executive in this process.

c. **Directors** must ensure:

   i. Strategic development and implementation of policy, corporately and within their areas of control.

   ii. Effective delegation of responsibilities within their areas of control.

   iii. Effective support for managers' decisions and recommendations in terms of the provision of appropriate resources.

   iv. A framework is in place to ensure that staff are adequately skilled and experienced to safely undertake their work.

   v. Necessary reporting procedures are in place.

   vi. A framework is in place to monitor compliance with guideline.

d. **Service Lead** will be responsible for:

   i. Monitoring the implementation of the safer sleeping risk assessment.

   ii. The Service Lead will ensure that an annual audit of the risk assessment is carried out, assisted by the Children, Young People and Families SDU Quality Lead, will receive audit reports and action plans and will be expected to implement the recommendations in action plans. The audit findings will be reported to the SDU Quality meeting.

e. **Senior Managers** will be responsible for:

i. Ensuring staff who work directly with new born babies and to whom they have direct line management responsibility for complete the safe sleep risk assessment and adhere to the safer sleeping guideline.

ii. They will receive audit reports and make action plans to ensure changes are made.

f. **Community midwives and community student midwives** will be responsible for:

i. Advocating Breastfeeding as a protective measure against SIDS.

ii. Holding the safer sleeping discussion between 28 and 36 weeks in ante natal appointments and documenting this in the records (sticker provided). The Lullaby Trust leaflet should be given along with the Mothers and Others Guide which contains information on night time parenting. www.lullabytrust.org.uk/safer-sleep

iii. Completing the Safe Sleep assessment in the Parent Held Record (within 5 days of discharge from hospital) including a plan to reduce any identified risk or be responsible for handing over to the relevant health visitor if the midwifery team cannot complete this.

iv. Reviewing the baby's sleeping area at home.

v. Working with the family to discuss any identified risks and ways to reduce or manage these risks.

vi. Regularly reviewing the baby's sleeping arrangements and advise on safe sleeping practices. This should be documented in maternal/patient records.

g. **Starting Well Public Health Nurses (Health Visitors and student health visitors) will** be responsible for:

i. Advocating Breastfeeding as a protective measure against SIDS.

ii. Reviewing the safe sleep risk assessment after discharge from midwifery care.

iii. Working with the family to discuss any identified risks and ways to reduce or manage these risks.

iv. Complete the safe sleep assessment in the Parent Held Record, reviewing any plan to reduce risks identified by the midwife.

v. Reviewing the baby's sleeping arrangements at the new birth and 6 week postnatal contact and advise on safe sleeping practices. This should be documented in the electronic patient record and Parent Held Child Health Record.

h. **Neonatal Nurses/ hospital midwives** will be responsible for:

i. Advocating Breastfeeding as a protective measure against SIDS.

ii. Having a knowledge of the safer sleeping policy and ensure consistent advice is passed on to all parents who require any information.

iii. Providing parents with safer sleeping literature from the Lullaby Trust.

iv. Ensuring that, on discharge from a delivery suite/ post natal ward/ neonatal unit/ the parents are informed that the community midwife (less than 10 days old) or health visitor (more than 10 days old) will conduct a safe sleep risk assessment at home.

v. (Neonatal nurses) Informing parents that whilst babies may be placed on their tummies whilst monitored in the neonatal unit, the safest place for a baby to sleep is on their back.

i. **Consultants Paediatricians** will be responsible for:

i. Advocating Breastfeeding as a protective measure against SIDS.

ii. Having a knowledge of the safer sleeping policy and ensure consistent advice is passed on to all parents who require any information.

iii. Informing the baby's Health Visitor if there are any sleeping concerns.

j. **Paediatric Nurses will be responsible for**

i. Advocating Breastfeeding as a protective measure against SIDS.

ii. Having a knowledge of the safer sleeping policy and ensure consistent advice is passed on to all parents who require any information.

iii. Providing parents with safer sleeping literature from the Lullaby Trust.

iv. Informing the baby's health visitor if there are any sleeping concerns.

k. **Nursery Nurses maternity support workers and breastfeeding support workers** will be responsible for:

i. Advocating Breastfeeding as a protective measure against SIDS.

ii. Having a knowledge of the safer sleeping policy and ensure consistent advice is passed on to all parents who require any information.

iii. Informing the baby's health visitor if there are any sleeping concerns.

l. **Staff in Other Organisations e.g. Social Workers, General Practitioners, Children's Centre staff, staff in Education settings**

i. Advocating Breastfeeding as a protective measure against SIDS.

ii. Having a knowledge of the safer sleeping policy and ensure consistent advice is passed on to all parents who require any information.

iii. Informing the baby's health visitor if there are any sleeping concerns.

6. Monitoring and Audit

a. The Audit Tool is in Appendix 5.

b. The safer sleeping documentation will be audited annually. The Service Lead will ensure that an annual audit of the risk assessment is carried out, assisted by the SDU Quality Lead.

7. Training and competencies

a. All Starting Well team leaders, Health Visitors, Nursery Nurses and Breastfeeding Support Workers will receive training in relation to this policy as part of the Trust's initial Breastfeeding Management training and Breastfeeding update training every 2 years.

b. Staff will be given training into giving practical solutions to parents who choose to bed share or co sleep with their baby, so that the risk is minimised.

c. Any deficiencies identified through audit will be discussed and further training opportunities reviewed.

8. Guidance

a. The evidence surrounding the risks of SIDS is set out in Appendix 1. All relevant health professionals should read this and ensure they have an understanding of these risks.

b. All parents will be given the opportunity to discuss safe sleeping arrangements on a one-to-one basis with Community Practitioners, and encouraged to seek further advice should their circumstances change.

c. The first safer sleeping discussion with the parents will occur by the midwife between 28 and 36 weeks during an ante natal appointment. Other useful websites that midwives feel may benefit individual mothers should also be given here.

d. The Safe Sleep Assessment will take place on the first postnatal visit by the community midwife and documented in the parent held record

e. The Risk Assessment Pro Forma is in Appendix 2.

f. Where a range of factors have been identified (through the completion of the safe sleep assessment) the health professional and parents will work together to identify ways to reduce the risk as far as is practically possible. This will be documented in the parent held record and in the clinical record.

9. Key safe sleeping messages for professionals to give to parents

a. All staff giving advice should refer to the UNICEF 'health professionals guide to caring for your baby at night' https://353ld710iigr2n4po7k4kgvv-wpengine.netdna-ssl.com/babyfriendly/wp-content/uploads/sites/2/2016/07/Co-sleeping-and-SIDS-A-Guide-for-Health-Professionals-2.pdf

b. To work through some of the risks, they can also use the parent's guide to caring for their baby at night https://www.nicuef.org.uk/babyfriendly/baby-friendly-resources/leaflets-and-posters/caring-for-your-baby-at-night/

c.

The key messages are:

i. The safest place for their baby to sleep is on their back, always in a cot/basket with a firm water proof mattress in the parent's room for the first six months.

ii. Do not share a bed with the baby if mother or partner;

- are smokers (no matter where or when they smoke);
- have been drinking alcohol;
- are unwell;
- take medication or drugs that make them drowsy; or
- feels very tired..

iii. Not to share a bed with their baby if it was born premature or of low birth weight.

iv. Never to sleep with the baby on a sofa, arm chair or settee.

v. Not to share a bed if their baby is ill or has a high temperature.

vi. Even without any of the above risk factors and the parents choose to bed share with their baby, there is still a small risk that their baby could die of SIDS, be suffocated accidentally, become entrapped between a wall and bed accidentally or roll out of an adult bed.

d. The evidence to support this is:

i. There is no evidence that bed-sharing reduces the risk of SIDS [39, 40].

ii. Sleeping on the back carries the lowest risk of SIDS [30, 31].

iii. Room sharing lowers the risk of SIDS [4, 32].

iv. The risk of SIDS is significantly increased when infants bed-share with mothers who smoke cigarettes. [4, 21, 32]

v. Bed-sharing with an adult who is extremely fatigued or impaired by alcohol or drugs (legal or illegal) that impair arousal can be hazardous to the baby or infant.[4, 21, 34]

vi. The use of soft bedding, pillows and covers that can cover the head increase the risk of death in all sleeping environments.[3, 34]

vii. Sleeping with an infant on a sofa is associated with particularly high risk of sudden unexpected death in infancy. [4, 34]

viii. Bed-sharing with a baby who is premature or low birth-weight increases the risk of infant death.[26]

ix. Bed-sharing with an ill baby or a baby with a high temperature increases the risk of infant death. [27]

x. Breast-feeding is always best for babies but sharing a bed, even if there are no recognised factors, carries a risk. [4, 25, 32, 35, 39, 40]

10. Completion of the safer sleeping risk assessment form

a. The form is designed to gather as much information about a baby's sleeping situation in order that a risk assessment can be undertaken with the parents. . The format requires practitioners to indicate yes/no answers and also add free text. This must be completed in full for every baby living in Worcestershire irrespective of where the baby was born.

b. The aim of the risk assessment is that it allows for a discussion between health practitioners and parents and enables parents to make informed choices in a relaxed environment. Any actions arising from the assessment should be made in partnership with each other.

c. Practitioners must document the name, date of birth, address and NHS number of the baby, and the date of assessment. The sleeping place must be seen in order that appropriate advice is given. If the practitioner does not see, observe and assess where the baby sleeps then she must document the reason why, and document what action is to be taken to ensure this happens as soon as possible. Every effort must be made to observe where the baby sleeps. The practitioner must see where the baby sleeps during the day time as well as the night time.

d. The assessment, should, wherever possible be completed with both mother and father present, to ensure both parents are included in the discussions and decision making.

e. Identification of risks: In partnership with the parents, the risk assessment should be completed and any risks identified will be highlighted in the appropriate box.

f. Discussion of risks: Any risks identified should form the basis of discussion with the parents. Resources, such as the UNICEF guidance for health care professionals and parents (see section 9a for link), and the Lullaby Trust Leaflet given to parents should be used as part of this discussion.

g. Actions identified: In partnership with the parents, actions to reduce the risk as much as possible should be discussed and documented. These should be realistic, for example-

a parent who smokes 20 cigarettes a day is unlikely to be able to quit immediately. Advice on smoking cessation, hand washing and changing clothes before holding the baby and ensuring their baby is not brought into bed with them is more realistic.

h. The risk assessment form should be signed by the midwife and health visitor.

i. Once the assessment and actions are complete, the top copy of the risk assessment should remain in the child's health record (red book), and a second copy should be scanned into the child's electronic patient record.

j. If the parents refuse to show the room in which the baby sleeps, this should be documented, with an explanation where possible as to why this was the case.

11. Breast Feeding and Safe Sleeping

a. Breastfeeding provides significant health benefits to babies including increased protection against respiratory tract infections, ear infections and gastroenteritis; the longer the baby breastfeeds the greater the health benefits.

b. Breastfeeding should therefore be promoted as the healthiest nutrition for babies, and families should be supported to continue to breastfeed for as long as they wish.

c. Several studies have found that breastfeeding protects against the risk of SUDI and should be recommended as a protective measure. (See Appendix 1 Protective Factors for references).

d. However, no studies have found bed-sharing/co-sleeping under any circumstances to be safe, and some studies have shown a significant risk, even if the parents are non-smokers.

e. It is recognised that mothers who bring their babies into bed to feed tend to continue to breastfeed longer than those who do not. However, it is easy to fall asleep whilst breastfeeding as lactation hormones induce sleepiness. If breastfeeding parents indicate that they intend to bed-share, then advice from the UNICEF leaflet should be given (see section 9b for link) (each midwife and HV will have a copy of this).

f. Actions to minimise the potential risks regarding safe sleeping must be discussed, including the management of night time feeds (see Appendix 1: Co Sleeping: Specific Circumstances). The key risk reduction messages still apply to breastfeeding mothers. Whilst providing messages to mothers to support breastfeeding it should always be stated that:

   i. The safest place for a baby to sleep is in their cot/Moses basket/crib in their parents' bedroom.

   ii. You should not share a bed if you or your partner smoke, have been drinking or taking drugs that make you drowsy or feel very tired.

   iii. If a mother does fall asleep when breastfeeding, as soon as she wakes the baby should be returned to their cot/Moses basket.

   iv. Never fall asleep with a baby on a sofa or armchair.

g. Midwives and Health Visitors should use the safe sleeping assessment to help breastfeeding mothers put in place a strategy to minimise the risk of unintentional co-sleeping

12. Out of County Babies

a. **Babies with a Worcestershire Health Visitor but not a Worcestershire Midwife** must have the safer sleeping risk assessment and discussion completed by their Health Visitor. The discussion should be recorded in the clinical note and the risk assessment form should be scanned onto the baby's electronic patient record.

b. **Babies with a Worcestershire Midwife but not a Worcestershire Health Visitor** must have the safer sleeping risk assessment and discussion completed by their Community Midwife. Once the baby is discharged to Health visiting Services, the Community Midwife must file the bottom copy of the risk assessment in the post natal records. **Note: These are the only babies where the form should be filed in the Post Natal Notes- all other occasions; the form will be scanned into the baby's electronic patient record.**

Appendix 1

RESEARCH ON SAFER SLEEPING

RISK FACTOR	WHY IT'S A RISK
Infant sleeping in parental bed **Infant sleeping on sofa**	Bed-sharing is just one form of co-sleeping. Forms of co-sleeping such as sharing a mat, futon, or the floor are different from bed-sharing because the surfaces are different, and may not have the same risks as that of soft mattresses, quilts, water beds, sofas, couches or car seats etc. It is important to be aware that adult beds are not designed to assure infants safety. Blair et. Al.[4] found that: • Co-sleeping with an infant on a sofa was associated with particularly high risk of sudden infant death syndrome. • The risk linked with bed-sharing among younger infants seemed to be associated with recent parental consumption of alcohol, overcrowded housing conditions, extreme parental tiredness, and the infant being under a heavy cover such as a quilt. • Among infants whose parents do not smoke or infants older than 14 weeks there was no association between infants being found in the parental bed and an increased risk of sudden infant death. • Sharing a room with the parents was associated with a lower risk of sudden infant death syndrome. The authors of this study conclude that there has been little in the way of direct observation data until recently, but it is becoming clear that sharing a bed both for infants and mothers results in complex interactions that are completely different from isolated sleeping and that need to be understood in detail before application of simplistic labels such as 'safe' or 'unsafe'. They go on to say "...*perhaps it is not bed-sharing per se that is hazardous but rather the particular circumstances in which bed-sharing occurs*. *That some of these circumstances may be modifiable has important implications in terms of social guidelines and health education"* [4]. Bed-sharing and co-sleeping have received considerable negative comment in the medical literature in recent years as a cause of infant deaths.[5,6,7,8,9] and directives to "never sleep with your baby" fail to make important distinctions between the different forms of co-sleeping and bed-sharing. There is no research evidence that shows bed-sharing, even without recognised risk factors, is safe and no study has ever found bed-sharing to be associated with a reduced risk of SIDS [39, 40, 52]**.** The condition of the sleeping surface i.e. the bed in Western cultures, the condition and frame of mind of the adult bed-sharers/co-sleepers, and the purposes for bed-sharing/co-sleeping - are very important in assessing the dangers of sleeping with a baby or infant.

	Specific Circumstances Precautions need to be taken if families elect to bed-share e.g. bed-sharing should be avoided entirely if the mother smokes (either throughout her pregnancy or after) as maternal smoking combined with bed-sharing increases the chances of SIDS. If there is another person sharing the bed who smokes there should be no bed-sharing, so *there should be no bed-sharing if either or both adults smoke*. Accidental suffocation can and does occur in bed-sharing situations. In the overwhelming number of cases in which overlaying by an adult occurred, extremely unsafe sleeping conditions were identified, including situations where adults were • not aware that the infant was in the bed, • sleeping with a partner who was drunk or had consumed alcohol • desensitised by drugs or medications, • Indifferent to the presence of the baby. It should never be assumed that the other adult sharing the same bed knows that the baby is present. Parents should discuss with each other and agree the safe sleeping arrangements for their baby. Cases of suffocation often occur while the parent and infant sleep on a sofa or couch together, there is also the potential for wedging and accidental asphyxia of infants sleeping alone on a sofa.[54]
Smoking	Studies have demonstrated a significantly increased risk of SIDS when infants bed-share with mothers who smoke cigarettes. Exposure to cigarette smoke as a foetus and in infancy appears to contribute to this risk and is independent of other known risk factors including social class.[4,18,19,20,21,22,23,24]. Babies and infants therefore should never bed-share with carers who smoke, no matter how many cigarettes, or where, even if they never smoke around the baby. There is evidence that infants bed-sharing with non-smoking mothers are at increased risk of SIDS [40, 48] compared with infants of smoking mothers who do not bed-share [40]. Thus bed-sharing poses a risk whether parents/carers smoke or not.
Car Seats and Travel Systems	Parents need to be made aware of the risks associated with day time naps and night-time sleeping in inappropriate sleeping environments e.g. car seats and travel systems as babies have been reported to stop breathing when sleeping in these situations [36, 37, 38]. There have been local incidences of babies dying whilst asleep in car seats.
Co-sleeping Cribs.	In December 2016 the Surrey Coroner issued a warning about the safety of the design of the Bednest crib after a baby asphyxiated when the side panel was in the half-folded state. The design has now been modified but older cribs are in circulation. Parents should be advised to check that a modification kit has been used if using a second hand Bednest crib.
Young, premature and low birth weight babies	Babies under 11 weeks of age who sleep in an adult bed with parents are at increased risk of sudden infant death, even if their parents are non-smokers and the baby is breastfed [25, 26]
Ill baby, or high temperature	These babies are at increased risk of Sudden Infant Death and it is not known whether co- sleeping increases this risk further [27]

Temperature. Over wrapping associated with SUDI [4,48,65,66,67,68]	Overheating (heating on all night, excess bedding) is associated with SUDI Some of this effect is explained by the prone sleeping position The combination of over wrapping (excessive layers of bedding and/ or clothing, including hats) and signs of infection confers a greatly increased risk of SUDI. Similarly the combination of over wrapping and prone sleeping carries a higher risk than either alone.
Parental Alcohol Use [4,21,34]	Sedates parents and impairs their level of consciousness. Reduces a parents responsiveness and awareness of the infant in bed.
Parental prescribed medication[21,34]	Sedates parents and impairs their level of consciousness. Reduces a parents responsiveness and awareness of the infant in bed. Less aware of, or less able to respond to the infant. Higher risk medication includes: sleeping tablets, anti-depressants, some cough remedies and some antihistamines and painkillers- GP or pharmacy advice should be sought.
Parental illicit drug use [4,21,34]	Sedates parents and impairs their level of consciousness. Impacts on responsiveness and awareness of infant in bed. Less aware of, or less able to respond to the infants needs
Parental tiredness[4,21,34]	Impacts on responsiveness and awareness of infant in bed. Less aware of, or less able to respond to the infants needs
Cultural Diversity	Whilst cultural differences need to be considered, research shows that co-sleeping in other cultures is different from the bed-sharing that occurs in this country [4, 41, 42, 43]. It has been reported that there is a 20-fold increase in the risk of suffocation when infants were placed to sleep in adult beds rather than on those surfaces designed for infants [44]. Placing infants to sleep in adult beds should be discouraged [45] and infants should sleep in a cot that conforms to national safety standards [46].
Sleeping alone (daytime sleep)	Blair et al [47] found that the same risk factors are significant for both night and day time deaths. They found that 75% of babies who died during the daytime were solitary sleepers and a significant number had their heads covered. Sharing a room with a carer during the day was associated with a lower risk of sudden infant death syndrome. Consequently all the safety sleep messages apply to daytime sleep as well as night time sleep.
Twins/ Multi birth co-sleeping	The risk of babies sleeping together is mainly to do with lack of space, therefore causing the babies to overheat, or be injured once the babies start moving. However, babies should be in their parents' bedroom for the first 6 months of life. The advice from the Lullaby Trust (previously FSID), if parents decide to place twins/ multi births together is: • Babies should be placed in a cot large enough to sleep all babies • Once they start moving, they should be placed in their own cot • They should be placed feet to foot on either end of the end of the cot (twins). If more than 2, there needs to be enough space for babies to be side by side. • They should have their own blankets/ sheets • There should be nothing placed in the middle of the cot to separate them

PROTECTIVE FACTOR	WHY IT PROTECTS
Breast feeding	Several published studies have found that breast feeding protects against the risk of SIDS [49, 50] and should be recommended as a protective measure [51, 63]. Mother-child co-sleeping has been found to extend the duration of breastfeeding in the human infant, who, relative to other mammals, develops more slowly, requires frequent feedings, and is born neurologically less mature [10, 11, 12] and bed-sharing has long been promoted as a method to facilitate breastfeeding.[13, 14, 15, 16, 17]. Nevertheless, it is significant that no studies have found bed-sharing/co-sleeping under any circumstances to be safe and at least 5 studies have shown a statistically significant risk even if the parents are non-smokers [4, 25, 32, 35, 40.] UNICEF Baby Friendly policy is that parents need a discussion about the management of night feeds so that they are able to risk assess and make an informed choices around bed-sharing
Dummy use	Many studies have identified a protective association between dummy (pacifier) use and a reduced risk of SIDS [55, 56, 57, 58]. A meta-analysis of research studies demonstrated a significantly reduced risk of SIDS with pacifier use *particularly when placed for sleep* [59] and a later, more compelling population-based study (which was too late to be included in the meta- analysis) showed an even greater degree of protection with dummy use citing a 90% reduced risk of SIDS in babies who used a dummy, compared to those who did not:. *"Pacifiers may prevent accidental hypoxia as a result of the face being buried into soft bedding, or overlain by objects (such as blankets…) by providing an air passage created by the bulky handle"* and *"sucking on a pacifier may enhance the development of neural pathways that control the potency of the upper airway*" [60] NICE CG37 recommends that if a dummy is used it should not be stopped until the baby is over 26 weeks old [69] As a result the Lullaby Trust now recommends that if parents chose to use a dummy it should be offered when settling the baby to sleep *every time the baby goes to sleep* and that it need not be replaced if it falls out. As the protective association appears to occur as the baby falls asleep. Babies who refuse a dummy should not be forced to have one [51] **If baby is breastfeeding do not give them a dummy until they are 4 weeks old to ensure breastfeeding is established.** (as recommended by The Lullaby Trust and Unicef) It has been suggested that dummy use may be negatively associated with breast feeding. When this relationship is analysed statistically it appears that dummy use is more likely to be *a consequence of breast feeding difficulties than a cause of them* [61] and introduction of a dummy to breast feeding infants after the age of 1 month does not increase the risk for cessation of breastfeeding [62].

Appendix a

NHS
Worcestershire Health and Care
NHS Trust

The Safe Sleep assessment

* Please place a sticker (if available) otherwise write in space provided.

Health professional assessment (signatures)

Midwife: .....

(Interpreter):.....

Date:...../...../.....

Health Visitor: .....

(Interpreter):.....

Date:...../...../.....

Surname:

First names:

NHS number: Unit no:

Address: ..... Sex: M / F

.....Post code: .....D.O.B:. ...../...../.....

G.P: Code:

H.V: Code:

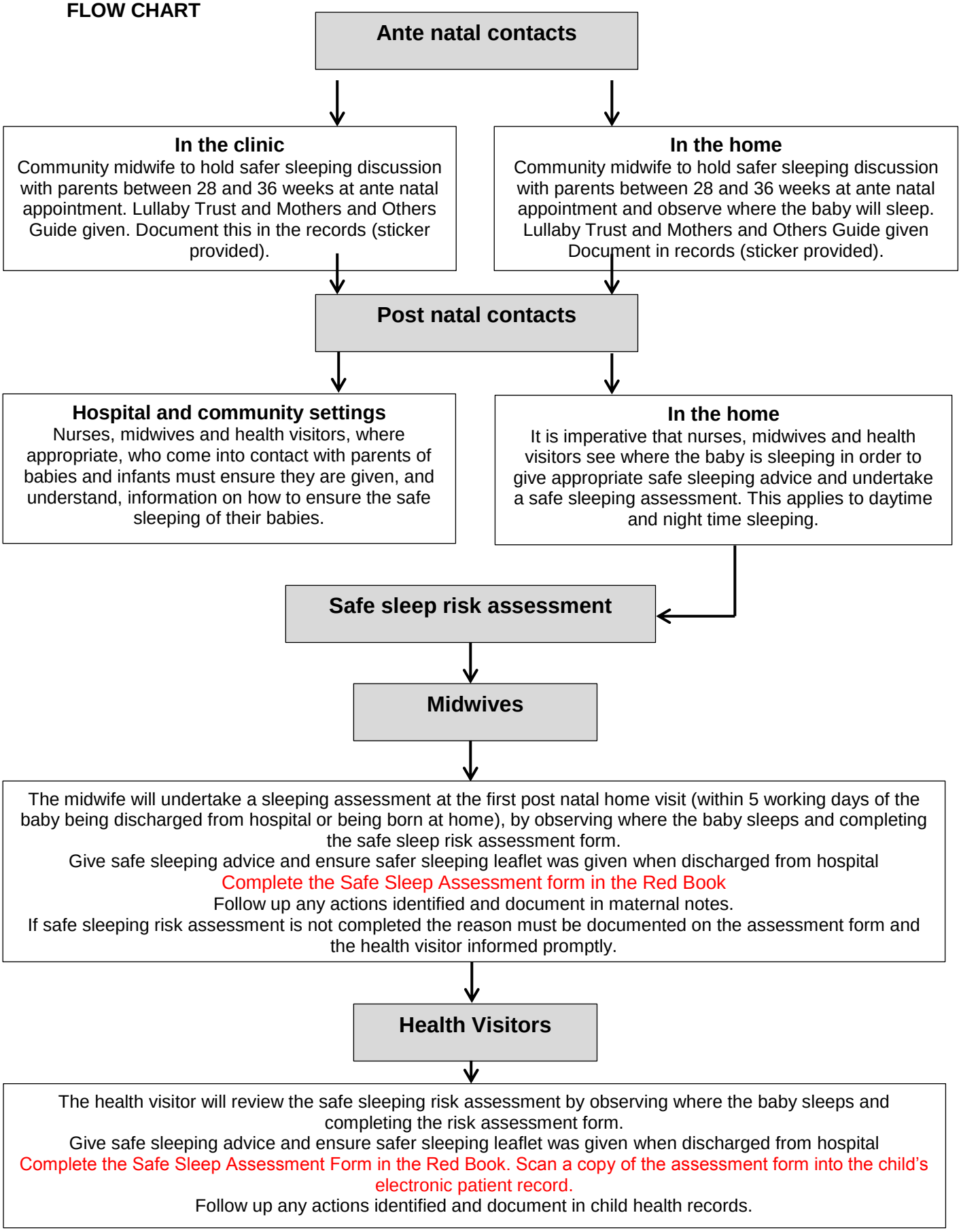
(Further information can be entered on notes pages at back of record if needed)		Yes/No (MW)	Yes/No (HV)	MW: Any concerns identified? Plan to reduce any risk	HV: Notes on any concern / plan
1	Where did the baby sleep last night? Is this where baby normally sleeps? Where does baby sleep in the day? - Advice for the first 6 months				
2	Is baby placed on back to sleep?				
3	Is baby placed feet to foot?				
4	Is temperature of room/ clothing of baby as advised?				
5	Are soft toys and pillow avoided in cot with the baby?				
6	Do parent(s) or key carers ever sleep on a sofa or armchair with the baby?				
7	Do parent(s) or any key carers smoke?				
8	Do parent(s) or any key carers drink alcohol?				
9	Do parent(s) or any key carers take any drugs or medication?				
10	Have parent(s) /key carers considered safer sleep when away from home?				
11	Are parent(s) or key carers aware of signs that baby is unwell and know how to seek advice?				
12	**Health Professional:** Have you seen where the baby sleeps?				

Top copy remain in PCHR 2nd copy to Midwife 3rd copy to HV 4th copy to Child Health (if required)

The Safe Sleep assessment 16

Appendix 3

FLOW CHART



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Appendix 5

AUDIT TOOL
GUIDANCE NOTES:
TICK YES/NO TO INDICATE WHETHER FORM HAS BEEN FILLED IN CORRECTLY
DOCUMENT RESPONSE – OVER FAINT GUIDANCE NOTES

QUESTION	YES	NO	RESPONSE AS STATED ON FORM
Was the baby's name, DOB, address and NHS number present on the form			*NA*
Were the family asked where their baby sleeps at night?			*Where did they say their baby sleeps*
Were the family asked where their baby sleeps during the day			*Where did they say their baby sleeps*
Were the family asked where their baby slept last night?			*Where did they say their baby slept*
Did the health professional document whether they saw where the baby sleeps?			*State where the baby sleeps*
Were the family asked if anyone in the household smokes?			*Document parents response*
Were the parents/carers asked if they take medication/ drugs?			*Document parents response*
Were the parents/carers asked if they drink alcohol?			*Document parents response*

Was there evidence that the following Lullaby Trust Recommendations were discussed? Had the boxes been ticked?	
Back to sleep/Feet to foot?	Yes/ No
Room Temperature/Suitable bedding?	Yes/ No
Sofa/Car seats?	Yes/ No
Use Of Dummies?	Yes/ No
What to do if baby unwell/has a temperature?	Yes/ No

QUESTION	YES	NO	RESPONSE AS STATED ON THE FORM
If risks were identified was a plan to reduce these documented on the form?			*Document the risks identified*
Had this been reviewed by the health visitor?			*Document what types of info was recorded*
Was the form signed and dated by the health professional?	Yes	No	*NA*

Appendix 6

Worcestershire Health and Care NHS
NHS Trust

Equality Analysis

Title of Policy/Function (Function Includes: Services; Projects; Strategy; Processes; Systems; Practices; Procedures; Protocols; Guidelines; Care Pathways etc..)	**New**	**Existing/Revised**
Safer Sleeping Guideline		Yes

Short description of Policy/Function (aims and objectives, is the policy/function aimed at a particular group if so what is the intended benefit):
The guideline is primarily aimed at midwives and health visitors, to ensure that they provide a consistent message to all parents who have a new born baby- about the risks of safer sleeping and cot death. The intended benefit is to ensure all parents are aware of the risks of cot death- and especially those that are relevant to them. This is performed by all health professionals completing a risk assessment, in partnership with the family- and reviewing where the baby sleeps. This will hopefully minimise the risk of cot death by parents placing their baby to sleep in a safe place and position.

Name of Lead/Author(s)	**Job Title**	**Contact details**
Julia Greer	SUDIC Nurse and Quality Lead for CYPF SDU	07501 228 236

When the policy/function involves patients/staff/partners/stakeholders etc please where possible include them in the Equality Analysis to demonstrate openness, transparency and inclusion and particularly by those who this policy/function is most likely to have impact.

Does this Policy/Function have any potential or actual impact that is positive(+), neutral (N) or negative (-) impact on the following protected characteristics please indicate:				
	+	**N**	**-**	**Please provide a rational/justification for <u>each</u> of the following regardless of impact**
Age	*			Positive impact for all new born babies in Worcestershire.
Disability		*		The guideline does not discriminate against people with a disability and health professionals would tailor their discussions suitable to a person's understanding.
Gender Reassignment		*		This guideline does not discriminate against people who have undergone gender re-assignment.
Pregnancy and Maternity	*			Pregnant women will have more information provided to them antenatally about safer sleeping
Race		*		The guideline does not discriminate against different races and health professionals would use resources (translators/ leaflets in different languages) suitable to a person's understanding.
Religion and Belief		*		Although some different cultures do adopt different

				sleeping methods with their babies, the advice given to *all* parents is based on evidence and does not discriminate in any way
Sex		*		This guideline applies to both men and women.
Sexual orientation		*		Midwives/Health Visitors would provide the advice given in this guideline to all parents regardless of their sexual orientation.
Marriage and Civil Partnership		*		
Other Groups who could experience inequality, eg carers, homeless, travelling communities, unemployed, people resident within deprived areas, different socio/economic groups eg low income families, asylum seekers/refugees, prisoners, people confined to closed institutions or community offenders, people with different work patterns eg part-time, full-time, job-share, short-term contractors or shift workers - *Access, location and choice of venue, timings of events and activities. Support with caring responsibilities*				
This doesn't apply- the guideline gives advice for what to do if parents travel around different homes. The aim is to ensure that they are given the safest advice possible				

Analysis conducted by: (minimum of 3 people)			
	Name	**Job Title**	**Contact details**
1	Julia Greer	SUDIC Nurse	07501 228236
2	Beverley Downing	Team Leader 0-19 Public health Nursing Service.	07918 747471
3	Wendy Taylor	Health visitor	07918 766 241

Start date of policy/function	24/05/17	**Period valid for :** 3 Years
Review date of policy/function	24/05/20	

Service Delivery Unit:									
Reference/Version:	8	**Date Equality Analysis completed**:	D	D	M	M	Y	Y
			2	7	0	3	1	7

If you have identified a potential discriminatory impact on the policy/function please refer it to the author together with suggestions to avoid or reduce the impact.

A copy of the completed Equality Analysis must be attached to the policy/function and a copy sent to:

Patrick McCloskey
Equality Inclusion Practitioner
Isaac Maddox House, Shrub Hill Road, Worcester, WR4 9RW
Tel: 01905 761324