

2.4 Outcomes for mothers and babies

Pregnancy should result in a healthy mother and child post-delivery, the baby having an optimum birth weight and ideally successfully breast fed. These outcomes are not always achieved.

Key maternal and child health outcomes are measured by:

- Maternal deaths
- Infant mortality
- Low birth weight
- Breastfeeding initiation and continuation

There are also a range of interventions with associated indicators which are in place to support women in pregnancy, with the aim of reducing negative outcomes for both mother and child. These include:

- Antenatal appointment attendance by 12th week of pregnancy
- Antenatal screening uptake
- Healthy Start vitamin uptake
- Maternity services indicators i.e. emergency caesarean rates, home birth rate, etc.

Baby Intervention is a voluntary home visiting programme for vulnerable parents, an Early Intervention Worker visits the family regularly, from the start of pregnancy in order to offer support.

Baby Intervention work, in partnership with midwives and health visitors and aims to enable mums to:

- Have a healthy pregnancy
- Improve their child's health and development
- raise their family's income

Research has shown that building a relationship with a support worker makes a difference to the outcomes of vulnerable babies and their families in terms of:

- Reduced child abuse and neglect
- Improved school readiness
- Reduced youth crime
- Improved employment for mothers

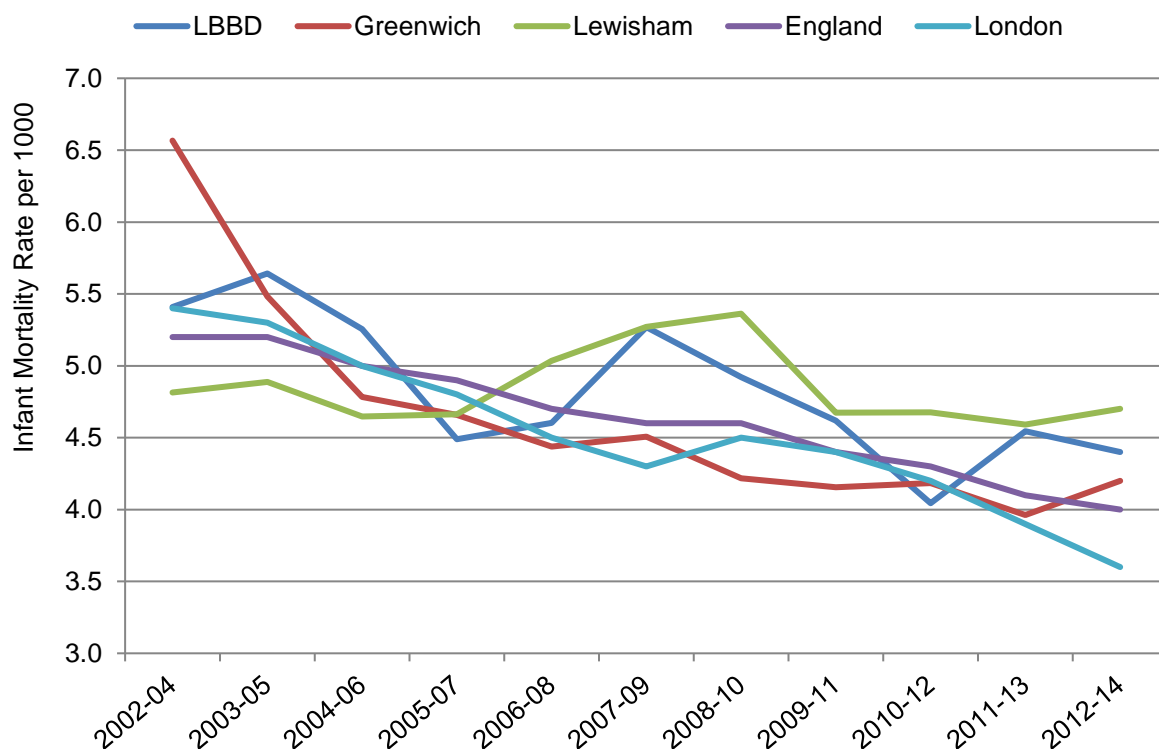
2.4.1 Infant mortality

Infant mortality rates refer to the number of deaths within the first year of life per 1,000 live births. Wide variations are seen in annual rates due to the small number of deaths, with three-year rolling averages used to even out this variation.

Figure 2.4.1 shows the 3 year average Infant Mortality Rate (IMR) in Barking and Dagenham compared to two statistical neighbouring boroughs (Greenwich and Lewisham), London and England. The IMR for LBBDD in 2012/14 is slightly worse (4.4 per 1,000 live births) than the England and London averages (4 and 3.6

respectively). Figure 2.4.1 and Table 2.4.1¹ illustrates that whilst the London and national infant mortality rates show a downward trend, the trend in Barking and Dagenham has fluctuated over the years. In 2010-12 the infant mortality rate in Barking and Dagenham fell in line with national and regional averages, before rising again in recent years. Greenwich has experienced a general downward trend with Lewisham fluctuating with a more recent decreasing trend. However, overall based on level of confidence reported by PHOF there are not any significant differences between Barking and Dagenham, Barking and Dagenham's statistical neighbours, London and the national rate (Figure 2.4.2).

Figure 2.4.1: Trends in Infant Mortality Rate (rate per 1,000 live births), Barking and Dagenham, Greenwich, Lewisham, London and England, 2001/03-2012/14



Source: HSCIC

¹ HSCIC 2016, [Online] available from: <https://indicators.hscic.gov.uk/webview/> [Last accessed: 11 April 2016]

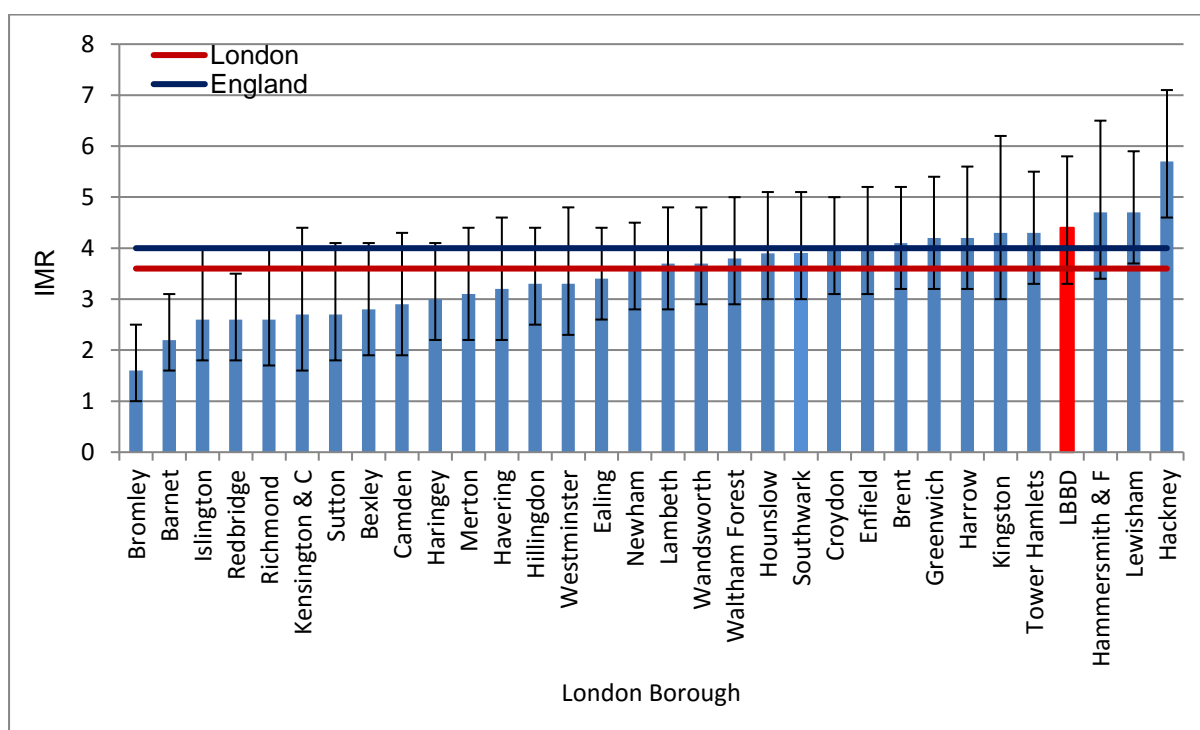
Table 2.4.1: Infant mortality rate per 1,000 live births, Barking and Dagenham, 2002/04-2012/14

	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
Barking & Dagenham	5.4	5.6	5.3	4.5	4.6	5.3	4.9	4.6	4.0	4.6	4.4

Source: PHE

In 2012-14, in comparison with all London boroughs, Barking and Dagenham ranked 4th highest for IMR as well as being above the London and national average. It has gone up from being the 10th highest rate in London in 2011-13 to the 4th highest rate in 2012-14.

Figure 2.4.2 Infant Mortality Rate (Per 1,000 live births), London boroughs, London and England average, 2012-14



Source: HSCIC

There were 21 stillbirths in Barking and Dagenham in 2013 or 5.8 per 1,000 total births. Stillbirth rates vary by age of mother (Table 2.4.2). Nationally, stillbirth rates are highest in mothers over the age of 40, and below the age of 20². Mothers aged over 40 are 1.7 times more likely to have a stillbirth, mothers aged under 20 are 1.4 times more likely to have a stillbirth.

² PHE-NCMHIN, 2014, "Facts and figures on infant mortality and stillbirths", [Online] available from: <http://www.chimat.org.uk/resource/view.aspx?RID=222265> [Last accessed: 11 April 2016]

Table 2.4.2: Stillbirths by age of mother, Barking and Dagenham, 2014

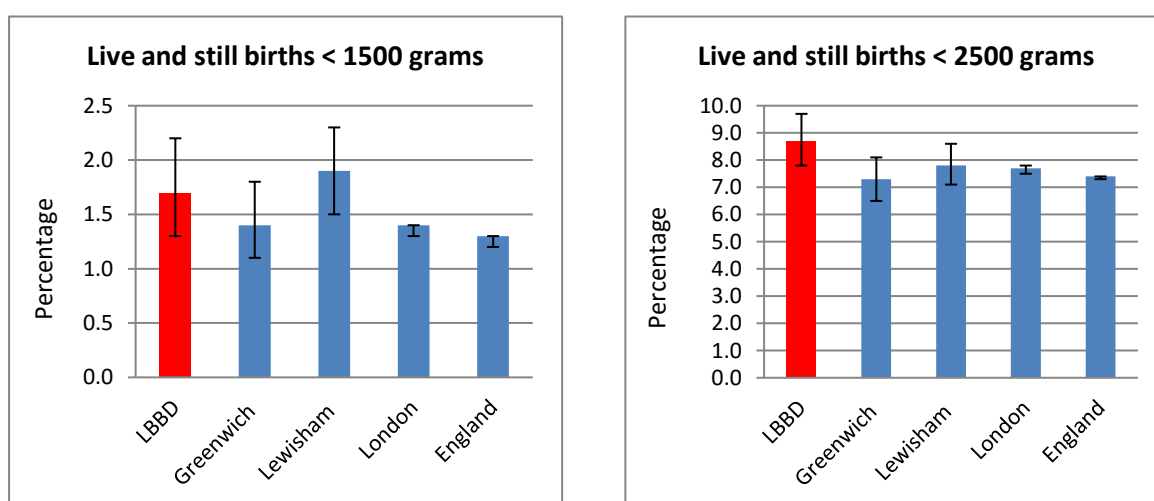
Maternal Age	Stillbirths
All ages	21
< 20	1
20-24	5
25-34	11
35-39	2
40+	2

Source: HSCIC, "Stillbirths: number by maternal age group-2014"

2.4.2 Low birth weight

Low birth weight is subdivided into two categories; 'very low birth weight' comprised of infants weighing under 1,500g and 'low birth weight' comprising of infants under 2,500g. Figure 2.4.3 shows in 2014 the percent of births in Barking and Dagenham with very low birth weight was higher than London but significantly higher than England. In the same period of time the percent of low birth weight was higher than two statistical neighbour (Greenwich and Lewisham), significantly higher than London and national average.

Figure 2.4.3: Rate of low birth weight in Barking and Dagenham compared to two statistical neighbours, regional and national averages, 2014



HSCIC, Low birthweight births, February 2016

In 2012 the wards with highest levels of babies born with low birth rates were Mayesbrook, Thames and Whalebone, all with over 12% of babies born with low birth weights. The wards with the lowest rates are Abbey and Heath wards with under 6%.

Low birth weight is associated with foetal and neonatal mortality and morbidity, inhibited growth and cognitive development, and chronic diseases later in life. A baby's low weight at birth is either the result of preterm birth (before 37 weeks of gestation) or due to restricted foetal (intrauterine) growth.

Table 2.4.3: Low birth weight by ward

Ward	Number of births	Number born under 2,500g	Percent born under 2,500g
Abbey	301	18	5.98
Alibon	192	18	9.38
Becontree	238	16	6.72
Chadwell Heath	156	15	9.62
EastBrook	153	10	6.54
Eastbury	211	21	9.95
Gascoigne	294	35	11.90
Goresbrook	196	14	7.14
Heath	223	13	5.83
Longbridge	171	17	9.94
Mayesbrook	183	24	13.11
Parsloes	144	15	10.42
River	200	17	8.50
Thames	207	25	12.08
Valence	182	13	7.14
Village	210	22	10.48
Whalebone	204	26	12.75

Source: ONS 2012

Birth weight is also affected by the mother's own foetal growth and her diet from birth to pregnancy, and thus her body composition at conception. Mothers in deprived socio-economic conditions more frequently have low birth weight infants than those in wealthier circumstances. In those settings, the infant's low birth weight results primarily from the mother's poor nutrition and health over a long period of time, including during pregnancy, and the higher prevalence of infections and pregnancy complications, underpinned by poverty.

Table 2.4.4 shows the percentage of babies with low birth weight born to Barking and Dagenham residents compared with two other statistical neighbours (Greenwich and Lewisham), London and England over the 9 years leading up to 2014. Rates in Barking and Dagenham have fluctuated over the years and continue to do so, declined slightly in the year 2013 but increased in 2014. In 2014 Barking and Dagenham had the third highest rate of the London boroughs as well as a significantly higher rate than London and England averages.

Table 2.4.4: Percentage of low birth weight babies in Barking and Dagenham, Greenwich, Lewisham, London and England, 2006-14

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Barking & Dagenham	8.9	8.2	7.6	8.2	7.0	8.3	8.6	8.1	8.7
Greenwich	7.8	7.0	7.8	7.7	6.7	7.3	7.6	7.9	7.3
Lewisham	8.5	8.6	7.9	8.2	7.7	8.3	8.4	7.8	7.8
London	8.3	7.9	7.9	7.9	7.8	8.0	7.9	7.9	7.7
England	7.9	7.5	7.5	7.5	7.3	7.4	7.3	7.4	7.3

Source: ONS/CHIMAT

The proportion of low birth weight babies is higher amongst women who have multiple births. In 2012 10.9% of babies born in multiple births had very low birth weights and 56.6% had low birth weights. Data suggests that in Barking and Dagenham the proportion of low birth weight babies is highest amongst women from black Caribbean, other Asian ethnicities, women who are aged 19-24 yrs and amongst women who have multiple births³.

³ NHS Comparators

2.4.3 Antenatal booking within 12 weeks

Women are encouraged to have their first antenatal booking appointment by the 12th week of their pregnancy so that they can take advantage of screening, healthy start vitamins and support from the midwife. This first appointment is often called a 'booking appointment'. There is research evidence that shows that women who delay this first appointment often have worse outcomes for both themselves and their baby.

The proportion of pregnant women seeing a midwife by 13 weeks in Barking and Dagenham had increased during 2013/14 from 63.1% to 86.6%, but slightly decreased in quarter 1 of 2014/15 and had an over 4% drop in the third quarter of 2014/15. In the same period of time, there has been a sharper decline for Greenwich CCG but there have not been any changes for Lewisham CCG. Data for London and England is not available.

Table 2.4.5: Percent of women who see a midwife by 12 weeks and 6 days of pregnancy, Quarter 1 2013/14 to Quarter 3 2014/15

	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	Q1 2014/15	Q2 2014/15	Q3 2014/15
NHS Barking and Dagenham CCG	*	63.1	63.1	86.6	84.4	85.6	80.3
NHS Greenwich CCG	10.7	9.7	85.5	82.5	89.8	85.3	80.3
NHS Lewisham CCG	97.1	91.4	97.4	90.9	92.8	101.4	92.7
England					88.3	-	-

HSCIC, December 2015. "Antenatal assessments within 13 weeks, Quarter 1, 2013/14 to Quarter 3, 2014/15"

* The number of maternities at a CCG does not meet validation criteria

Data for England for previous quarters not available. HSCIC/PHE

Analysis of the full year data available for 2012/13 suggests that focused work is needed to support earlier engagement with pregnant women from black and mixed ethnic backgrounds (Table 2.4.6). The percentage of Chinese booking at 12 weeks is high but this is probably due to low numbers therefore not a reliable indicator.

Table 2.4.6: Booking at 12 weeks by ethnic group 2012/13 (% of women in ethnic group)

	Barking and Dagenham
White British	87.0
White Irish	80.0
Other White	72.1
Mixed	74.5
Indian	79.1
Pakistani	82.1
Bangladeshi	77.0
Other Asian	82.7
Black Caribbean	79.6
Black African	74.3
Other Black	75.8
Chinese	91.7
Other Ethnic Groups	73.1
Not Known	54.6

Analysis by age of mother shows that late booking is most common among women aged <19 years and women aged 40 years and above (Table 2.4.7).

Table 2.4.7: Booking at 12 weeks by age of mother 2012/13 (% of women in age group)

	Barking and Dagenham
<19yrs	75.0
19-24yrs	89.2
25-34yrs	79.6
35-39yrs	79.3
40yrs and above	74.8

NHS comparators

Analysis by previous birth (Table 2.4.8) suggests that booking by 12 weeks is lower amongst women having their first child, but the large proportion where 'not known' also highlights that there are substantial gaps in data collection.

Table 2.4.8: Booking at 12 weeks by Previous Birth 2012/13

	Barking and Dagenham
1 st Birth	46.3
Subsequent Birth	53.7
Not Known	83.0

NHS comparators

Using NHS Comparators, it is possible to assess GP practice variation in particular maternity outcomes⁴. The percentage of mothers seen by a midwife by 12 weeks of gestation is a measure of primary and community care performance.

2.4.4 Antenatal and neonatal screening

There are four national screening programmes which relate to pregnancy and the newborn child:

- Infectious diseases in pregnancy.
- Foetal anomaly screening programme (FASP).
- Haemoglobinopathy and newborn blood spot screening.
- Newborn infant physical examination and newborn hearing screening.

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) established an Antenatal and Newborn Screening Co-ordinator post in 2009 who is responsible for the co-ordination of all the antenatal and newborn screening programmes that are recommended by the National Screening Committee.

The data presented for screening is at a hospital trust level, not by borough of residence. Barking and Dagenham account for over a third of births at BHRUT and although there is some variation between boroughs, the changing demographics of the boroughs has reduced these differences.

⁴ This data has been provided to practice commissioning leads and consortium performance leads.

NHS comparators

2.4.5 Infectious diseases in pregnancy

There is routine screening for syphilis, hepatitis B, HIV and rubella susceptibility; tests for these conditions are carried out because there is the potential for interventions to prevent or limit the harm to the baby, as well as provide better care and support to the mother.

From June 2010 all women who are rubella susceptible are offered the MMR vaccine on the postnatal ward prior to discharge as set out in NICE⁵ recommendations.

The quarterly coverage for HIV screening in pregnancy at BHURT has remained consistently high across the five quarters reported (Table 2.4.9). Similar performance is also reported at Lewisham and Greenwich NHS Trust and London as a whole.

Table 2.4.9: HIV screening in pregnancy coverage

Maternity Service	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
BHRUT	99%	99.9%	99.7%	-	99.7%	99.9%		
Lewisham and Greenwich NHS Trust (Lewisham site)	99.8%	100%	99.8%	-	99.7%	99.9%		
Lewisham and Greenwich NHS Trust (QEH site)	99.5%	99.5%	99.7%	-	99.8%	99.8%		
London	99.7%	99.8%	99.8%	-	99.8%	99.7%		

PHE, Jan 2015⁶

2.4.6 The Foetal Anomaly Screening Programme (FASP)

The Foetal Anomaly Screening Programme (FASP) consists of a blood test to screen for down's syndrome and a foetal anomaly scan between 18 and 21 weeks which assesses the risk of down's syndrome as well as identifying other foetal abnormalities, which may be incompatible with life or associated with morbidity. This gives women and their partners the opportunity to know the risk of certain abnormalities that may benefit from antenatal intervention or that requires early intervention following delivery.

There are two stages to the blood test for down's syndrome risk, a combined first trimester test (NT, Free Beta hCG & PAPP-A) and a Triple Test (AFP, uE3 & Free Beta hCG) in the second trimester of pregnancy.

⁵ Routine postnatal care of women and their babies, NICE clinical guideline 37, 2006
<http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf>

⁶ PHE, 2015. "Infectious diseases in pregnancy screening: programme overview", [Online] available from:
<https://www.gov.uk/guidance/infectious-diseases-in-pregnancy-screening-programme-overview> [Last accessed: 13 April 2016]

The 2010/11 report for BHRUT⁷ stated that:

- 64.6% of women booking with the trust received the combined first trimester test and 10.0% received the triple test in the second trimester.
- The ratio of uptake of dating scans to women was 118.2%⁸ (some women will have had more than one scan) and 90.1% of women took up the anomaly scan.
- The median age of the population screened was 31.7 years.
- 66 amniocentesis and 102 Chorionic Villus Sampling procedures were done during 2010/11. These are the main pre-natal diagnostic tests.

2.4.7 Haemoglobinopathy (sickle cell and thalassaemia) screening

There are two main blood conditions identified through screening, they are sickle cell disease and thalassaemia. Both relate to genetically inherited mutations of the haemoglobin molecule (Hb) responsible for transporting oxygen in the red blood cells; the mutations reduce the ability of red blood cells to carry oxygen.

Clinically significant sickle cell disease is a result of individuals inheriting the sickle gene from both parents or a sickle gene and another specific variant. Sickle cell carriers, sometimes called sickle cell trait, are individuals who only inherit one sickle gene. Carriers rarely have clinical symptoms and are therefore not always aware they carry the gene unless screened. There is a similar pattern of inheritance for thalassaemia although the clinical presentation is different. There has been a national antenatal and newborn screening programme since 2001 in England. Barking and Dagenham is a high prevalence area for sickle cell and thalassaemia diseases which are routinely screened. The data for 2010/11 reported that:

- 12,992 women booked during this period at BHRUT.
- 11,209 (86.3%) women were screened.
- 787 partners⁹ were offered screening and of these 364 (46.3%) took up the screening opportunity.
- Out of the 364 couples screened, 35 (9.6%) couples were identified as 'at risk'. A further 41 (11.3%) couples were already known to be at risk.

⁷ NHS Antenatal Screening Programmes Annual Report 2010 – 2011 (BHRUT)

⁸ Suspected inability to identify duplicate scans – i.e. where the woman was too early for screening on her first ultrasound scan

⁹ Partner screening was introduced in December 2009 and so this figure only represents the final quarter of performance.

2.4.8 Newborn blood spot screening

The UK National Screening Committee (UK NSC) recommends that all babies in the UK are offered screening for nine rare conditions: sickle cell disease (SCD), cystic fibrosis (CF), congenital hypothyroidism (CHT), phenylketonuria (PKU), medium-chain acyl-CoA dehydrogenase deficiency (MCADD), maple syrup urine disease (MSUD), isovaleric acidaemia (IVA), glutaric aciduria type 1 (GA1) and homocystinuria (pyridoxine unresponsive) (HCU).

The overall goal is to prevent ill health, disability and death through early diagnosis and effective intervention. Population coverage is a key objective of the programme. To measure performance, data is collected annually against the screening standards.

Although the bloodspot test is undertaken by midwives the pathway involves the child health information system based within community services and primary care providers to address incomplete tests.

The responsibility for delivery of the standards is a commissioning one and hence data is reported by Clinical Commissioning Groups (CCGs) to highlight where commissioners need to address quality and uptake issues.

The national standards for this screening programme were updated in August 2013¹⁰ but the data is still not available at PHE online at the time of writing this report. Three KPIs for newborn blood spot screening were developed by the UK NSC's Routine Reporting Task Group (NHS-Screening Programmes, 2013):

- KPI NB1 – Newborn blood spot screening – coverage (CCG responsibility at birth)
- KPI NB2 – Newborn blood spot screening – avoidable repeat tests
- KPI NB3 – Newborn blood spot screening – timeliness of the availability of the result

NB4 was introduced in Q1 2015/16 and has replaced NB3, however due to data quality issues it will be collected but not published throughout 2015/16

- KPI NB4: Newborn blood spot screening – coverage (movers in)

Barking and Dagenham newborn blood screening data For KPI NB1 and NB3, 2013/14 and 2014/15 has been provided by North East London NHS Foundation Trust (NELFT)¹¹ and 2015/16 data source is PHE¹², presented in Table 2.4.10 below.

KPI - NB1: is the proportion of babies registered within the CCG both at birth and at the time of report who are eligible for newborn blood spot screening and have a

¹⁰ NHS-Screening Programmes, 2013. 'Standards for newborn blood spot screening', [online] available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/391122/Standards_for_newborn_blood_spot_screening_August_2013_v1.0.pdf [accessed: 17 August 2015]

¹¹ Personal communication (11-05-2015) between Behrooz Tavakoly and Samuel Owiredu (Business Manager LBB, NELFT)

¹² PHE, 2015. "NHS screening programmes: KPI reports 2015 to 2016", [Online] available from: <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2015-to-2016> [Last accessed: 13 April 2016]

conclusive result recorded on the Child Health Information System within an effective timeframe. For this KPI, PKU is used as a proxy for all tests and the test must be completed by 17 days of age.

KPI - NB3: is the proportion of newborn blood spot screening results which are screen negative for all five conditions, available for communication to parents within six weeks of birth.

Table 2.4.11 shows the B&D blood screening performance for indicators NB1 and NB3 by quarters in 2013/14 and 2014/15 by colour coding (red and green).

Table 2.4.11 Barking and Dagenham Newborn blood spot screening programme performance for KPI NB1 and NB3, Q1 2013/14 to Q2 2015/16

KPI	Name of the organisation that this data is being submitted FOR	Numerator	Denominator	Performance	Acceptable	Achievable
Q1 2013-14 KPI Data Submission						
NB1	NHS Barking & Dagenham	726	770	94%	>= 95.0%	>= 99.9%
NB3	NHS Barking & Dagenham	723	726	100%	>= 95.0%	>= 98.0%
Q2 2013-14 KPI Data Submission						
NB1	NHS Barking & Dagenham	788	823	96%	>= 95.0%	>= 99.9%
NB3	NHS Barking & Dagenham	755	759	99%	>= 95.0%	>= 98.0%
Q3 2013-14 KPI Data Submission						
NB1	NHS Barking & Dagenham	985	999	99%	>= 95.0%	>= 99.9%
NB3	NHS Barking & Dagenham	881	933	94%	>= 95.0%	>= 98.0%
Q4 2013-14 KPI Data Submission						
NB1	NHS Barking & Dagenham	902	922	98%	>= 95.0%	>= 99.9%
NB3	NHS Barking & Dagenham	799	857	93%	>= 95.0%	>= 98.0%
Q1 2014-15 KPI Data Submission						
NB1	NHS Barking & Dagenham	846	852	99%	>= 95.0%	>= 99.9%
NB3	NHS Barking & Dagenham	748	795	94%	>= 95.0%	>= 98.0%
Q2 2014-15 KPI Data Submission						
NB1	NHS Barking & Dagenham	872	878	99%	>= 95.0%	>= 99.9%
NB3	NHS Barking & Dagenham	769	819	94%	>= 95.0%	>= 98.0%
Q3 2014-15 KPI Data Submission						
NB1	NHS Barking & Dagenham	757	782	97%	>= 95.0%	>= 98.0%
NB3	NHS Barking & Dagenham	726	735	99%	>= 95.0%	>= 98.0%
Q4 2014-15 KPI Data Submission						
NB1	NHS Barking & Dagenham	884	906	98%	>= 95.0%	>= 98.0%
NB3	NHS Barking & Dagenham	818	844	97%	>= 95.0%	>= 98.0%
Q1 2015-16 KPI Data Submission						
NB1	NHS Barking & Dagenham	777	793	98%	>= 95.0%	>= 98.0%
NB3: NB4 was introduced in Q1 2015/16 and has replaced NB3, however due to data quality issues it will be collected but not published throughout 2015/16						
Q2 2015-16 KPI Data Submission						
NB1	NHS Barking & Dagenham	872	881	99%	>= 95.0%	>= 98.0%
NB4: NB4 was introduced in Q1 2015/16 and has replaced NB3, however due to data quality issues it will be collected but not published throughout 2015/16						

Source: PHE - Newborn Screening Programme

2.4.9 Newborn Infant Physical Examination (NIPE) and newborn hearing screening

Newborn hearing screening and NIPE guidelines are less well established than other screening programmes and this is most likely to result from less well developed links between hearing screening and maternity services. Hearing screening follows a different pathway than other programmes and is coordinated by dedicated hearing screening coordinators. More robust links are needed between the local antenatal and newborn screening coordinators and hearing screeners in order to have a well coordinated service for mothers and babies. BHRUT has local guidelines in place for hearing screening but not for NIPE. Currently for hearing screening data is available for quarter one and two 2015/16 (Table 2.4.12) but there is no data for NIPE yet.

Table 2.4.12 Newborn hearing screening (KPI-NH1*) quarter 1&2, 2015/16, Barking and Havering, London, England and five London Boroughs

NH1: Newborn hearing screening – coverage (Acceptable ≥ 95.0%, Achievable ≥ 99.5%)						
Area	Q1 2015-16 (01/04/2015 - 30/06/2015)			Q2 2015-16 (01/07/2015 - 30/09/2015)		
	Total number of newborn	Number of newborn Screened	Performance (%)	Total number of newborn	Number of newborn Screened	Performance (%)
England	157,596	160,231	98.4	160,762	164,022	98.0
London	30,905	31,696	97.5	31,154	32,085	97.1
Barking and Havering	1,639	1,692	96.9	1,685	1,748	96.4
Bexley and Greenwich	1,836	1,870	98.2	N/A	N/A	N/A
Lambeth, Southwark, Lewisham	3,456	3,509	98.5	N/A	N/A	N/A

Data source: PHE Screening¹³

* NH1: The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age (hospital programmes-well babies, NICU babies) or by 5 weeks corrected age (community programmes-well babies).

Midwives have an important role in promoting hearing screening prior to discharge from hospital and their role should be incorporated into local guidelines and training initiatives. Hearing screeners should be members of the local antenatal and newborn steering groups. Although the newborn physical examination takes place this is often seen as part of routine postnatal care as opposed to a formal screening programme. As the national screening programme is rolled out from 2011, units will need to ensure robust guidelines are in place.

2.4.10 Uptake of healthy start

Healthy Start¹⁴ is a statutory scheme providing a nutritional safety net and encouragement for breastfeeding and healthy eating for over half a million pregnant women and children under 4, in low income and disadvantaged families across the UK. It is an important intervention to prevent birth defects and promote infant and maternal wellbeing and includes the distribution of vitamin drops for children and tablets for women. Table 2.4.13 shows that there is some variation between reporting quarters for Healthy Start in Barking and Dagenham, although uptake is

¹³ PHE Screening, 2016. "NHS screening programmes: KPI reports 2015 to 2016", [Online] available from: <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2015-to-2016> [Last accessed: 14 April 2016]

¹⁴ <http://www.healthystart.nhs.uk/>

generally similar to the London and England average. There is substantial variation in neighbouring boroughs which raises concerns about the robustness of the data.

Table 2.4.13 Trends in Healthy Start Scheme uptake and uptake of vitamins, 2012/13

Area	Healthy Start scheme uptake %			Children's drops uptake %			Women's tablets uptake %		
	11/12	12/13		11/12	12/13		11/12	12/13	
	Q4	Q1	Q2	Q4	Q1	Q2	Q4	Q1	Q2
England	79.6	70.4	76.1	3.0	3.5	3.6	5.0	6.6	7.3
London	78.2	65.3	73.1	3.5	4.0	4.9	4.8	7.5	9.3
Barking and Dagenham	77.8	70.5	74.7	5.8	5.0	5.4	5.5	7.5	7.0

Source: Department of Health, 2014

2.4.11 Method of delivery

Although delivery using instruments or by caesarean section have increased, most babies are born head first and without such interventions. This is known as spontaneous vertex delivery, and 62.7% of babies were born in this way in 2014/15 in Barking, Havering and Redbridge University Hospital Trust. Emergency caesarean sections accounted for 18.3% of births, 8% were elective caesarean sections and 14.6% were instrumental (Table 2.4.12). Overall caesarean sections comprised of 26.3% of all maternities. Age of mother and ethnicity influence the likelihood of a mother having a caesarean, with older mothers more likely to have caesarean and black mothers more likely to have a caesarean than white or Asian mothers.

Table 2.4.12: Method of delivery (%) in BHRUT, 2012/13

Method of delivery	2012/13	2013/14	2014/15
Normal delivery (spontaneous vertex)	61.6	61.6	62.7
Elective caesarean delivery	8.9	8.9	8
Medical & Surgical induction/Other	29.1	29.1	29.3

Source: HSCIC¹⁵

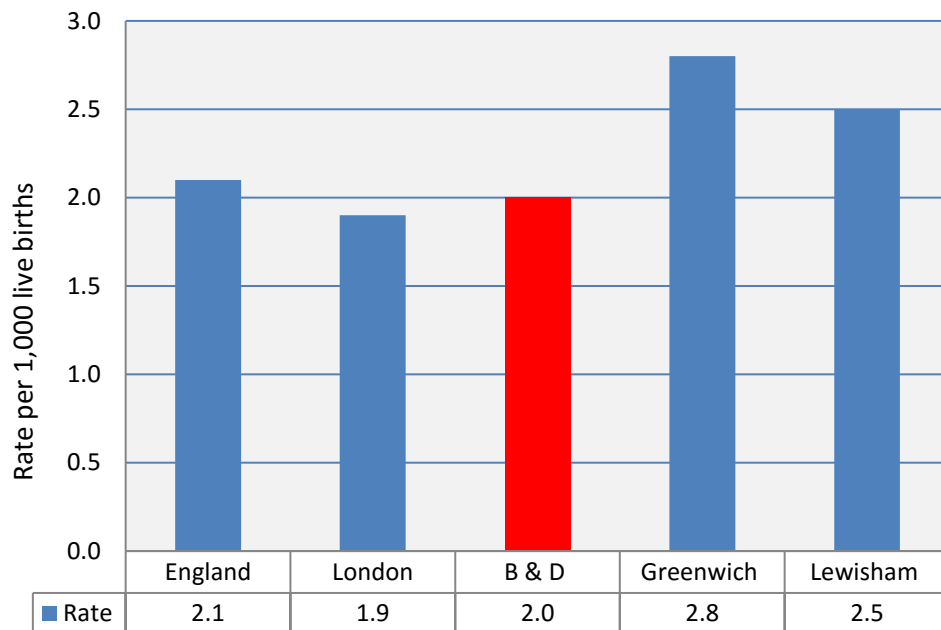
2.4.12 Neonates

According to the recorded data by Health and Social Services Information Centre, and ONS, in 2012-14 there have been 23 early neonatal deaths in Barking and Dagenham which accounts for 2 deaths per 1,000 live births, compared to 1.9 and 2.1 per 1,000 live births for London and England respectively. Figure 2.4.4 below shows the rate is lower than the two statistical neighbours; Lewisham and Greenwich. Data at Local authority level for previous

¹⁵ HSCIC, 2015. "NHS Maternity Statistics - England, 2014-15" [Online] available from: <http://www.hscic.gov.uk/searchcatalogue?productid=19422&q=NHS+Maternity+Statistics+&sort=Relevance&size=10&page=1#top> [Last accessed: 14 April 2016]

years is not available; therefore, it is not possible to compare 2012-14 death rates with previous years.

Figure 2.4.4 Early neonatal mortality rate (per 1,000 live birth) Infant age under 7 days, LBB, Statistical neighbours, London and England Crude rate 3 year average (2012-14)¹⁶



Source: HSCIC

¹⁶ NHS, HSCIC, 2015. 'Early neonatal mortality' [online] available from: <https://indicators.ic.nhs.uk/webview/> [accessed 13 August 2015]