



North East London
Clinical Commissioning Group

Maternity Services Equity and Equality needs assessment

North East London Local Maternity System

November 2021



Contents of this report

Section	Slides
1. Foreword	5
2. Introduction	6
2.1 Our area	6
2.2 Our people	7
2.3 Our local health structure	8
2.4 Our health and care partners	9
2.5 Our local health network	10
2.6 Our Local Maternity System	11
3. Equity and Equality Assessment	12
4. Analysis of inequalities in North East London Local Maternity System (NEL LMS)	13
4.1 Overview of analysis (purpose, methodology, key data sources, caveats)	14 – 19
4.2 Overview of the key findings (NEL and borough level) from the analysis	20 – 32
4.3 Key outstanding information gaps	33
5. Annex	
1 - 5: Detailed findings across all indicators: Women and babies	
• Annex 1 - Demographic profile of women in NEL accessing Maternity services in NEL	34 – 39
• Annex 2 - Access to and usage of health services during pregnancy	40 – 44
• Annex 3 - Long Term Conditions (LTCs) and other risk factors during pregnancy	45 – 53
• Annex 4 - Delivery methods	54 – 63
• Annex 5 - Outcomes for women and babies	64 – 72

Section	Slide
Annex 6 - Overview of the Female Genital Mutilation (FGM) population	73 – 77
Annex 7 – Covid-19 infections and admissions	78 – 80
Annex 8 – Metrics, sources and definitions	81 – 85
Annex 9 – Data completeness and coverage by borough and trust	86 – 97
6. Community assets mapping	98
6.1 Aim of community assets mapping	99
6.2 Our approach	100 – 101
6.3 Key caveats to asset mapping	102
6.4 NEL: Statutory and Commissioned Assets	103
6.5 Asset overview categorised around social determinants of health	104
6.6 Community Asset comparison by borough	105
6.7 Key findings from our community mapping	106
7. Case Studies across NEL LMS	107
7.1 Holistic support for an entire family: Children’s Centre, The Magpie Project and the Alternatives Trust	108 – 109
7.2 Pregnant and substance reliance: Homerton University Hospital Foundation Trust, Hackney Orbit and Comet	110
7.3 Hearing from all communities: BHRUT and local faith communities	111
7.4 Vulnerable Pregnant Women: Bart’s Health NHS Trust and Maternity Mates	112 - 113

Section	Slide
8. Staff Experience – WRES indicators	114
8.1 Overview of the National WRES dataset	115
8.2 Key caveats and limitations of the WRES data and assumptions	116
8.3 Overall distribution of Midwifery staff by ethnicity 2020/21	117
8.4 I1 – I9 indicator data	118 – 126
9. Action plan	127
9.1 Purpose and Requirements of the Action Plan	128
9.2 Recommendations for further data analysis	129
9.3 Recommendations for further community asset mapping and co-production	130
10. Acknowledgments	131

Note: Throughout this report we have used the terminology Black, Asian and Minority Ethnicity (BAME) or Black and Minority Ethnicity (BME) in line with the context from the National policies and guidelines where it has been used.

We have also used 'pregnant women' for brevity in our section 4 analysis, the data represents all pregnant people, whatever their gender identity. On an individual basis, pregnant people are referred to using the language of their choice.

Foreword

By Diane Jones, Chief Nurse and Caldicott Guardian at North East London Clinical Commissioning Group

North East London is a community of over two million people, living across eight boroughs. It's the second largest health economy in the UK with one of the fastest growing populations. Four of our boroughs are within the top ten most diverse Local Authorities in England and Wales, and five of our boroughs are in the twenty most deprived.

Our two million people demonstrate a real richness in diversity; diversity of ethnicity, culture, experience and thought. And with this diversity, there needs to be equity. Understanding what access, experience and expectation means for pregnant people in North East London. It's about meeting their needs to ensure we respond to each person's unique health and social situation, so that care is safe and personal for all.

East London has the highest birth rate in the UK. Our health and care services must cope with this growth and continue to ensure the best possible outcomes for mothers and babies. We know from the women and families we see, there are health, social and economic inequities and inequalities for women of Black and Minority Ethnic (BME) backgrounds and those from the most deprived areas when accessing and experiencing maternity services.

As a Local Maternity System (LMS), we are working in partnership with local women and their families, health partners and community groups to determine how maternity and neonatal services need to respond to each person's situation, remaining respectful of their diversity.

This Equity and Equality assessment provides data and findings for health outcomes, community assets (anything that can be used to improve the quality of community life) and staff experience, forming part one of a two-step process. All the discoveries and outcomes from the assessment will inform the second step; to co-produce an equity and equality action plan, ensuring it is aligned with the health inequalities work of the Integrated Care System (ICS). Both pieces of work combined aim to improve maternity and neonatal care by; ensuring equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas, and also race equality for staff.

Alongside this Equity and Equality assessment and action plan, we are working with maternity units on the Ockenden priorities, one of which focuses on the needs of BME women feeling supported and listened to by health care professionals to ensure that women have their voices heard. We are also working on supporting and strengthening the workforce to ensure all our BME women receive continuity of carer, alongside the rest of our population, by 2023.

Good care and positive experiences for all those who use maternity services will influence long-term health and educational outcomes. We are committed to progressive change regarding equity and equality so that care is safe for all pregnant people and their babies.

2.0 Introduction

2.1 Our area

North East London (NEL) is a vibrant, diverse and distinctive area of London steeped in history and culture.

The 2012 Olympics regenerated much of Stratford (Newham) and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities.

Additionally, the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel (Tower Hamlets) and confirmed funding for a new health and wellbeing hub in Redbridge, making it an exciting time to live and work in North East London.



2.2 Our people

North East London (NEL) Clinical Commissioning Group (CCG) is co terminus with eight local authorities:



Population

- With a population of over 2 million, it is the second largest health economy in England.
- Our population is predicted to increase by 13% to 2.2 million by 2028.
- This growth is faster than the London average with the greatest growth at 20% expected in Newham.

Ethnicity

- Our local communities are richly diverse with over 50% identifying as Black, Asian and Minority Ethnic groups.
- Four of our boroughs in the top ten most diverse Local Authorities in England and Wales.

Deprivation

- Five of our boroughs are in the 20 most deprived in England.
- Many local people: rely on benefits, experience fuel poverty, unemployment and live in poor housing. There are significant variations across our boroughs in terms of health and care outcomes, population, services & quality, relationships between organisations and resources.

2.3 Our local health structure

Within North East London there are five NHS Trusts - three acute and two community/mental health:



- In April 2022 NEL CCG will become an Integrated Care Board (ICB), working with partners to form the Integrated Care System (ICS) in enabling transformation of health and care systems for all our communities. The North East London ICS will be underpinned by place based partnerships in each borough.
- At a local place level, providers work collaboratively through strategic partnerships and provide services at scale. Each of our local areas has been built on strong place-based partnerships and have grown organically to respond to the need to shift the emphasis and settings of care from the hospital to the community.

2.4 Our health and care partners



5

NHS Trusts
3 acute and 2
community/mental health



47

Primary
care
networks



7

GP
federations



8

Healthwatch
organisations



272

GP practices



320

Dental
surgeries



250+

Care Homes

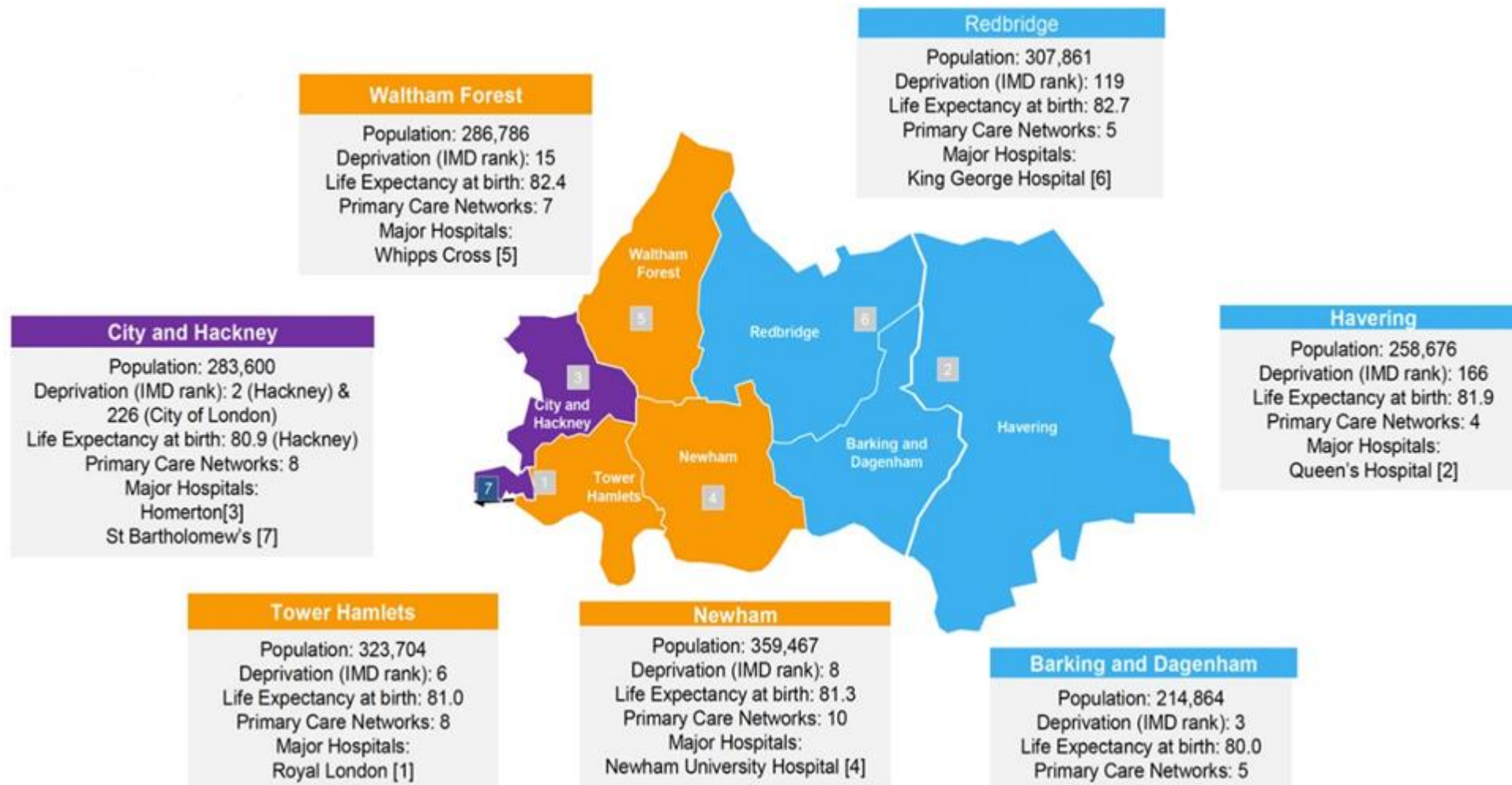


2100+

Community assets and
voluntary sector
organisations

- At a neighbourhood level, our 47 primary care networks work across practices and health and social care services, supporting a systems approach to population.
- NEL Integrated Care System (ICS) will support and transform the health of our local population by addressing and tackling health inequalities.

2.5 Our local health network



2.6 Our Local Maternity System

High quality, safe, equitable and *personalised care*

NEL Local Maternity System (LMS) has a responsibility and duty to listen to all women and their families accessing maternity and neonatal services across NEL.

We want to continuously and actively collaborate, with all those who interact with our service, to improve access and health outcomes for mothers and babies, using their experiences to transform services with providers and other stakeholder.

East London has the highest birth rate in the UK. Our health and care services must cope with this growth and continue to ensure the best possible outcomes for mothers and babies. We want to make sure that all babies born in North East London have the best possible start in life and that their parents experience the best possible pregnancy and birth.

There are three providers working over five acute sites for maternity services, each with an obstetric labour ward and a midwifery led unit. There are also two freestanding midwifery led birth units.

Barts Health Trust

- The Royal London Hospital
- Newham University Hospital
- Whipps Cross Hospital

Barking, Havering and Redbridge University Trust

- Queen's Hospital

Homerton University NHS Foundation Trust

- Homerton University Hospital

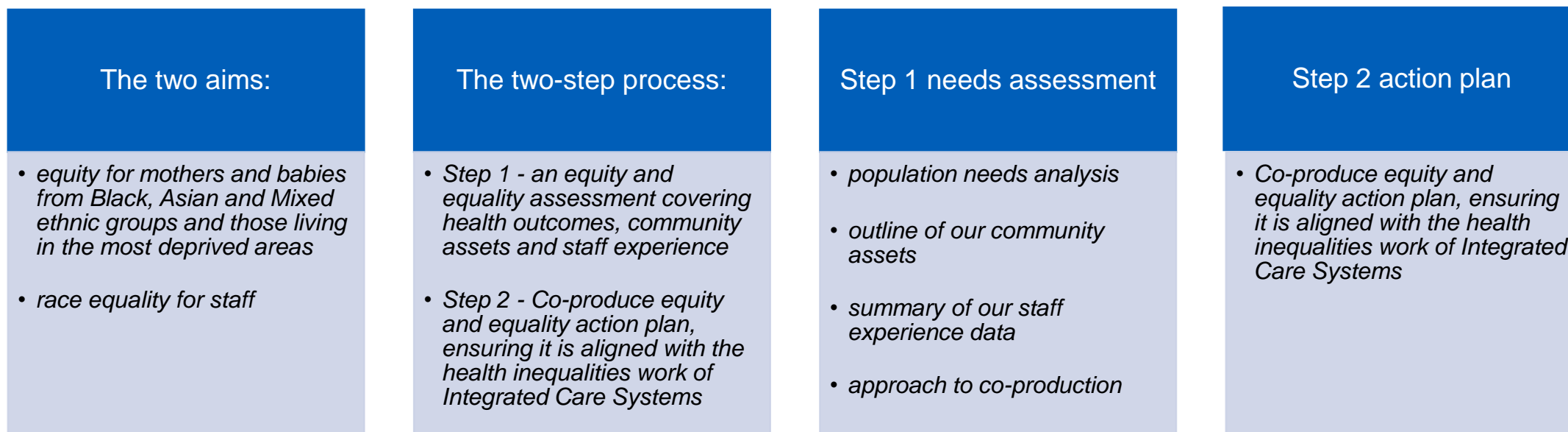
NEL LMS is accountable to NEL CCG/Integrated Care Board (ICB) delegated to the Quality committee and the London Maternity Perinatal Board. NEL LMS has a representative membership from sector-wide stakeholders to ensure clinical, system level and service user input is used to inform and direct targeted service improvement interventions.

3.0 Equity and Equality Needs Assessment process

The Equity and Equality needs assessment has been conducted in direct response to the recently published 2021/22 priorities and operational planning guidance. Supplementing the Local Maternity Transformation plans developed in 2017 with a co-produced equity and equality analysis that follows a two-step process:

1. Submitting an equity and equality analysis (covering health outcomes, community assets and staff experience) and a co-production plan – **by 30 November 21**
2. Co-producing equity and equality actions plans setting out how the NHS will work in partnership to ensure equity for women and babies and race equality for staff – **by 28 February 22**

This report forms step 1, the Equity and Equality needs assessment.





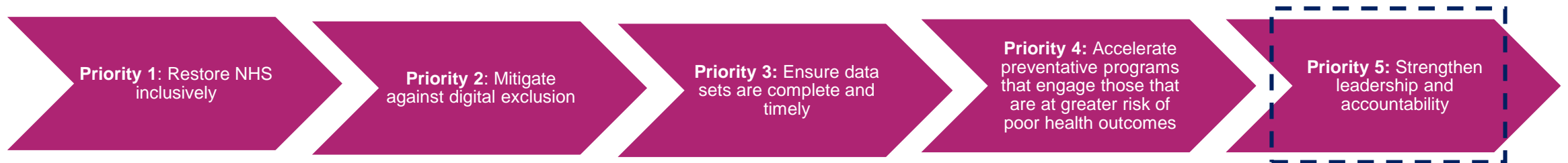
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Clinical Commissioning Group

4. Analysis of inequalities across the NEL Local Maternity System (LMS)



4.1 Background and aim of this analysis

MBRRACE-UK reports about maternal and perinatal mortality show **worse outcomes** for those from **Black, Asian and Mixed ethnic groups** and those living in the most deprived areas. In September 2021, NHSE responded to those findings by issuing guidance to Local Maternity Systems (LMS). This guidance is structured around the **five health inequalities priorities** described in the *20/21 priorities and operational planning guidance: Implementation guidance*.



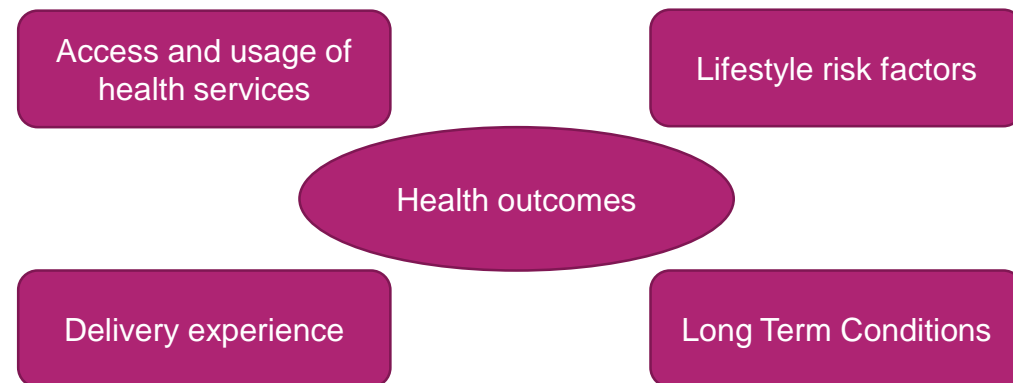
- The aim of the analysis in section 4.0 and 8.0 is to **support the equity and equality needs assessment covering health outcomes, community assets and staff experience** (excluding community assets) using the available data. The scope of this analysis includes:
 - an initial high level analysis of the scale and scope of possible inequalities for women and babies in NEL in health outcomes and across wider factors that are known to be linked to these.
 - An identification of the major gaps in the analysis - e.g. due to time constraints and/or lack of available/good quality data;
 - A list of recommendations for possible further analysis based on our initial findings to help the inform and target co-produced action plans.

4.1 Our approach

- Our analysis focuses **only** on those pregnant women that **gave birth in NEL in 20/21**. It focuses on identifying potential inequalities across **4 main ethnic groups** of pregnant women and babies (**Black, Asian, Mixed, Other**) relative to White women and across the **5 deprivation quintiles**.
- At NEL we understand the importance of adopting inclusive language in our perinatal services. We acknowledge that social disadvantage and marginalisation contribute to poorer health outcomes, as do barriers to quality healthcare. At NEL we are committed to promoting the use of language that reflects and represents the diversity of our population, so that no one is excluded. This will also be further reflected in our Equity and Equality Plan. Whilst in this report we have used the term 'pregnant women' for brevity, the data represents all pregnant people, whatever their gender identity. On an individual basis, pregnant people are referred to using the language of their choice.

- We have looked at a vast range of metrics covering health outcomes and other relevant indicators that we know may have an important influence not only on health outcomes but also on the overall experience of women and babies.

- **Hospital Episode Statistics (HES)** and **Secondary Uses Service (SUS)** have been our two primary data sources for this analysis. While there is a **Maternity Services Data Set (MSDS)**, our high level assessment of this data suggested that for many of our indicators of interest, the data are not sufficiently complete to base the analysis on. Data from the MSDS has been limited therefore to a very small set of indicators.
- The full list of metrics, sources and definitions are set out in Annex 1 of this report.



- We have also analysed the nationally available data on the 9 **Workforce Race Equality Standard (WRES)** indicators and nationally available data on the profile of victims of **Female Genital Mutilation (FGM)** in NEL.

4.1 Key caveats and limitations of the data & analysis (1)

1. Our pregnant population only include those that **gave birth** in 2021



- This analysis of inequalities only covers women that gave birth in 20/21. Metrics calculated on this population are therefore based on the c.9 months up to delivery (this means, for example, that for some women, an A&E attendance 'during pregnancy' may have taken place in 19/20 (i.e. if the delivery happened before Q3 in 20/21).

2. City of London not included in this analysis



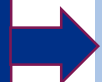
- The profile (both ethnicity and deprivation) is significantly different to that of Hackney. It also has a relatively small population compared with the overall population of Hackney. To avoid risks of this area skewing the overall results and therefore potentially providing misleading averages for Hackney as a whole, we were asked to exclude it from our analysis.

3. Differences have not been tested for **statistical significance**



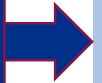
- Testing for statistical significance is important as it provides confidence that observed differences are real, reliable and not due to chance. Given the complexity in testing for statistical significance and the scale of metrics covered in our analysis, we have not been able to test for significance within the scope of this work. To mitigate against risk of drawing spurious conclusions, we have limited references to differences to those we think are more likely to be significant.

4. Differences in **ages** have not been taken into account



- Rates are not age standardised so the variation between ethnicity or deprivation could be age-driven in part. The importance in this may vary by indicator and some outcomes may be influenced greatly by the woman's age and therefore any variation in population age structures may have a confounding effect.

5. Variations in the completeness and consistency of coding across the main data sources



- Trusts may interpret guidance differently or have differing coding completeness. This may skew the borough results. There may also be a number of patients which have not been matched to an address and these will not be reported within the borough numbers (and some of these patients could be in high risk groups) or assigned to a deprivation quintile (as this is based on patients resident address).
- Further information on this by metric is included Annex 2 of this report

4.1 Key caveats and limitations of the data & analysis (2)

6. Findings based on **very low numbers** may be misleading

- In small samples, even small 'random' differences can lead to unreliable conclusions about 'true' differences between groups. This is relevant to two three main indicators in this analysis: (1) Still birth rates (2) postnatal mortality and the (3) prevalence of epilepsy. This is due to the incidence/prevalence of these outcomes being relatively rare in the overall population in England.

7. We have not investigated the distribution of women of **Mixed ethnicity**

- While women in this group make up a relatively small proportion of the 'pregnant' population in NEL (i.e. **2%** on average) there are a number of indicators at both the NEL and borough level in which this group appears to be an very notable outlier. As we do not know the make up nor distribution of this group of women, we have not been able to make any assessment of whether there may be one or more sub-groups within this category that disproportionately experience adverse outcomes than White or other ethnicities, nor whether they are more at risk of poor outcomes given differences in prevalence rates across risk factors for example.

8. Our analysis has only looked at **one year** of data – and coincides with the height of the Covid pandemic

- We have not analysed time trends for any of the metrics included in this analysis. In the absence of looking at patterns both within and across years, we are unable to conclude at this stage whether the differences between ethnicities and deprivation status that we have observed in this analysis also apply over different time periods or if Covid has affected trends over time.

9. Not all boroughs have LSOAs in the **4th and 5th IMD quintile**

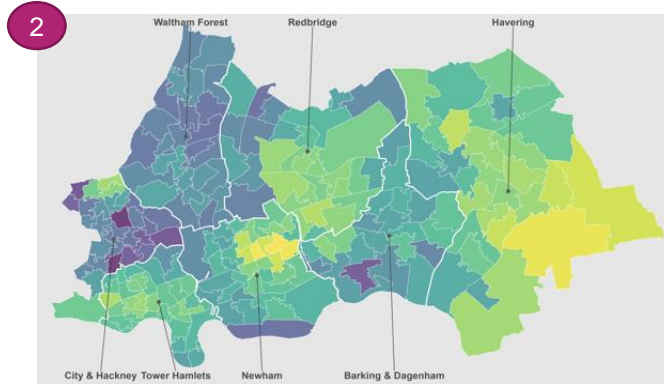
- All NEL boroughs have at least 1 Lower Layer Super Output Area (LSOA) within their boundary in each of 1st, 2nd and 3rd (i.e. the most deprived) quintiles in England. Not all, however, have at least 1 LSOA in the 4th and 5th (i.e. the least deprived) quintile. This included Barking and Dagenham, Hackney (neither have any LSOAs in the 4th or 5th quintile), and Newham (no LSOAs in the 5th quintile).

10. Observed differences across ethnic groups have **not been controlled** for differences in deprivation and vice versa

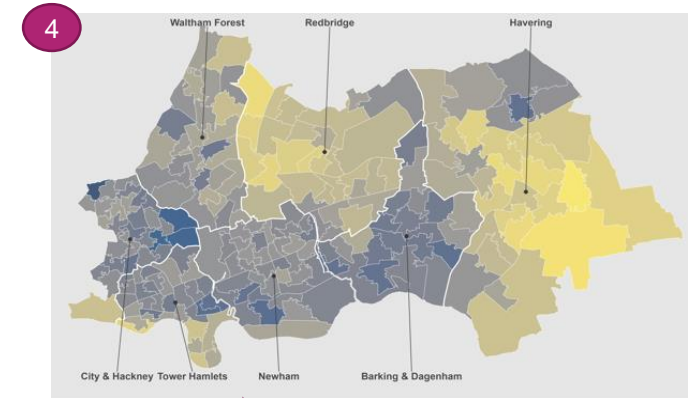
- Where differences between ethnicities have been observed, we have not assessed the extent to which it may be deprivation (or indeed other factors such as age) that are driving these observed differences rather than ethnicity alone. Controlling for differences in deprivation status would enable us to better assess us for example, whether Asian women living in the most deprived areas have the same outcomes as White women in the most deprived areas?

4.1 NEL has among the most ethnically diverse and deprived boroughs in England

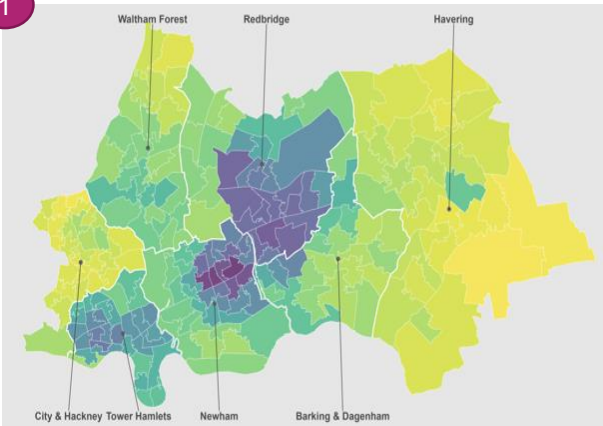
This map shows the prevalence and concentration of people of **Asian** ethnicity by neighbourhood - darker colours indicate higher %



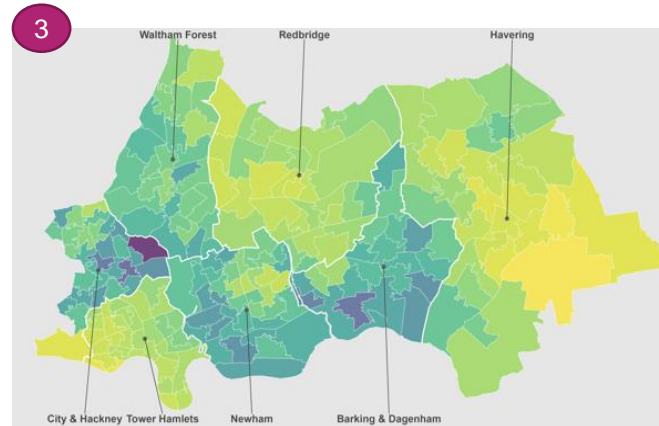
This map shows the prevalence and concentration of people of **Mixed** ethnicity by neighbourhood - darker colours indicate higher %



This map shows the prevalence and concentration of people of **Black** ethnicity by neighbourhood - darker colours indicate higher %

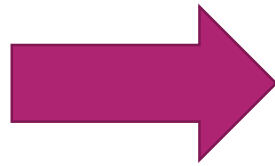


This map shows the IMD score - darker colours indicate higher deprivation

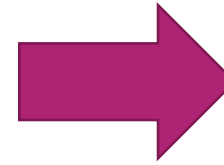


4.1 This diversity means that the effects of any inequalities are amplified as they impact more people

There were 25,950 babies born in NEL in 2020/21

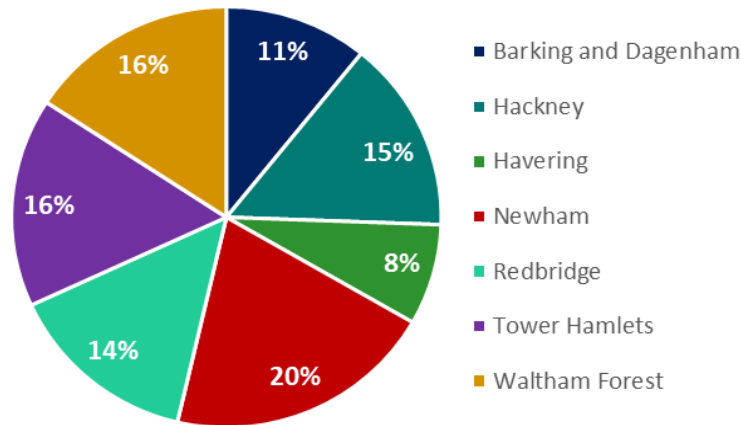


58% of those babies were born to Black, Asian, Mixed and Other ethnicity women

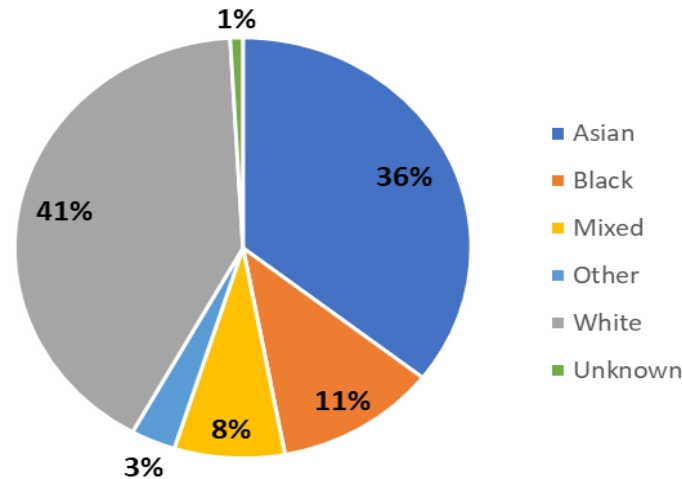


72% of those babies were born to women in two most deprived quintiles

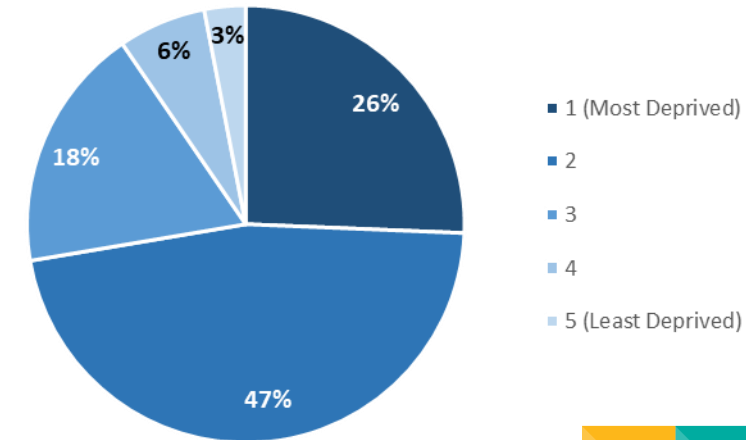
% of babies born by borough in 2020/21



% of babies born by ethnicity in NEL (2020/21)



% of babies born by deprivation quintile in NEL (2020/21)



*Source: Hospital Episode Statistics (HES)

4.2 Key findings from our analysis – NEL level (1)

1. The stillbirths among babies born to Black and Asian women are concentrated in 3 boroughs with rates markedly higher than for babies born to White women

2. Babies born to Black and Asian women are more likely to have had a neonatal admission than those born to White women

3. Babies born to Black and Asian women are also nearly twice as likely to have a low birth weight than those born to White women

4. In total across NEL there were 5 women that died within 42 days of delivery (i.e. direct deaths)

- Overall across NEL, there were **90** stillbirths in 20/21. While we have calculated the rates across each ethnicity, without further analysis, the size of the sample means that any conclusions on the 'true' differences between ethnicities based on these numbers alone may not be reliable.
- Across NEL, the rate of babies born stillbirth was higher for babies born to Black women (**3.8 per 1000**) and Asian women (**4 per 1000**) compared to the rate for those both to White women (**2.6 per 1000**). This compares with the national average of **3.8 per 1000** babies.
- Stillbirths to Asian and Black women tend to be concentrated in **3 boroughs** – Hackney, Newham and Waltham Forest – with the rates for babies born to Asian women (**6.5 per 1000**) and Black women (**9 per 1000**) being highest in Newham. The rate for Other ethnicities was even higher at **12.7 per 1000**.
- In contrast, there were stillborn babies born to White women **across all NEL boroughs** with the exception of Newham.

- On average, nearly a quarter of babies born in NEL were admitted to neonatal care (**24%**) although there is a much higher degree of variation between boroughs. Havering and Barking and Dagenham had the highest proportion of admissions (**48% and 39%**) which was over 3 times the percentage of admissions in Hackney (**11%**), Tower Hamlets (**16%**) and Waltham Forest (**12%**).
- On average at NEL level, Asian and Black ethnicities had the highest percentage of babies admitted to neonatal care (**27% for both**), compared with **22%** for babies born to White women.

- Across NEL, **11%** of babies born to Black and Asian women had a low birth weight – nearly **double the rate** for babies born to White women (**6%**). This disparity is largest within Hackney where the percentage of babies born with low birth weight of Black and Asian ethnicity is nearly **three times as high** as the percentage found for White ethnicities. In Waltham Forest and Tower Hamlets this difference is **twice as high**.

- Concerns around Information Governance (IG) - in terms of risks around re-identification - mean that we are not able to provide an ethnic breakdown of this group of women
- Also, without further analysis (e.g. looking across a larger number of years) we are unable to draw any reliable conclusions on potential disparities across ethnicities on this sample alone.

4.2 Key findings from our analysis – NEL level (2)

5. We have been unable to collect and validate data at this stage on neonatal deaths or infant mortality

- It has not been possible within the time frame allowed for this analysis to collect, validate and analyse data on these outcomes and how they vary by ethnicity and deprivation status. This will be covered within the scope of the proposed next steps of our analysis into maternity inequalities.

6. Black women are more likely to have attended A&E than White women within 6 months of delivery

- On average across NEL, Black ethnicities (**11%**) had the highest percentage of women attending A&E within 6 months of delivery, compared to White (**7%**) and Other ethnicities (**7%**) who had the lowest percentage.

7. Women in Black, Mixed and Other groups tend to present to healthcare services at least 2 weeks later into their pregnancy than White women

- On average across NEL, Mixed women take an average of **11 weeks** into their pregnancy to present, Black women **11 weeks**, and women from Other ethnicities **10 weeks**, compared **8 weeks** for White women.
- In Newham, for example, the average gestational age at first contact was approximately **twice as high** for Black and Mixed ethnicities than White ethnicities (i.e. **9, 10 and 4 weeks** respectively). In Tower hamlets, Black and Mixed women made first contact between **3 and 4 weeks later** than White women.

8. Black and Asian women are also more likely to have attended A&E during their pregnancy than White women

- On average across NEL, **37%** of Black women **and 31%** of Asian women had at least **one attendance to A&E** during their pregnancy compared with **23%** among White women. This pattern is consistent at the borough level, with Black women having the **highest percentage of women** with an A&E attendance during pregnancy in all 7 NEL boroughs.
- The differences between rates among Black and White women are largest in Tower Hamlets and Newham. In Tower Hamlets, for example, the rates for these same two ethnicities are **42%** compared with **26%** and in Newham are **48%** compared with **35%**. Similarly, in Havering the rate among Black women (**23%**) is more than twice that for White women (**11%**).

9. Black women are also more likely than White women to have been admitted to hospital during their pregnancy

- On average across NEL, **38%** of Black women had at least one admission to hospital during their pregnancy compared with **29%** among White women.
- Hackney (as well as having the highest overall proportion of women with an admission), has the largest variation between ethnicities with **65%** of Black women having an admission compared with **50%** for White women.

4.2 Key findings from our analysis – NEL level (3)

10. Black pregnant women are almost twice as likely to be obese than White women

- On average across NEL, **36%** of Black women giving birth in 2021 were obese compared with **19%** of White women and **22%** of Asian women. The difference between White, Asian and Mixed women are relatively less marked.
- At the borough level, Black women also have the highest rates of obesity across every NEL borough with the exception of women of **Mixed ethnicity** in Barking & Dagenham where the rate is as high as **45%**

11. Asian pregnant women are more than 3 times - and Black women more than two times –likely to have diabetes than White women

- **26%** of Asian women had diabetes (T1/T2/gestational) compared with **15%** of Black women and only **7%** of White women. This is despite their having comparatively lower obesity rates than other ethnicities.
- Variations between ethnicities looks to be highest within Newham and Tower hamlets. Prevalence rates among Asian women in these two boroughs are **27-28%** compared with **17-19%** among Black women and **7%** among White women.

12. Black pregnant women tend to have higher rates of hypertension than White women

- Across NEL, the prevalence rate of hypertension among Black women is **higher** compared with all other ethnicities. On average **8%** of Black women that gave birth in 2021 have hypertension compared with **5%** among White women. And this disparity is a trend across all 7 NEL boroughs. In Havering the prevalence among Black women is by far the highest at **11%** and more than double that of White women at **5%**

13. Black and Asian women are less likely than White women to be taking folic acid in pre/early pregnancy although deprivation is potentially the more important driver underlying differences

- On average across NEL, the rate among White women is relatively higher than those among both Asian and Black women (i.e. **44%, 37% and 37%** and respectively)
- On average across NEL, deprivation appears to be **more closely correlated** with the likelihood of women having a (good) folic acid status. On average across NEL, the rate among women in the **least deprived** quintile is **67%** which is **almost twice as high** as for those in the **most deprived quintile (36%)**. This closely linked correlation may – in part – be explained by the cost associated with taking folic acid supplements for which women in the least deprived areas may be more able to afford.

14. Black pregnant women are more likely to be out of employment compared with all other ethnicities

- On average, a **higher proportion** of women in ethnic minority groups are not in employment compared with White women (i.e. **10-13%** across **BME** groups compared with **8%**). On average, the rate is highest among Black women at **13%**.
- As expected, deprivation appears to be strongly linked to the likelihood of being out of employment with **13%** of women in the most deprived areas not being in employment compared with **4%** in the least deprived (i.e. **more than three times the rate**).

4.2 Key findings from our analysis – NEL level (4)

15. There are no consistent trends in the rates for 'complex social factors' but this may be due to lack of reporting consistency

16. The likelihood of a vaginal delivery is relatively similar across ethnicities, with larger variations in unplanned C-section deliveries

17. Black and Asian women are more likely to have an unplanned C-section compared with White women

18. White women are twice as likely to deliver via forceps compared to Black women

19. Asian women are more likely than White women to have a second or third degree tear

- **Redbridge (15%)** and **Barking & Dagenham (13%)** have much higher rates of women that gave birth in 2021 having complex social factors, with the rate in **Tower Hamlets (2%)** being the lowest. On average, the proportion of White women with complex social factors (**8%**) is either **very similar** or even **slightly higher** than compared with all ethnic minority groups (**6-8%**) with the exception for women of Other ethnicity (**9%**).
- However, the accuracy of these findings may be undermined by inconsistent reporting practices both within and across boroughs due to the relatively large scale and variety of factors that make up this indicator.
- Across and between boroughs, the rates for Asian, Black and White women for vaginal deliveries (which do not include assisted vaginal deliveries) are **relatively consistent** at approximately **57%**.
- While the average rate of vaginal delivery for Mixed women across NEL is only slightly higher at **59%**, the rate among this group is **markedly** higher than in any other ethnicity in three of the boroughs: Newham (**71%**), Redbridge (**67%**) and Havering (**65%**).
- In contrast, average unplanned C-sections rates vary much more across borough from **4%** in Hackney to **24%** in Havering.
- Overall across NEL, approximately **30%** of deliveries take place via C-sections (planned/unplanned)
- On average across NEL, Asian women are **twice as likely** as Mixed or Other women to have an unplanned C-section (**19%** compared with **9%**) and are also more likely than White women to give birth in this way (**13%**).
- On average, Black women are **also more likely** than White women (and compared with other non-Asian ethnicities) to have an unplanned C-section (**i.e. 18%** compared with **13%**).
- On average across NEL, **8%** of white women had deliveries via forceps' compared with **4%** among Black women.
- In contrast the average rates among Asian (**7%**), Mixed (**7%**), Other (**7%**) and White (**8%**) women are relatively similar.
- More than a quarter of women in all boroughs had a second degree tear. **30%** of Asian women had a second degree tear compared with **25%** among White women and **19%** among Black women.
- Third degree tears are significantly more rare, with less than **3%** of women across NEL suffering from this. On average, the rate among Asian women is **3%**, higher than for White women (**2%**) and Black women (**1%**).

4.2 Key findings from our analysis – Borough level (1)

- Overall stillbirth rate of 3.4 in 1000 and one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated
- Babies born to Asian (10%) and Black (11%) women twice as likely as babies to White women (5%) to have a low birth weight.
- Black women (16%) **twice as likely** than White women (8%) to have had an unplanned C-section
- Black and Mixed women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Black, Asian and Mixed women more likely than White women to have attended A&E or been admitted to hospital with 6 months of delivery than White women
- Black and Mixed women are two times more likely than White women to be obese and Black women twice as likely to have hypertension

- Overall stillbirth rate of 1 in 1000 and lowest in NEL
- Has the highest average rate across NEL of women having an unplanned C-section (24%) with rates for Black (32%) and Asian (28%) women are markedly higher than for White women (22%)
- Black women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Black women (11%) more than twice as likely as White women (5%) to have hypertension
- Asian women (25%) more than twice as likely as White women (10%) to have diabetes



- Overall still birth rate of 3 in 1000 It was one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated
- Babies born to Black (14%) and Asian (15%) women nearly three times as likely than those to White women (5%) to have a low birth weight
- Babies born to Black women (20%) twice as likely to be admitted to neonatal care than those to White women (10%)
- More than half of women admitted to hospital during pregnancy with rates much higher among Black (65%) than White (50%) women
- Highest average rate of planned C-section across NEL (26%) with rates much higher for Black (37%) and Asian (30%) women than for White (22%)

- It has one of the highest rates of stillbirths across NEL at almost 5 in every 1000 births and one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated.
- Highest rates in NEL of stillbirths among Black, Asian and Other ethnicity women (6.5 per 1000 among Asian women, 9 per 1000 among Black women, and 12.7 per 1000 among Other ethnicities)
- It has the **highest average proportion** of women giving birth to babies with **low birth weight** in NEL (c.1 in 10)
- Black and Mixed women tend to present to healthcare services more than 4 weeks later into their pregnancy than White women.
- Has among the largest disparities between Black and White women in attending A&E during pregnancy (and the largest average rate across NEL overall). Also has one of the largest disparities between Black, Asian and White women in diabetes prevalence

4.2 Key findings from our analysis – Borough level (2)

- Overall stillbirth rate of 2.5 in 1000
- Babies born to Asian (37%) and Black (34%) women much more likely those born to White women to be admitted to neonatal care (25%)
- Black women are twice as likely and Asian women are three times more likely to have diabetes than White women.
- Black women (9%) are three times more likely than White women (3%) to have hypertension
- Black women (35%) are much more likely to be obese than White women (20%)

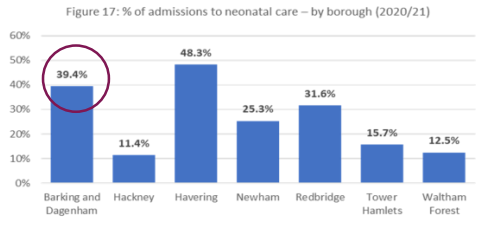
- Highest overall stillbirth rate in NEL at 6.2 in 1000 and is based mainly by stillbirths to White women and those Unknown ethnicity – who have a very high rate at 12 per 1000 births
- Babies born to Black (12%) and Asian (11%) women are **twice as likely** to have a low birth weight than those born to White women (5%)
- It has one of the largest difference in rates between Black (42%) and Mixed (40%) women compared with White (26%) women attending A&E during pregnancy
- It is has the **highest** average rate across NEL of women attending A&E with 6 weeks as well as 6 months after delivery (7% and 10%)
- It has the highest average rate across NEL of diabetes prevalence (21%) and **has one of** the largest differences in rates between Asian (28%) and Black (19%) women compared with White women (7%)



- Overall stillbirth rate of 2.2 in 1000
- Second highest average rate across NEL of babies admitted to neonatal care (40%)
- Black women twice as likely than White women to have attended A&E and been admitted to hospital within 6 months of delivery
- Second highest average rate across NEL of women having an unplanned C-section (23%) with rates higher among Black (29%) and Mixed (29%) women compared with White women (21%)
- Mixed ethnicity women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Highest average prevalence rate of obesity (27%) across NEL with rates for Mixed (45%) and Black (35%) women markedly higher than among White women (25%)
- Prevalence of hypertension twice as high among Black and Mixed women compared with White women

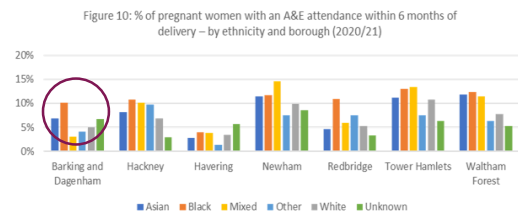
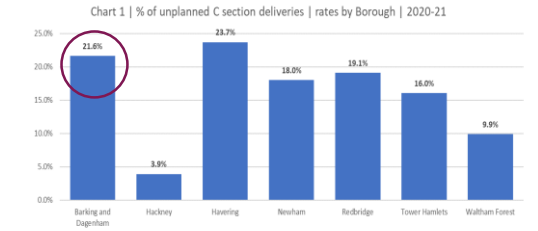
4.2 Key findings – Barking & Dagenham

- **2,805** births in 20/21 (11% of total NEL births)
- **50%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **30 years**

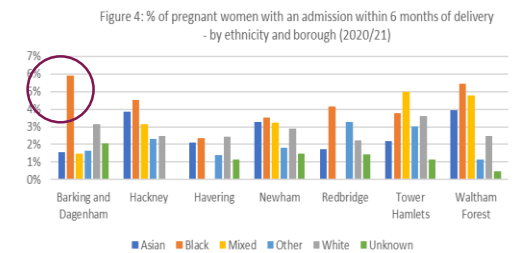
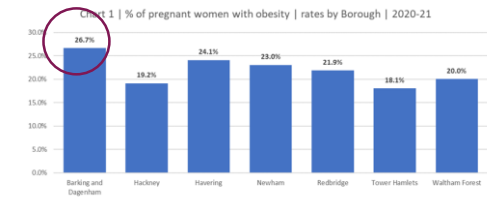


- It has the **second highest** average rate across NEL of women giving birth to babies that are admitted to neonatal care

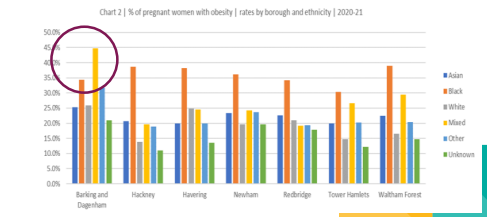
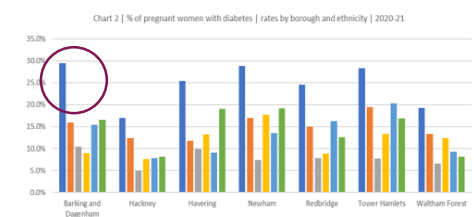
- It has the **second highest** average rate across NEL of women having an unplanned C-section (22%) with rates among Black (24%), Asian (24%) and Mixed (24%) women higher than those among White women (20%)



- It has the **highest** average rate of pregnant women that are obese (27%) across NEL and rate among Mixed and Black and women in particular are much higher than those among White women (45% and 35% compared with 25%)
- It also has the **third highest** average prevalence rate across NEL of **diabetes** (18%) as well as the highest rate among Asian women compared with all other boroughs at almost 30%. This rate is also three times higher than the rate for White women (10%)
- The prevalence of **hypertension** is also **much higher** among Black and Mixed women compared with White women (7% and 7% compared with 3%)



- Black women **twice as likely** than White women to have **attended A&E** within in 6 months of delivery (10% compared with 5%) and to have been admitted to hospital within in 6 months of delivery (6% compared with 3%)



4.2 Key findings - Hackney

- **3,830** births in 20/21 (15% of total NEL births) - HES
- **41%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**



Figure 21: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)

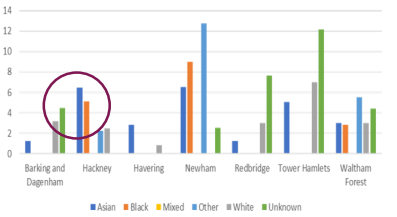
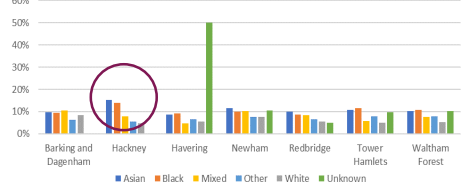
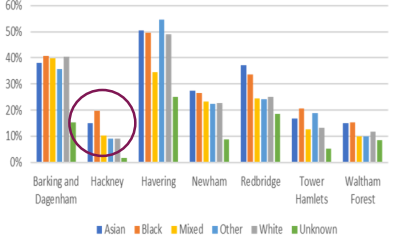


Figure 8: % of babies born with low birth weight - by ethnicity and borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black and Asian women are **concentrated** – 3 per 1000 births and mainly to Black and Asian ethnicity women – stillbirths to women of Asian ethnicity highest at **6.5** in every 1000 births
- The proportion of babies born with low birth weight born to Black and Asian women is nearly **three times as high** as for White women (**14%** and **15%** versus **5%**)
- Babies born to Black women are twice as likely to be admitted to neonatal care than those to White women (**20%** versus **9%**)

Figure 15: % of admissions to neonatal care - by ethnicity and borough (2020/21)



- Black women more than **twice as likely** to be **obese** than White women
- It has the **highest average** proportion of women with **hypertension** in pregnancy (**6%**) across NEL with rates among Black women **higher** than among White women (**9%** versus **5%**)

Chart 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21

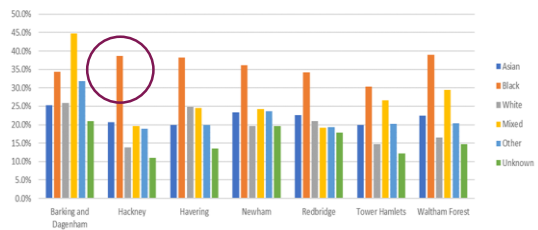


Chart 1 | % of pregnant women with hypertension | rates by Borough | 2020-21

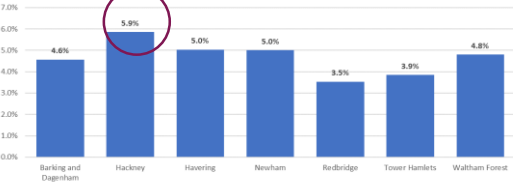
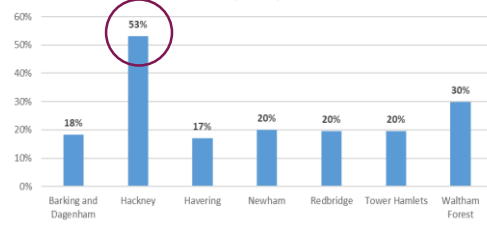


Figure 9: % of pregnant women with an admission during pregnancy - by borough (2020/21)



- On average **more than half** of women are **admitted to hospital during pregnancy** (highest across NEL) with rates higher among Black and Asian women compared with White women (**65%** and **58%** versus **50%**)
- Black and Asian women were also **more likely to attend A&E within 6 weeks** of delivery compared to White women (**8%**, **7%** versus **5%**)
- Black and Asian women are also **much more likely** than White women to be **admitted to hospital** within 6 weeks of delivery (**18%** and **18%** compared with **11%**)

Figure 7: % of pregnant women with an A&E attendance within 6 weeks of delivery - by ethnicity and borough (2020/21)

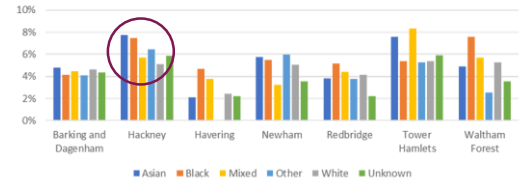


Figure 1: % of pregnant women with an admission within 6 weeks of delivery - by ethnicity and borough (2020/21)

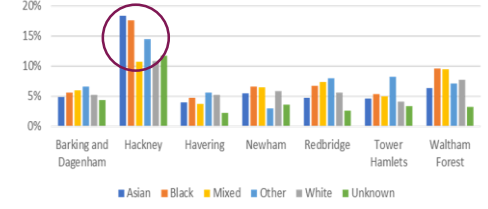


Chart 1 | % of planned C section deliveries | rates by Borough | 2020-21

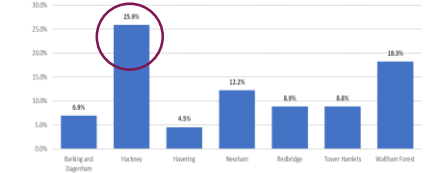
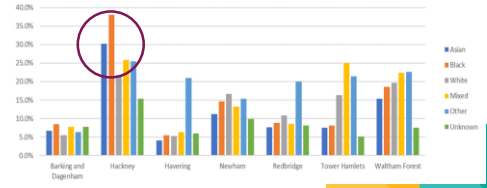
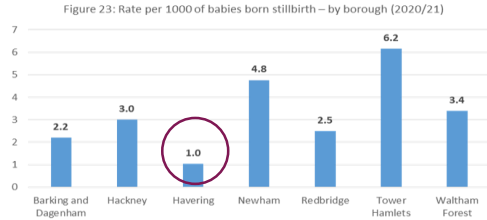


Chart 2 | % of planned C section deliveries | rates by borough and ethnicity | 2020-21

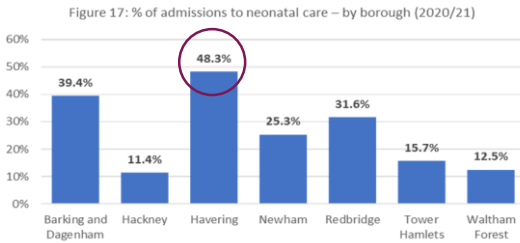


4.2 Key findings – Havering

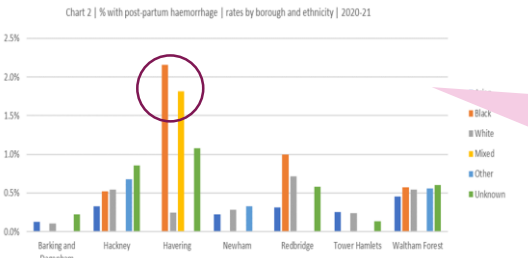
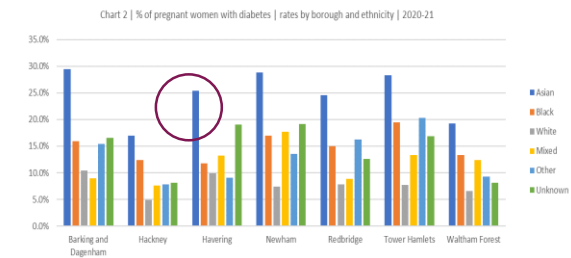
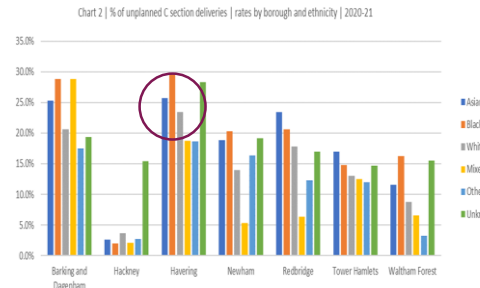
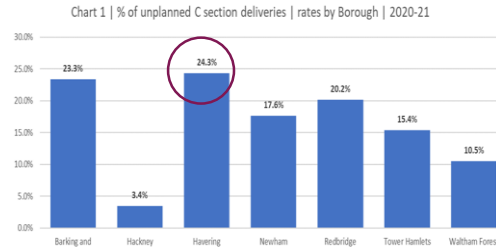
- **2,010** births in 20/21 (**8%** of total NEL births)
- **31%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**



• While it has the **lowest** rates of stillbirths per 1000 births overall, **nearly half** of women (49%) have babies that are admitted to neonatal care – although no notable differences across ethnicities with rates for BME babies either the same or less than for those born to White women.



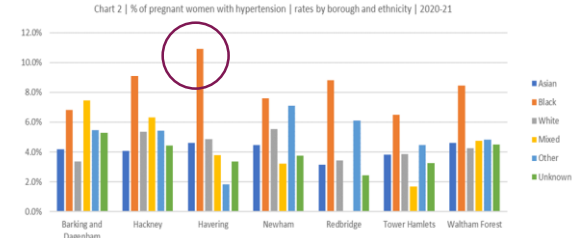
• It has the **highest average** rate across NEL of women having an **unplanned C-section (24%)** with rates for Black and Asian women are **markedly higher** than for White women (**32%** and **28%** compared with **22%**)



• Black women are **10 times** more likely and Mixed women **9 times** more likely than White women to suffer **post partum haemorrhages (2.2% and 1.8% compared with 0.2%)**

• Black women more than twice as likely as White women to have hypertension (**11% compared with 5%**)

• While it has one of the **lowest** overall average prevalence of **diabetes** across NEL (**13%**) the rate among Asian women is more than **twice as high** as for White women (**25% compared with 10%**)

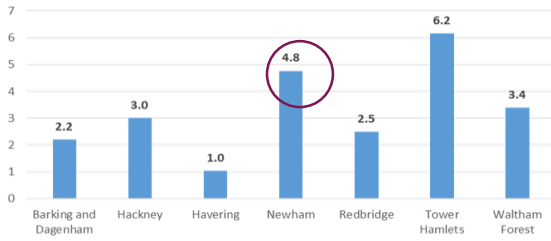


4.2 Key findings – Newham

- 5,282 births in 20/21 (20% of total NEL births)
- 55% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 30 years



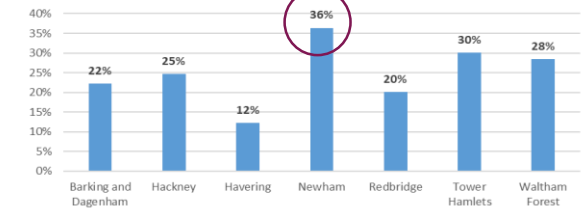
Figure 23: Rate per 1000 of babies born stillbirth – by borough (2020/21)



- It has one of the **highest rates of stillbirths** across NEL at almost 5 in every 1000 births.

- Largest average rate across NEL of women attending A&E during pregnancy
- It is one of the two boroughs with the **largest difference** in rates between Black and White women (48% versus 35%)

Figure 10: % of pregnant women with an A&E attendance during pregnancy - by borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black and Asian women are **concentrated** – and also has the **highest rates** for these two groups at **6.5 per 1000** among Asian women and **9 per 1000** among Black women. The rate found for Other ethnicities was even higher at **12.7 per 1000**.

Figure 21: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)

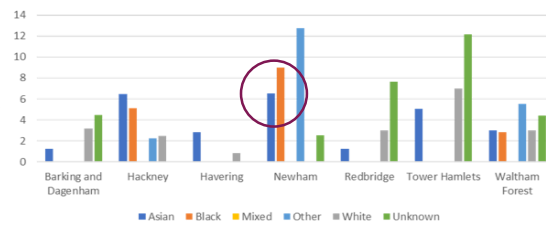
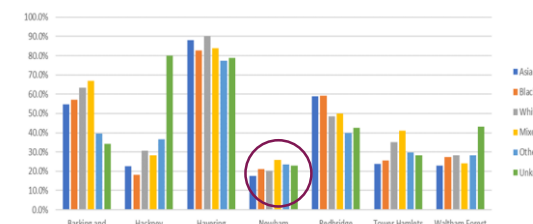
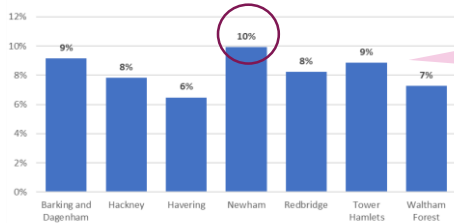


Chart 2 | Folic acid status | rates by borough and ethnicity | 2020-21



- While rates within ethnicities of 'good' folic acid stats are very similar, it has the **lowest average rate** across all women among all the NEL boroughs at **20%**.

Figure 7: % of babies born with low birth weight – by borough (2020/21)



- On average, has the **highest proportion** of women giving birth to babies with **low birth weight** in NEL – around 1 in 10

- It has one of the **highest average rates of diabetes** (20%)
- It is one of the two boroughs with the **largest differences** in rates among Asian, Black and White women (28%, 17% and 7%)

Chart 1 | % of pregnant women with diabetes | rates by Borough | 2020-21

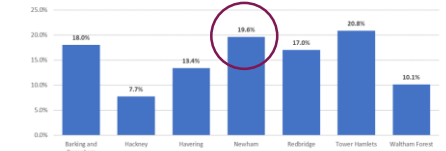
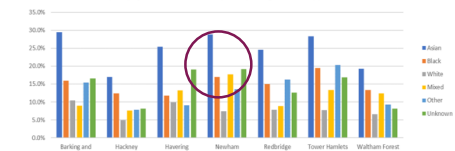


Chart 2 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21

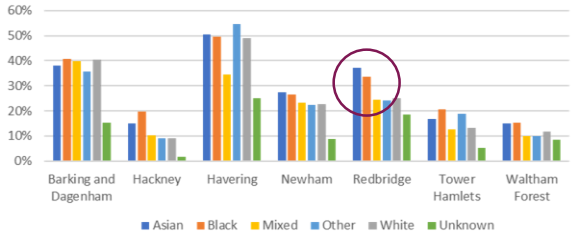


4.2 Key findings – Redbridge

- **3,757** births in 20/21 (14% of total NEL births)
- **59%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**



Figure 15: % of admissions to neonatal care – by ethnicity and borough (2020/21)



- It has the **third highest** average rate across NEL of women giving birth to babies that are admitted to neonatal care.
- Rates among babies born to Asian and Black women are much higher than those born to White women (**37%, 34%** compared with **25%**)

- Black women are **twice as likely** to have **attended A&E** within 6 months of delivery compared with White women (**11% compared with 5%**) and are **twice as likely** to have been admitted to hospital over the same time frame (**4% compared with 2%**)

Figure 4: % of pregnant women with an admission within 6 months of delivery - by ethnicity and borough (2020/21)

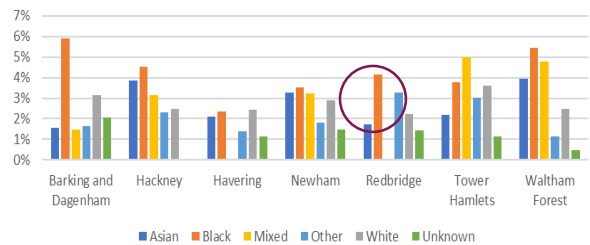
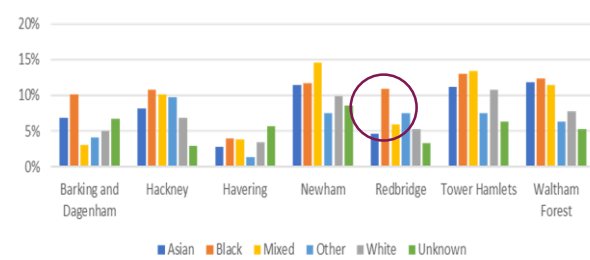


Figure 10: % of pregnant women with an A&E attendance within 6 months of delivery – by ethnicity and borough (2020/21)



- Black women are much more likely to be **obese** than White women (**34%** compared with **21%**).
- Black women are **twice as likely** and Asian women are **three times more likely** to have **diabetes** than White women.

Chart 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21

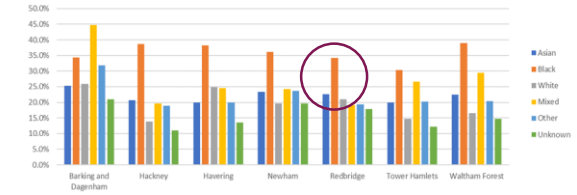


Chart 2 | % of pregnant women with hypertension | rates by borough and ethnicity | 2020-21

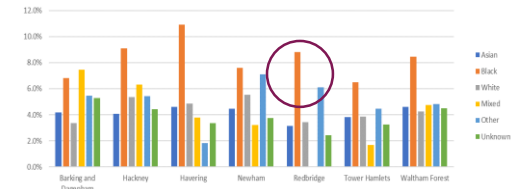
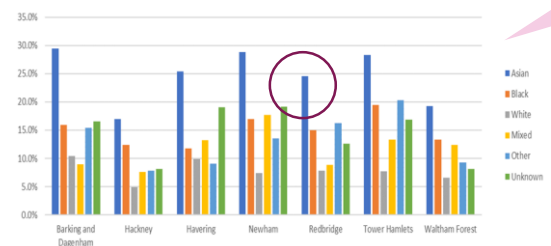


Chart 2 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21



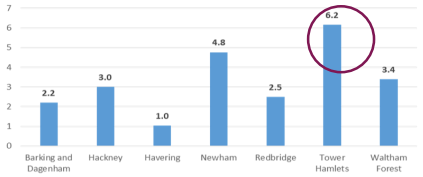
- Black women are also more than twice as likely than White women to have hypertension (**9%** compared with **3%**)

4.2 Key findings – Tower Hamlets

- **4,166** births in 20/21 (16% of total NEL births)
- **61%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**



Figure 23: Rate per 1000 of babies born stillbirth – by borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black and Asian women are **concentrated** (and has the highest overall rate in NEL at **6.2 per 1000**)
- This rate is based mainly by stillbirths to White women and those Unknown ethnicity – who have a **very high rate at 12 per 1000** births

Figure 21: Rate per 1000 of babies born stillbirth – by ethnicity and borough (2020/21)

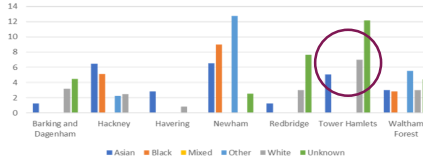
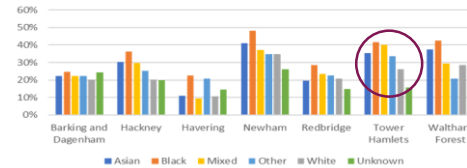
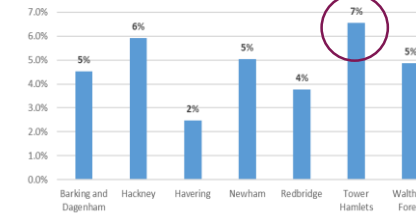


Figure 3: % of pregnant women with an A&E attendance during pregnancy - by ethnicity and borough (2020/21)



- It has the **second highest** average rate of women attending A&E during their pregnancy
- It has one of the largest differences in rates between Black and Mixed women compared with White women (**42%, 40%** compared with **25%**)

Figure 9: % of pregnant women with an A&E attendance within 6 weeks - by borough (2020/21)



- It has the **highest** average rate across NEL of women attending A&E within 6 weeks as well as 6 months after delivery (**7%** and **10%**)
- Asian and Mixed women tend to have higher rates of within 6 week attendances compared with White women

Figure 7: % of pregnant women with an A&E attendance within 6 weeks of delivery – by ethnicity and borough (2020/21)

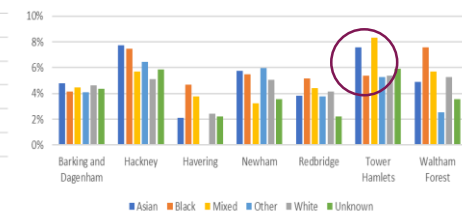
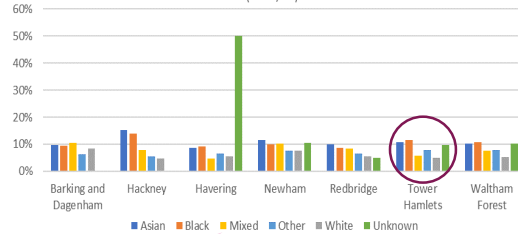


Figure 8: % of babies born with low birth weight – by ethnicity and borough (2020/21)



- Babies born to Black and Asian women are **twice as likely** to have a low birth weight than those born to White women (**12%** and **11%** versus **5%**)

Chart 2 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21



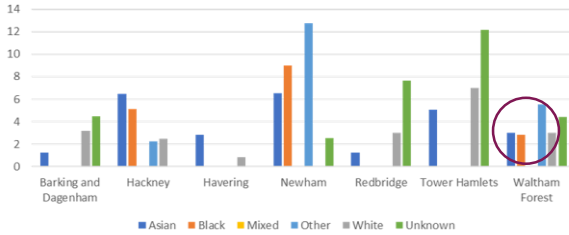
- It has the highest average rate across NEL of diabetes prevalence (**21%**)
- It also has one of the largest differences in rates between Asian and Black women compared with White women (**28%** and **17%** compared with **7%**)

4.2 Key findings – Waltham Forest

- 4,100 births in 20/21 (16% of total NEL births)
- 39% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 32 years

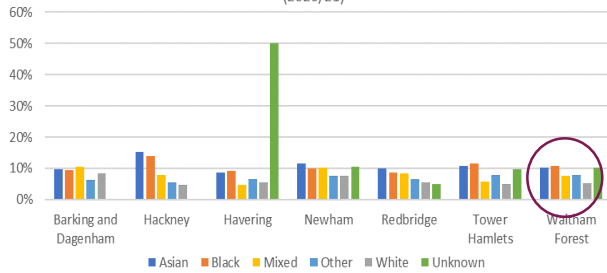


Figure 21: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black, Asian and Other women are **concentrated** (and has 3.4 per 1000 across all ethnicities)
- It has one the largest disparities in low birth weight – with the rates for Asian and Black women twice as high as for White women (10% and 11% compared with 5%)

Figure 8: % of babies born with low birth weight – by ethnicity and borough (2020/21)



- Black, Asian and Mixed women are **more likely** to have **attended A&E** within 6 months of delivery compared with White women (12%, 12% and 11% compared with 8%) and are also **more likely** to have been admitted to hospital over the same time frame (5%, 4% and 5% compared with 2%)

Figure 10: % of pregnant women with an A&E attendance within 6 months of delivery – by ethnicity and borough (2020/21)

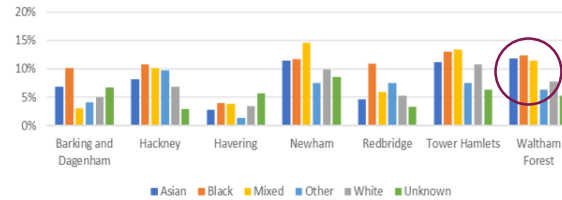


Figure 4: % of pregnant women with an admission within 6 months of delivery - by ethnicity and borough (2020/21)

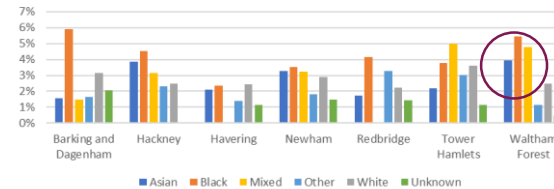
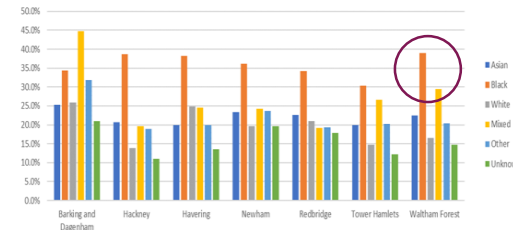
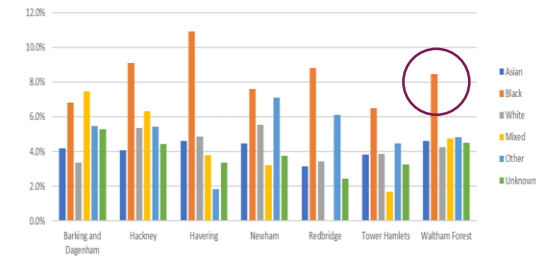


Chart 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21



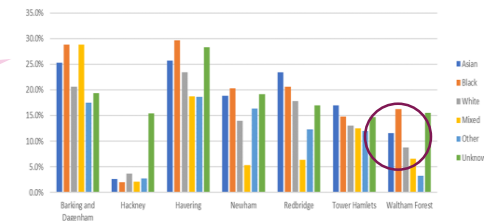
- Black and Mixed pregnant women are **more likely** to be obese than White women (39%, 29% compared with 16%) and Black women are twice as likely as White women to have hypertension (8% compared with 4%)

Chart 2 | % of pregnant women with hypertension | rates by borough and ethnicity | 2020-21



- Black women are near **twice as likely** than White women to have an unplanned C-section (15% compared with 8%)

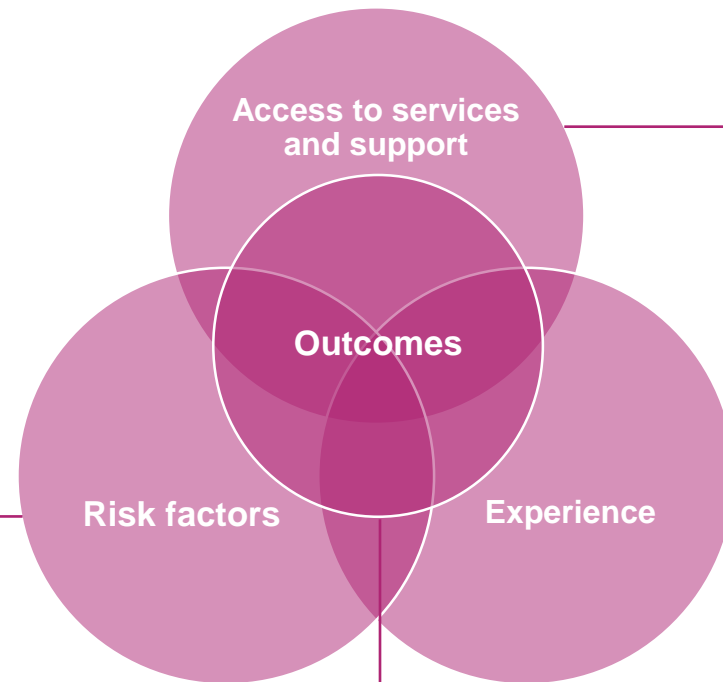
Chart 2 | % of unplanned C section deliveries | rates by borough and ethnicity | 2020-21



4.3 Key indicators not covered in this analysis

As this analysis is an **initial** assessment of inequalities for women and babies using data that is (readily) available in the time frame given for this analysis. There are a number of metrics (examples listed here) that have not been included but should be considered as part of any further more comprehensive/in-depth analysis.

Further work would be needed to assess the current availability and quality of data on these indicators and the feasibility of collection by system partners.



- DNA rate of hospital appointments
- Ultrasound bookings and DNA rates
- Enrolment on LTC related management programmes
- Usage of postnatal mental health services
- Post-natal home health visits
- Referrals to hospital by GPs
- Rates of GP registration
- Rates of GP appointments

- Smoking rates
- Rates of substance abuse
- Prevalence of co-morbidities
- Prevalence of diabetes by type
- Prevalence of significant mental health issues (SMI)

- Premature labour
- Rate of babies born with a disability
- Neonatal mortality (1st year of life)
- Maternal mortality
- Rate of admission to ITU post delivery
- Postnatal depression diagnosis

- Survey data from women by ethnicity on lived experience of health care services – pre and post natal
 - Access to interpreters
 - Cultural sensitivity
 - Listening to preferences and concerns

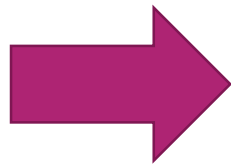
Annex 1 – Demographic profile of women in NEL accessing Maternity services

Key notes and data caveats

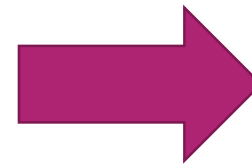
- Unless otherwise specified, the data has been sourced from **Secondary Uses Services (SUS)** and refer to the financial year **20/21**
- The population we have extracted from SUS - on which this demographic profile is based - includes **all** women who had **contact with Maternity services in 20/21 regardless of whether they went on to become pregnant or give birth.**
- This means that the population considered here is **much broader** than the population of pregnant women that went on to give birth in 20/21 (i.e. the population of women on which our initial analysis of inequalities is based).
- It does, however, provide a helpful and boarder view of the number and profile women **overall** in NEL accessing these services. Further, this population will also account for pregnant women that used these services who may have gone on to have a miscarriage or a termination (and who therefore will not have been included the population sample for our inequalities analysis).
- Overall, **c.15%** of the NEL women included in our demographic profile did not have an ethnicity in their record (when extracted from SUS) and we have no way of estimating whether the distribution of this 15% are skewed towards a particular ethnicity. If they are however, this could skew the findings presented in this report so the analysis should be treated with some caution.

Size and distribution of the women making contact with NEL Maternity services in 20/21

Total of 61,215 women in NEL made contact with these NEL Maternity services in 20/21⁽¹⁾

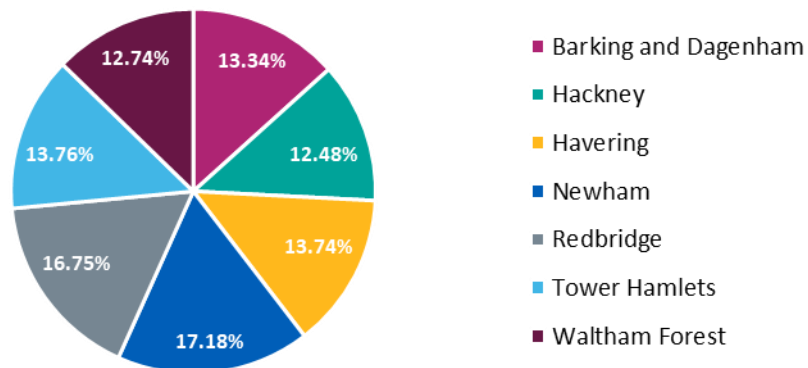


25,950 (42%) of these women went on to give birth in the same year⁽²⁾

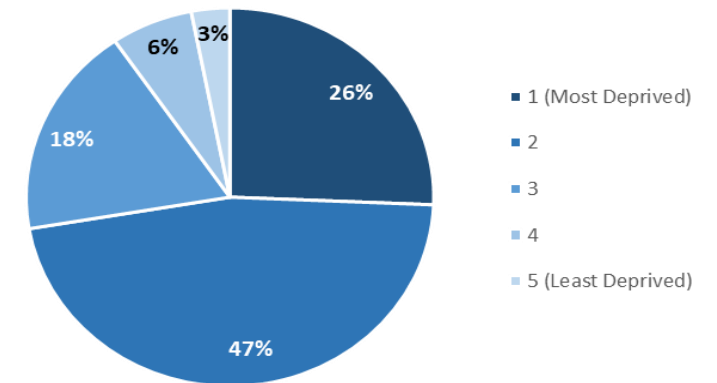


72% of those babies were born to women in two most deprived quintiles

% of women by borough who made contact with maternity services in NEL (2020/21)



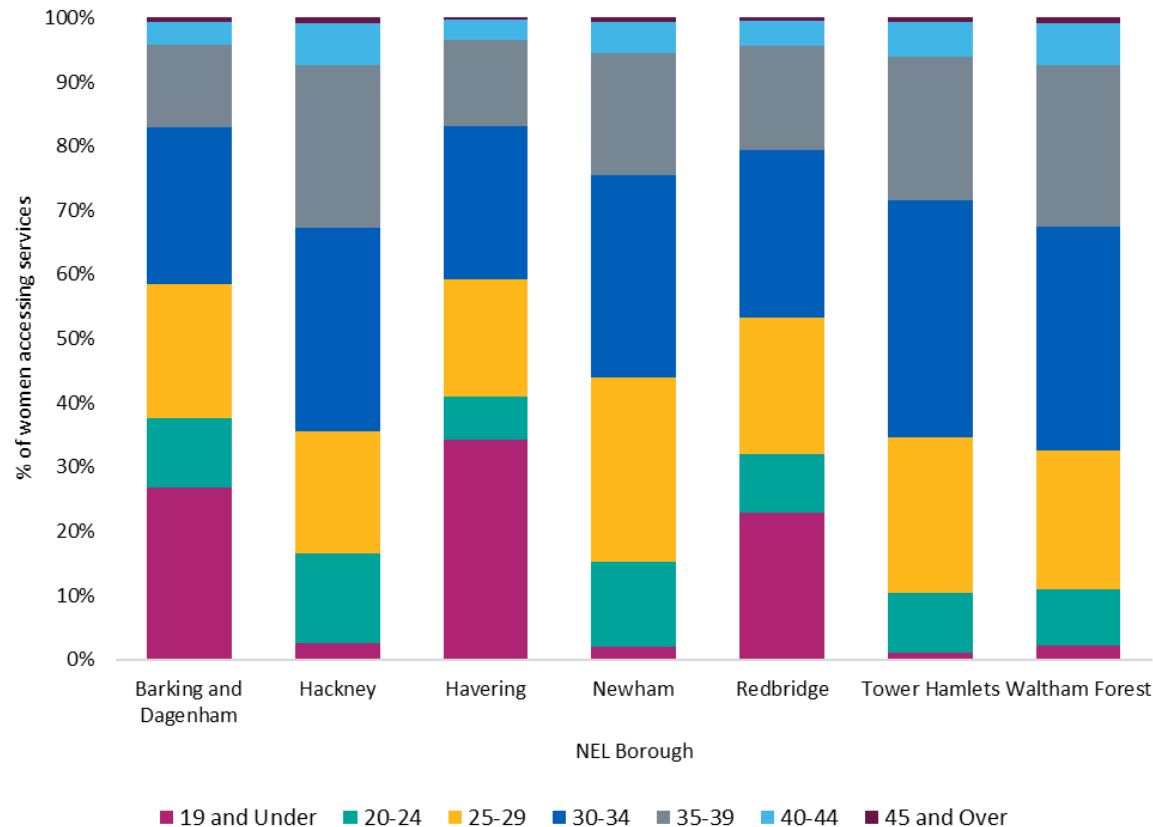
% of babies born by deprivation quintile in NEL (2020/21)



(1)Source: Secondary Uses Services, (2)Source: Hospital Episodes Statistics

Age profile of women accessing Maternity services

Figure 1: Breakdown (%) of all women accessing Maternity services by age (20/21)



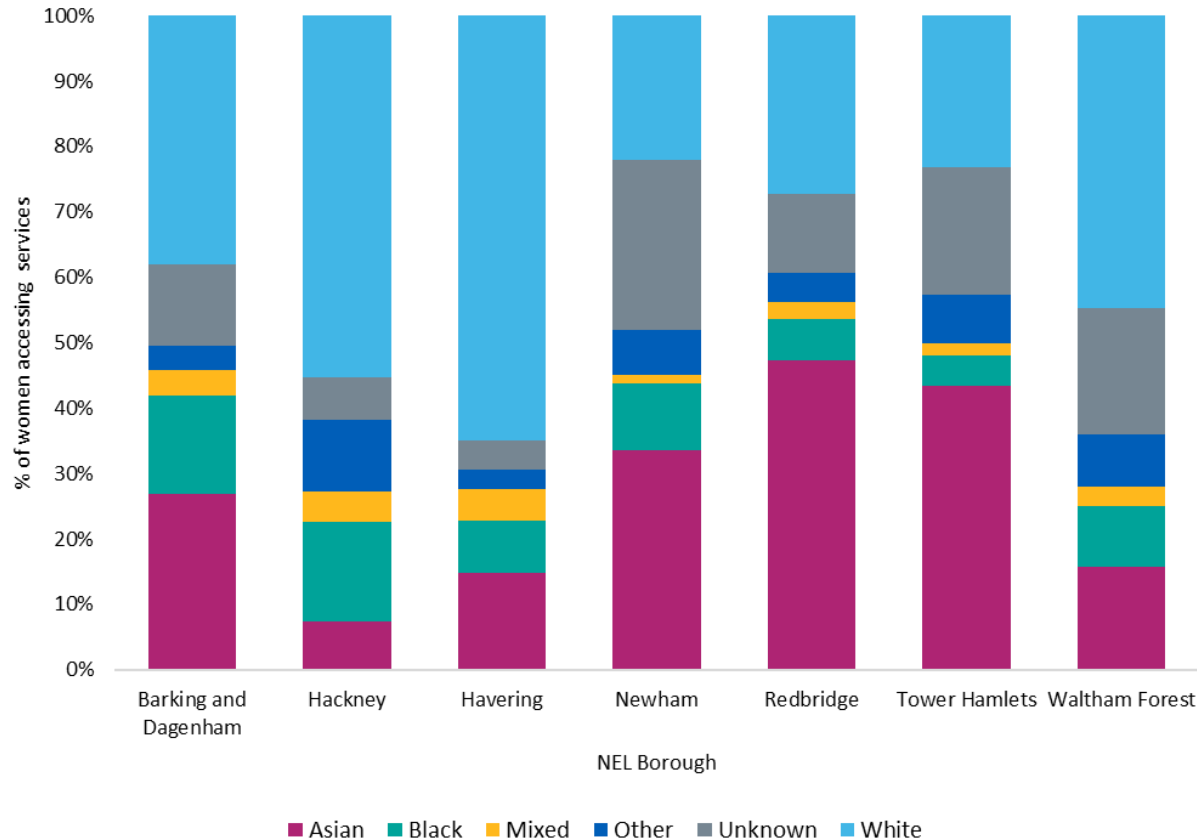
Key findings:

- The average proportion across NEL of women aged 19 or under that accessed these services is **13%** compared with **10%** for those aged 20-24, **22%** for those aged 25-29, and **55%** for those aged 30 and above.
- These NEL averages do, however, mask relatively large differences at the borough level. Variations in age vary most in relation to the proportion of women aged 19 or under. The population accessing these services in Barking and Dagenham, Havering and Redbridge is much younger than in other NEL boroughs. In Havering, for nearly **35%** of the women are aged 19 and under and in Barking and Dagenham this rate is **27%**. This is a stark difference to other NEL boroughs, where the proportion is less than **5%**.
- In contrast, the profile of women in Tower Hamlets, Waltham Forest and Hackney are much older with between **65-68%** of women over 30 compared with the **41-56%** across the other boroughs.

Source: Data from SUS

Ethnicity profile of women accessing Maternity services

Figure 2: Breakdown (%) of all women accessing Maternity services by ethnicity (20/21)



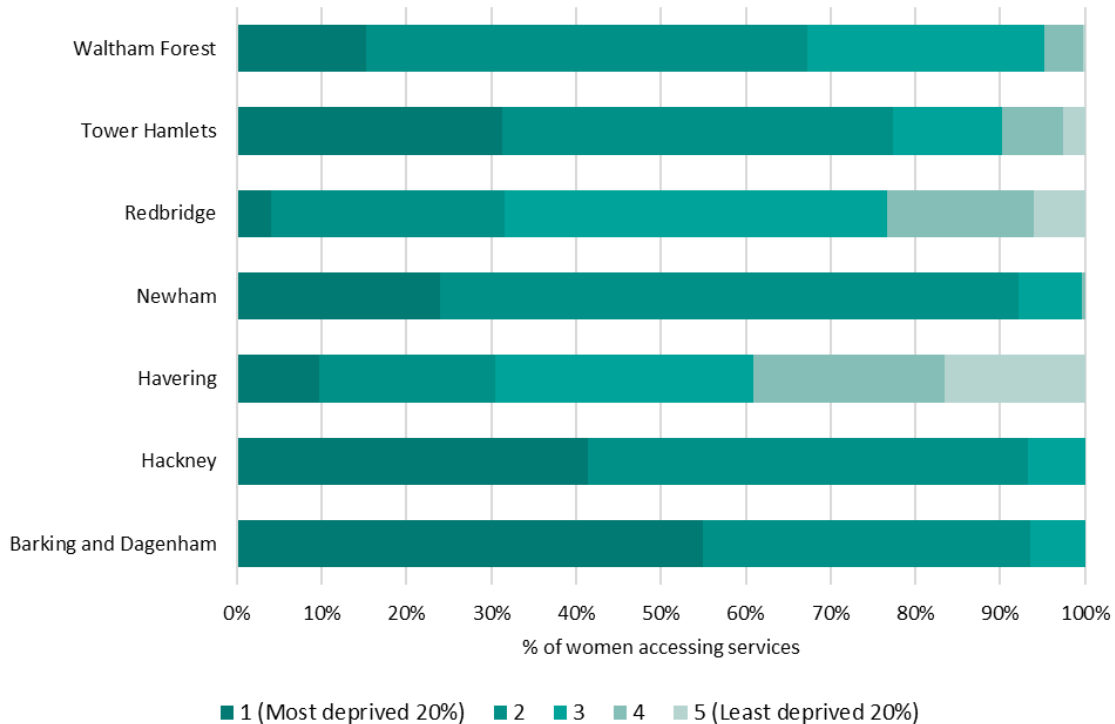
Source: Data from SUS

Key findings:

- On average across NEL, just under half (**47%**) of women accessing these services were of Asian, Black, Mixed or Other background.
- As with age, NEL averages do, however, mask relatively large differences at the borough level. Newham, Redbridge and Tower Hamlets have the most diverse populations with , Black, Asian, Mixed and Other women, accounting for between **52-61%** of population of women accessing these services compared with **31%** in Havering and **36%** in Waltham Forest.
- Both these latter boroughs have the highest proportion of White women **65%** and **45%** respectively.
- With the exception of Hackney – in which Black women make up the majority of the BME population (i.e. **15%** out of the overall **38%** BME proportion of this specific population) - Asian women tend to represent the largest proportion of the BME population compared with either Black or women of Mixed ethnicity.
- Tower Hamlets and Redbridge have particularly high proportion of Asian women (**43%** and **47%** respectively) compared with the other NEL boroughs where less than a **quarter (25%)** are in this group.
- Newham has the smallest proportion of this population with White ethnicity at **22%** and Redbridge has the largest Asian proportion across NEL at just under half (**48%**).

Deprivation profile of women accessing Maternity services

Figure 3: Breakdown (%) of all women accessing Maternity services by deprivation - IMD quintile (20/21)



Key findings:

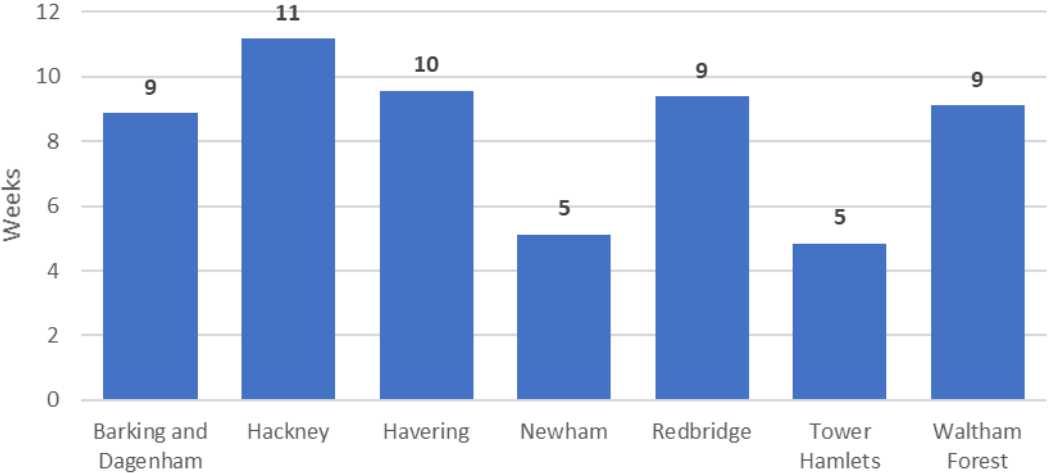
- Overall, the population of women in NEL accessing this services is **highly skewed** towards the most deprived quintiles with an average of **67%** of women living in areas in the two most deprived quintiles.
- As with both age and ethnicity, however, this masks a lot of variation at the borough level, with over **half** of the women in this population in Barking and Dagenham living in the most deprived quintile compared with **under 5%** in Redbridge and **10%** in Havering. These two boroughs also have the highest proportion of women living in areas that are in the two least deprived quintiles (**23%** and **39%** respectively).
- Further, neither Barking and Dagenham, Newham nor Hackney, include within them any LOSAs in the two least deprived quintiles (i.e. 4 and 5) which suggests the populations in these boroughs are particularly deprived relative to the other boroughs. It does not imply, however, that there are no women in these boroughs in higher income groups.
- There do not appear to be any other obvious similarities however between these two areas in relation to their age and ethnic profiles.

Source: Data from SUS

Annex 2 – Access and usage of healthcare services during pregnancy

Gestational age at first contact with NHS services

Figure 1: Average gestational age at first contact – by borough (2020/21)



Key findings

- Across NEL, women tend on average to first present at before 12 weeks, with 9-10 weeks being the range for four of the seven boroughs. Of the other three boroughs, women in Newham and Tower Hamlets tend to present a lot sooner than the other boroughs across NEL (5 weeks). In contrast, women in Hackney tend to present a lot later than in the other boroughs at 11 weeks gestational age.
- On average across NEL, women of Mixed (11 weeks), Black (11 weeks) and Other (10 weeks) ethnicity made first contact around 2 weeks later into their pregnancy than White women (8 weeks). Asian ethnicities had the earliest average gestational age at first contact at around 7 weeks.
- At borough level, Newham and Tower Hamlets appear to have the largest disparity between ethnic minorities (excluding Asian ethnicities) and White women (and as above, are also the two boroughs with the youngest average gestational age at first contact). In Newham, for example, the average gestational age at first contact was more than twice as high for Black and Mixed ethnicities than White ethnicities (i.e. 9, 10 and 4 weeks respectively). In Tower hamlets, Black and Mixed women made first contact between 3 - 4 weeks later than White women and between 6-7 weeks later than Asian women..
- While White ethnicities in the other boroughs also tended to have the lowest average gestational ages at first contact compared with all other ethnicities, the differences – while potentially material – are not as stark as above.
- Across NEL, women in the most deprived quintile (8 weeks) first made contact on average around a week earlier than women in the least deprived quintile (9 weeks). At the borough level, however, the picture is more mixed.
- Interestingly, the average gestational age at first contact for the most deprived pregnant women in Tower Hamlets (3 weeks) was at least 2 times earlier than in Newham (7 weeks) and Barking & Dagenham (8 weeks), and at least 3 times earlier than the rest of the boroughs. Further, the difference between women in the most and least deprived areas (i.e. 3 weeks versus 11 weeks) is much larger within Tower Hamlets than observed within all the other boroughs.

Figure 2: Average gestational age at first contact – by ethnicity and borough (2020/21)

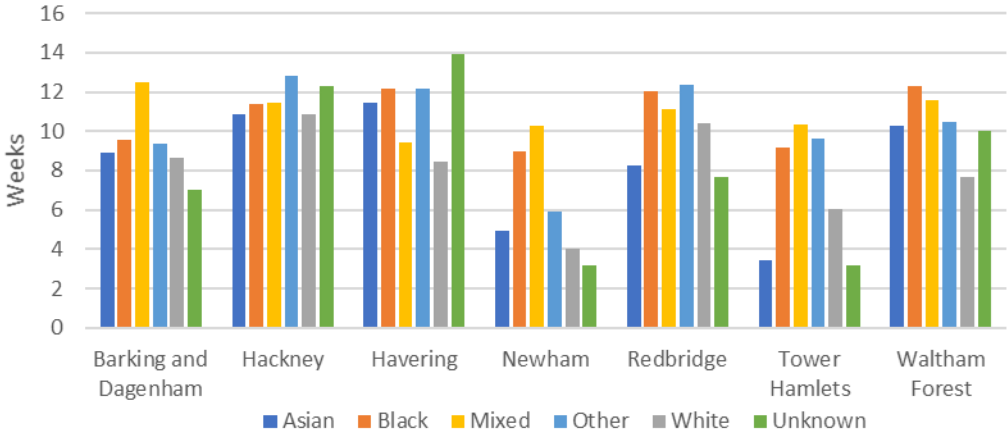
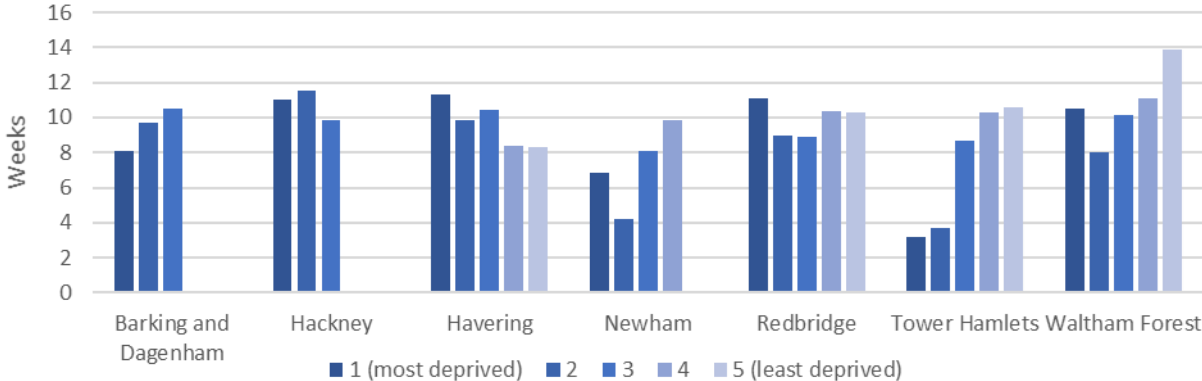
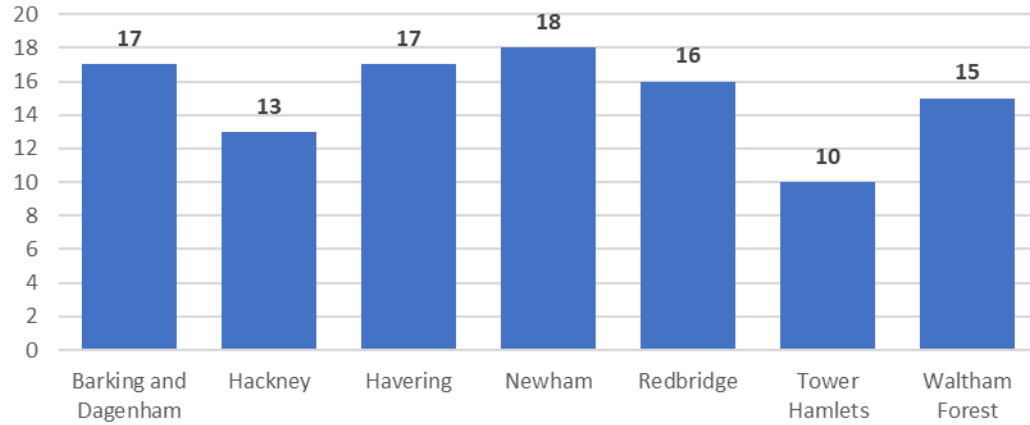


Figure 3: Average gestational age at first contact – by deprivation and borough (2020/21)



Outpatient appointments during pregnancy

Figure 4: Median no. of outpatient appointments during pregnancy - by borough (2020/21)



Key findings

- Across the NEL boroughs, the average number of outpatient appointments per woman that gave birth in 2021 was **15**, with no large variations observed at the borough level. The main outlier is Tower Hamlets in which the average number per woman is **10** compared with **15-18** across the other boroughs.
- There also appears to be relatively little variation within boroughs across ethnicity and therefore does not suggest any significant inequalities at this level.
- Similar to the findings on ethnicity, there does not appear to be a significant variation by deprivation status and where there is variation, this tends to be larger across than within boroughs.
- Of the boroughs, Newham had the largest variation between both ethnicities and deprivation quintiles. Women in the **most deprived** quintile had on average **19** outpatient appointments compared with **15** in the **least deprived** quintile. Similarly, Black and Asian women in Newham had **19** outpatient appointments compared with **17** for White women and **15** for Mixed ethnicities.

Figure 5: Median no. of outpatient appointments during pregnancy - by ethnicity and borough (2020/21)

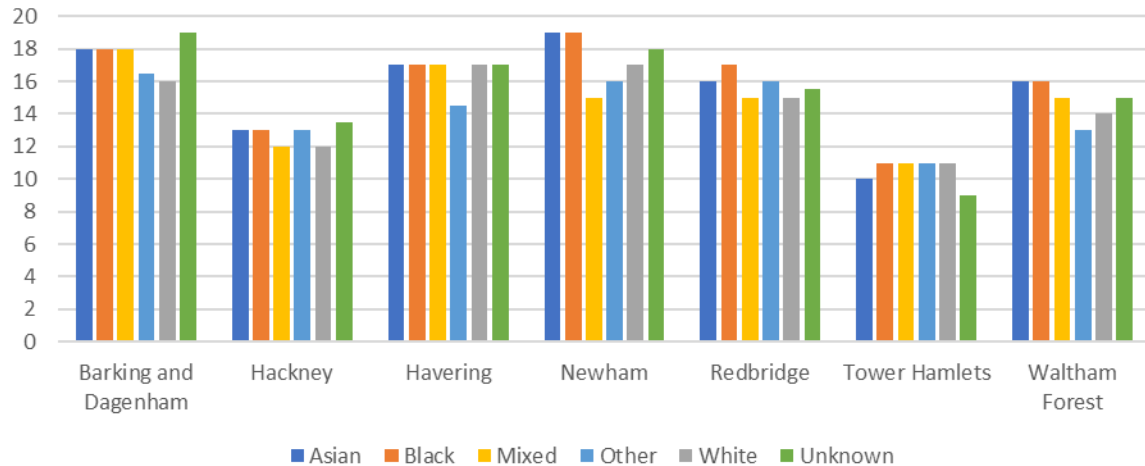
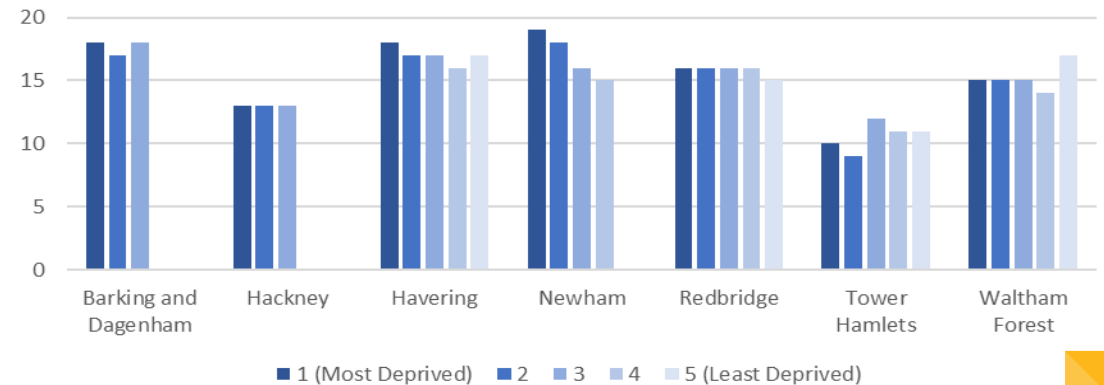


Figure 6: Median no. of outpatient appointments during pregnancy - by deprivation and borough (2020/21)



A&E attendances during pregnancy

Figure 7: % of pregnant women with an A&E attendance during pregnancy - by borough (2020/21)

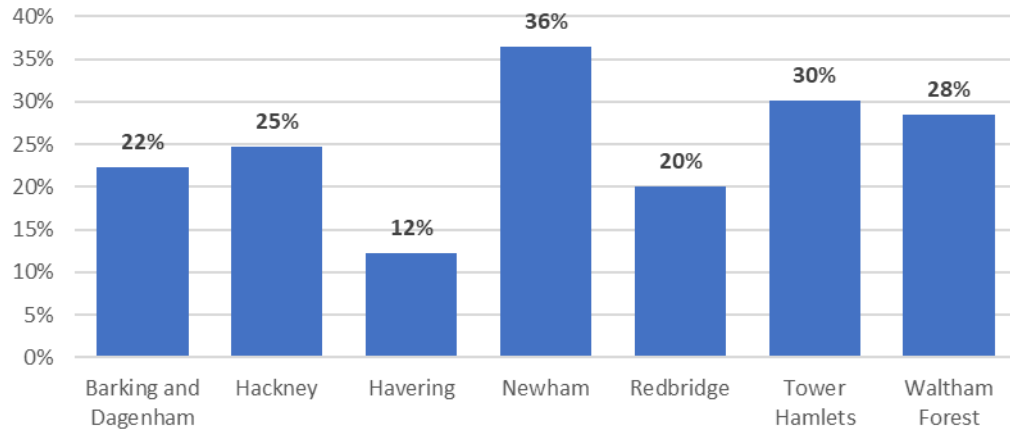
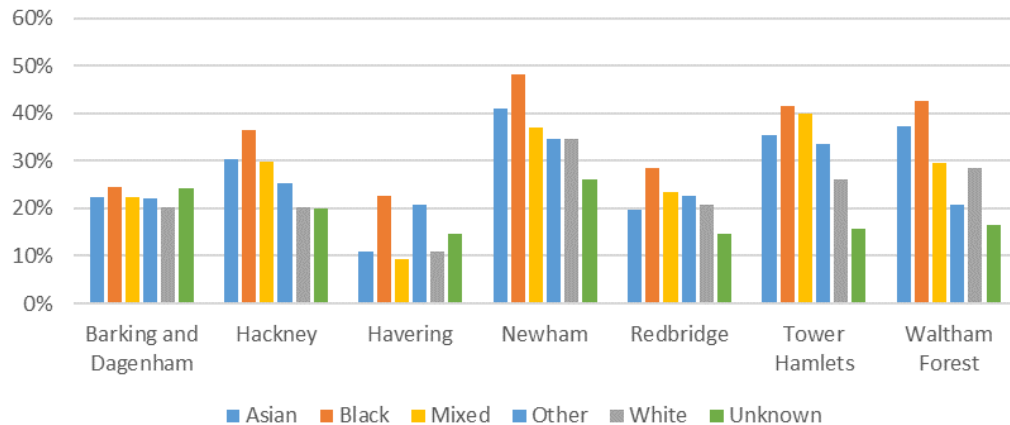


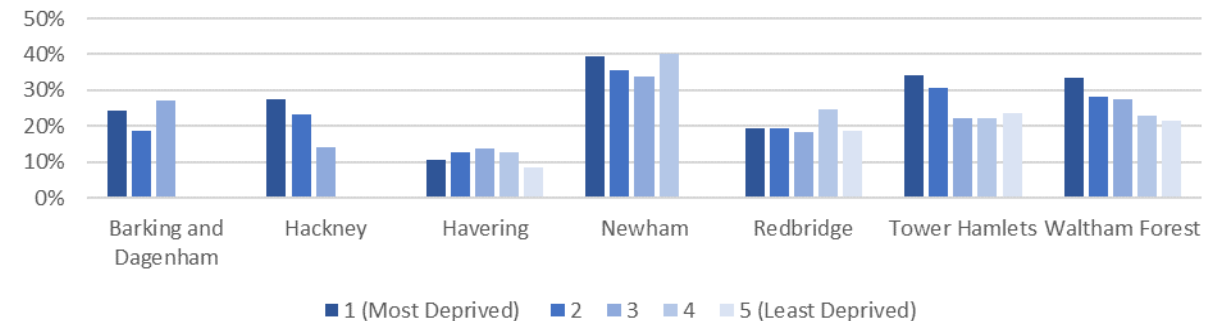
Figure 8: % of pregnant women with an A&E attendance during pregnancy - by ethnicity and borough (2020/21)



Key findings

- On average across NEL, **27%** of the women that gave birth in 2021 were admitted to A&E **at least once** during their pregnancy. There are, however, two notable outliers – i.e. Newham, who has the largest proportion of women attending A&E attendance (**36%**) and Havering with the lowest at **12%**.
- On average across NEL, Black women and Asian women tend to be **more likely** to have attended A&E during their pregnancy than White women with rates among these groups at **38%**, **31%** and **23%** respectively. This pattern is consistent at the borough level, with Black women having the **highest percentage** of women with an A&E attendance during pregnancy in all 7 NEL boroughs.
- The differences between rates among Black and White women are largest in Tower Hamlets and Newham. In Tower Hamlets, for example, the rates for these same two ethnicities are **42%** compared with **35%** and in Newham are **48%** compared with **37%**. Similarly, in Havering the rate among Black women (**23%**) is **more than twice** that for White women (**11%**).
- Barking and Dagenham and Redbridge appear to be the two main exceptions, with the differences across ethnicities within these boroughs much smaller than compared to those within the others.
- A clear trend exists between deprivation and A&E attendances across NEL, the proportion of women with an A&E attendance in the most deprived quintile (**30%**) **was double the proportion** for the least deprived quintile (**15%**)
- Focusing on boroughs, deprivation seems to be closely linked to A&E attendances across Hackney, Tower Hamlets and Waltham Forest as the most deprived quintiles have much higher percentages of women with an A&E attendance during pregnancy, compared to their least deprived quintiles (**28% vs 15%** for Hackney, **34% vs 24%** for Tower Hamlets, and **33% vs 21%** for Waltham Forest).

Figure 9: % of pregnant women with an A&E attendance during pregnancy - by deprivation and borough (2020/21)



Admissions to hospital during pregnancy

Figure 10: % of pregnant women with an admission during pregnancy - by borough (2020/21)

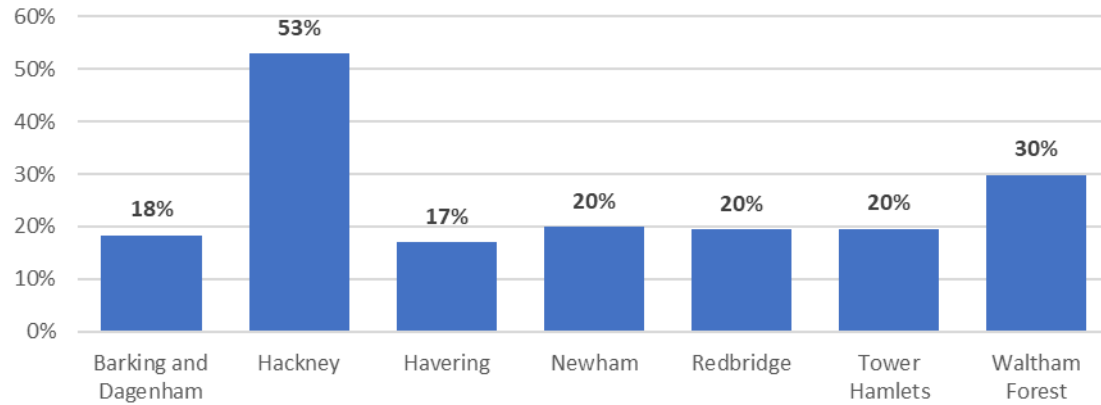
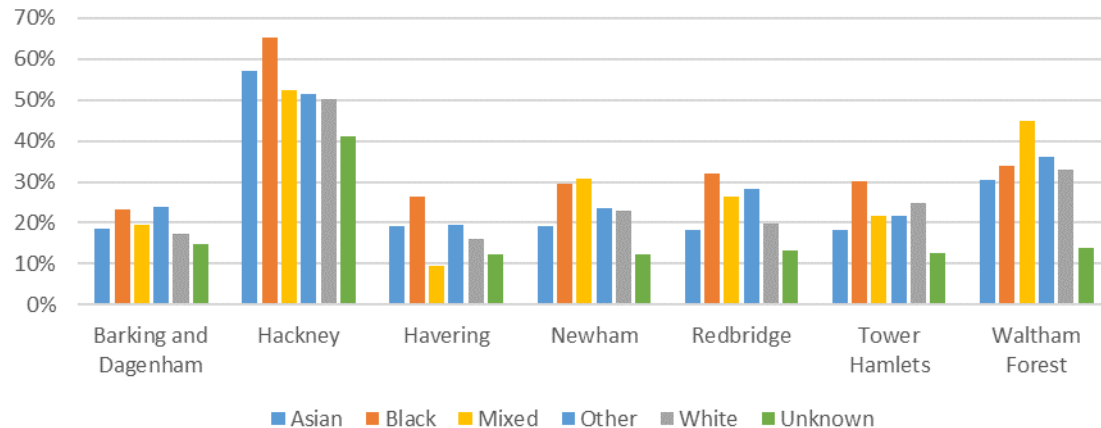


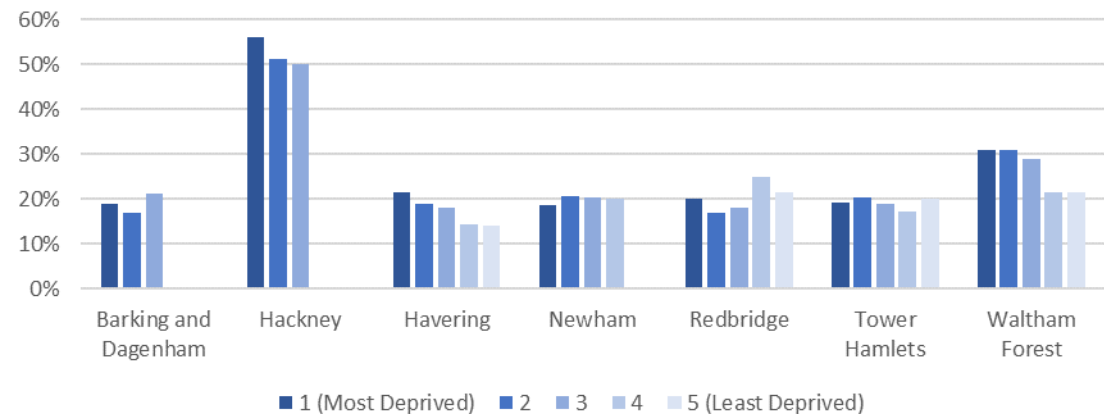
Figure 11: % of pregnant women with an admission during pregnancy - by ethnicity and borough (2020/21)



Key findings

- On average across NEL, **26%** of women that gave birth in 2021 had an admission to hospital during their pregnancy. The main outlier is Hackney at **53%** which is **more than double than** all other boroughs with the exception of Waltham Forest in which the rate is **30%** (and is also still higher than compared with the other five boroughs across whom rates are relatively similar at **18-20%**).
- When looking at differences in ethnicity in NEL, Black women (**38%**) had nearly double the percentage of women admitted to hospital compared to Asian women (**21%**) and **9%** more than White women (**29%**).
- With the exception of Waltham forest, Black women are more likely than White women to be admitted to hospital during their pregnancy across all of the boroughs. Hackney, as well as having the highest overall proportion of women with an admission, has the largest variation between ethnicities with **65%** of Black and **57%** of Asian women having an admission compared with **50%** for White women.
- When looking at differences in deprivation across NEL, the proportion of pregnant women with an admission decreases from the most deprived quintile (**29%**) to the least deprived quintile (**18%**).
- At the borough level, however, the correlation appears to be largest in Hackney, Havering and Waltham Forest – where the difference in rates across the two groups is larger compared with the other boroughs. Of these, Waltham Forest had the largest difference in rates between the most deprived quintiles and the least deprived (**31%** versus **21%**).

Figure 12: % of pregnant women with an admission during pregnancy - by deprivation and borough (2020/21)



Annex 3 – LTCs and other risk factors during pregnancy

Prevalence of obesity

Figure 1 | % of pregnant women with obesity | rates by Borough | 2020-21

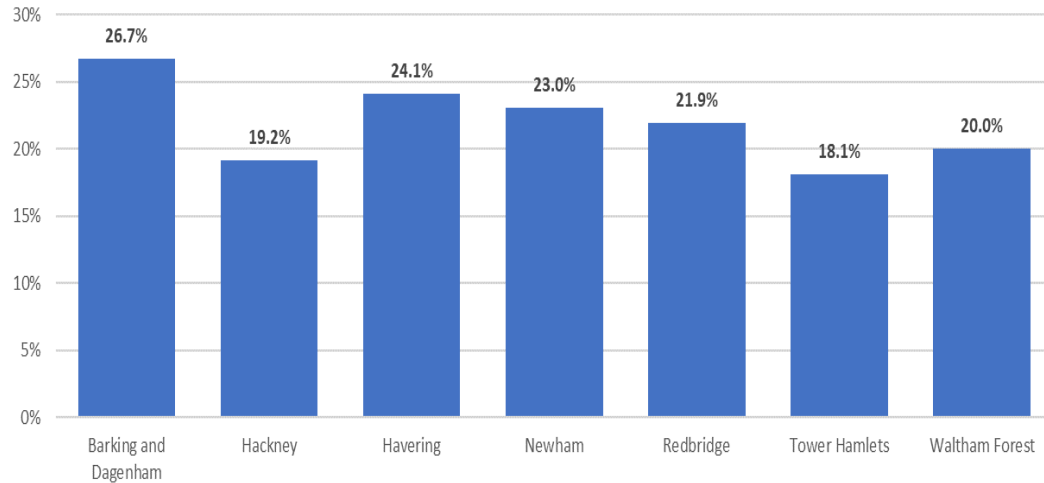


Figure 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21

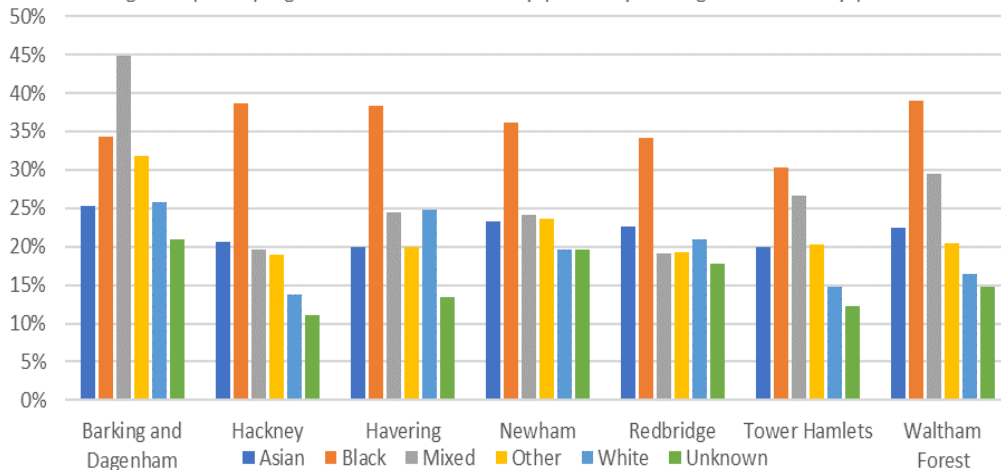
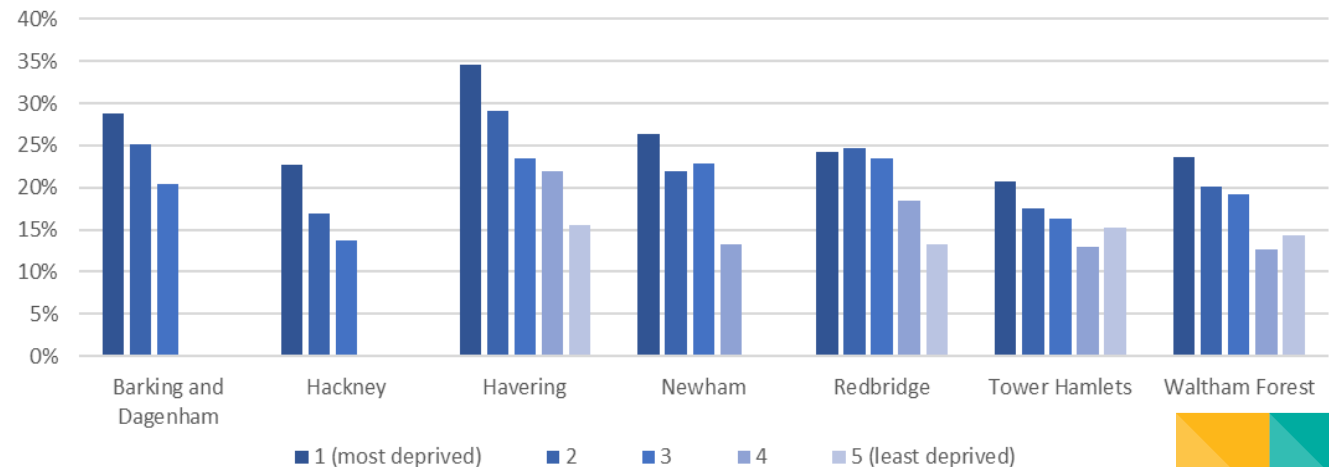


Figure 3 | % of pregnant women with obesity | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- Overall at the NEL level, around a **fifth** of women that gave birth in 2021 are classed as obese. Barking and Dagenham has the highest prevalence rate (**26.7%**) and Tower Hamlets the lowest (**18.1%**)
- On average across NEL, **36.4%** of Black women are obese, which is **twice as high** as the average across White women (**19%**). The difference between White, Asian and Mixed women are relatively less marked.
- At the borough level, Black women also have the highest rates of obesity across every NEL borough with the exception of women of **Mixed ethnicity** in Barking & Dagenham where the rate is as high as **45%**
- Deprivation appears to be a strongly correlated with obesity, with rates among the **most deprived** quintile at **25%** which is **far higher** than among those in least deprived which is **15%** on average. At the borough level, both Having and Newham have **the largest difference** between rates in the most and least deprived group. The difference in Having is **35% vs 16%** and in Newham it is **26% vs 13%**.

Prevalence of diabetes

Figure 4 | % of pregnant women with diabetes | rates by Borough | 2020-21

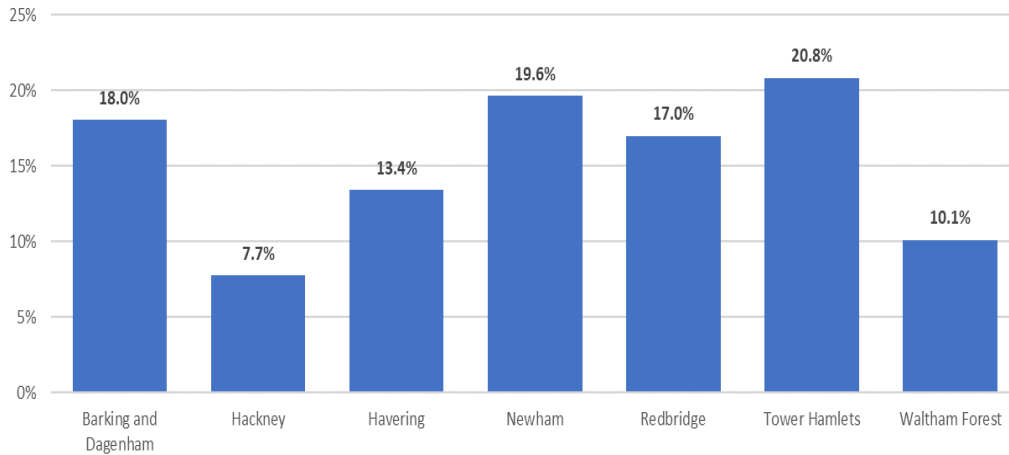
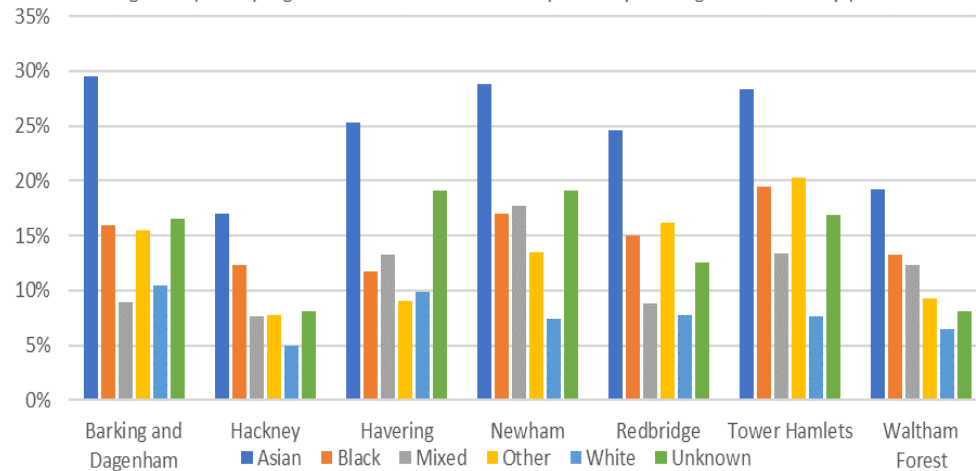


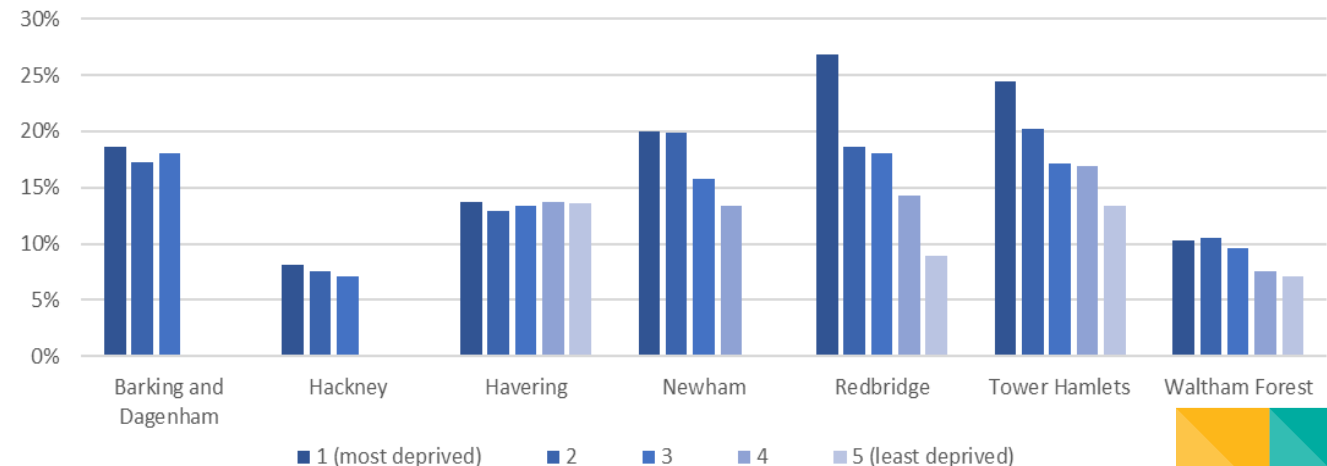
Figure 5 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21



Key findings

- This metric combines all diabetes types – i.e. T1, T2 and gestational diabetes
- There is a relatively wide variation in prevalence rates for diabetes across NEL boroughs among women that gave birth in 2021 - ranging from **around 20%** in Tower Hamlets and Newham to as low as **10%** in Waltham Forest and **8%** in Hackney.
- Overall across NEL, there is a large variation across ethnicities with prevalence rates among all ethnic minority groups **much higher than** those among White women. Rates among Asian and Black ethnicities - in particular- are **markedly higher** than for White women. Rates among Asian women are more than **three times higher** than rates among White women (i.e. **26%** compared with **7%**) and **twice as high** among Black women (**15%**).
- There is evidence that Asians may be more predisposed than other ethnicities to becoming diabetic which may – in part – explain this otherwise significant difference. However, the variation is sufficiently large to warrant further analysis .
- Variations between ethnicities looks to be highest within Newham and Tower Hamlets. Prevalence rates among Asian women in these two boroughs are **27-28%** compared with **17-19%** among Black women and **7%** among White women.
- **Deprivation also appears to be strongly correlated** with prevalence rates. Overall across NEL **17%** of women in the most deprived quintile have diabetes compared with **12%** in the least deprived.
- This correlation appears especially strong for Newham, Redbridge and Tower Hamlets where the prevalence rate is between **20-26%** among those in the **most deprived** groups compared with **7-13%** among the **least deprived**.

Figure 6 | % of pregnant women with diabetes | rates by Borough and Deprivation Quintile | 2020-21



Prevalence of epilepsy

Figure 7 | % of pregnant women with epilepsy | rates by Borough | 2020-21

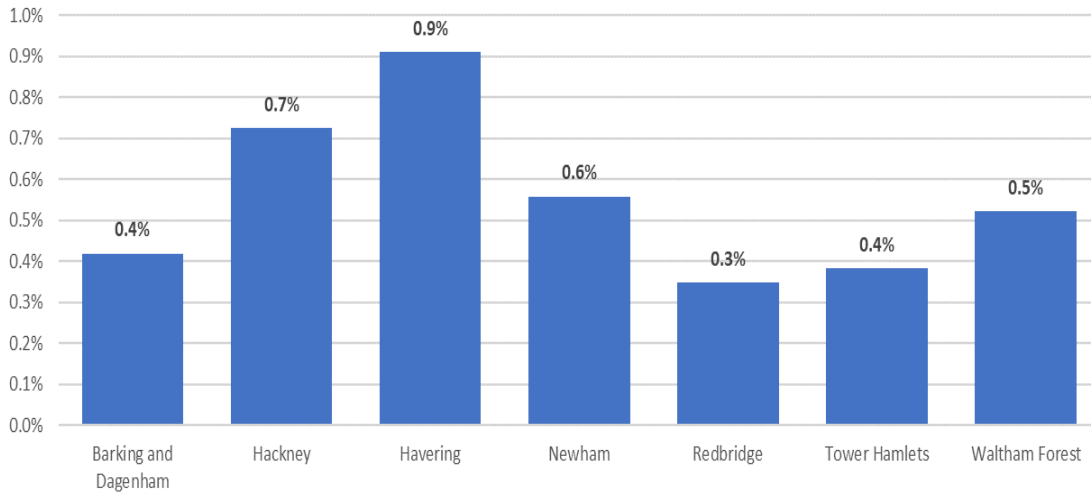
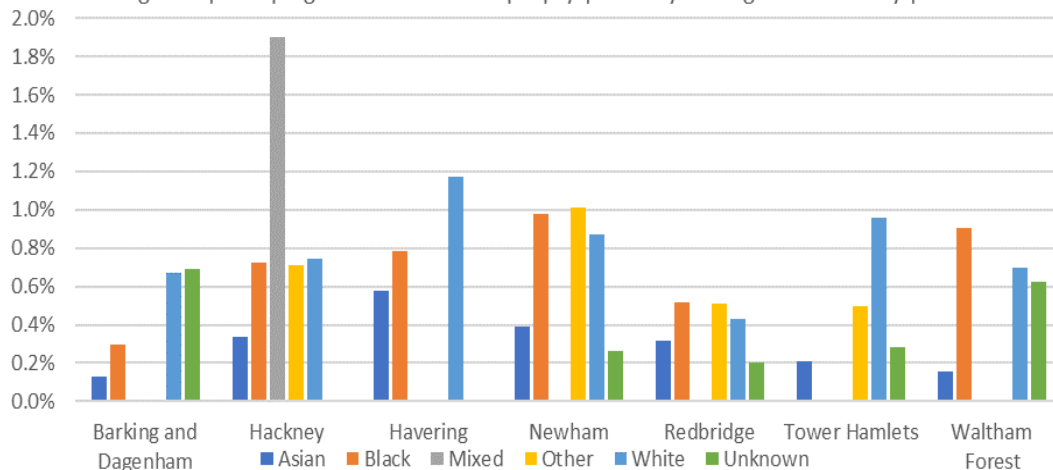


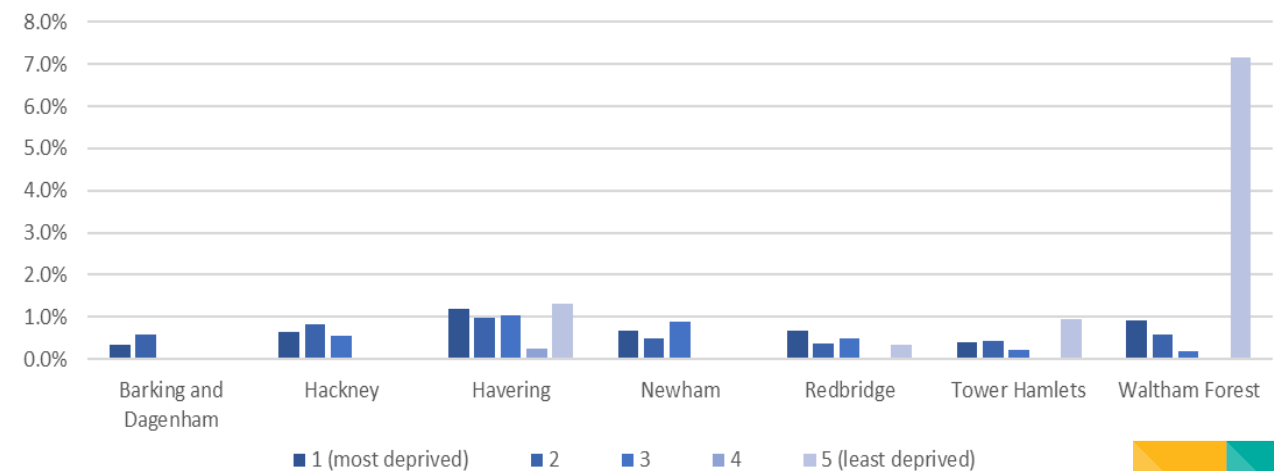
Figure 8 | % of pregnant women with epilepsy | rates by borough and ethnicity | 2020-21



Key findings

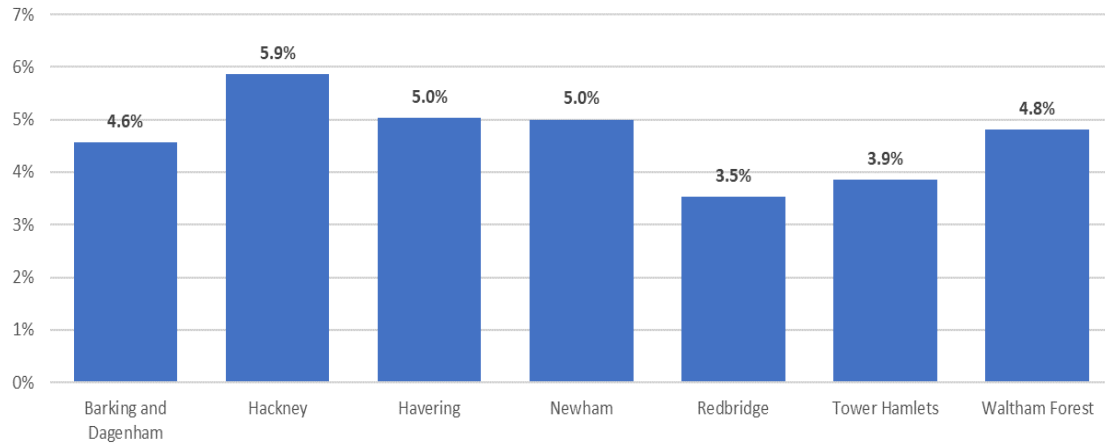
- On average across NEL, prevalence rates among women that gave birth in 2021 are very low across all NEL boroughs - at less than **1%**. There is, however, large variation at the borough level with Havering and Hackney with the highest rates at **0.9%** and **0.7%** respectively which is over **twice the rate** in other boroughs including Redbridge and Tower Hamlets.
- Overall, prevalence across Asian, Black and White women are **very similar** with rates among White slightly higher (**0.5%**, **0.5%** and **0.6%** respectively) and unlikely to be statistically significant.
- Only Hackney appears to have women of Mixed ethnicity with epilepsy giving birth that year and this group also has the highest recorded rate at the borough level at **1.9%**.
- Deprivation appears to have a stronger relationship with prevalence rates with rates among women in the **least deprived areas six times higher** than those in the least deprived (i.e. **0.6%** versus **0.1%**).
- The relatively small overall numbers for this indicator means the above findings should be treated with caution because a small degree of 'random' variation in the data can have a disproportionate impact on the observed finding/trend.**

Figure 9 | % of pregnant women with epilepsy | rates by Borough and Deprivation Quintile | 2020-21



Prevalence of hypertension

Figure 10 | % of pregnant women with hypertension | rates by Borough | 2020-21



Key findings

- On average, the rate of hypertension across the majority boroughs is around **5%**. **Hackney** has highest prevalence (**6%**) and **Redbridge** lowest (**3.5%**)
- Across NEL, the prevalence rate among Black women is **higher** compared with all other ethnicities. On average **8%** of Black women that gave birth in 2021 have hypertension compared with **5%** among White women. This disparity is a trend across all 7 NEL boroughs. In Havering, the prevalence among Black women is by far the highest at **11%** and is **more than double the rate** among White women (**5%**)
- In contrast, the average rates at the NEL level among women in other ethnic minority groups are **relatively similar** with those among White women (i.e. **4-5%** compared with **5%**).
- On average across NEL deprivation does not appear to be strongly correlated with prevalence rates – with the average prevalence at **4-5%** of women across all quintiles. However, the **very high prevalence** rate among women in Waltham Forest living in the least deprived areas (**at 11%**) is skewing this average as for some boroughs the data does suggest high levels of deprivation may be a key factor. Havering, for example, has the largest variation – with **10%** of women in the most deprived having epilepsy compared with **6%** in the least deprived areas. Similarly, in Redbridge the rate drops from **4%** in the most deprived areas to **1.7%** in the least.

Figure 11 | % of pregnant women with hypertension | rates by borough and ethnicity | 2020-21

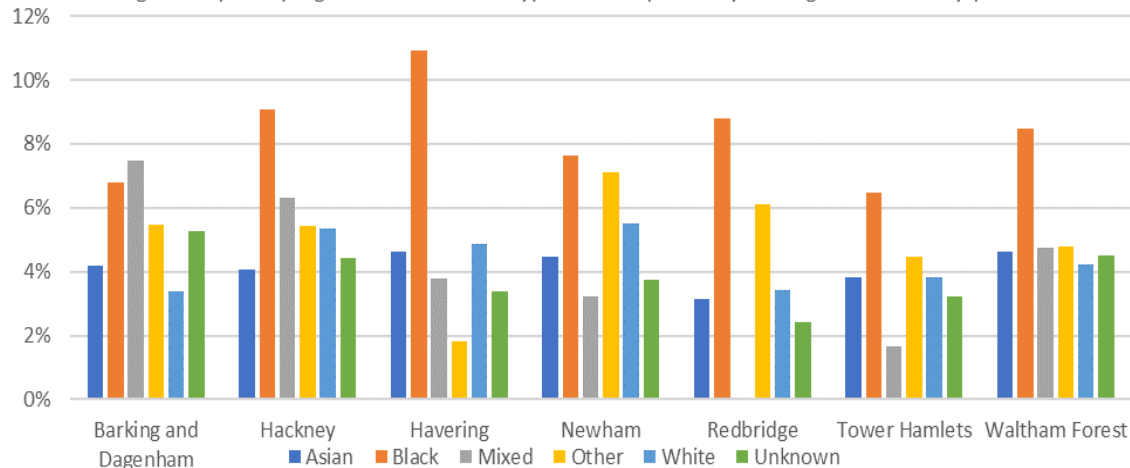
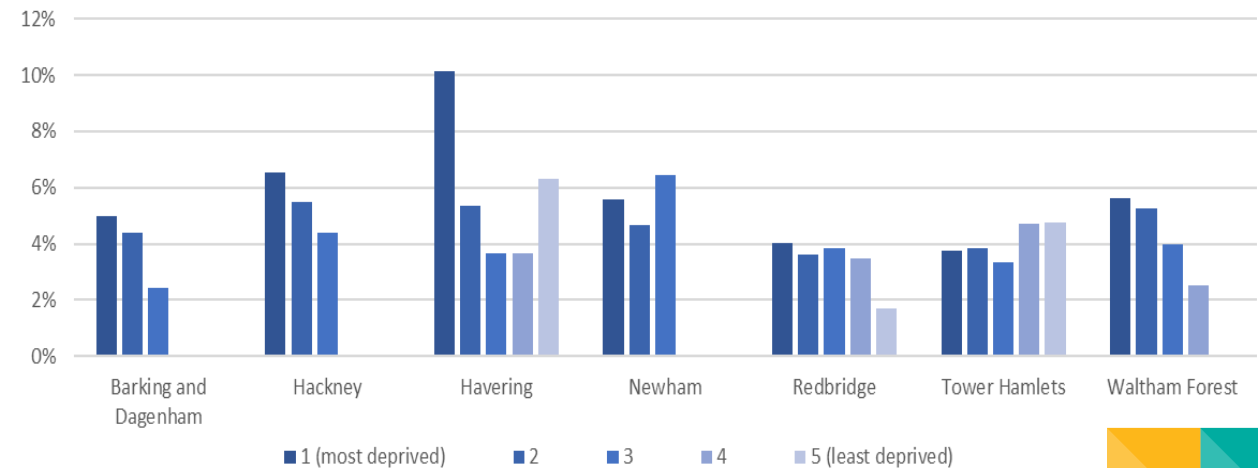
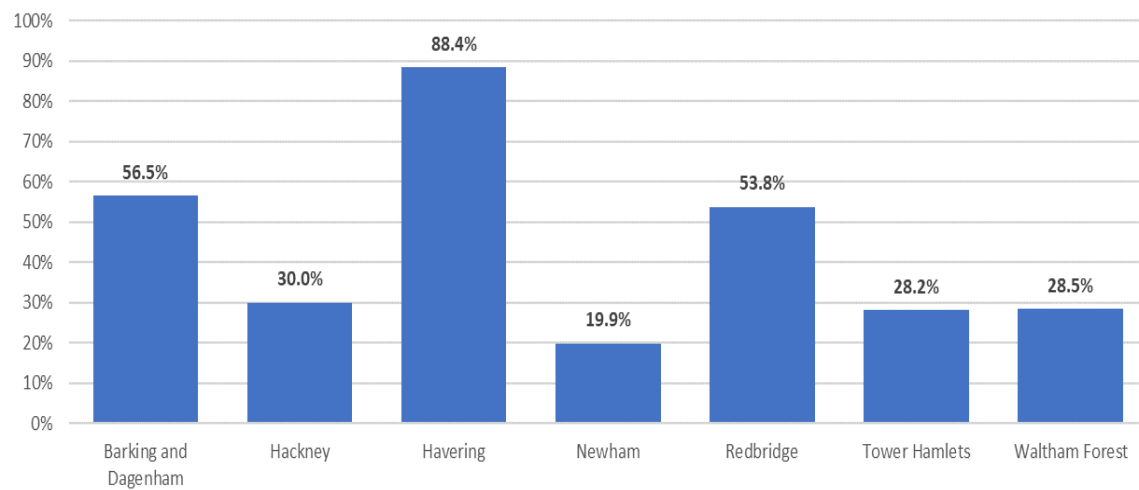


Figure 12 | % of pregnant women with hypertension | rates by Borough and Deprivation Quintile | 2020-21



Folic acid status

Figure 13 | Folic acid status | rates by Borough | 2020-21



Key findings

- This relates to the prevalence of women that are known to have been taking Folic acid supplements in early pregnancy.
- Overall, there is a lot of variation across NEL boroughs. The proportion of women with a (good) folic acid status is highest in Havering at **88%** and is **substantially higher** than the rates across the others which vary between **20%** in Newham and **57%** in Barking and Dagenham.
- On average across NEL, the rate among White women is relatively higher than those among both Asian and Black women (i.e. **44%**, **37%** and **37%** and respectively). While this difference is perhaps not as large as those observed for other indicators, it is known to have a direct link on outcomes for babies.
- On average across NEL, deprivation appears to be **more closely correlated** with the likelihood of women having a (good) folic acid status. On average across NEL, the rate among women in the **least deprived quintile is 67%** which is **almost twice as high** as for those in the **most deprived quintile (36%)**. This closely linked correlation may – in part – be explained by the cost associated with taking folic acid supplements for which women in the least deprived areas may be more able to afford.

Figure 14 | Folic acid status | rates by borough and ethnicity | 2020-21

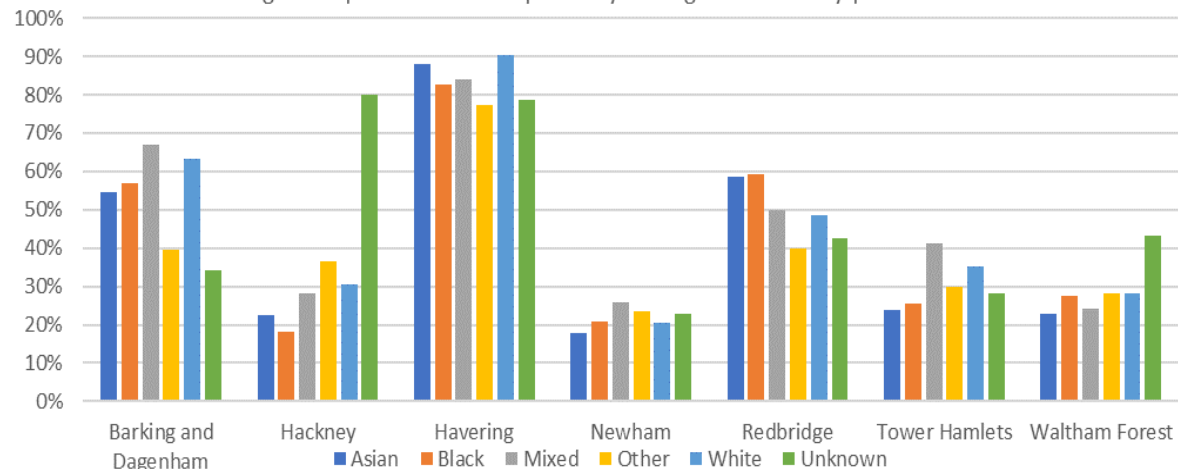
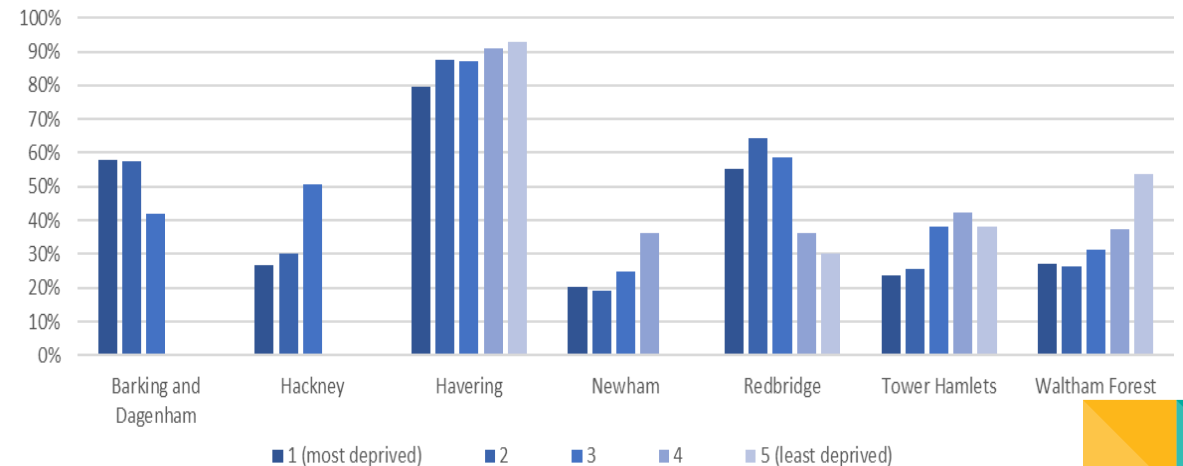


Figure 15 | Folic acid status | rates by Borough and Deprivation Quintile | 2020-21



Prevalence of complex risk factors

Figure 16 | Complex social factors indicator | rates by Borough | 2020-21

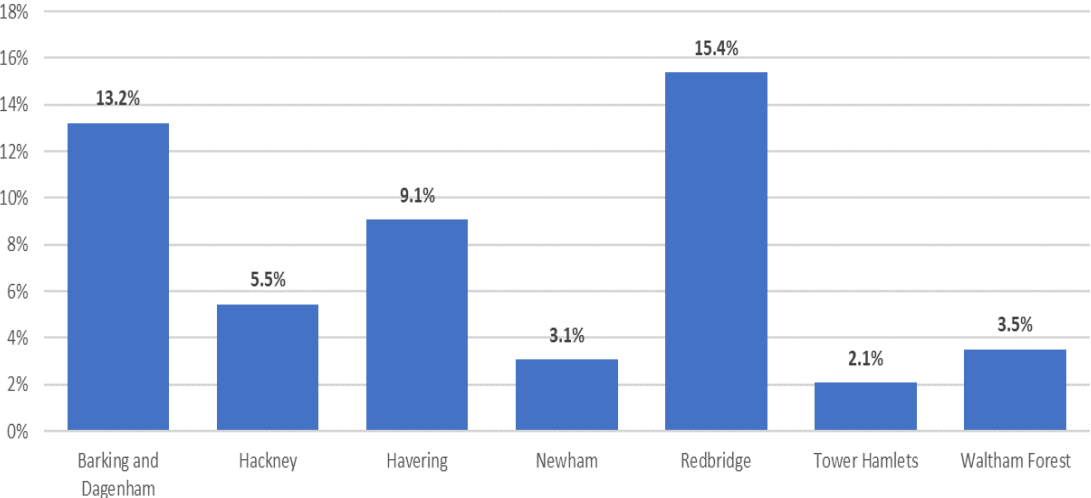


Figure 17 | Complex social factors indicator | rates by borough and ethnicity | 2020-21

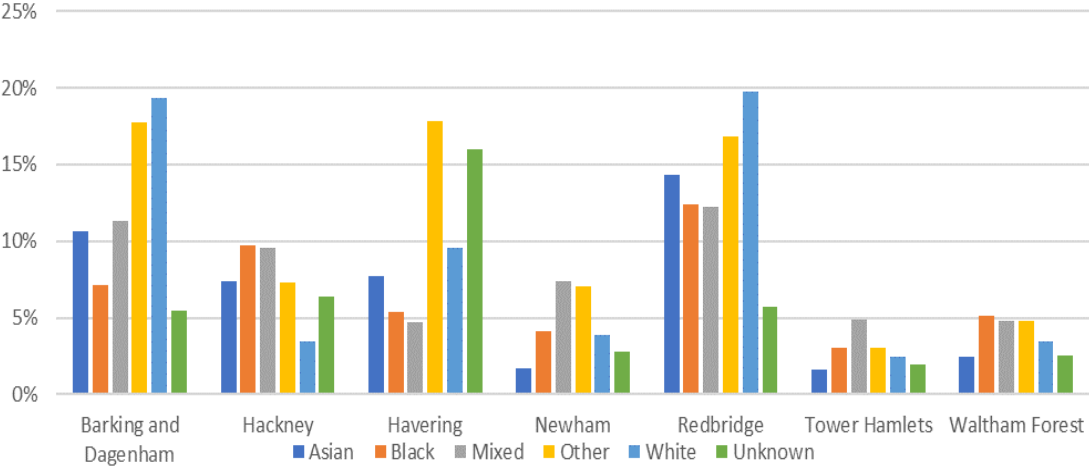
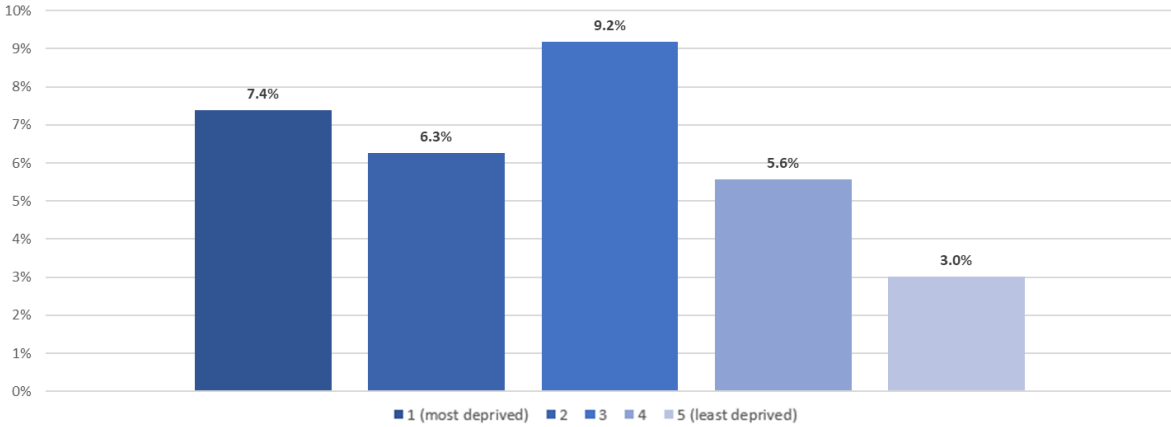


Chart 18 | Complex social factors indicator | rates by IMD 2019 Deprivation Quintile | 2020-21



Key findings

- Midwives record whether one or more 'social complex' factors are present. This list both large and varied and includes, for example women who are aged under 20, experience domestic abuse, misuse substances, or recent migrants for example (see slide 87 for the complete list).
- **Redbridge (15.4%)** and **Barking & Dagenham (13.2%)** have much higher rates of women that gave birth in 2021 having complex social factors, with the rate in **Tower Hamlets (2.1%)** being the lowest.
- On average, the proportion of White women with complex social factors (**8%**) is either **very similar** or even **slightly higher** than compared with all ethnic minority groups (**6-8%**) with the exception for women of Other ethnicity (**9%**).
- This, however, masks a lot of variation both across and between boroughs – particularly in Redbridge and Barking and Dagenham in which the rates among White women are **much higher** than for ethnic minority groups. In Barking and Dagenham for example, the rate among White women is **19%** compared with **7-10%** for Black and Asian women.
- On average across NEL, deprivation appears to be closely correlated with this indicator with women in the least 40% having had much lower rates than the most deprived 60% (i.e. **5%** compared with **8%**)
- **Given the range of factors included in this list, there is potentially high risk of this metric being interpreted differently by Midwives both within and between boroughs. Without further information on local recording practices for this metric, this risk around consistency of recording means that the findings above should be treated with caution**

Disability status

Figure 19 | % disabled | rates by Borough | 2020-21

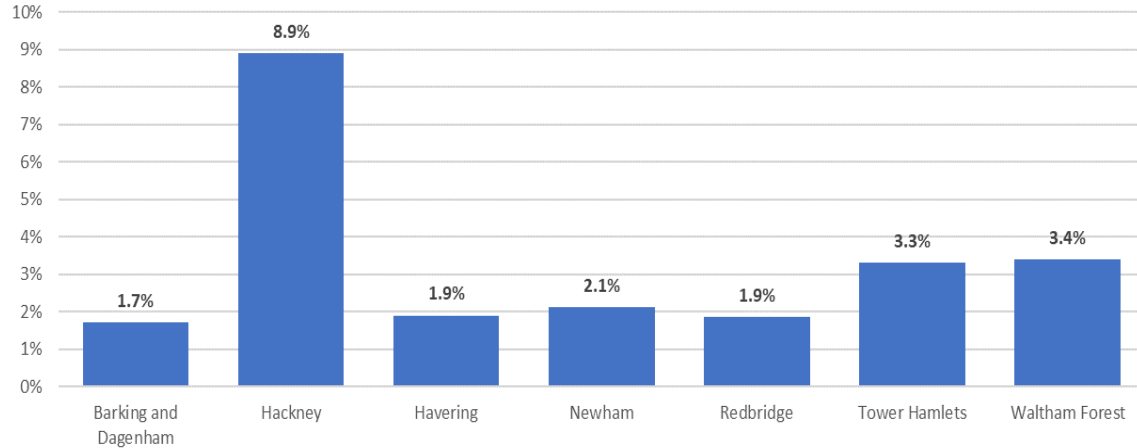


Figure 20 | % disabled | rates by borough and ethnicity | 2020-21

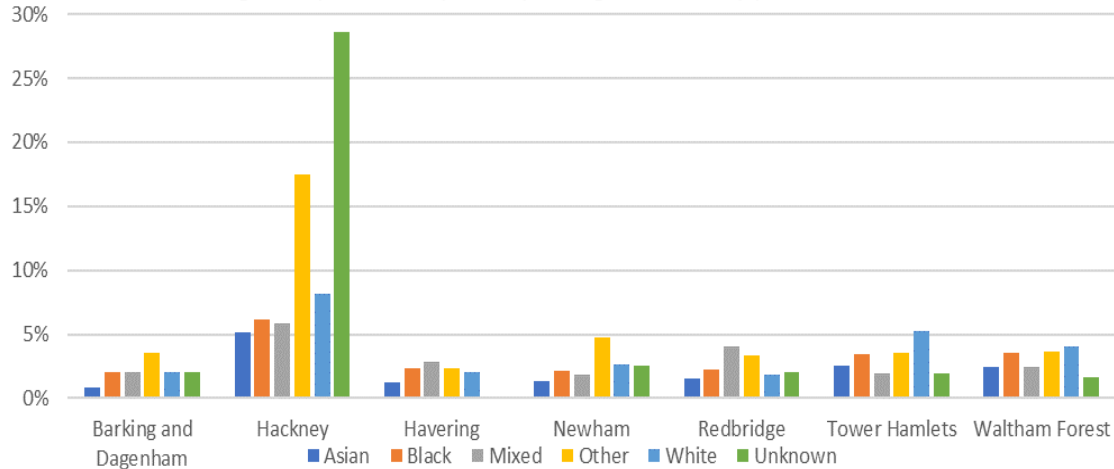
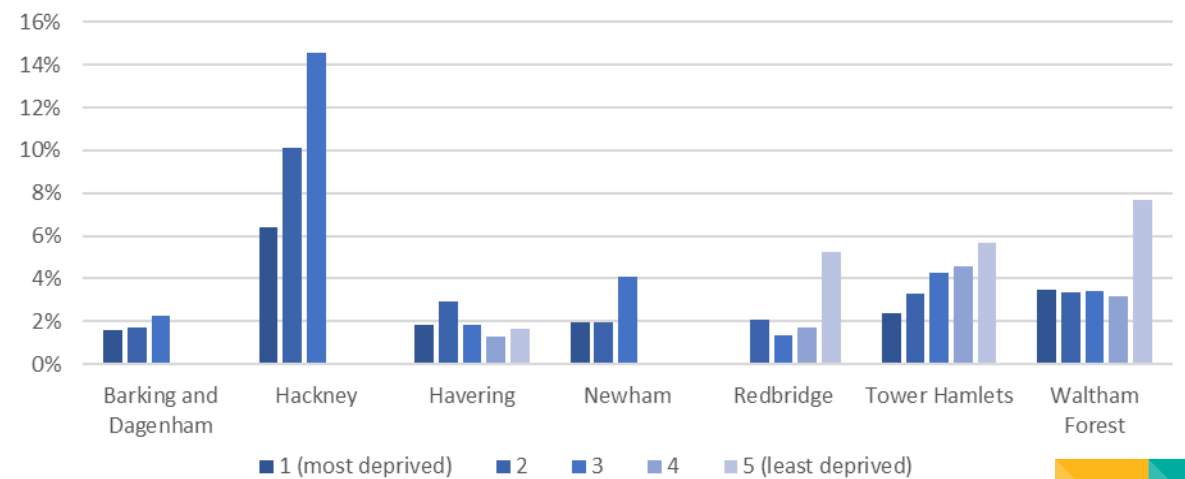


Figure 21 | % disabled | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- Across the NEL boroughs between **2-3%** of women that gave birth in 2021 are disabled. The notable exception is Hackney, with **9%** of women having a disability – which is more **than three times** the rate across most of the other boroughs.
- On average, the rate of disability tends to be **higher** for White women than for women in most ethnic minority groups (i.e. 4% for White women compared with **2-3%** across Black, Asian and Mixed women). The exception is women in the **Other** ethnicity group for whom the average rate is **7%** - however, this average rate is heavily skewed by Hackney in which the rate for this group is exceptionally high relative to all other ethnicities at **18%**. This variance warrants further analysis.
- As with ethnicity, deprivation does not appear to be highly correlated to disability rates, with the average rate for women in the most deprived area the same as for those in the least deprived (i.e. **3%** across both)

Employment status

Figure 22 | % unemployment or long term sick or disabled | rates by Borough | 2020-21

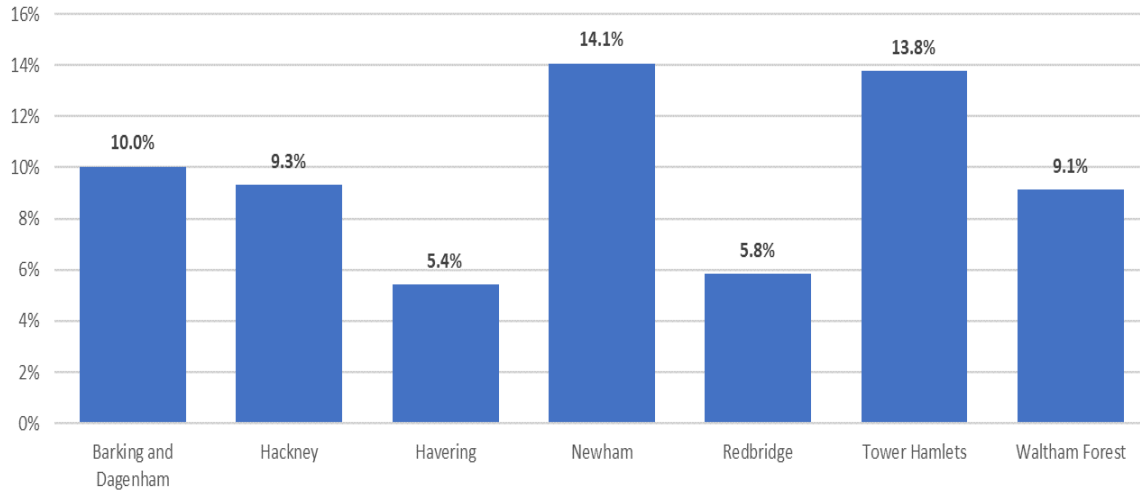
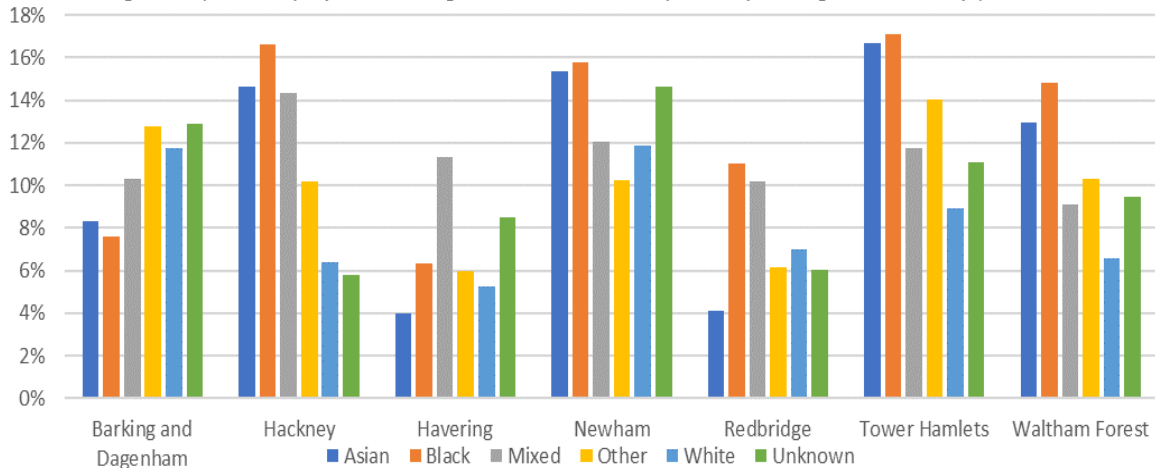


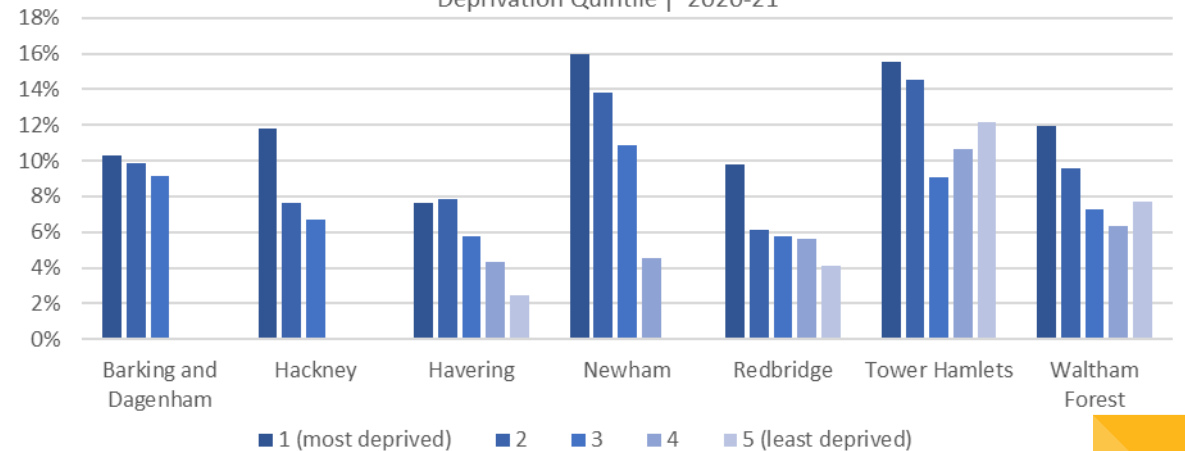
Figure 23 | % unemployment or long term sick or disabled | rates by borough and ethnicity | 2020-21



Key findings

- This indicators shows the rate among women that gave birth in 2021 who are not in employment, due to unemployment, long term sickness or disability.
- Overall, Newham and Tower Hamlets have a much higher proportion of women not in employment. Both have rates at **14%** which are **more than twice** the rate in Havering and Redbridge at **5%** and **6%** respectively.
- On average, a **higher proportion** of women in ethnic minority groups are not in employment compared with White women (i.e. **10-13%** across ethnic minority groups compared with **8%**). On average, the rate is highest among Black women at **13%**.
- Hackney and Tower Hamlets have the **largest relative difference** in rates between Asian and Black women compared with White women. In Hackney, for example, **14%** of Asian Women and **17%** of Black women are not in employment which is at least **twice the rate** as that for White women at **7%**.
- As expected, deprivation appears to be strongly linked to the likelihood of being out of employment with **13%** of women in the most deprived areas not being in employment compared with **4%**.

Figure 24 | % unemployment or long term sick or disabled | rates by Borough and Deprivation Quintile | 2020-21



Annex 4 – Delivery methods

Vaginal Births

Figure 1 | % of vaginal deliveries | rates by Borough | 2020-21

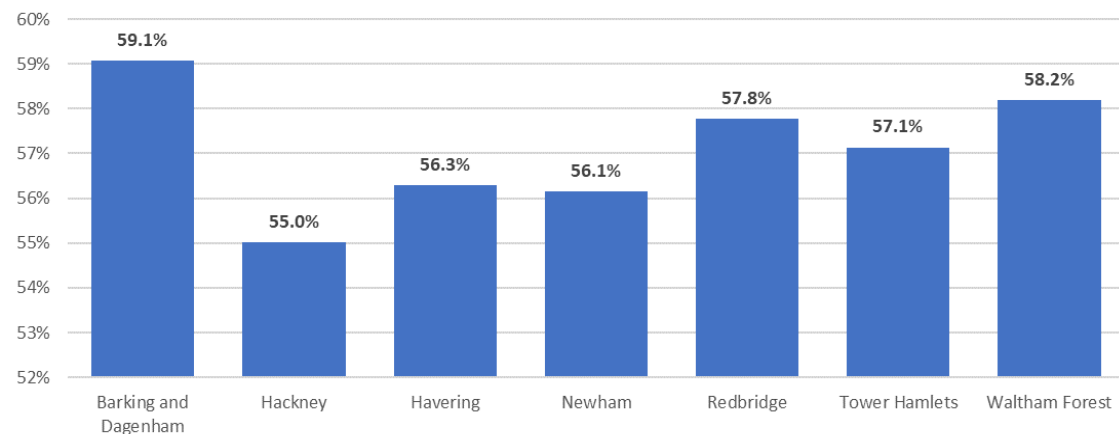


Figure 2 | % of vaginal deliveries | rates by borough and ethnicity | 2020-21

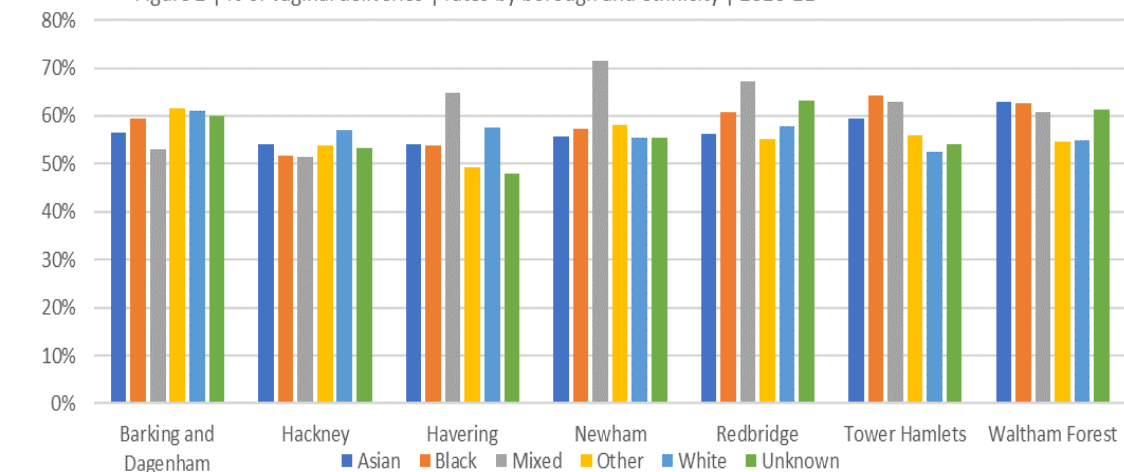
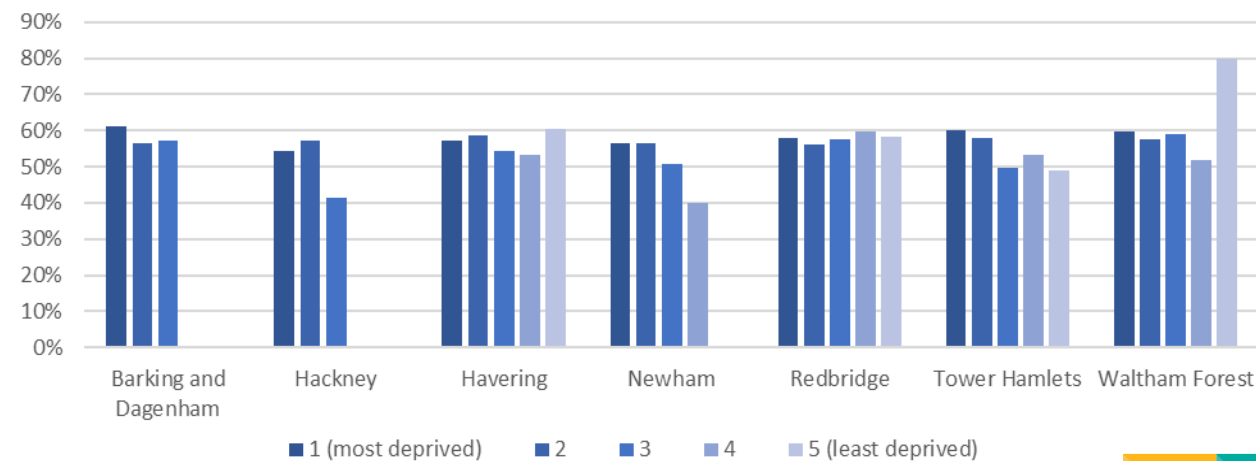


Figure 3 | % of vaginal deliveries | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- This includes (a) spontaneous Vertex and (b) Spontaneous Other Cephalic births.
- Overall, just over half of the women across of the NEL boroughs that gave birth in 2021 had a vaginal delivery. The variance across individual boroughs is relatively low with the lowest rate in Hackney (**55%**) and the highest in Barking & Dagenham (**59%**).
- Across and between boroughs, the rates for Asian, Black and White women are **relatively consistent** at approximately **57%**. While the average for Mixed women across NEL is only slightly higher at **59%**, the rate among this group this markedly higher than in any other ethnicity in three of the boroughs: Newham (**71%**), Redbridge (**67%**) and Havering (**65%**)
- There does not appear to be a strong link to deprivation, with the average NEL rate among women in the most deprived areas at **58%** being comparative for those in the least deprived (**58%**). At the borough level, the main outlier is Waltham Forest in which **60%** of women in the least deprived area had a vaginal birth compared with **80%** among those in the least deprived.

Forceps births

Figure 4 | % of forceps deliveries | rates by Borough | 2020-21

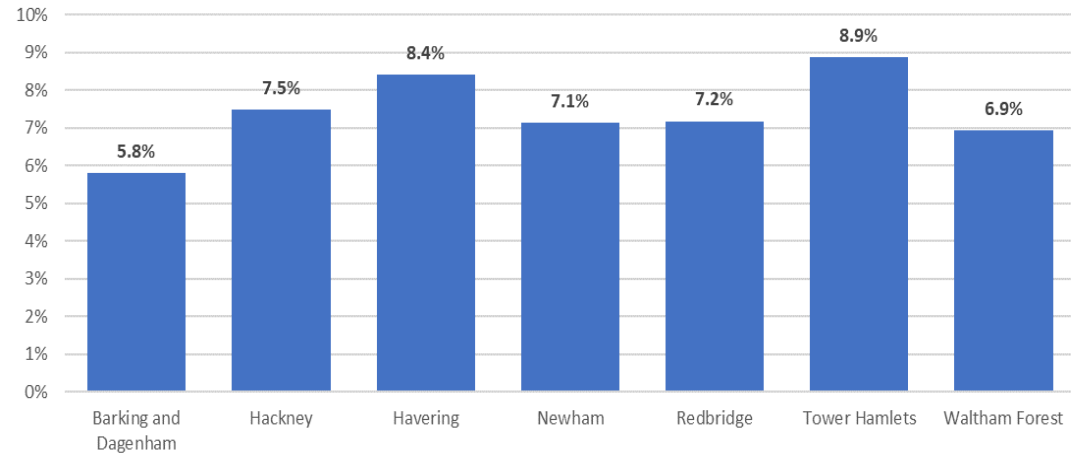


Figure 5 | % of forceps deliveries | rates by borough and ethnicity | 2020-21

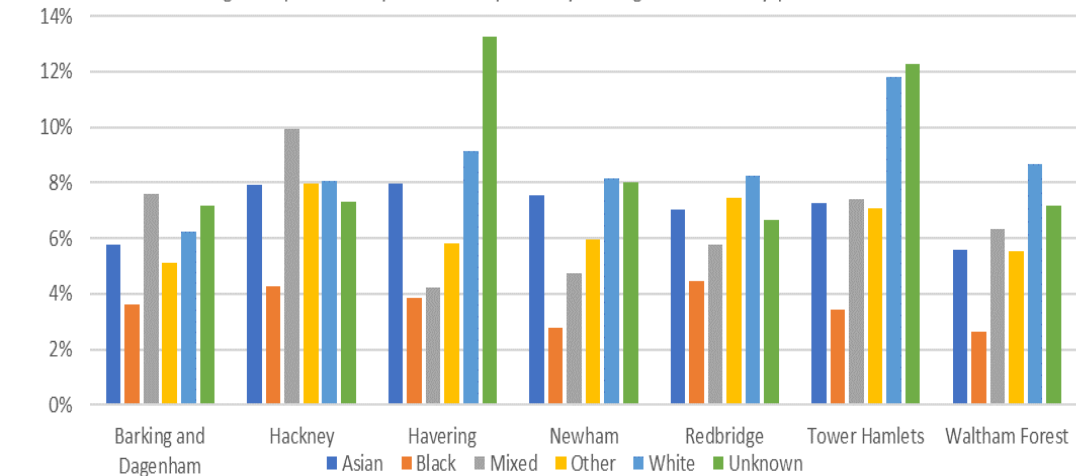
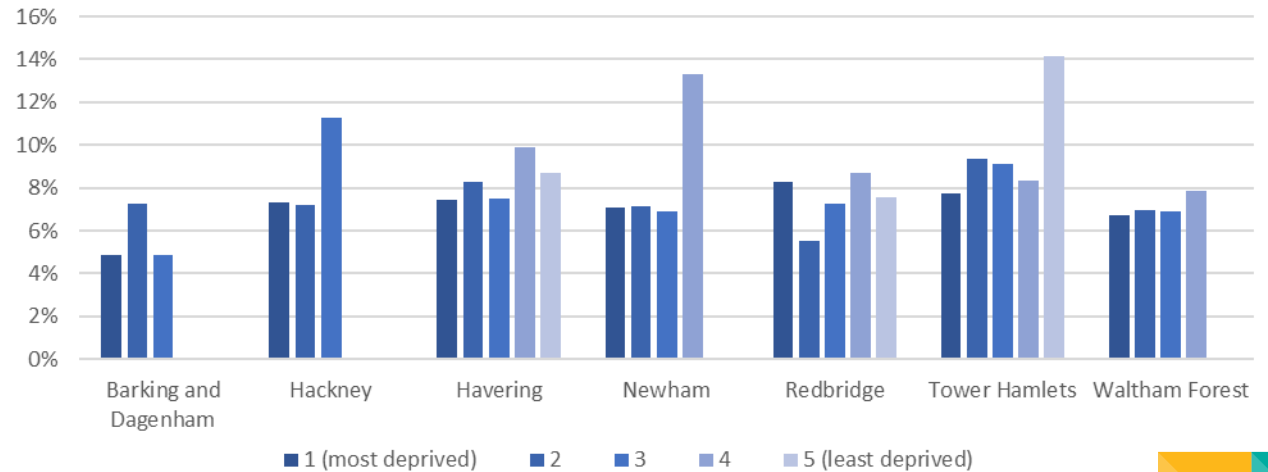


Figure 6 | % of forceps deliveries | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- On average across NEL, **7%** of women that gave birth in 2021 did so via forceps although this ranges from **9%** in and Tower Hamlets to **6%** Barking & Dagenham.
- On average across NEL, White women are **2 times as likely** to deliver via forceps compared to Black women (**i.e. 8% versus 4%**). In contrast the average rates among Asian (**7%**), Mixed (**7%**), Other (**7%**) and White (**8%**) women are relatively similar. These patterns at the NEL level are relatively consistent at the borough level – with no major outlier boroughs.
- There appears to be a relatively small correlation with deprivation with **7%** of women in the most deprived areas giving birth in this way compared with **9%** for those in the least deprived. At the borough level, however, there are two key outliers: Newham and Tower Hamlets where the rate for those the **least** deprived areas are almost twice as high as for those in the **most** deprived.

Unplanned C-Sections

Figure 7 | % of unplanned C section deliveries | rates by Borough | 2020-21

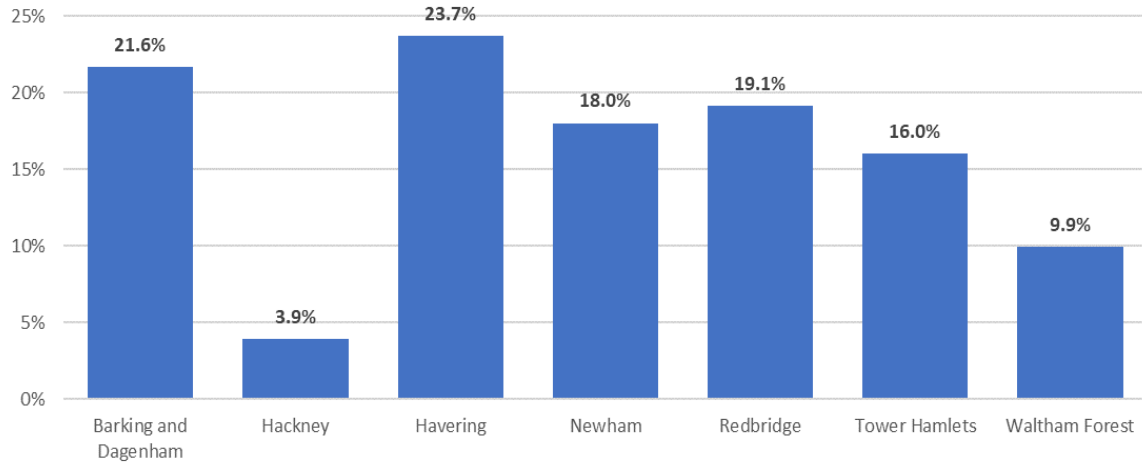


Figure 8 | % of unplanned C section deliveries | rates by borough and ethnicity | 2020-21

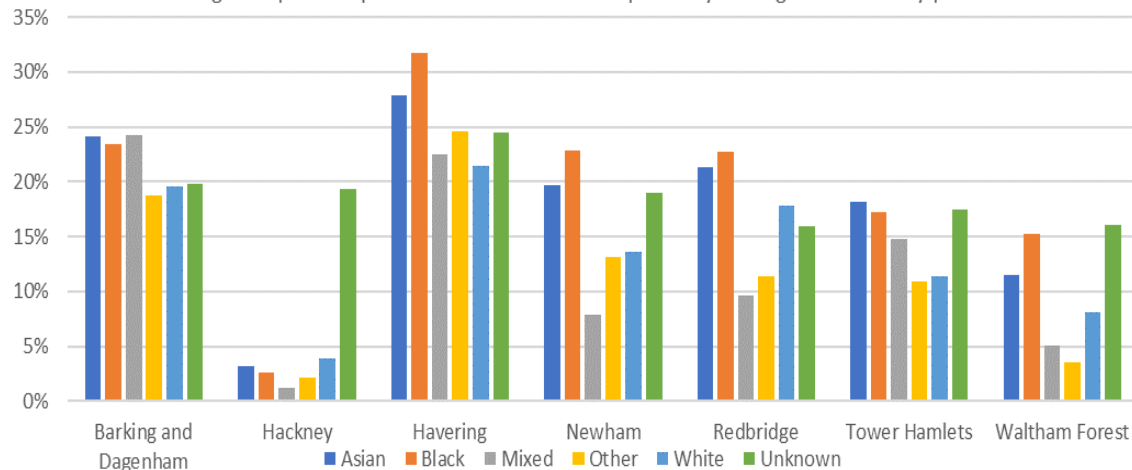
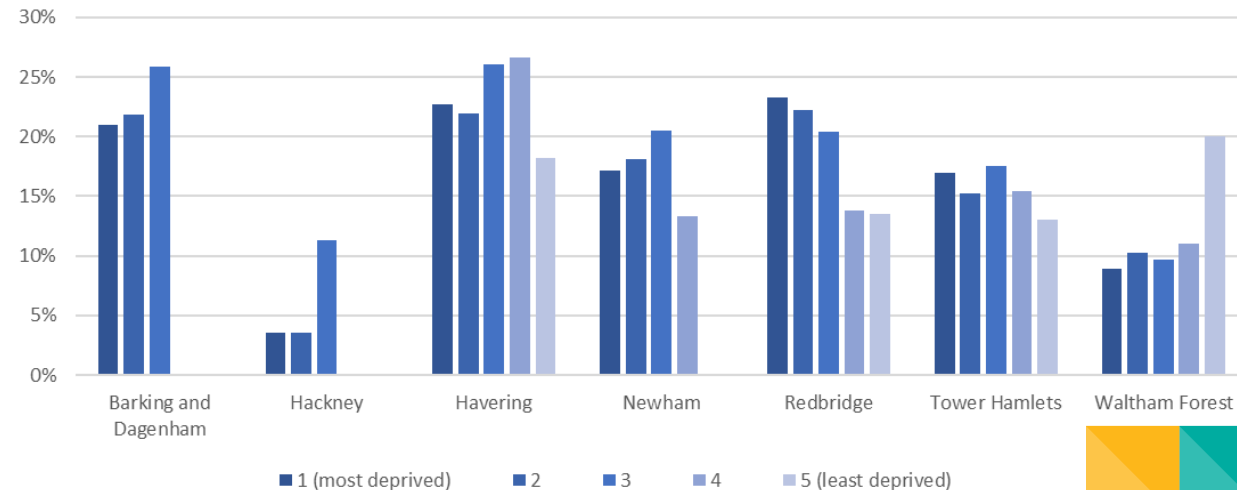


Figure 9 | % of unplanned C section deliveries | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- Overall, there is a lot of variation in the rate of women having unplanned C-sections of those that gave birth in 2021. Two boroughs had over a **fifth** of women giving birth in this way: Barking and Dagenham (**22%**) and Havering (**24%**) compared with **10-19%** across Newham, Tower Hamlets and Waltham Forest. Hackney is the main outlier with a substantially smaller rate at **4%**.
- On average across NEL, Asian women are **twice as likely** as Mixed or Other women to have an unplanned C-section (**19%** compared with **9%**) and are also more likely than White women to give birth in this way (**13%**). On average, Black women are also more likely than White women (and compared with other non-Asian ethnicities) to have an unplanned C-section (**i.e. 18%** compared with **13%**).
- At the borough level, differences between rates for Asian and Black women compared with White women are largest in Newham, Havering and Redbridge. In Newham, for example, the rate among Black and Asian women is **23%** and **20%** compared with **14%** for White women. Similarly, the rate among Black and Asian women in Redbridge is **21%** and **23%** compared with **18%** for White women. In Havering, the rate among Black and Asian women is **32%** and **28%** compared with **22%** for White women.
- At the NEL level, deprivation seems to be much correlated to rates of un-planned C-sections than ethnicity, with less deprived areas having only slightly higher rates than those in the least deprived (**i.e. 15%** compared with **16%**). At the borough level both Redbridge and Waltham Forest are the main outliers. In Waltham Forest, for example, just under **10%** of those in the **most** deprived areas had an unplanned C-section compared with **20%** among those in the least deprived. The finding is reversed for Redbridge, however, in which the rate is **23%** among women in the **most** deprived areas compared with **14%** in the **least** deprived.

Planned C-Sections

Figure 10 | % of planned C section deliveries | rates by Borough | 2020-21

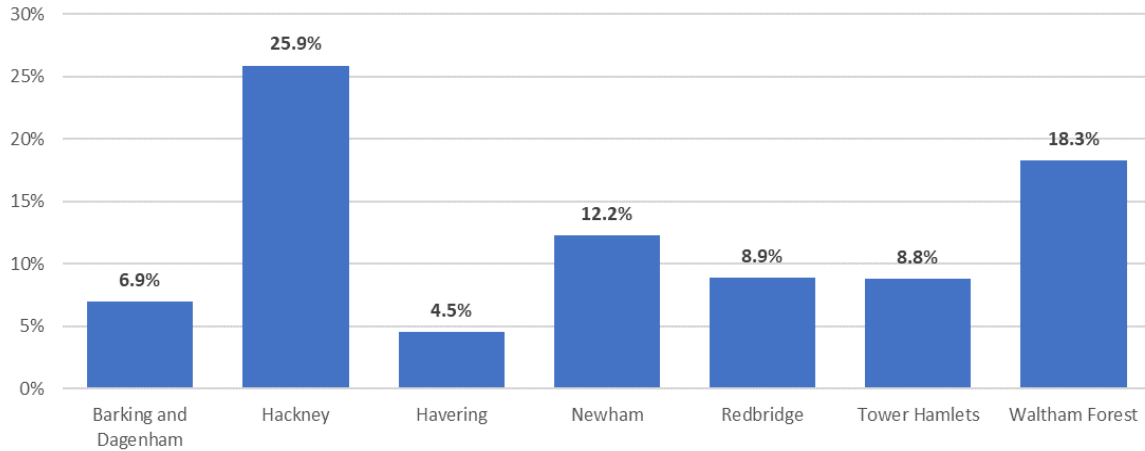


Figure 11 | % of planned C section deliveries | rates by borough and ethnicity | 2020-21

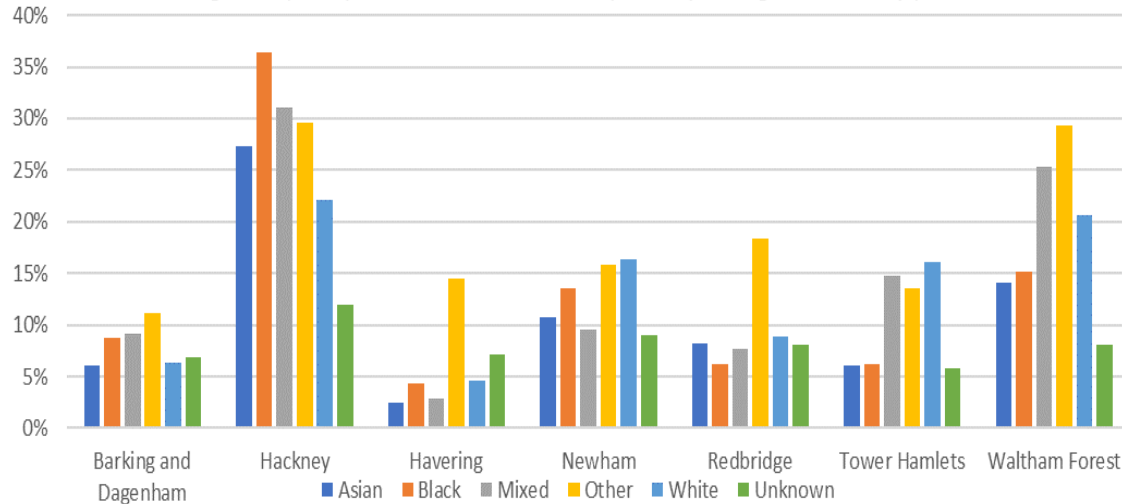
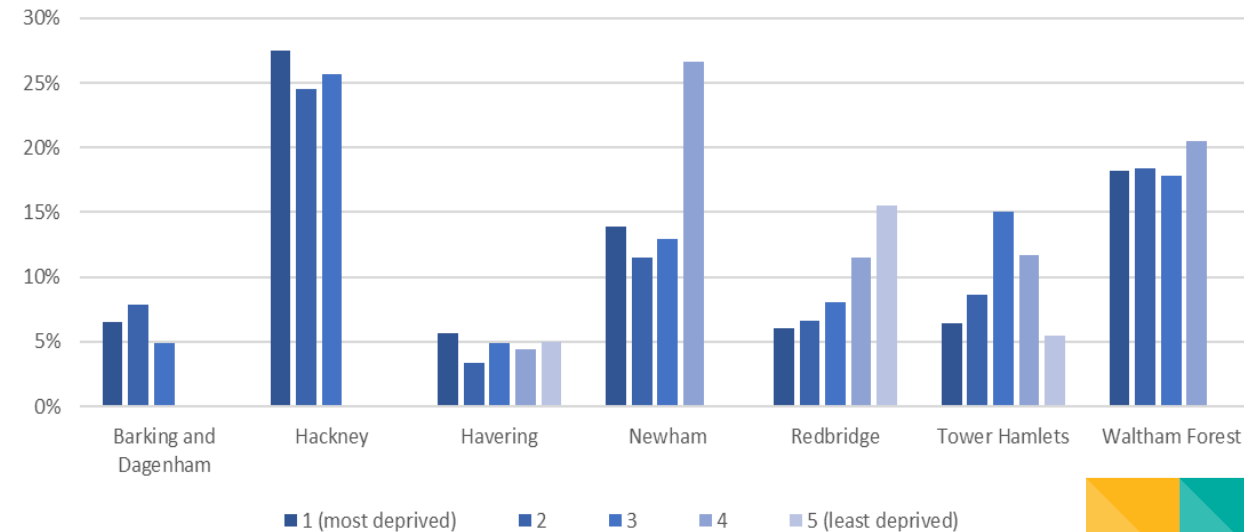


Figure 12 | % of planned C section deliveries | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- As with unplanned C-sections, there is a lot of variation across boroughs and this appears to be closely linked to rates of unplanned C-sections. Those boroughs that have the **highest rates** of unplanned C-sections (i.e. Barking and Dagenham, Havering and Redbridge) also have the **lowest rates** of planned C-sections (i.e. at **7%**, **5%** and **9%** respectively). Similarly, Hackney - who by far had the **lowest rate** of unplanned C-section compared with all other NEL boroughs - also has the **highest planned** C-section rate by far - with a **quarter of women** giving birth in this way.
- On average across NEL, Black and Mixed women have the highest rates at **16%** and **18%** respectively and higher than the rate for both Asian and White women which are **9%** and **14%** respectively.
- The differences are, however, being driven largely by the relatively large disparities between ethnicities in Hackney in particular where **37%** of Black women and **30%** of Asian Women have both via planned C-section compared with **22%** among White women.

Ventouse deliveries

Figure 13 | % of planned C section deliveries | rates by Borough | 2020-21

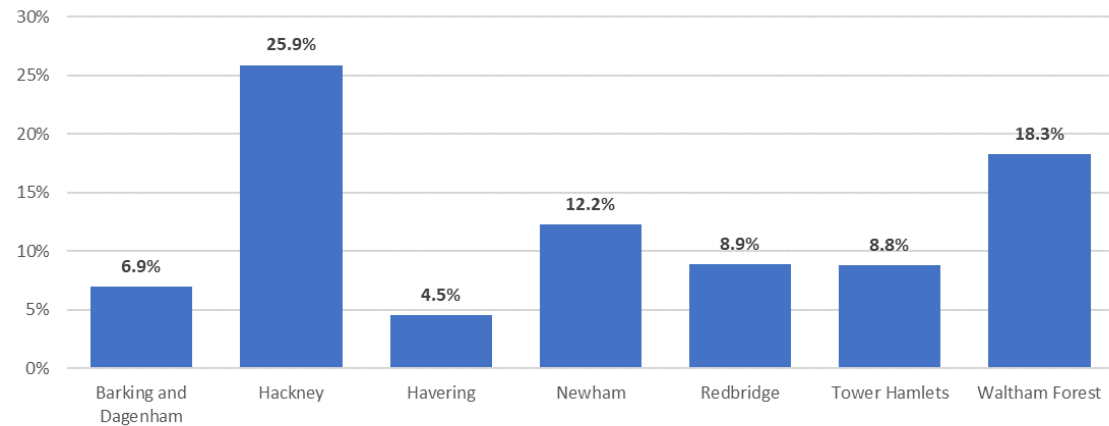
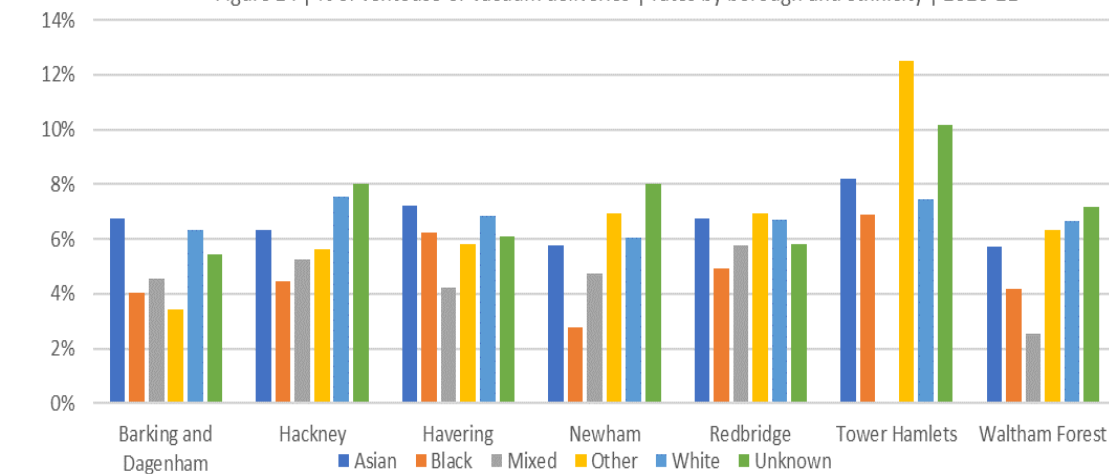


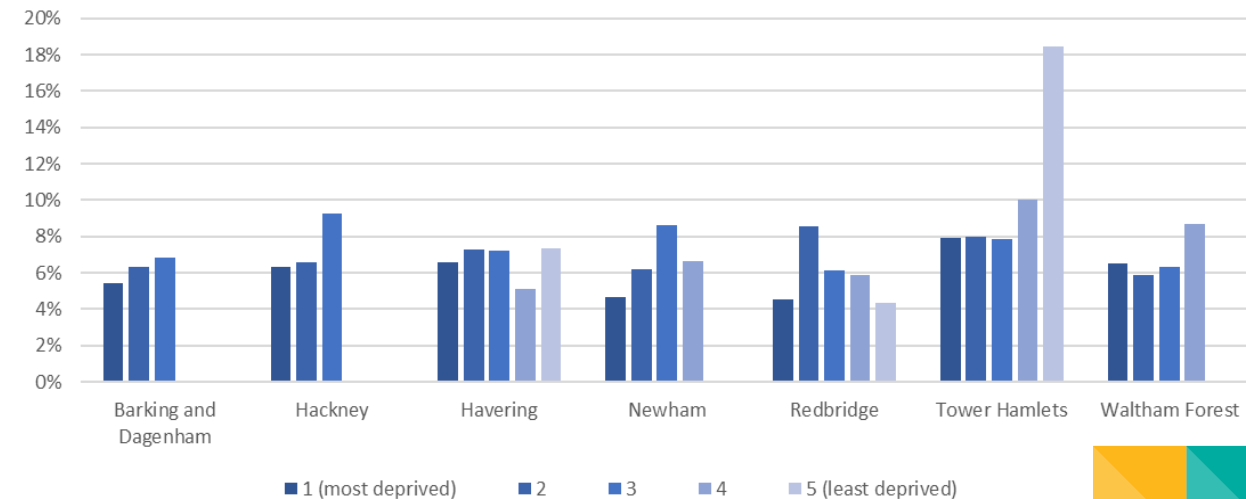
Figure 14 | % of ventouse or vacuum deliveries | rates by borough and ethnicity | 2020-21



Key findings

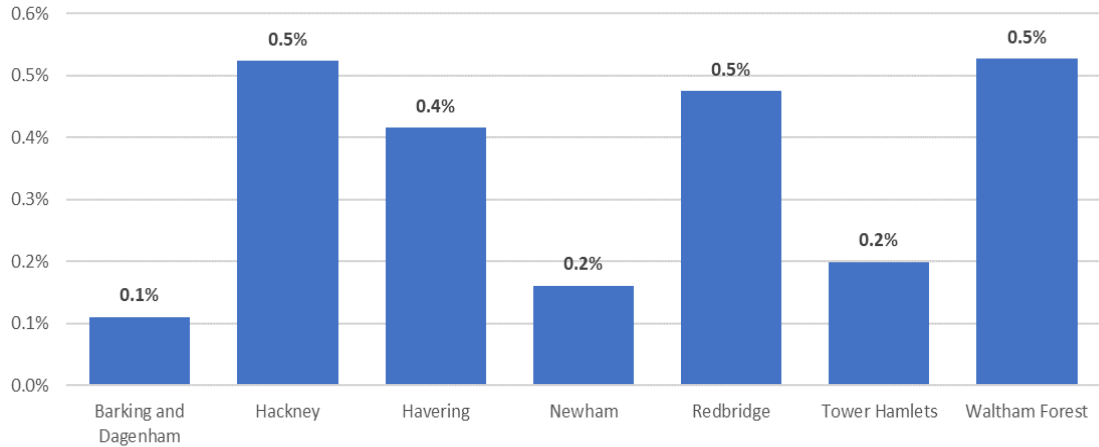
- Overall across NEL, there does not appear to be a lot variation in the rate of women having ventouse deliveries, with the rate ranging from **6%** in Barking and Dagenham to **8%** in Tower Hamlets.
- On average across NEL, the rates are almost identical for Asian, White and Other women (at **7%** in each group) and are higher than those among Black and Mixed women (**4%** among both groups).
- Two boroughs had over a **fifth** of women giving birth in this way: Barking and Dagenham (**22%**) and Havering (**24%**) compared with **10-19%** across Newham, Tower hamlets and Waltham Forest. Hackney is the main outlier with a substantially smaller rate at **4%**.
- On average across NEL, the correlations appears to be relatively mild with **6%** of women in the **most** deprived areas giving birth in this way compared with 8% for those in the **least** deprived.

Figure 15 | % of ventouse or vacuum deliveries | rates by Borough and Deprivation Quintile | 2020-21



Post-partum haemorrhages

Figure 16 | % with post-partum haemorrhage | rates by Borough | 2020-21



Key findings

- On average across NEL, less than **0.5%** of the women that gave birth in 2021 had a post-partum haemorrhage.
- On average across NEL, rates are highest among Black (**0.4%**) and lowest among Mixed women (**0.2%**). The average rate for Black women is, however, driven mainly by Havering which compared to all the other boroughs has highest rates for Black (2.2%) and Mixed (1.8%) women
- On average, the link with deprivation status appears relatively small.
- **Note: the low numbers in this cohort may be too small on which conclude meaningful (and statistically significant) differences and in the absence of further analysis of the data, trends presented here should be treated with caution.**

Figure 17 | % with post-partum haemorrhage | rates by borough and ethnicity | 2020-21

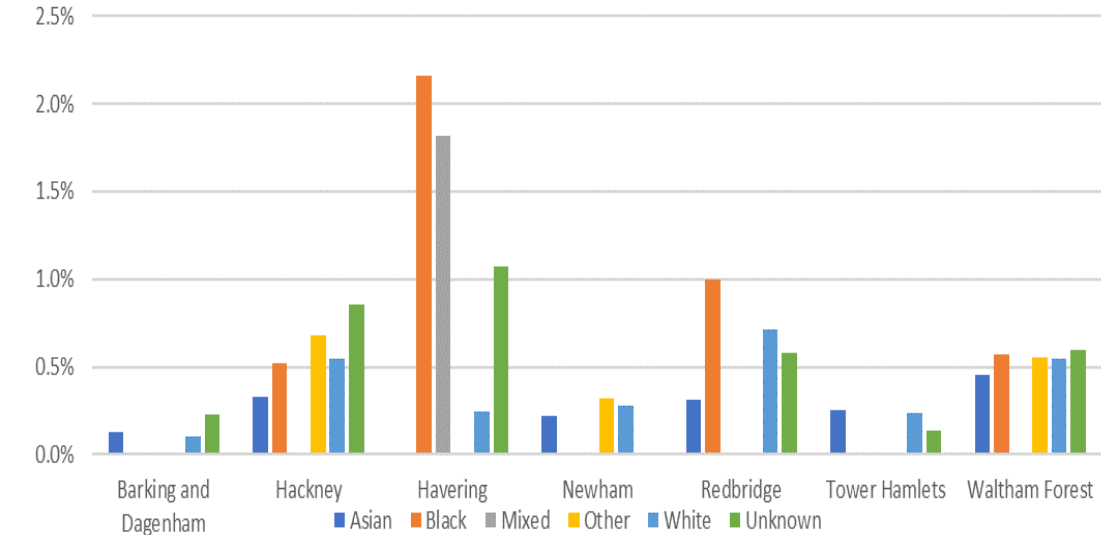
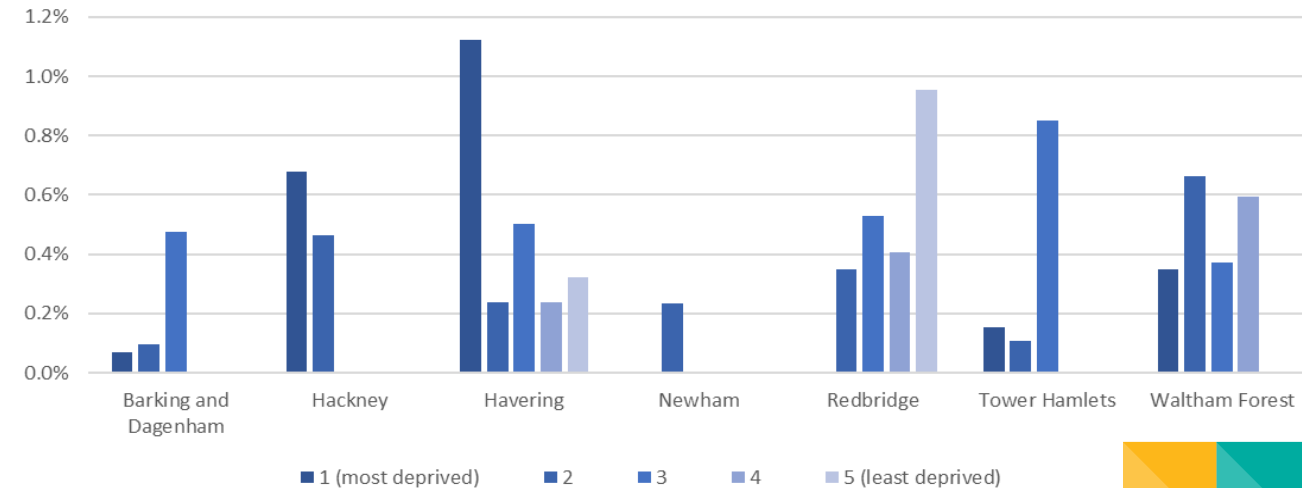


Figure 18 | % with post-partum haemorrhage | rates by Borough and Deprivation Quintile | 2020-21



First degree tears

Figure 19 | % of women with 1st degree tears | rates by Borough | 2020-21

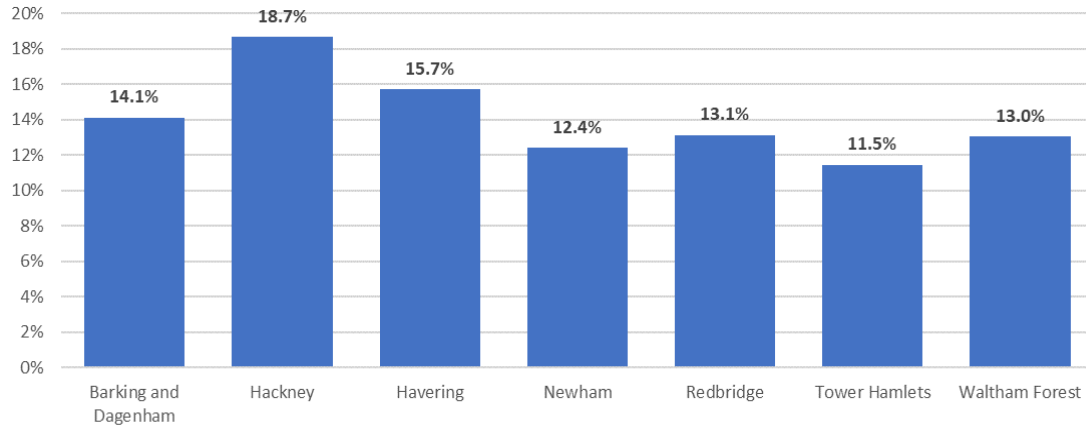
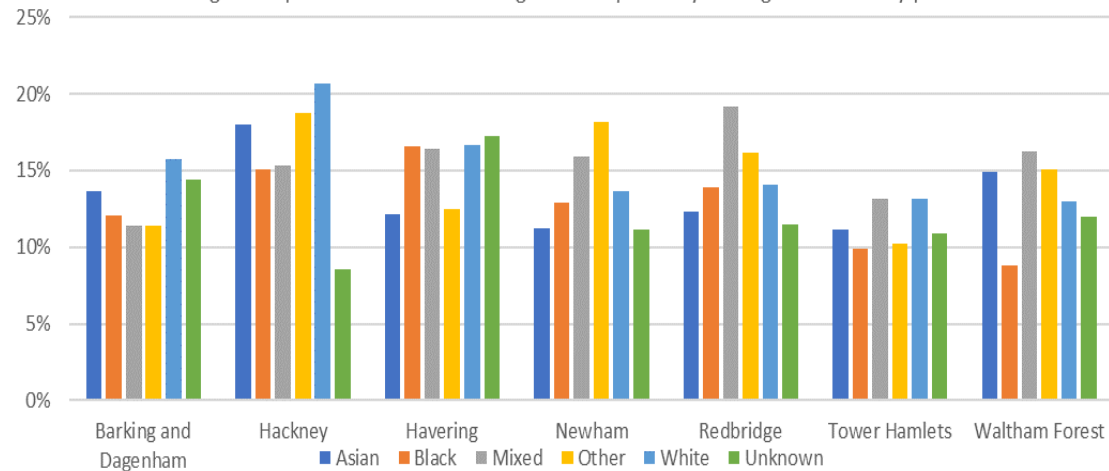


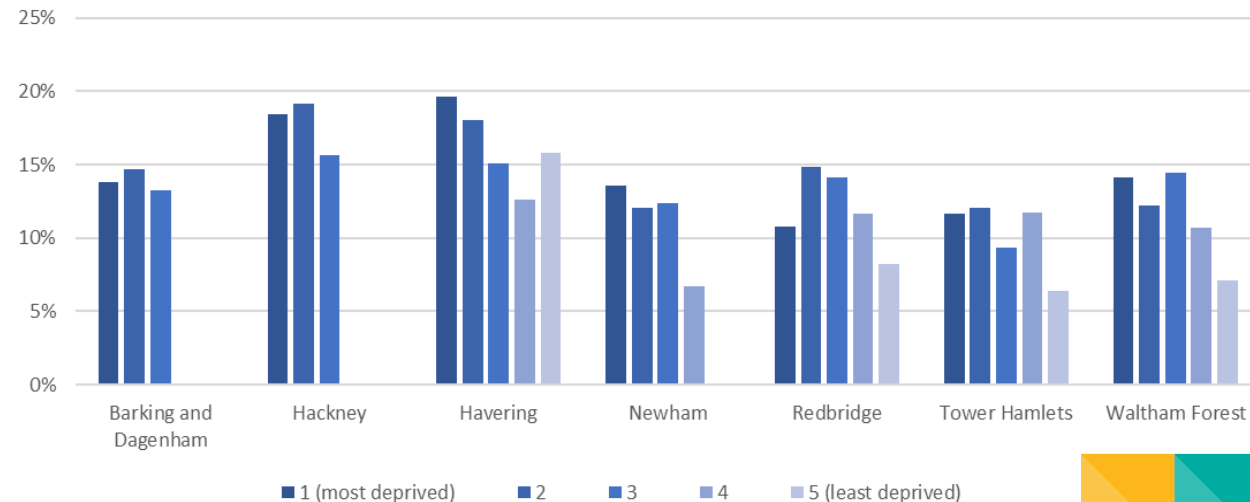
Figure 20 | % of women with 1st degree tears | rates by borough and ethnicity | 2020-21



Key findings

- These refer to small, skin-deep tears which usually heal naturally.
- Overall across the NEL boroughs, the rate of women with first degree tears ranges from 12% in Tower Hamlets to 19% in Hackney. On average, White women tend to have higher rates of 1st degree tears than women in other ethnic groups (i.e. 16% compared to between 12-15% for ethnic minority women).
- On average at the NEL level, there does appear to be a potentially stronger correlation with deprivation with 15% of women living in the **most** deprived areas having a first degree tear compared with 11% in the **least** deprived.

Figure 21 | % of women with 1st degree tears | rates by Borough and Deprivation Quintile | 2020-21



Second degree tears

Figure 22 | % of women with 2nd degree tears | rates by Borough | 2020-21

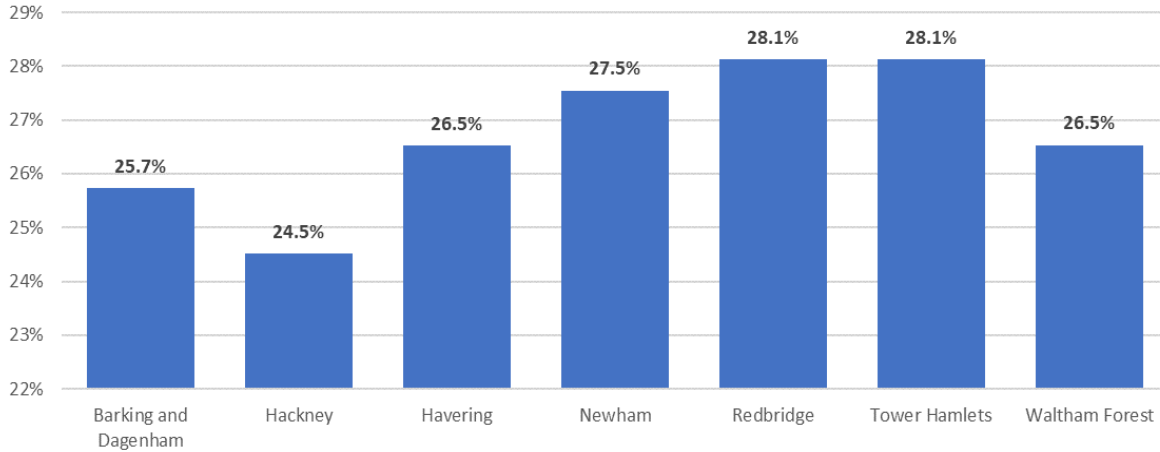


Figure 23 | % of women with 2nd degree tears | rates by borough and ethnicity | 2020-21

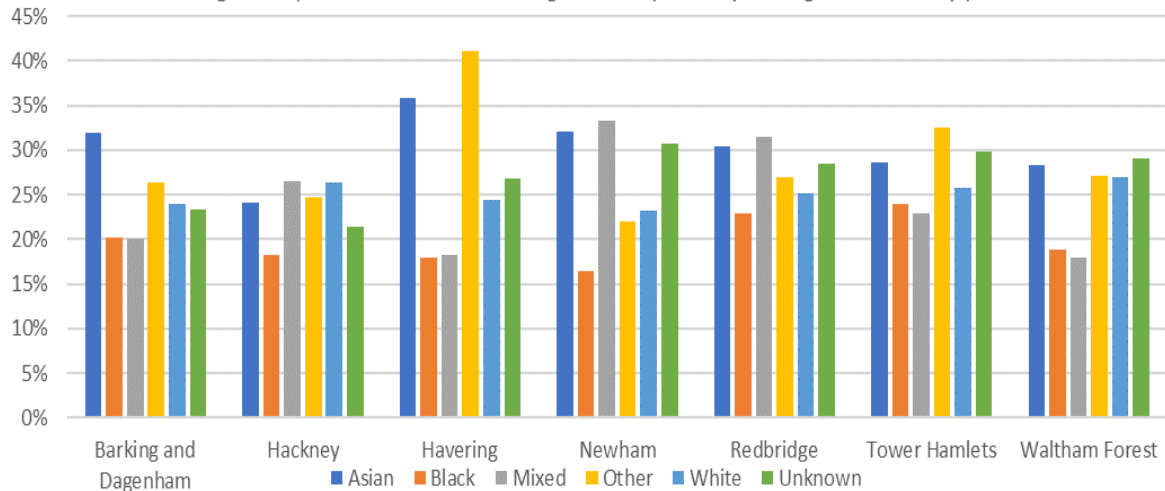
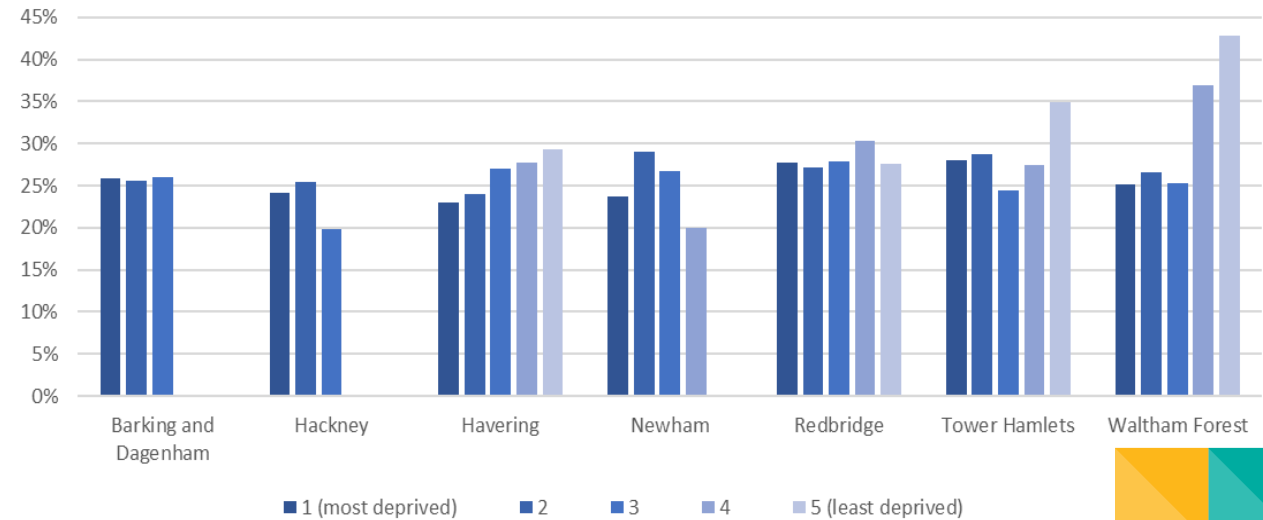


Figure 24 | % of women with 2nd degree tears | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- Second degree tears are deeper tears which affect the muscle of the perineum as well as the skin. These usually require stitches.
- Overall at the NEL level, **more than a quarter** of women in all boroughs had a second degree tear. This rate ranges from **25%** in Hackney to **28%** in Redbridge and Tower Hamlets.
- On average across NEL, Asian women **are much more likely** than White women to have a second degree tear (e.g. **30%** compared with **25%**). In contrast, the rate among Black women was markedly lower at **19%** (and also lower than the rates for Mixed and Other women for whom the rate is **24%** and **27%** respectively). The rate Asian women is highest in Havering at 35%.
- In contrast to first degree tears, on average across NEL the correlation with deprivation appear to be more marked (and of the opposite direction) with women in the **most** deprived area **much less likely** to have a second degree tear than those in the least deprived (i.e. **25%** versus **30%**).

Third degree tears

Figure 25 | % of women with 3rd degree tears | rates by Borough | 2020-21

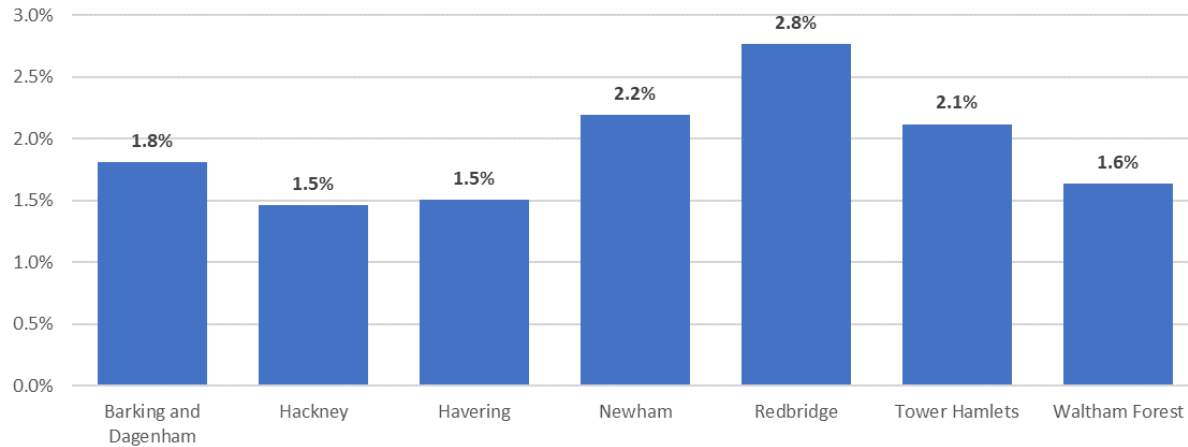


Figure 26 | % of women with 3rd degree tears | rates by borough and ethnicity | 2020-21

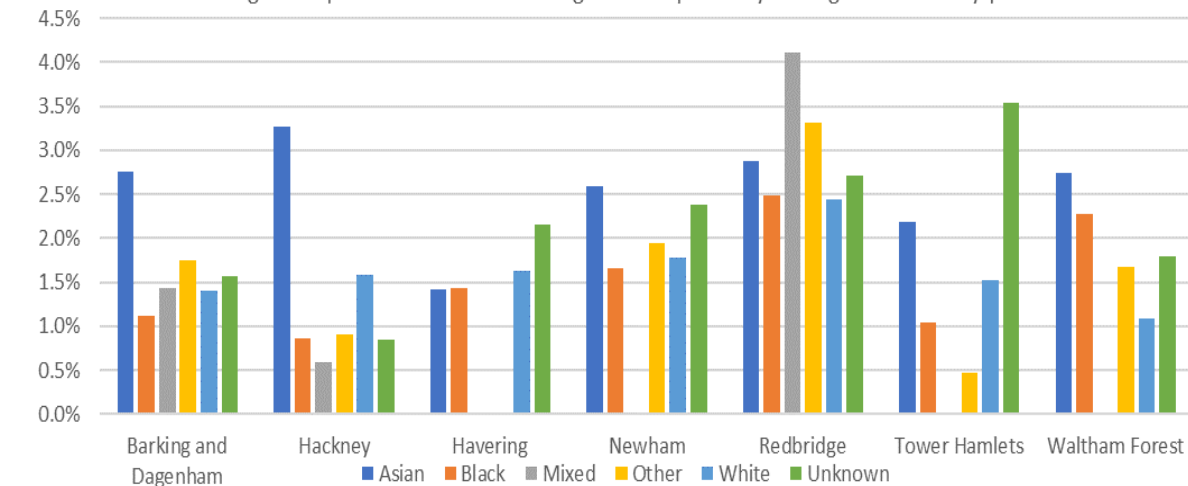
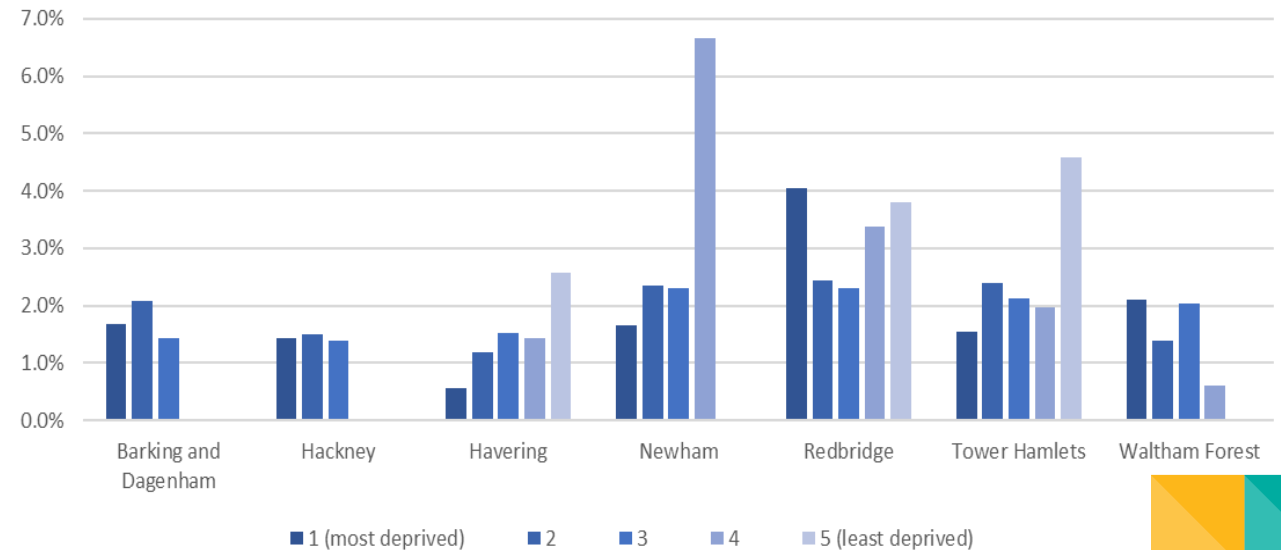


Figure 27 | % of women with 3rd degree tears | rates by Borough and Deprivation Quintile | 2020-21



Key findings

- Third-degree tears are those which extend away from the vaginal wall, towards the perineum to the anal sphincter.
- Overall at the NEL level, third degree tears are significantly more rare than either first or second degree tears with less than **3%** of women experiencing across each of the boroughs. The rate does, however, range from **1.5%** in Hackney and Havering to **2.8%** Redbridge – which is almost **double**.
- On average across NEL, Asian women are more likely to suffer third degree tears than White women (**3%** versus **2%**). In contrast, the rate among Black women is **1%**, lower than for women in those same ethnic groups.
- As with second degree tears, women in the **most** deprived appear to be **less likely** to have a third degree tear than those in the **least** deprived (i.e. **1.6%** versus **3.3%**).
- **NOTE: as with other metrics that are based on relatively low numbers, without further analysis, these findings should be treated with caution.**



Annex 5 – Outcomes for women and babies

Stillbirths

Figure 1: Rate per 1000 of babies born stillbirth - by borough (2020/21)

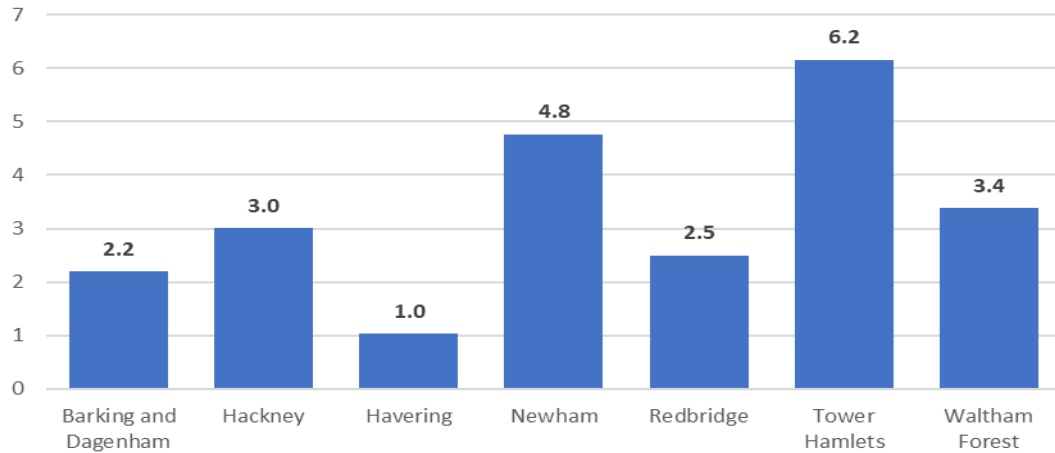
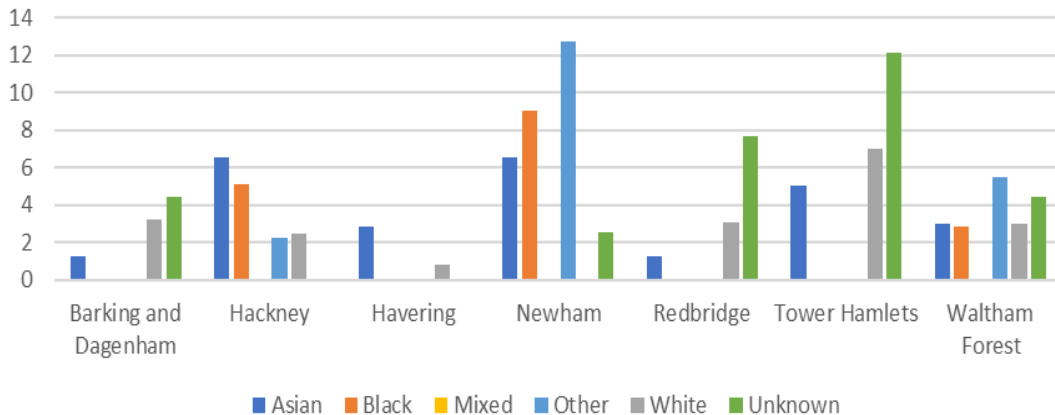


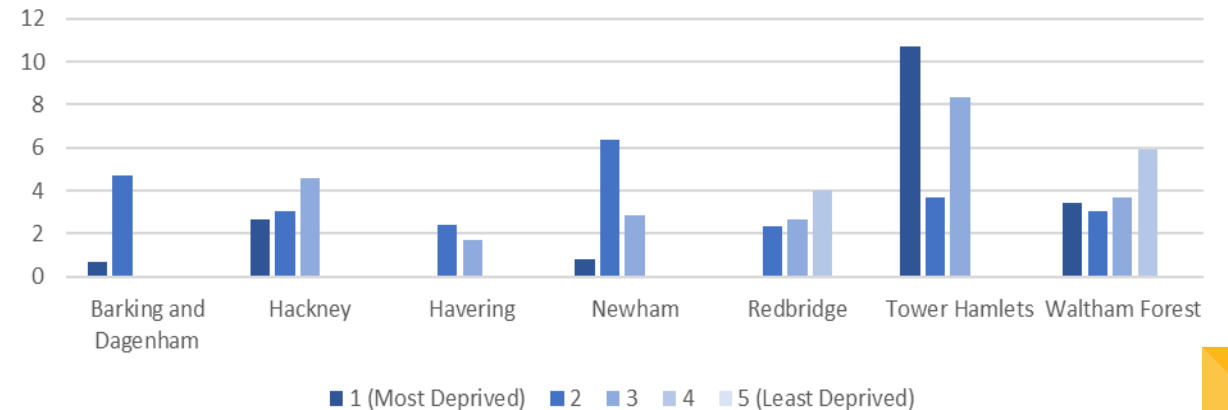
Figure 2: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)



Key findings

- Overall there were **3.6 babies per 1000** born stillbirth in NEL. Tower Hamlets had the **highest rate** per 1000 of babies born stillbirth at **6.2 per 1000**, this was 6 times higher than the rate found in Havering (i.e. at **1 per 1000**).
- Across NEL, the rate of babies born stillbirth was higher for Black (**3.8 per 1000**), Asian (**4 per 1000**) and Other ethnicities (**4.1 per 1000**) compared to the rate for White (**2.6 per 1000**) and Mixed ethnicities (**0**).
- Stillbirths to Asian and Black women tend to be concentrated in 3 boroughs – Hackney, Newham and Waltham Forest – with the rates for Black (**6.5 per 1000**) and Asian women (**9 per 1000**) being highest in Newham.
- In contrast, there were stillborn babies to White women across all NEL boroughs with the exception of Newham. There were also no stillbirth babies to Mixed women across all NEL boroughs.
- Two notable outliers are Other ethnicities (**12.7 per 1000**) in Newham and Unknown (**12.1 per 1000**) in Tower Hamlets for whom the rate was higher than for all groups in all boroughs.
- Across NEL, the rate of babies born stillbirth was highest among women living in areas within the second most deprived quintile at **4.2 per 1000**, compared to those living in areas within the least deprived quintile where **0** babies were born stillbirth.
- Across the NEL boroughs, Tower Hamlets had the highest rate of babies born as stillbirth in their most deprived quintile (**10.7 per 1000**), this was at least **3 times greater** than the rate found in the most deprived quintile in the other boroughs across NEL.
- **As the numbers are very low for this outcome measure, the findings should be treated with a high degree of caution ahead of further analysis (in Phase 2)**

Figure 3: Rate per 1000 of babies born stillbirth - by deprivation and borough (2020/21)



Admissions to neonatal care

Figure 4: % of admissions to neonatal care – by borough (2020/21)

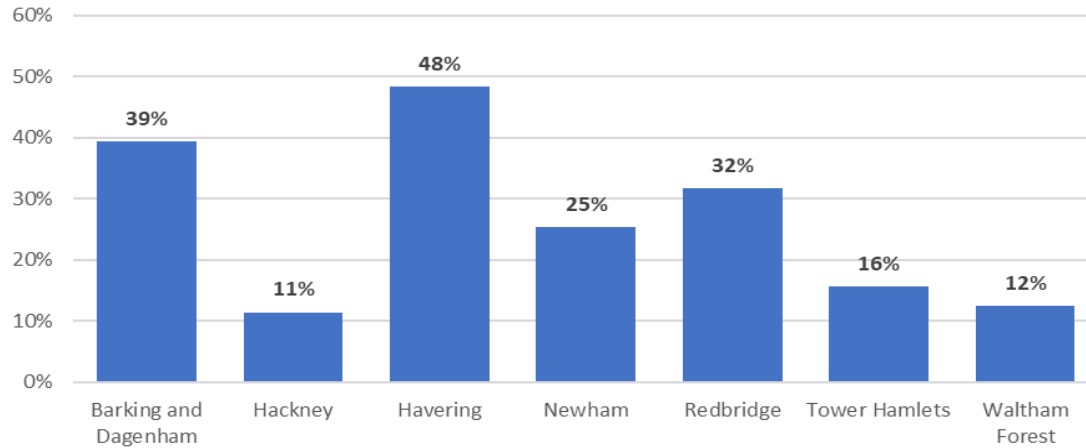
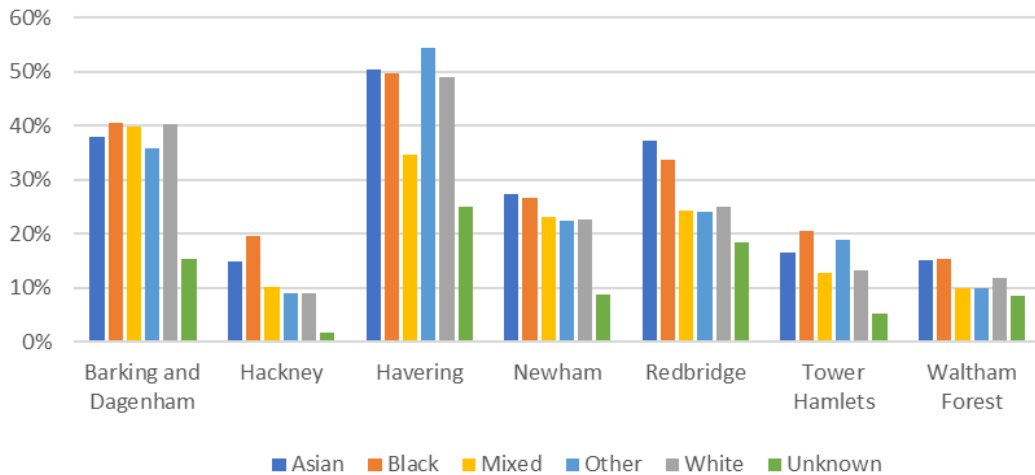


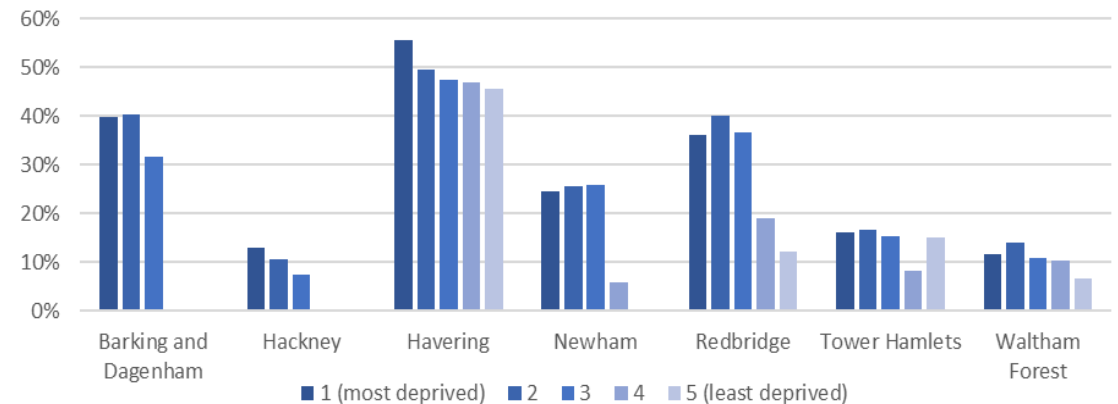
Figure 5: % of admissions to neonatal care – by ethnicity and borough (2020/21)



Key findings

- On average, nearly a quarter of babies born in NEL were admitted to neonatal care (**24%**) although there is a lot of variation between boroughs. Havering and Barking and Dagenham had the highest proportion of admissions (**48%** and **39%**) which was **over 3 times** the percentage of admissions in Hackney (**11%**), Tower Hamlets (**16%**) and Waltham Forest (**13%**).
- On average at NEL level, Asian and Black ethnicities had the highest percentage of babies admitted to neonatal care (**27%** for both), compared with **22%** for babies born to White women and **18%** for babies born to Other ethnicities..
- The variation between Black and White women is **highest** in Hackney with **20%** of babies born to Black women admitted to neonatal – which is over double the rate for White ethnicities (**9%**) as well as Mixed (**10%**) and Other (**9%**).
- On average across NEL, differences between deprivation quintiles appear relative small, i.e. ranging from **23%** for those living in the **most deprived** areas to **26%** in the least.
- At the borough level however, there appears to be a correlation between deprivation and admissions, most prevalent in Havering and Redbridge where the rates for those in the **most deprived** areas are at **36-56%** compared with **12-45%** for those living the **least deprived** areas.

Figure 6: % of admissions to neonatal care – by deprivation and borough (2020/21)



Low birth weight

Figure 7: % of babies born with low birth weight – by borough (2020/21)

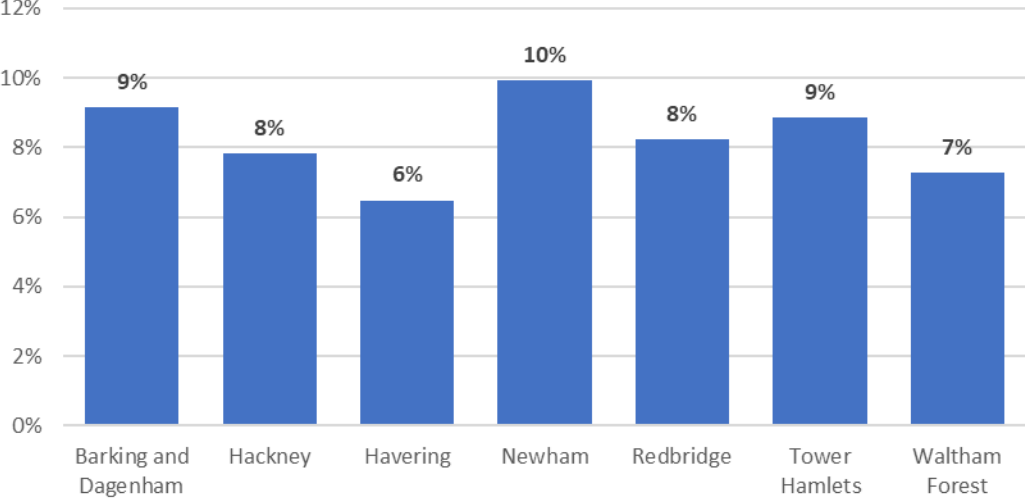
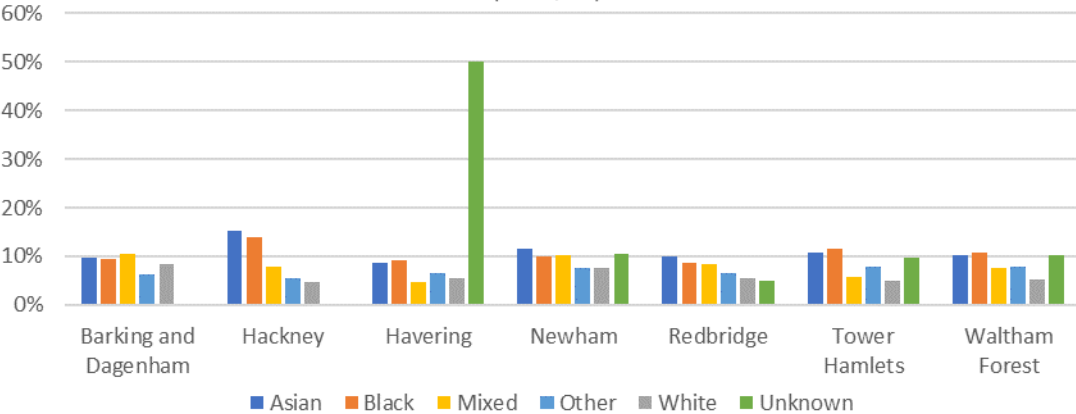


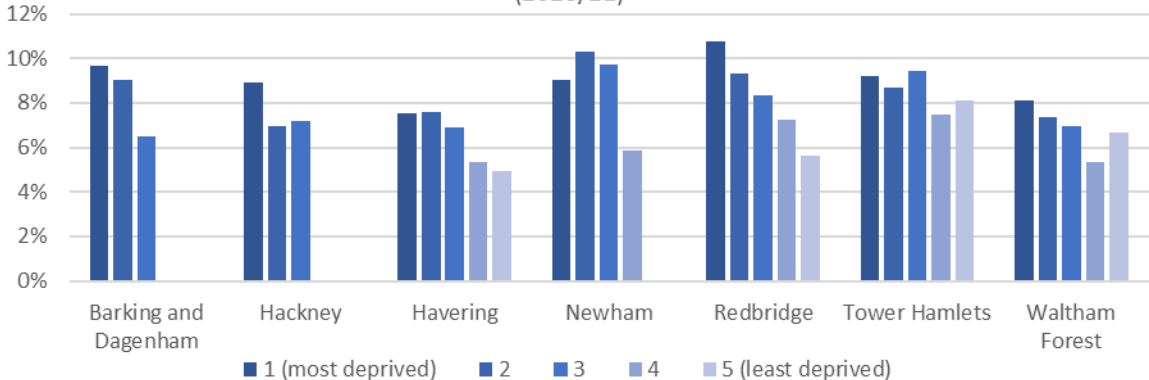
Figure 8: % of babies born with low birth weight – by ethnicity and borough (2020/21)



Key findings

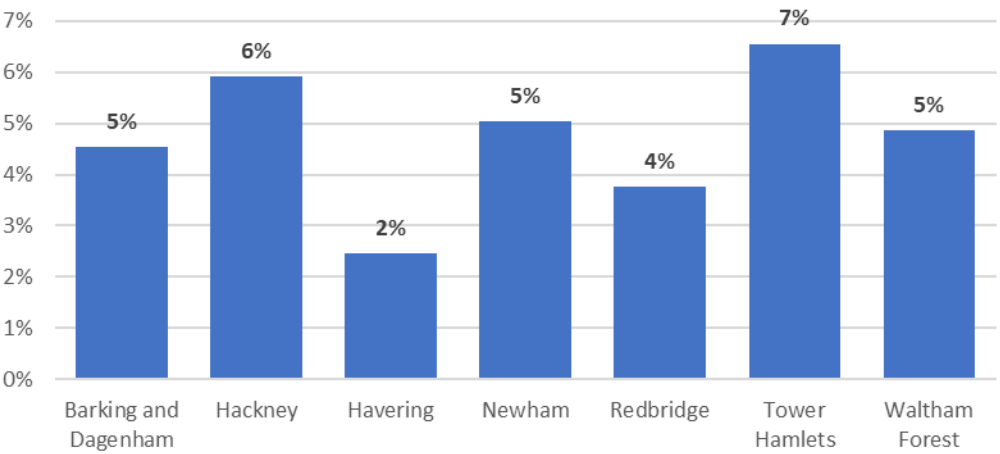
- Across NEL, **8%** of babies were born with low birth weight – with some variation across this average (**6-10%**).
- Havering, despite having the **highest percentage** of babies admitted to neonatal care, had the **lowest percentage** of babies born with low birth weight relative to all other NEL boroughs. Though it looks like Havering has a very high rate of low birth weight for Unknown ethnicity babies, there are only 4 babies with unknown ethnicity for Havering, and 2 of them had low birth weight.
- Approximately **1 in 10** babies born (**10%**) in Newham had a low birth weight.
- Across NEL, **11%** of babies born to Black and Asian women had a low birth weight – almost **double the rate** for babies born to White (**6%**).
- This disparity is largest within Hackney, Tower Hamlets and Waltham Forest. In Hackney, the percentage of babies born with low birth weight of Black and Asian ethnicity is **nearly three times as high** (between **14-15%**) as the percentage found for White ethnicities (**5%**). In Tower Hamlets and Waltham Forest this difference is **twice as high** (**10-12% vs 5%** for both boroughs).
- For the majority of boroughs, the percentage of babies born with low birth weight increases with deprivation with **9%** of babies in the **most deprived** group in NEL with a low birth weight compared with **6%** for the **least deprived** group.

Figure 9: % of babies born with low birth weight – by ethnicity and borough (2020/21)



A&E attendances within 6 weeks of delivery

Figure 10: % of pregnant women with an A&E attendance within 6 weeks - by borough (2020/21)



Key findings

- On average across NEL, **5%** of women had an A&E attendance within 6 weeks of delivery. Havering had the lowest percentage of women with an A&E attendance (at **2%**) which is at least twice as low as the average rate within the other boroughs.
- On average, there was little variation in the rates found between ethnicities in NEL (**5-6%** for all ethnicities). This does, however, mask key differences at the borough level.
- In Havering, for example, Black ethnicities (**4%**) and Mixed ethnicities (**4%**) had approximately **double the rate** of women with at least one A&E attendance than White (**2%**) and Asian ethnicities (**2%**).
- Across NEL, the percentage of women with an A&E attendance living in the most deprived areas was twice as high as those in the least deprived (i.e. **6%** versus **3%**).
- The link appears to be largest in Redbridge and Havering. In Redbridge the percentage for the most deprived quintile (**5%**) is **more than double** the percentage for the least deprived quintile (**2%**). Similarly, in Havering the rate is **5% versus 3%**.

Figure 11: % of pregnant women with an A&E attendance within 6 weeks of delivery - by ethnicity and borough (2020/21)

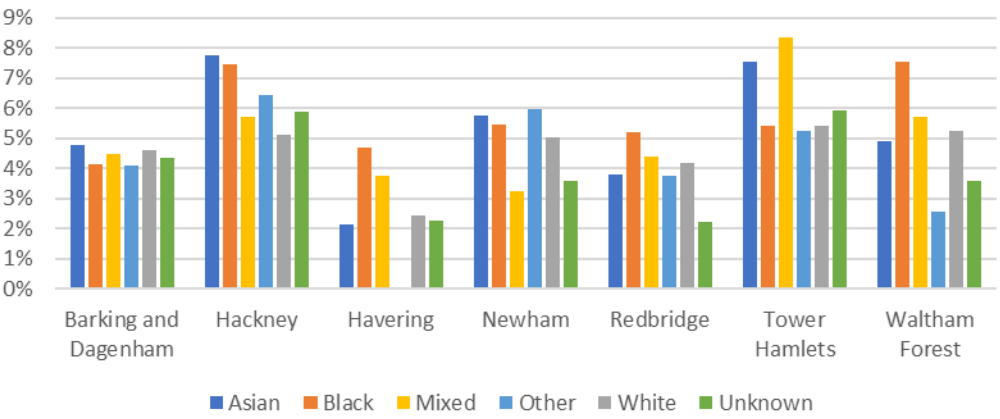
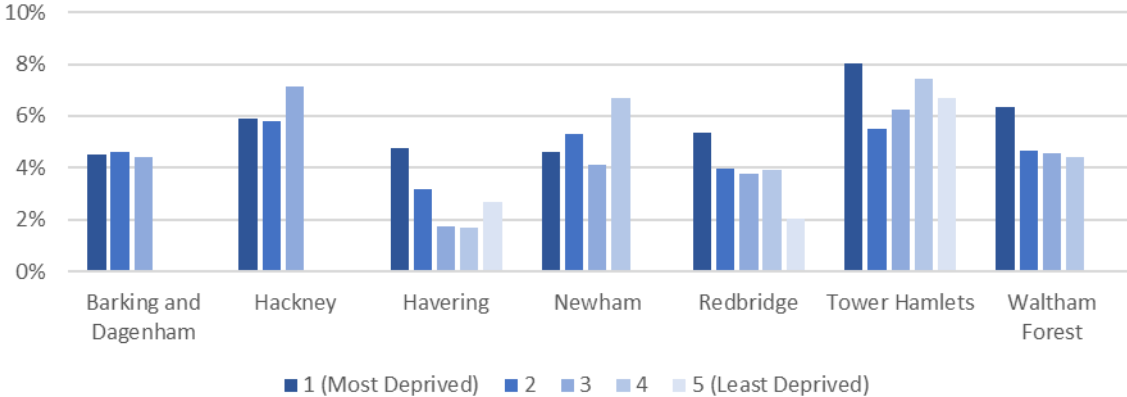


Figure 12: % of pregnant women with an A&E attendance within 6 weeks of delivery - by deprivation and borough (2020/21)



Admissions to hospital within 6 weeks of delivery

Figure 13: % of pregnant women with an admission within 6 weeks of delivery - by borough (2020/21)

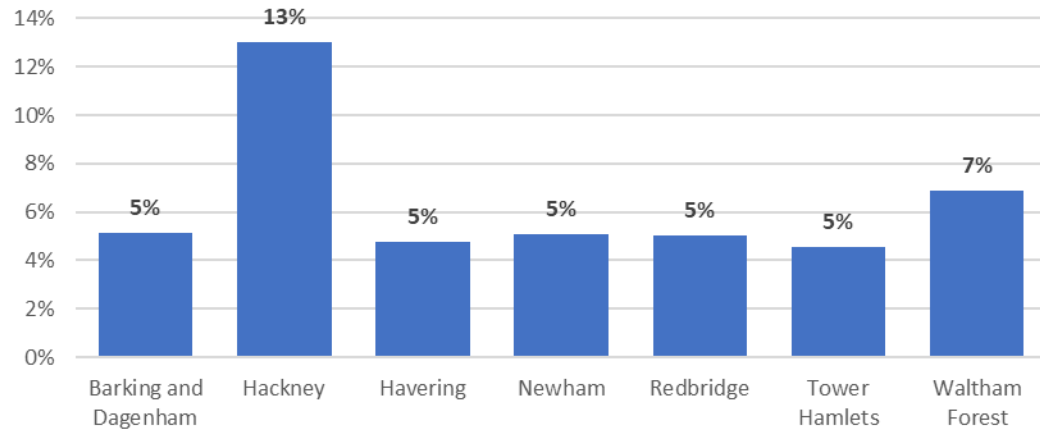


Figure 14: % of pregnant women with an admission within 6 weeks of delivery - by ethnicity and borough (2020/21)

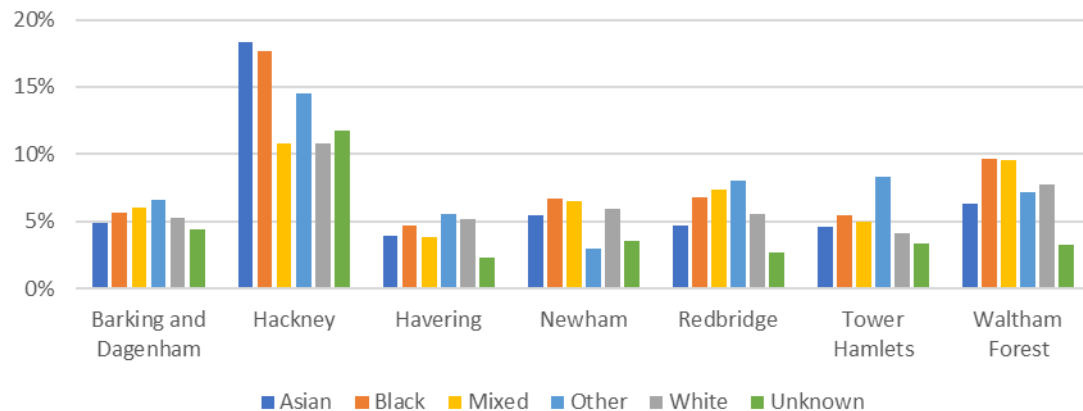
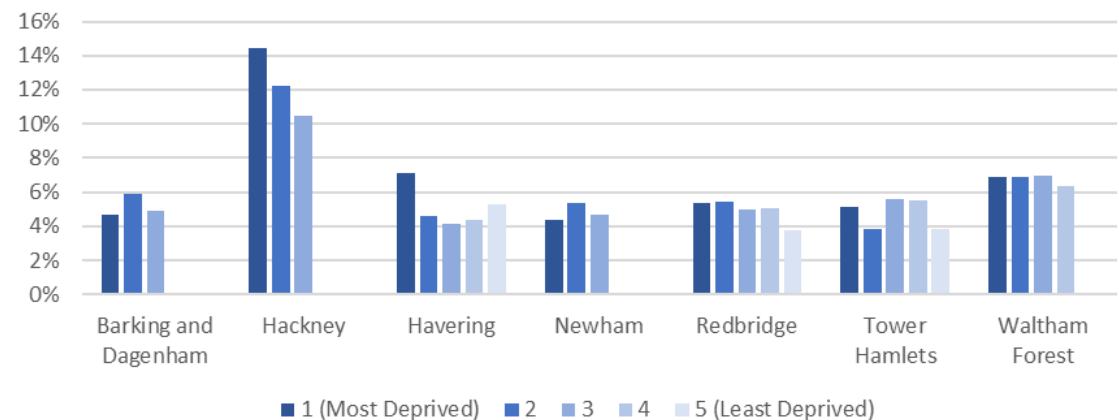


Figure 15: % of pregnant women with an admission within 6 weeks of delivery - by deprivation and borough (2020/21)



Key findings

- On average across NEL, **6%** of women were admitted to hospital within 6 weeks of delivery. Hackney (**13%**) had the largest percentage of women with an admission, this was more than **twice as high** as the value found for other boroughs across NEL.
- When focusing on ethnicity across NEL, differences between ethnicities relatively minimal. At the borough level, Hackney is the one notable exception – with a **large observed disparity** in rates among Black and Asian women (at **18%** for both) compared with those among White women (**11%**).
- Across NEL, the percentage of women with an admission to hospital fell from the most deprived quintile (**7%**) to the least deprived quintile (**4%**), however these differences do not appear overly marked.
- However, as with ethnicity Hackney is also the outlier here, with the largest difference in rates between the most deprived (**14%**) and least deprived quintiles (**10%**) – although Hackney does not have any of its LSOAs in the top two least deprived quintiles (and may therefore understate the ‘true’ scale of the difference).

A&E attendances within 6 months of delivery

Figure 16: % of pregnant women with an A&E attendance within 6 months of delivery - by borough (2020/21)

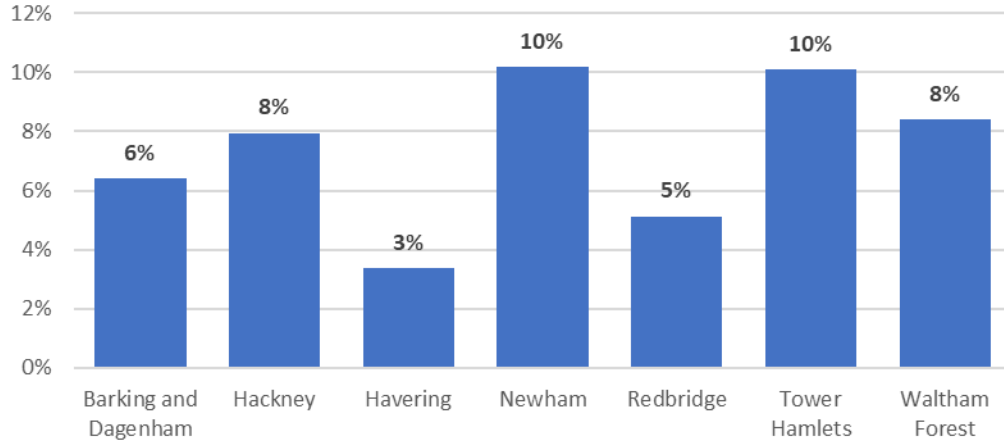


Figure 17: % of pregnant women with an A&E attendance within 6 months of delivery - by ethnicity and borough (2020/21)

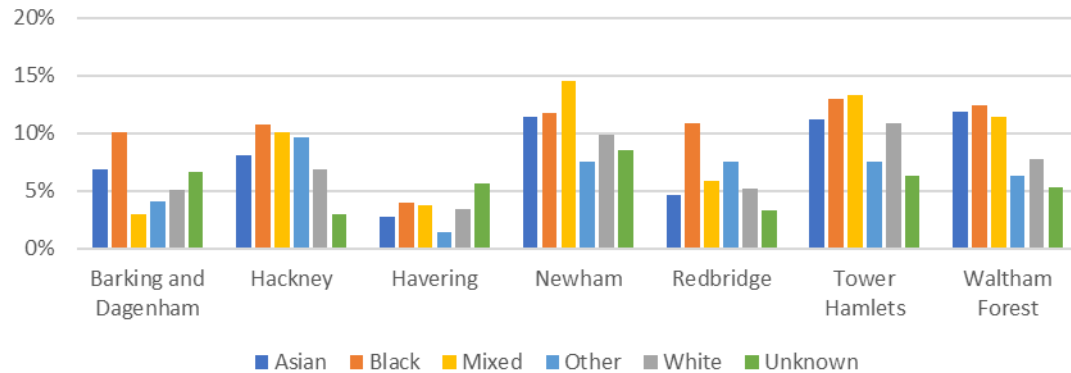
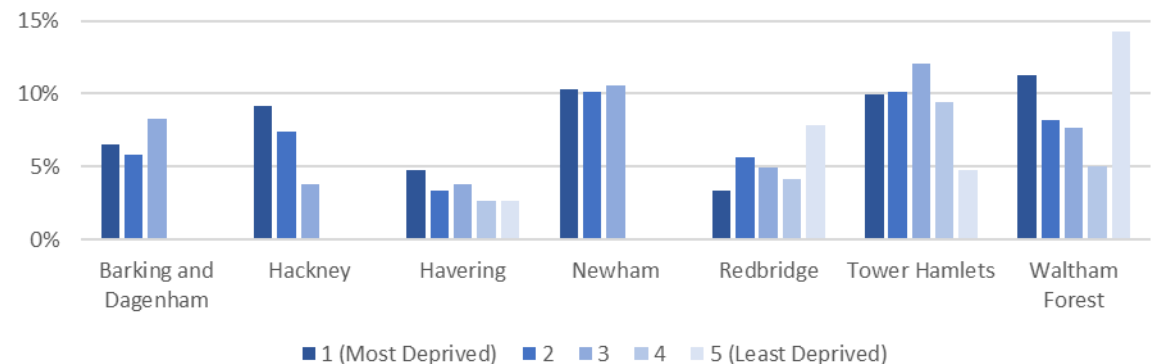


Figure 18: % of pregnant women with an A&E attendance within 6 months of delivery - by deprivation and borough (2020/21)



Key findings

- On average across NEL, **8%** of women had an A&E attendance within 6 months of delivery (excluding the first 6 weeks). The percentage of women with an A&E attendance within 6 months varies between the NEL boroughs, with the rates in Newham (**10%**) and Tower Hamlets (**10%**) **double that** in Redbridge (**5%**), and **three times** greater than the rate in Havering (**3%**).
- On average across NEL, Black ethnicities (**11%**) had the highest percentage of women attending A&E within 6 months of delivery, compared to White (**7%**) and Other ethnicities (**7%**) who had the lowest percentage.
- Both Black and Mixed ethnicities had the highest percentage of pregnant women with an A&E attendance in all of the boroughs. In Barking and Dagenham and Redbridge, for example, the percentage of Black women (**10%** in both) with an A&E attendance was **double the** percentage found for White women (**5%** in both).
- On average across NEL, the percentage of women with an A&E attendance is **almost double** among those in the **most deprived** quintile compared with the least deprived (i.e. **9%** compared with **5%**), suggesting a strong link between deprivation and A&E attendances.
- In Hackney and Tower Hamlets, for example, the percentage of women with an A&E attendance for the most deprived quintile is double the percentage for the least deprived quintile (**8%** vs **4%** for Hackney, and **10%** vs **5%** for Tower Hamlets). Redbridge is the main outlier to this as the percentage found for the **least deprived** quintile (**8%**) is **double the value found** for the most deprived quintile (**4%**).

Admission to hospital within 6 months of delivery

Figure 19: % of pregnant women with an admission within 6 months of delivery - by borough (2020/21)

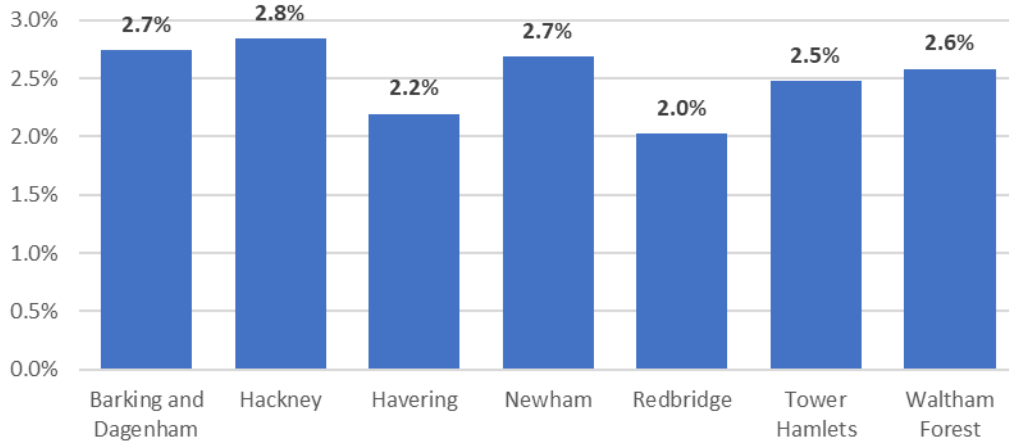


Figure 20: % of pregnant women with an admission within 6 months of delivery - by ethnicity and borough (2020/21)

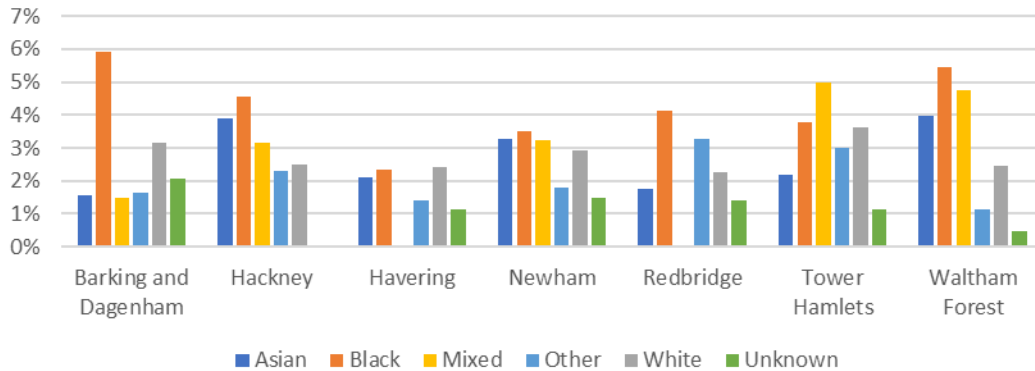
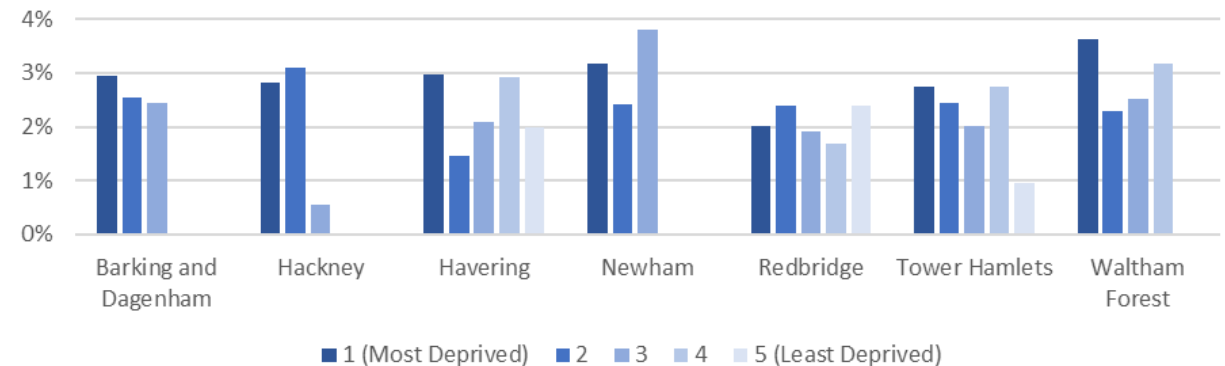


Figure 21: % of pregnant women with an admission within 6 months of delivery - by deprivation and borough (2020/21)

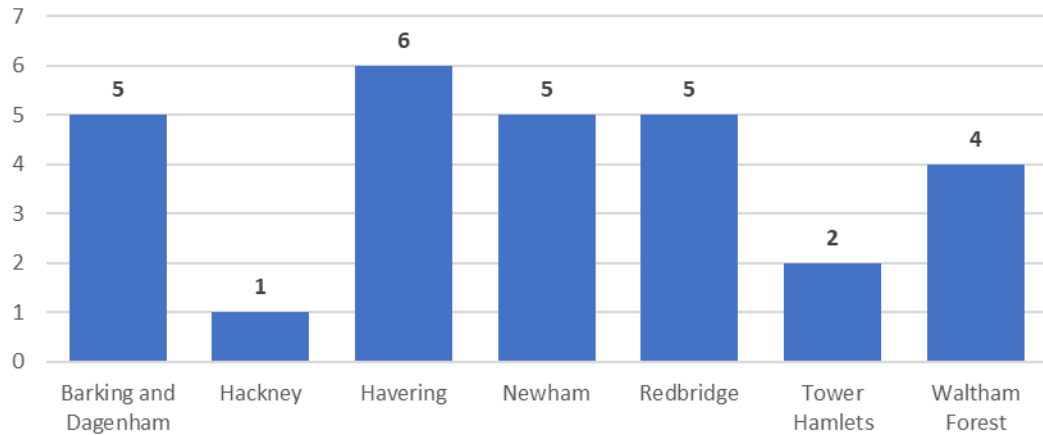


Key findings

- On average across NEL, **3%** of women that gave birth in 2021 were admitted to hospital within 6 months of delivery (excluding the first 6 weeks).
- On average across NEL as a whole, differences between ethnicities were minimal. However, Black ethnicities had the highest percentage of women with an admission within 6 months of delivering for all boroughs, other than Tower Hamlets where Mixed ethnicities had the highest.
- This average does, however, mask much large variations observed within individual boroughs.
- In Barking and Dagenham, for example, Black ethnicities (**6%**) had **more than double** the rate of women admitted compared with those for White women (**3%**).
- On average across NEL, differences between deprivation quintiles in NEL are relatively small, with **3%** of women in the most deprived quintile having an admission compared to **2%** for those in the least deprived. This finding appears to be relatively consistent at the borough level with Hackney and Tower Hamlets the two notable outliers. In Tower Hamlets and Hackney the percentage of women with an admission in their most deprived quintile is at **least 2 times greater** than the percentage found in their least deprived quintile (**3% vs 1%** for both boroughs).

Outpatient appointments within 6 weeks of delivery

Figure 22: Median no. of outpatient appointments within 6 weeks of delivery - by borough (2020/21)



Key findings

- In NEL, the median number of outpatient appointments within 6 weeks was **4**, although there is a lot of variation across boroughs. Similar to outpatient appointments during pregnancy, Tower Hamlets (**2** appointments) and Hackney (**1** appointment) had less than **half the median number** of outpatient appointments within 6 weeks of delivery, compared to the other boroughs in NEL (**4-6** appointments).
- Across NEL, the median number of appointments between ethnicities was broadly the same (**3-4** appointments).
- Across NEL, the median number of outpatient appointments for the most deprived quintile is **3** appointments, compared to a median of **5** appointments for the least deprived quintile.
- It seems that number of outpatient appointments is consistent within boroughs (across ethnicity and deprivation) but varies mainly between boroughs across NEL.

Figure 23: Median no. of outpatient appointments within 6 weeks of delivery - by ethnicity and borough (2020/21)

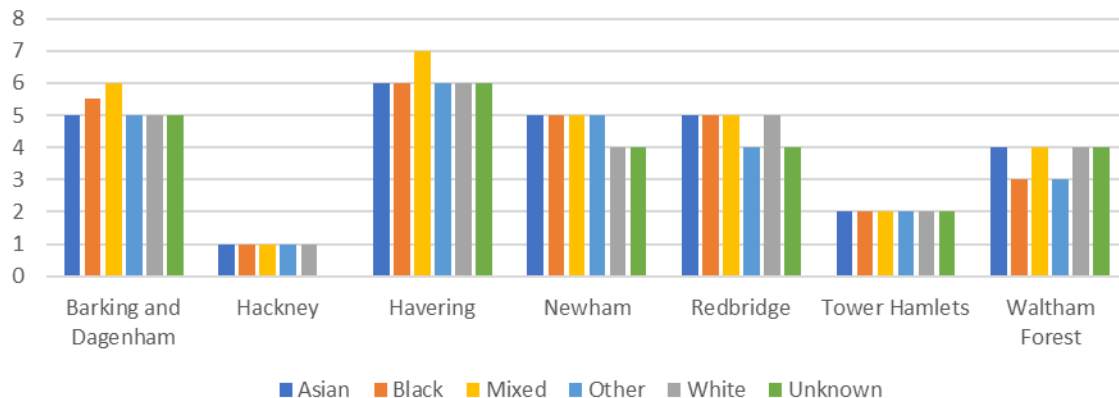
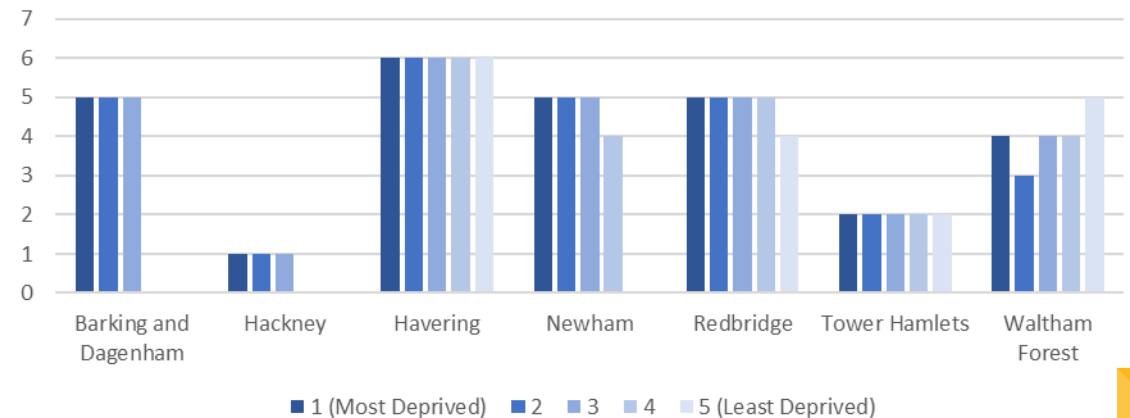


Figure 24: Median no. of outpatient appointments within 6 weeks of delivery - by deprivation and borough (2020/21)



Annex 6 – Overview of the FGM population

Overview of the National FGM Enhanced Data set

- The data analysis in this section are drawn from the Female Genital Mutilation (FGM) Enhance Data Set covering the period 20/21. Anonymised borough level data are made publically available by NHS Digital.

1. What is the FGM enhanced data set?

- It is a repository for individual level data collected by healthcare providers in England - including acute hospital providers, mental health providers and GP practices - about patients who have had FGM.
- It is mandatory for acute hospital providers, mental health providers and GP practices to submit to the FGMed ([SCCI 2026 Information Standards Notice](#))
- This enhanced data set supports the DHSCs FGM prevention programme by presenting an national picture of the prevalence of FGM in the NHS in England.
- This submission is managed and published on a quarterly basis by NHS Digital and collects information.
- It builds on the FGM Prevalence Dataset which collected data from acute trusts between April 2014 and March 2015. The Enhanced Dataset began collecting data on 1 April 2015 in Trusts and GP practices in October 2015.
- There are **19** different data fields that are included in the dataset (see table)

2. What indicators have we included in this report?

- Overall for the period 20/21, the completeness of a large majority of data field was extremely low with many being less than **35%** complete and in some cases as low as **15%** (see table for coverage rates). We have, therefore, limited our analysis of FGM women in the 20/21 data set to indicators **No. 1** (Total women with FGM), **No. 2** (FGM type), **No. 4** (Age at attendance), and **No. 12** (Identification method) as they have the best completion % .
- The trends on low completeness rates apply across all boroughs with Hackney being the exception' having the 'best' data coverage, with having approx. **90%** coverage for some of the indicators. This could be a potential further area for exploration to understand whether there is any good practice within Hackney that could be shared across the other boroughs.

No.	Indicator	% unknown/not reported (NEL)	% unknown/not reported (London)
1	Total no. women/girls with FGM (2015-21 and 2020-21)	N/A	N/A
2	No. individual women by FGM Type	29%	43%
3	No. individual women with FGM Type 4 by Subtype	57%	54%
4	Age of Attendance	0%	0%
5	No. Newly recorded women	N/A	N/A
6	Age at which FGM was carried out	85%	54%
7	Region of Birth	66%	45%
8	Region of Origin	70%	61%
9	Country where FGM Carried Out	82%	61%
10	No. of Daughters Under 18	85%	59%
11	Referring Organisation Type	72%	44%
12	FGM Identification Method	2%	17%
13	Treatment Function Area	69%	26%
14	Pregnant at Attendance	71%	34%
15	Average no. of attendances per woman	N/A	N/A

Key data caveats, notes and definitions

1. High proportion of 'unknown' and/or 'not reported' data

- This is the case for most of the indicators for FGM women in the 20/21 dataset which is why we have limited our analysis to the data on (1) FGM type and (2) age at attendance – both of which had the highest completion rates. However, the (average) completion rates across NEL for these two indicators is still below the level that we would normally require to be able draw reliable and meaningful conclusions so even the findings on these two metrics should be interpreted with caution.
- Further, it is unclear whether - and to what extent – the pressure on the system due to Covid has impacted the completeness of reporting against data fields by NHS staff and if completeness rates were better in previous years (and indeed whether they may improve going forward as Covid pressure subside).
- While on average, the data coverage for 20/21 is relatively poor across both the London region and England, overall, data quality across NEL appears to be **worse** than compared with London and England overall

2. Data suppression

- Where numbers are low, NHSD has suppressed the data to minimise the risk of individuals being identified. This means that:
 - all values from 1 to 7 have been coded as 5, and numbers above that have been rounded to the nearest 5)
 - This means that both overall values and averages presented in this analysis may be skewed due to the rounding conventions applied to the published dataset.

3. Risks of underreporting numbers due to Covid

- NHSD notes that the reporting period 20/21 coincides with the increased pressure on NHSE services due to Covid and that 'fewer individuals continue to be reported making FGM related attendances'. NHSD notes that it is unclear whether this reflects (1) a reduction in the number of women and girls seen by NHS services at attendances related to their FGM and/or (2) a reduction the capacity of NHS services to report all the FGM-related attendances that have taken place.

4. We are unable to accurately estimate the % of FGM women pregnant in 20/21

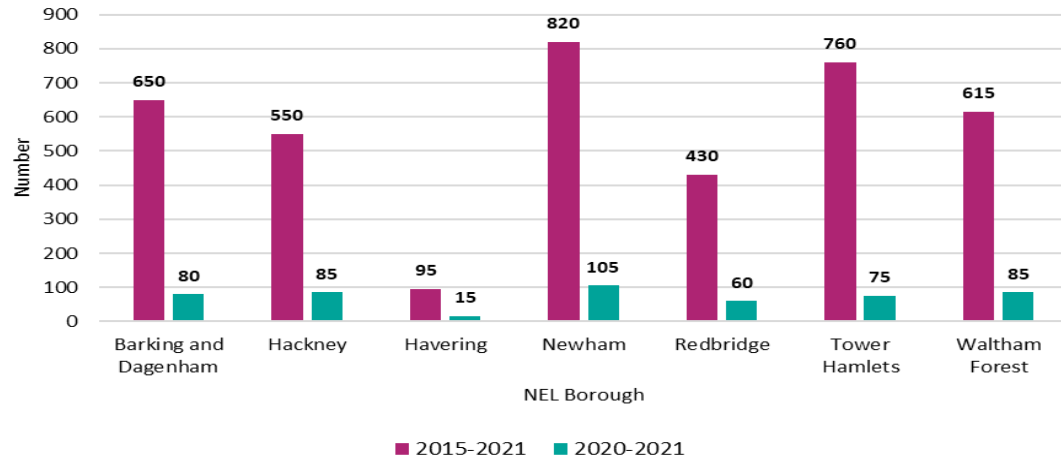
- This Data set records FGM victims regardless of whether they are or have been pregnant in the past. It does, however, include a field to indicate whether women were pregnant at the time of attendance. However, for the reasons relating to completeness – this data not been included in this analysis.

5. "Individuals"

- Note: Chart 1 refers to the total of "individuals"; i.e. referring to all patients in the reporting period where FGM was identified or a procedure for FGM was undertaken. **Each patient is only counted once.**

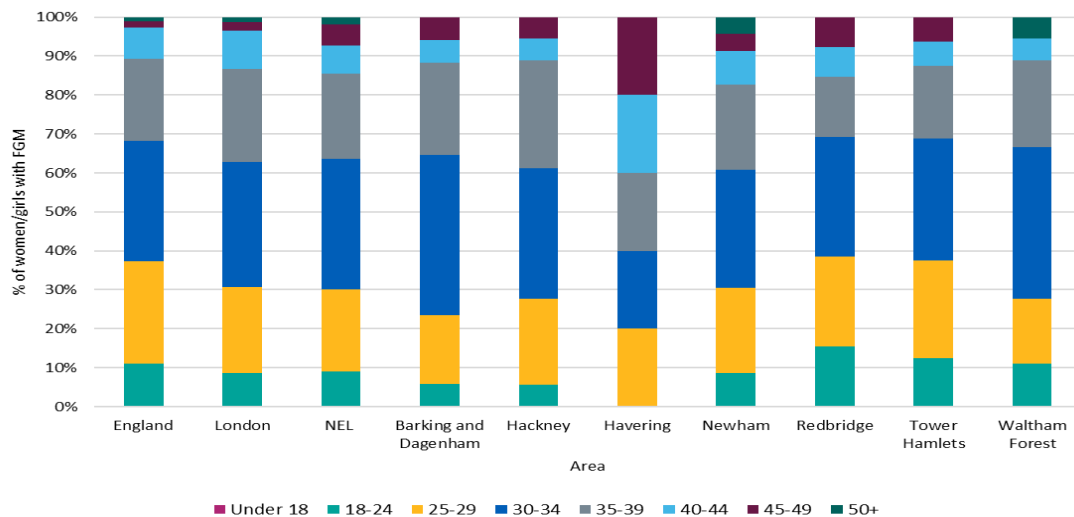
Overview of FGM population

Figure 1: Total no. of women/girls with FGM (2015-21 and 20-21)



Note: 20/21 numbers are a subset of the 2015-2021 data

Figure 2: Breakdown (%) of women/girls with FGM by age of attendance (20/21)

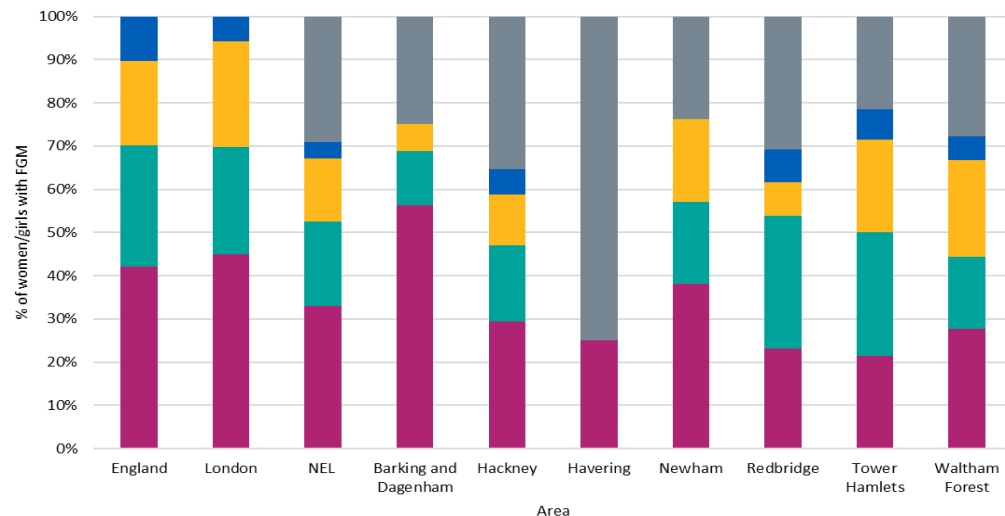


Key findings

- Overall, Newham, Tower Hamlets and Barking and Dagenham, have the highest number of unique women identified with FGM over the last six years. (See Chart 1). Newham and Tower Hamlets are also the two boroughs with the highest proportion of ethnic minority women. Newham had 105 women, and both Waltham Forest and Hackney had 85 women who either had FGM identified or a treatment for FGM in 20/21. This compares with **15-80** across the other 4 boroughs.
- Overall, the distribution at the NEL level across age groups is relatively consistent when compared with both London and England (See Chart 2). The age distribution across all boroughs tends to be skewed more towards women in the 30+ age groups with an average of **60%** reported as being in this age group in NEL overall.

Overview of FGM population (2)

Figure 3: Breakdown (%) of women/girls with FGM by Type (20/21)

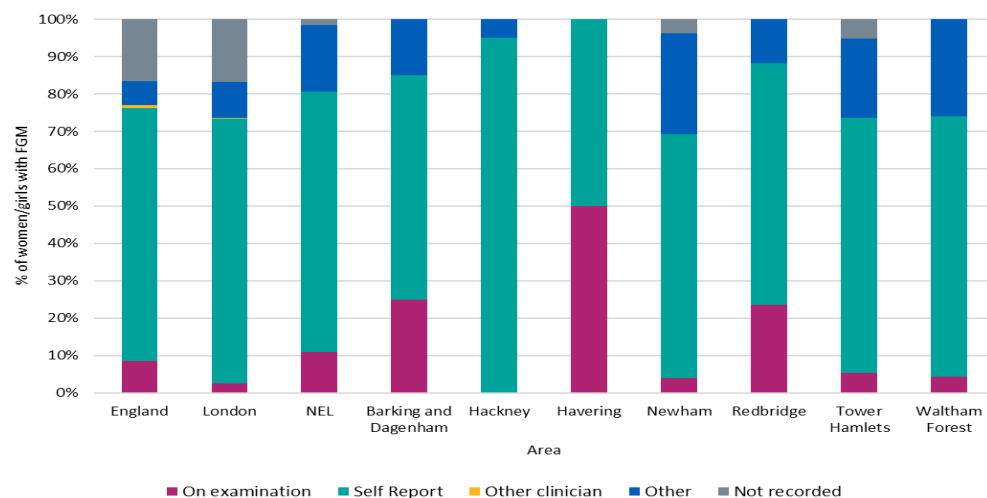


Key findings

- Similarly to London and national trends, Type 1 is the **most common** FGM type across NEL (**21-56%**) and Type 4 is the least common, with the highest proportion of Type 4 FGM are Redbridge (**8%**) and Tower Hamlets (**7%**). Barking and Dagenham has a much lower proportion of women with the more severe Type 2 and 3 FGM compared to the other NEL boroughs (as well as London and England averages) and has no reported cases of Type 4. (See Chart 3)

- In line with London and national trends, 'Self Report' is the most common method of identification for women and girls with FGM across NEL (**50-95%**), Hackney having the greatest proportion of almost all (**95%**) methods of identification being Self Report. This is different to Havering where only half identify through 'Self Report'. The other **50%** are identified 'On examination', which is unique both across NEL as well as England and London, where 'On examination' figures are **9%** and **3%** respectively. (See Chart 4)

Figure 4: Breakdown (%) of women/girls with FGM by their FGM identification method (20/21)



Annex 7 – Covid-19 infections & admissions

COVID-19 Infections by ethnicity and deprivation

Figure 1: % of pregnant women infected with COVID-19 - by borough (2020/21)

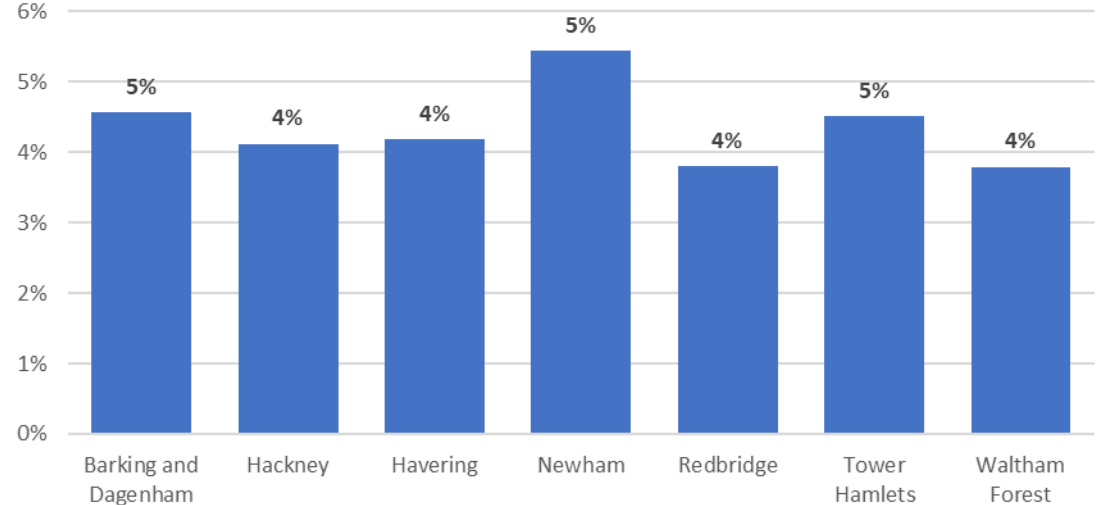


Figure 2: % of pregnant women infected with COVID-19 - by ethnicity and borough (2020/21)

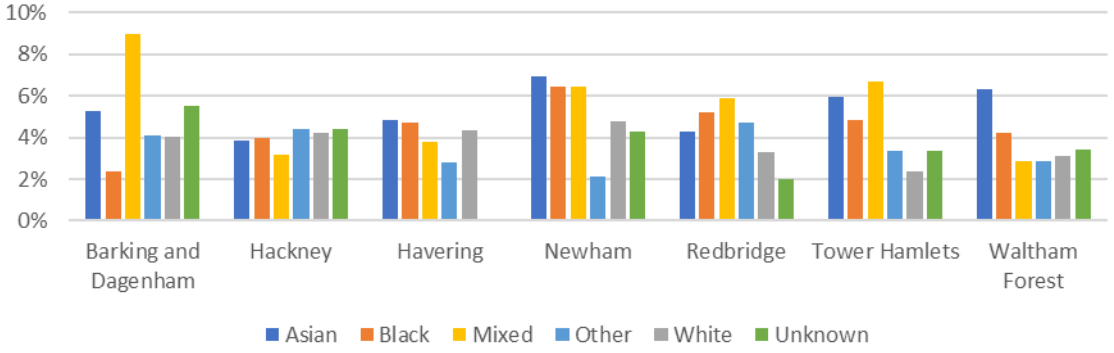
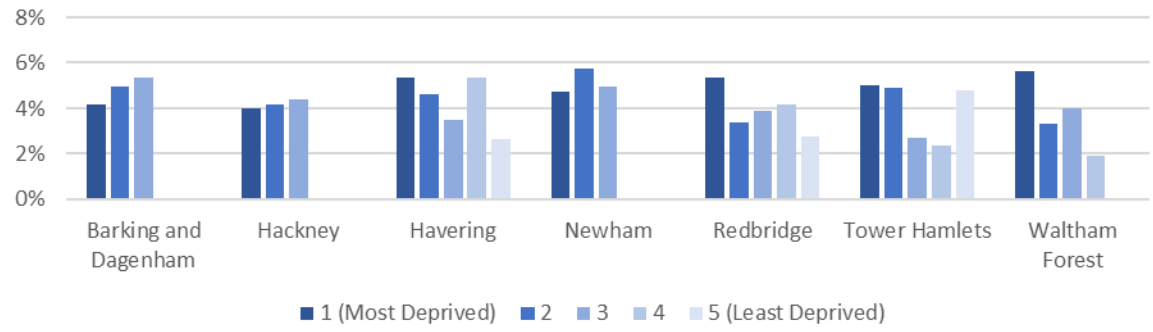


Figure 3: % of pregnant women infected with COVID-19 - by deprivation and borough (2020/21)

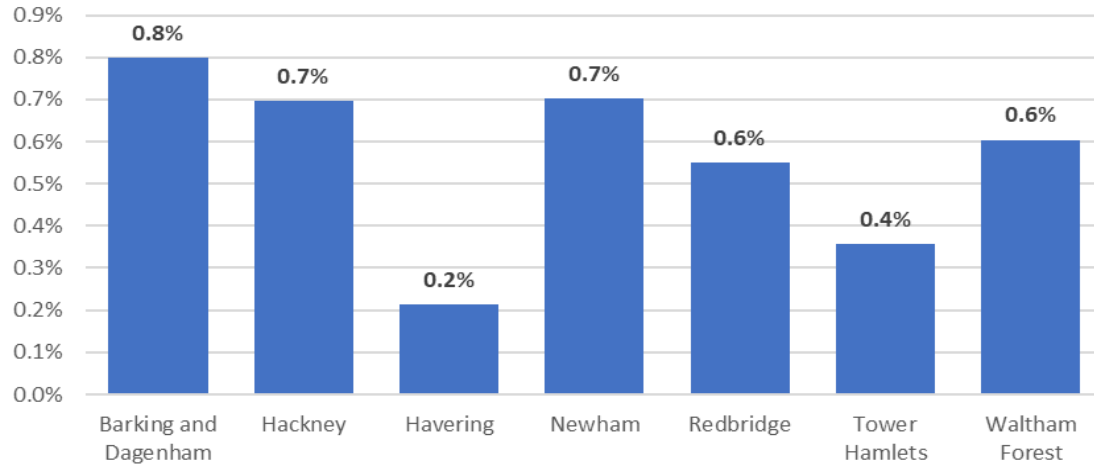


Key findings:

- Across NEL, **4%** of pregnant women were infected with COVID while pregnant. There were only small differences between boroughs, with all boroughs having an admission percentage between **4-5%**.
- With the exception of Hackney and Havering, in general women in ethnic minority groups across all boroughs were more likely to be infected with COVID than White women
- Within some boroughs, the rates of infection for women among Black, Asian and Mixed groups were **double** those among White women :
 - In Waltham Forest, the percentage of Asian women infected with COVID while pregnant was **two times higher** than for White ethnicities (**6%** compared with **3%**).
 - In Barking and Dagenham and Redbridge the percentage of women from a Mixed background infected by COVID was **twice** that for White women. In and Tower Hamlets the rate is **three times** as high.
- In addition to the inequalities within boroughs, there are some key inequalities across boroughs:
 - The percentage of pregnant women infected with COVID-19 of Black ethnicity is **three times** higher in Newham than in Barking and Dagenham (**6%** compared with **2%**).
 - The percentage of pregnant women infected with COVID-19 of Mixed ethnicity is **over two times** higher in Barking and Dagenham than in Hackney and Waltham Forest.
- Across NEL, although differences between deprivation quintiles appear relatively small, the percentage of women infected with COVID while pregnant fell from the most deprived quintile (**5%**) to the least deprived quintile (**3%**).
- This trend is most apparent in Havering, Redbridge and Waltham Forest, where the percentage of women with COVID while pregnant is **2 times higher** for the **most deprived** quintile than the **least deprived** quintile.

COVID-19 Admissions by ethnicity & deprivation

Figure 4: % of pregnant women admitted to hospital with COVID-19 - by borough (2020/21)



Key findings:

- Across NEL, **0.6%** of women were admitted to hospital with COVID while pregnant. Havering had the lowest percentage of women admitted to hospital at **0.2%** while the percentage for Barking and Dagenham (**0.8%**) was 4 times greater.
- In general, the proportion of pregnant women admitted into hospital with Covid across all ethnicities tended to be higher than for White women. In Hackney for example, while the proportion of infections across ethnicities was broadly similar, the opposite is true for admissions, with the rate among Black women (**1.1%**) nearly **twice** that of White women (**0.6%**)
- Similarly, in Barking & Dagenham, the percentage of pregnant woman admitted to hospital with COVID-19 of Mixed ethnicities (**6%**) is **6 times higher** than the value for all other ethnicities in the borough (less than **1%** for all).
- As with infections, deprivation also appears to be related to the probability of admission. Across NEL as a whole the rate for the most deprived quintile (**0.8%**) was **8 times greater** than the rate for the least deprived (**0.1%**).
- Although the percentage of pregnant women admitted to hospital with COVID-19 by deprivation quintile is low for all boroughs, the percentage admitted falls from the most deprived quintiles to the least deprived in all boroughs except Redbridge. Rates for women the most deprived quintiles ranged between **0.7-1.3%** compared with **0-0.5%** among those in the top two least deprived quintiles.

Figure 5: % of pregnant women admitted to hospital with COVID-19 - by ethnicity and borough (2020/21)

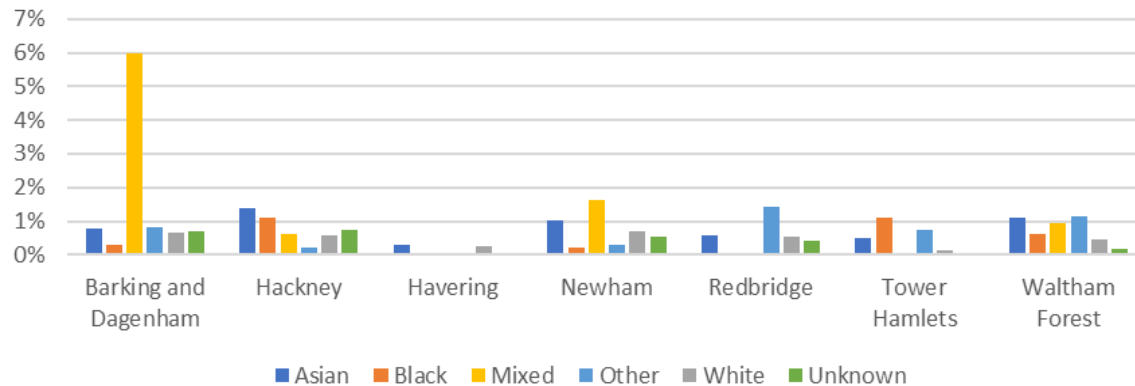
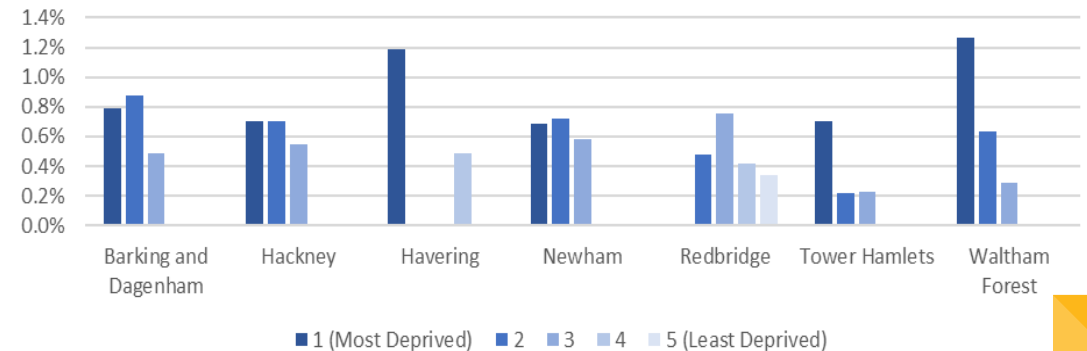


Figure 6: % of pregnant women admitted to hospital with COVID-19 - by deprivation and borough (2020/21)



Annex 8 – Metrics, data sources & definitions

Outcomes – data sources & definitions

Metric	Year	Source	Definitions/Notes
% of women with an admission within 6 weeks after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one admission within 6 weeks of delivery. Both elective and non-elective admissions are included.
% of women with an admission within 6 months after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one admission within 6 months of delivery, excluding the first 6 weeks. Both elective and non-elective admissions are included.
% of women with an attendance within 6 weeks after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one A&E attendance within 6 weeks of delivery.
% of women with an attendance within 6 months after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one A&E attendance within 6 months of delivery, excluding the first 6 weeks.
Median number of outpatient appointments within 6 weeks of delivery	2020/21	SUS	This metric focuses on the median number of outpatient appointments for women with all specialties within 6 weeks of delivery
% of babies born with extremely low birth weight by ethnicity and deprivation	2020/21	HES	This metric focuses on the percentage of babies born with low birth weight, where low birth weight is defined as less than 2500g. For ethnicity it is the mothers ethnicity that is captured rather than the baby's.
% of babies admitted to neonatal critical care	2020/21	HES	This metric focuses on the percentage of babies admitted to neonatal critical care. For ethnicity it is the mothers ethnicity that is captured rather than the baby's. A baby is considered in the neonatal period if they are within the first 28 days of their birth date.
Stillbirth rate	2020/21	HES	This metric focuses on the rate per 1000 of babies born stillbirth. For ethnicity it is the mothers ethnicity that is captured rather than the baby's.

Access and use of services – data sources & definitions

Metric	Year	Source	Definitions/Notes
% of women with at least 1 inpatient admission during pregnancy	2020/21	Secondary uses service (SUS) dataset	This metric focuses on the percentage of pregnant women who had at least 1 admission during pregnancy. Both elective and non-elective admissions are included.
% of women with at least 1 A&E attendance during pregnancy	2020/21	Secondary uses service (SUS) dataset	This metric focuses on the percentage of pregnant women who had at least one A&E attendance during pregnancy
Median number of outpatient appointments by Midwifery and Obstetrics during pregnancy	2020/21	Secondary uses service (SUS) dataset	This metric focuses on the median number of outpatient appointments for pregnant women with the midwifery and obstetrics specialties.
Average gestational age at first contact	2020/21	Maternity services (MSDS) dataset	This metric focuses on the average gestational age at first contact where first contact is defined as the date the women first contacted the NHS for antenatal/pregnancy care. This is either GP appointment or direct access to maternity services.

LTCs & risk factors – data sources & definitions

Metric	Year	Source	Definitions/Notes
Prevalence of Epilepsy (%)	2021	SUS	The rate of women giving birth in 2021 that have an ICD-10 diagnosis of epilepsy
Prevalence of diabetes (%)	2021	SUS	The rate of women giving birth in 2021 that have an ICD-10 diagnosis of type 1 or 2 diabetes
Prevalence of high blood pressure/hypertension (%)	2021	SUS	The rate of women giving birth in 2021 that have an ICD-10 diagnosis of hypertension
Prevalence of High BMI/ Obesity (%)	2021	SUS	The rate of women giving birth in 2021 that have a BMI of 30 or above
Folic Acid status	2021	HES	This records whether or not the woman has been taking folic acid supplements, as identified at First Contact or Booking Appointment. It combines national codes 01 (has been taking prior to pregnancy & 02 (started taking once pregnancy confirmed)
Disability indicator (%)	2021	HES	The rate amongst women that gave birth in 2021 who have a listed disability
Employment Status (%)	2021	HES	the rate among women that gave birth in 2021 who are not in employment, due to unemployment, long term sickness or disability.
Complex social factors (%)	2021	HES	Complex social factors include women aged under 20, women who experience domestic abuse, women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English or women who misuse substances including alcohol.

Delivery methods – data sources & definitions

Metric	Year	Source	Definitions/Notes
% Babies born by delivery Method – Vaginal Birth	2020-21	MSDS	The rate of babies being delivered by the method of Spontaneous Vertex, or Spontaneous other delivery
% Babies born by delivery Method – Forceps	2020-21	MSDS	The rate of babies being delivered by the method of Low forceps cephalic delivery or Other Forceps delivery
% Babies born by delivery Method – Planned C-Section	2020-21	MSDS	The rate of babies being delivered by the method of Elective Caesarean Section
% Babies born by delivery Method – Unplanned C-Section	2020-21	MSDS	The rate of babies being delivered by the method of Emergency Caesarean Section
% of women having a episiotomy	2020-21	HES	At present this derivation will always be NULL. This is a placeholder derivation, pending further discussion with subject matter experts within NHS Digital on the construction logic. This construction logic will be confirmed in a future release of the Technical Output Specification.
Post Partum Haemorrhage	2020-21	HES	Post-partum haemorrhage (PPH) is excessive bleeding from the vagina at any time after the baby's birth, up until 6 weeks afterwards. PPH is a complication that can occur during the third stage of labour after a baby's born
% of women with 1 st /2 nd /3 rd degree tears	2020-21	HES	Women who receive a tear during delivery 1st degree involves skin 2nd degree involved perineal muscles 3rd degree with partial anal sphincter involvement

Annex 9 – Data completeness and coverage by NEL borough and trust

Difference in population sizes by data source

- Our analysis has had to draw on a mix of **three main data sources: Secondary Uses Services (SUS), Hospital Episode Statistics (HES) and the Maternity Data Set (MSDS)**. While similar, there are differences in the total numbers of births and deliveries that each of the sources reports for 20/21 which means that in some cases, the denominators for some calculations will be difference depending on the source used.

20/21 cohort description	Data source		
	SUS	HES	MSDS
Total deliveries (i.e. unique women)	23,790	24,640	23,559
Total births	24,904	25,590	23,812

Outcomes– data coverage and completeness of metrics [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level							
	SUS	HES	MDS		TH	N	WF	BG	R	HV	HK	
% of women with an admission within 6 weeks after delivery	x			<i>N/A. Trusts will only record this for a an individual if they have ether attended or been admitted. If they did not have an attendance/admission there will be nothing recorded for this in their record (i.e. they would not record that the individual did not attend A&E). This means that we are unable to tell for any of those individuals that have not been flagged as having had an attendance/admission whether do they do in fact have one (or more) it but this has not been recorded for them.</i>								
% of women with an admission within 6 months after delivery	x											
% of women with an attendance within 6 weeks after delivery	x											
% of women with an attendance within 6 months after delivery	x											
Median number of outpatient appointments within 6 weeks of delivery	x											
% of babies born with extremely low birth weight by ethnicity and deprivation		x		94%	96%	98%	92%	97%	95%	93%	84%	
% of babies admitted to neonatal critical care		x		90%	100%	99%	94%	79%	82%	59%	95%	
Stillbirth rate		x		94%	97%	98%	92%	97%	95%	93%	84%	

*Based on recording of events in SUS, as not every woman will have an event we cannot accurately say if there are secondary care events missing.

Outcomes – data coverage and completeness of metrics [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Homerton
% of women with an admission within 6 weeks after delivery	X			N/A. Trusts will only record this for a an individual if they have ether attended or ben admitted. If they did not have an attendance/admission there will be nothing recorded for this in their record (i.e. they would not record that the individual did not attend A&E). This means that we are unable to tell for any of those individuals that have not been flagged as having had an attendance/admission whether do they do in fact have one (or more) it but this has not been recorded for them			
% of women with an admission within 6 months after delivery	X						
% of women with an attendance within 6 weeks after delivery	X						
% of women with an attendance within 6 months after delivery	X						
Median number of outpatient appointments within 6 weeks of delivery	X						
% of babies born with extremely low birth weight by ethnicity and deprivation		X		NB. Our current data extract does not provide this information at trust level and due to the short timescale we are unable to extract trust level data for these metrics.			
% of babies admitted to neonatal critical care		X					
Stillbirth rate		x					

Access to services – data coverage and completeness of metrics [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level							
	SUS	HES	MDS		TH	N	WF	BG	R	HV	HK	
% of women with at least 1 inpatient admission during pregnancy	x			100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*
% of women with at least 1 A&E attendance during pregnancy	x			100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*
Median number of outpatient appointments by Midwifery and Obstetrics during pregnancy	x			100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*
Average gestational age at first contact			x	100%**	100%**	100%**	100%**	100%**	100%**	100%**	100%**	100%**

*Based on recording of events in SUS, as not every woman will have an event we cannot accurately say if there are secondary care events missing.

**Based on recording of events in MSDS, any woman with any contact during their pregnancy will by necessity have a first contact, but those without any first contact will not be recorded at all

Access to services – data coverage and completeness of metrics [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Homerton
% of women with at least 1 inpatient admission during pregnancy	x			100%*	100%*	100%*	100%*
% of women with at least 1 A&E attendance during pregnancy	x			100%*	100%*	100%*	100%*
Median number of outpatient appointments by Midwifery and Obstetrics during pregnancy	x			100%*	100%*	100%*	100%*
Average gestational age at first contact			x	100%**	100%**	100%**	100%**

*Based on recording of events in SUS, as not every woman will have an event we cannot accurately say if there are secondary care events missing.

**Based on recording of events in MSDS, any woman with any contact during their pregnancy will by necessity have a first contact, but those without any first contact will not be recorded at all

LTCs & risk factors – data coverage and completeness of metrics [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level							
	SUS	HES	MDS		TH	N	WF	BG	R	HV	HK	
Prevalence of Epilepsy (%)	X			<i>N/A. Trusts will only record this for a an individual if they have been diagnosed with the condition. If they do not have the condition there will be nothing recorded for this in their record (i.e. they would not record that the individual does not have the condition). This means that we are unable to tell for any of those individuals that have not been flagged as having this condition, whether do they do in fact have it but this has not been recorded for them</i>								
Prevalence of diabetes (%)	X											
Prevalence of high blood pressure/hypertension (%)	X											
Prevalence of High BMI/ Obesity (%)	X											
Folic Acid status			X	71%	53%	46%	68%	75%	78%	97%	97%	
Disability indicator (%)			X	98%	95%	97%	98%	99%	98%	98%	99%	
Employment Status (%)			X	91%	87%	93%	91%	95%	95%	98%	81%	
Complex social factors (%)			X	86%	76%	76%	80%	87%	89%	98%	99%	



LTCs & risk factors – data coverage and completeness of metrics [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Hommerton
Prevalence of Epilepsy (%)	X			<i>N/A. Trusts will only record this for a an individual if they have been diagnosed with the condition. If they do not have the condition there will be nothing recorded for this in their record (i.e. they would not record that the individual does not have the condition). This means that we are unable to tell for any of those individuals that have not been flagged as having this condition, whether do they do in fact have it but this has not been recorded for them</i>			
Prevalence of diabetes (%)	X						
Prevalence of high blood pressure/hypertension (%)	X						
Prevalence of High BMI/ Obesity (%)	X						
Folic Acid status			X	71%	41%	100%	99%
Disability indicator (%)			X	98%	97%	100%	100%
Employment Status (%)			X	93%	93%	100%	100%
Complex social factors (%)			X	86%	71%	100%	100%



Delivery methods – data coverage and completeness [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Hommerton
% Babies born by delivery Method			x	99%	100%	98%	100%
Post Partum Haemorrhage		x		<i>Diagnosis codes do not exist in a flagged system. There is no way of telling if a diagnosis code doesn't exist because it wasn't recorded, as opposed to the patient not being diagnosed with a particular item</i>			
% of women with 1 st /2 nd /3 rd degree tears		x					



Delivery methods – data coverage and completeness [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level						
	SUS	HES	MSDS		TH	N	WF	BG	R	HV	HK
% Babies born by delivery Method			x	99%	99%	100%	99%	99%	99%	99%	99%
Post Partum Haemorrhage		x		<i>Diagnosis codes do not exist in a flagged system. There is no way of telling if a diagnosis code doesn't exist because it wasn't recorded, as opposed to the patient not being diagnosed with a particular item</i>							
% of women with 1 st /2 nd /3 rd degree tears		x									



Coverage rates across of all MDS metrics (1)

MDS metric	1. % of women included in the relevant data tables/columns	2. % of women included in the data table with a known ethnicity recorded (Black, White, Mixed, Asian or other)
Gestational age at booking	92%	91%
Mental health prediction indicator (Whether or not the recommended questions for prediction and detection of mental health issues were asked.)	91%	96%
Disability indicator	91%	91%
Support status (Whether or not the mother feels she is supported in pregnancy and looking after a baby, from partner, family or friends.)	91%	91%
Employment Status	88%	92%
Complex social factors	80%	92%
Folic acid status	78%	92%
Language code (The language the patient prefers to use for communication with a Health Care Provider.)	55%	95%
Continuity of care (An indication of whether a mother has been booked onto a continuity of carer pathway, as defined by the Better Births recommendations)	43%	94%
Antepartum care plan	40%	94%

Coverage rates across of all MDS metrics (2)

MDS metric	1. % of women included in the data table	2. % of women included in the data table with a known ethnicity recorded (Black, White, Mixed, Asian or other)
Personalised antepartum care plan	39%	93%
Baby first feed breastmilk	31%	92%
Skin to skin contact	22%	98%
Alcohol units at booking	9%	95%
Smoking status at booking*	0%	0%

Note – This is a selection of indicators, the MSDS contains over 40 possible metrics.

*In MSDS specification it states this column is in as a placeholder pending further discussions



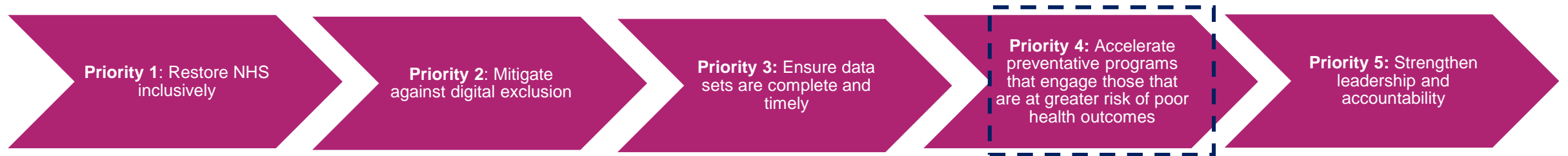
North East London
Clinical Commissioning Group

6. Community assets mapping

Prepared by Women's Health and Family Services: Maternity Mates



6.1 Aim of community assets mapping



The COVID-19 pandemic repeatedly demonstrated that harnessing effective, **local community assets** is integral to **reducing inequalities and improving health outcomes**.

Community assets are: almost always people centred, should have cultural competence at the heart of their services and are provided from accessible and trusted locations and build on the unique strengths of our local communities

The **purpose of mapping** our community assets is to:

- Build our knowledge of what services are available across NEL within each borough
- Determine what is effective and has proven to meet the needs of Black, Asian and Mixed ethnicity pregnant women and their babies, and those living in areas with high levels of deprivation
- Understand whether there is a consistent offer across NEL
- Identify what assets are missing from areas/boroughs
- Inform a 5 year development strategy

The **Guidelines suggest**, we should put into place a directory of services for health professionals which:

- Aid or enhance personal care plans
- Provide a platform for integration and partnerships between community assets and maternity systems to improve equity for women from Ethnic Minorities backgrounds and those living in areas with high levels of deprivation.

6.2 Our approach

We used research, third sector evidenced reports and outreach to identify those assets and resources supporting populations most likely to experience Health inequalities within maternity care.

Assets and resources are categorised around Social Determinants of Health, recognising the vital role they play in addressing wider issues that can improve health outcomes particularly for those experiencing intersectionality.

Women's Voices

- Support/service delivery
- Informal conversations
- Interviews and focus groups from third sector report

Clinical Commissioning Group; Local Public Health, Maternity Teams

- Commissioned local services

Council for Voluntary Services

- Members and individuals
- Community Centres
- Associations and faith groups
- Formal and informal entities

Local third and private sectors

- Charities and the Charities Commission
- Companies
- Housing Associations



Reference: [Public Health England](#), Health Guidance Matters, 28 February 2018

6.3 Key caveats to asset mapping

1. Volume of local assets

- We identified approximately 2104 community assets across NEL comprising of formal and mostly informal entities offering a service that is or could be relevant to pregnant women/new mothers from Ethnic Minorities living in areas with high levels of deprivation.

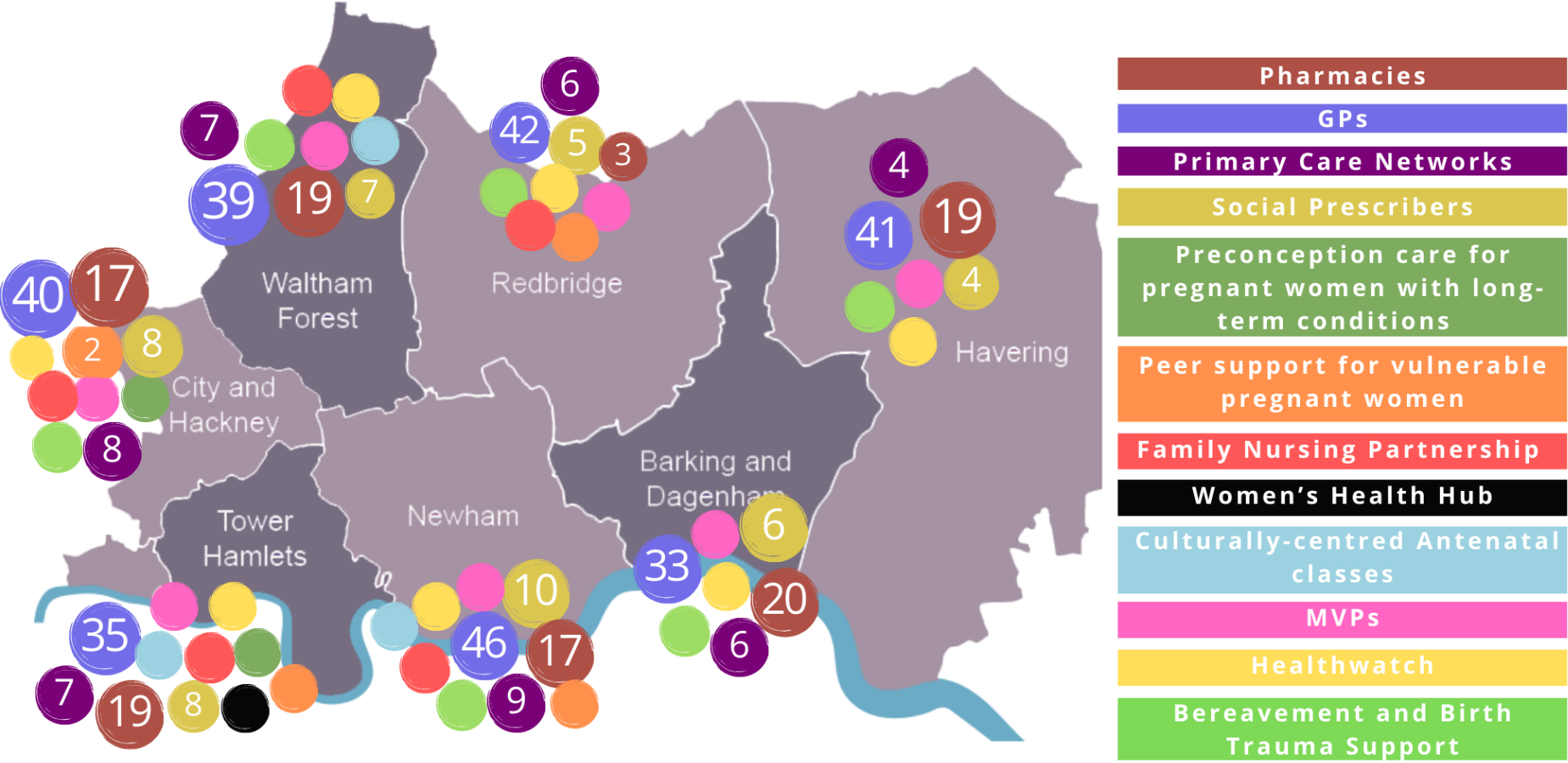
2. Quality Assurance Impact Assessment and Governance

- We recognise that, once all local community assets have been captured, it will be necessary to quality assure organisations contained within a directory (for example, Safeguarding, Governance structures and financial practices) to ensure that Maternity Services can make connections with confidence. This has not been possible within the time restraints of Stage 1 and could form a key part of Stage 3.

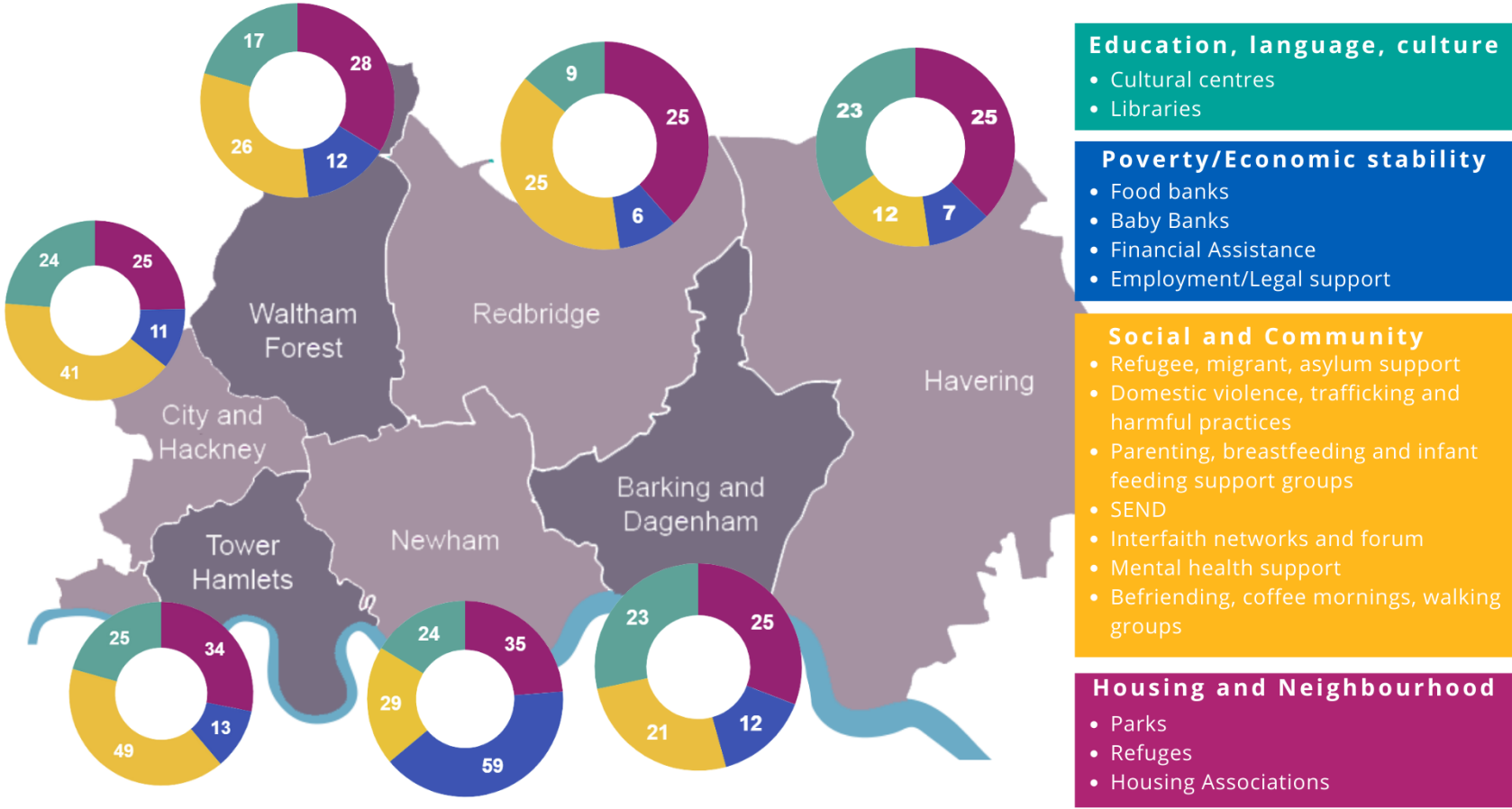
3. Incompleteness

- This Stage (1) is not an exhaustive, complete picture of all existing community assets. Has instead focussed on beginning the process by highlighting 'visible' assets to inform Stage 2's coproduction with local communities.
- Time limit, to concentrate on capturing community assets, our beneficiaries
- We have also not yet cross-referenced our identified assets with those held by local Social Prescribers who represent a valuable source of information
- We also recognise the need to enhance the level of information held against each asset to understand the precise offer of support available

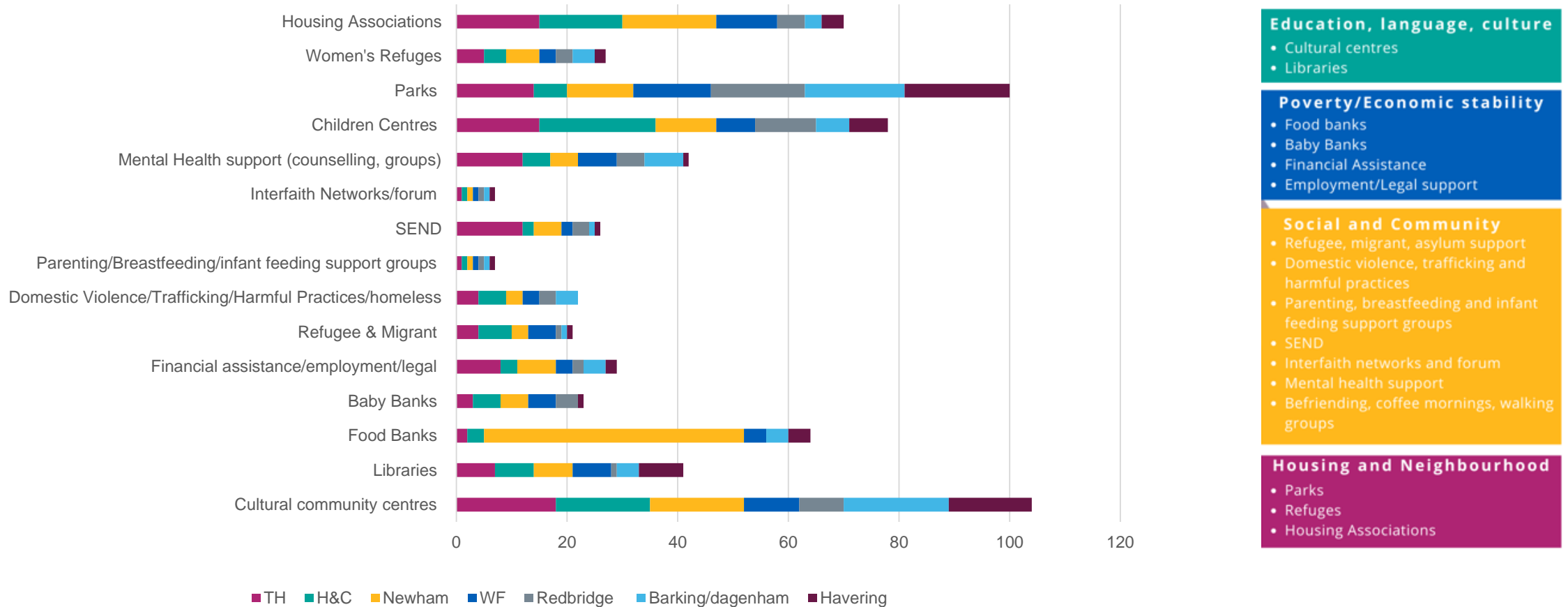
6.4 NEL: Statutory and Commissioned Assets



6.5 Asset overview categorised around social determinants of health



6.6 Community Asset comparison by borough



6.7 Key findings from our community mapping

1. Over 2100+ community assets

- Our local communities have a huge and diverse range of assets to draw upon and ensuring positive connections between these community assets and Maternity services will be hugely valuable.

2. Disparity across Boroughs

- The mapping exercise has revealed large differences between available local assets across boroughs. Whilst these differences may, at least in part, be explained by the distinct needs of the communities contained within each respective Borough, further analysis will be needed to fully understand where the most significant gaps are and how these can be best addressed as part of a future development strategy.

3. Multiple organisations have commenced community asset mapping

- Through this exercise, we have become aware of a number of other local services (E.g. social prescribing) that have taken preliminary steps to identify, map and navigating or directing women and their families to other services. We will look to co-ordinate our work with these agencies to avoid duplication and share resources wherever possible, this includes health care professionals making every contact count.

4. Perinatal Mental Health

- Perinatal Mental Health is one critical area of enormous importance to our LMS given the level and complexity of local need, nuances of intersectionality. Hence, where data analysis has not been possible at this stage. The work continues to echo trends of inequalities in health. It critically illuminates the need for maternity and perinatal mental health services to be re-built through the lenses and lived experiences of minoritised ethnic groups and communities. Co-production must be at the core of what we do.



North East London
Clinical Commissioning Group

7. Case Studies across NEL LMS

Showcasing partnerships between health care professionals and community assets for pregnant people and their families:

- 7.1 Holistic support for an entire family: Children's Centre, The Magpie Project and the Alternatives Trust
 - 7.2 Pregnant and substance reliance: Homerton University Hospital Foundation Trust, Hackney Orbit and Comet
 - 7.3 Hearing from all communities: BHRUT and local faith communities
 - 7.4 Vulnerable Pregnant Women: Bart's Health NHS Trust and Maternity Mates
-



7.1 Holistic support for an entire family: Children's Centre, The Magpie Project and the Alternatives Trust



Family: Pregnant mother (30), father (31) and, three children under 6, Bangladeshi.

Referral: Referral from older children's School as family are new to the area, no English, mother is pregnant, and father lost his job. Signposting for universal sessions and access to services.

Overview: Family relocated to Newham with no support network. Father is on a spouse Visa with NRPf and recently lost his job. They live in a private rented property at a cost of £1800 a month. In need of financial support.

Financial worries were affecting Mothers health and wellbeing, alongside arthritis and migraines. Referral was initially made for a low-income family with financial support needed. However, during assessment it was clear Mother needed counselling support as she has been feeling low with her pregnancy and was worried about baby and finances. Both parents needed ESOL (English to Speakers of Other Languages) classes as this was affecting their ability to access support. Father was limited with his employment search, as he had no English.

The Magpie Project: we provide a safe and fun place for mums and under-fives suffering in temporary or insecure accommodation. We believe all children have the right to a secure, safe place to play, healthy food, engaged, informed parents, and access to support, no matter what their family circumstances.

Alternatives Trust: empowers vulnerable families in the London Borough of Newham to transform their lives. A small dedicated team gives long-term, intensive support to over 100 women and their children each year through the We Are Family (WAF) programme. This is centred on a weekly therapeutic group which offers early intervention through parenting and life skills to 25-30 families each week.

Intervention and signposting

Mother

- ESOL class
- Referral to Talking Therapies for mother
- Access to Positive Parenting as mother needed support around boundaries
- Referral to Magpie and Alternatives for essentials, food and baby bag for the hospital
- Weaning webinars for baby
- New baby support with liaising with Health Team, BCG and breast feeding
- PIP completed for mother

Father

- ESOL class
- Advocacy and letter of access to clients Solicitor as father was applying to extend his Visa. Fee waiver of £2000 was granted

Whole family

- Shelter referral for family
- Referral to Newham Money for £250 vouchers
- Support with Homeless application made
- Referral to Newham Food Alliance for weekly food delivery
- Family Fund application made for Fridge Freezer which was granted
- Support with Child Benefit application
- Weekly £15 Vouchers from Alternatives during the lockdown for nappies and wipes
- Children's Centre provided bottles, bottle brush, clothes, nappies and wipes for family.
- Supported family to access Early Education for 2 year old funding for Child A
- Advocacy with universal Credit to sort out the payment as Child C was on DLA (UC was able to adjust the payment and family got higher payment)
- Supported family with DLA and carers allowance for Child C
- Liaised with School for Child C for EHCP

Outcomes

- Family were not aware about the Early Help support available when they were referred to the Children's Centre. This support has enabled mother to improve mental health and wellbeing as she has now completed all her Talking Therapy sessions. She is now able to contact the Children Centre herself and book in the play sessions for baby.
- New baby has accessed the Sensory baby sessions and mother understands the importance of tummy time and early communication with baby. Mother feels empowered within the community as she now has made new friends and confident to arrange GP appointment for herself. Father has completed his online ESOL classes.
- Child A has accessed the 15 hours nursery and is happy, thriving and there are no concerns with their developmental milestones.

7.2 Pregnant and substance reliance: Homerton University Hospital, Hackney Orbit and Comet



From **Hackney Orbit's** launch in 2015, the service has provided robust and sustained support for its service users. Strong relationships have been developed between the service users and the professionals, and a trusting and open dialogue has been created. Honest, and at times challenging conversations take place but always within a safe environment.

From the formal sessions that started in January 2016 there have been many successes and challenges within our work. There has continued to be a core group of service users and the children have greatly benefited from the crèche sessions that are led by Comet early years practitioners. They are offered a range of resources, play equipment and experiences that are rich, challenging, stimulating and fun, therefore supporting the child's development and the parent-child relationship.

I enjoy socialising and the activities

It helped me grow comfortable with my baby's development

I feel safe and comfortable there

I like the non-judgmental environment

It helps with my anxiety

I was happy with the support I received and how welcoming the group was

Hackney Orbit: provides antenatal, postnatal and holistic support to women experiencing current or historical substance and alcohol dependency. In addition to the support provided for women, the sessions are accessible to their partners and family members; parents, carers of children aged 5 or under where a person in the family is experiencing the effects of substance / alcohol use whether engaged in treatment or not.

7.3 Hearing from all communities: BHRUT and local faith communities

The role of **Midwife for Multi-Ethnic Empowerment** was introduced for the trust to proactively seek out and implement changes and solutions that will work towards reducing the health inequalities and disparities faced by Black, Asian and Minority Ethnic women during pregnancy and childbirth, both in their outcomes and experiences.



The Midwife currently in the role reported *'the solutions and answers already exist, the women who bear the brunt of these stark statistics can tell us exactly what we need to do to make immediate and sustainable changes, we just need to listen and act on what they tell us'*.

It was felt asking women to fill in surveys about their maternity experience at the point of leaving the hospital was not always the right time to gain their meaningful, detailed contributions to improving care. This method also excluded women who were not fluent in English from providing their feedback.

Instead, as part of her role, the midwife for Multi-Ethnic Empowerment undertakes targeted outreach work, working in partnership with faith and community groups representing the local communities, meeting and consulting with women during their mother and baby group sessions at local centres. Meeting with women in their own spaces, gives a sense of safety and familiarity, providing optimum environments for honest conversations amongst groups of women who already know each other and are able to provide peer support when needed.

To date, women have shared their positive experiences as well as constructive feedback regarding the aspects of their maternity care that they felt were unsafe, unkind or did not meet the expected standard of care. To ensure that women's voices are heard, consenting mothers will record their stories so they can be shared to the wider team and inform the changes that need to be made.

7.4 Vulnerable Pregnant Women: Bart's Health NHS Trust and Maternity Mates

The COVID-19 pandemic was an incredibly challenging period for our marginalised people who were already extremely isolated and facing unimaginably difficult circumstances that were only exacerbated by the crisis.

Case study 1: Mum was referred at 8 months pregnant, suffering from depression and anxiety. At the first introduction meeting, by video call due to Covid-19, the Maternity Mate (MM) reported mum seemed disengaged and disinterested. Alia opened up by text and explained that she couldn't speak freely as she shared her home with her husband and his large family. She felt isolated, had no friends or family and said her husband was verbally abusive and controlling. MM worked closely with mum's social worker and accompanied mum to her perinatal mental health appointments. Maternity Mates funded mum's taxi to these appointments when her husband refused to help.

At birth, MM helped mum manage pain through walking and massage. She also helped mum call her sister after the birth, as her husband had blocked mums contact with her family. Maternity Mates Support Assessors visited mum on the postnatal ward, and supported her wish to breastfeed. Mum told MM her husband's family kept taking the baby from her to give them formula. MM took Alia to the East London Sling Library so she could wear a sling with baby in to prevent them being taken. At the height of the pandemic, MM also arranged with the local Children's Centre a space for her and mum to meet weekly, in private, so mum could speak freely. MM also accompanied mum to baby massage classes and referred her to a culturally relevant support network for women who had been in similar situations.





Case Study 2: Mum was referred at 4 months pregnant as a single mum with no support from family and friends. She disclosed being raped in her home country. She was now in the UK as an asylum seeker, her level of English was very limited, and she did not feel prepared for the arrival of her baby.

Due to limited income, she needed support fulfilling her basic needs. Mum's Maternity Mate (MM) accompanied her to a food bank and helped her find affordable baby items online, since mum felt apprehensive about the pandemic and did not want donated second hand items. Maternity Mates Support Assessors supported her with a heater for the winter. Mum attended online antenatal class. It was difficult in the beginning since she did not have enough data credit to attend Zoom calls for the length of the course and her understanding of English was quite limited. Maternity Mates provided phone credit and found an Arabic interpreter so mum was able to attend and participate in the sessions.

The property where mum lived was in a terrible condition. Both the MM and Programme Coordinator liaised with the property manager on taking actions towards repair. To encourage exercise and get to know Newham, the MM and mum would go to different shops and compare prices, engaging in conversations around diet and healthy eating, since mum was not eating well.

Mum was taken to the hospital and induced due to low foetal activity. She was very scared but the same interpreter and the MM talked to her and the doctors to translate. Neither were allowed in the induction due to COVID-19 restrictions but they followed up closely with mum once the baby was born. On her leaving hospital, we arranged a taxi for her to get home.

A [Maternity Mate](#) is a female volunteer trained by Women's Health and Family Service, to provide practical and emotional support to women during pregnancy, childbirth and the early weeks of motherhood.



North East London
Clinical Commissioning Group

8. Staff Experience WRES indicators



8.1 Overview of the National WRES dataset

- The analysis presented in this report is based on nationally collected data on the Workforce Race Equality Standard (WRES). Our analysis of these data is focused on the three NEL acute trusts: Homerton University Hospital NHS Foundation Trust, Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust.

1. What is the WRES dataset?

The WRES programme was established in 2015 and requires NHS commissioners and NHS organisations (including private providers) to report yearly against 9 indicators of race equality. The WRES is mandated through the NHS standard contract. The annually published WRES Report and supporting data is intended to:

- enable organisations to compare their performance with others in their region and those providing similar services: and to
- provide a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda.
- The latest WRES Report and data covers the period 20/21.
- Link: <https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/>

2. Which of the WRES indicators have we included in this report?

- This analysis covers all **nine** of the WRES indicators (see table to the right)
- [Note: I = Indicator]

Workforce indicators For each of the four workforce indicators, compare the data for white and BME staff	
1	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: <ul style="list-style-type: none"> Non-clinical staff Clinical staff, of which <ul style="list-style-type: none"> Non-medical staff Medical and dental staff <i>Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.</i>
2	Relative likelihood of staff being appointed from shortlisting across all posts <i>Note: This refers to both external and internal posts</i>
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation <i>Note: This indicator will be based on data from a two-year rolling average of the current year and the previous year.</i>
4	Relative likelihood of staff accessing non-mandatory training and CPD
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff	
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
Board representation indicator For this indicator, compare the difference for white and BME staff	
9	Percentage difference between the organisation's board membership and its overall workforce disaggregated: <ul style="list-style-type: none"> By voting membership of the board By executive membership of the board

8.2 Key caveats and limitations of the WRES data and assumptions

1. Some of the indicators include in this analysis covers all staff groups (i.e. not split by specialty)

- The data reported nationally is not split by specialty. However, NHSD have been able to provide us with data for some indicators covered by the standard for Midwifery staff only (i.e. 1, and 5-7). This means that the data with the exceptions of indicators 2 - 9 (which covers all specialty). It is unclear how far the findings on the latter type of indicators will be representative of the experience of midwifery staff specifically.

2. The breakdown of ethnic groupings are limited

- The ethnicity groupings are limited to **White, BME and Null**. This means that we are unable to see inequalities across sub-groups (for whom inequalities may vary) in the way we are for the border analysis of maternity inequalities in which this analysis is part.

3. The published data does not also include information on gender split

- The data does not provide this split which means we cannot identify whether staff in ethnic minority groups may be at a particular disadvantage due to their gender. This is particularly relevant for this analysis as we know that a large majority of maternity staff will be made up of women.

4. The published data does not include the overall distribution of staff employed by ethnicity

- The publicly available data does not provide the overall split of staff by ethnicity group which means that we cannot directly assess for either over or under representation for those indicators that do not take account of differences in the absolute numbers of staff within each grouping (i.e. Board representation). This does not apply to the indicators for which NHSD has supplied data for midwifery staff (in which they also included data on the overall distribution of this staff type by ethnicity).

8.3 Overall distribution of Midwifery staff by ethnicity 2020/21

Figure 2: Breakdown (%) of Midwives in Bart's Health NHS Trust by ethnicity (20/21)

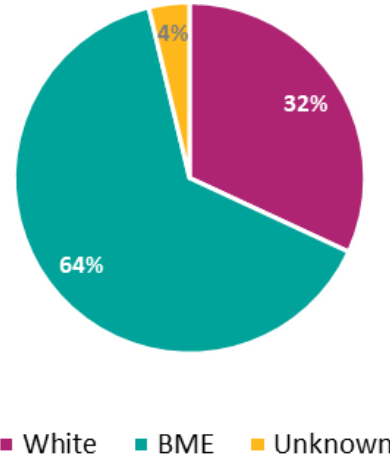


Figure 3: Breakdown (%) of Homerton University Hospital NHS Foundation Trust by ethnicity (20/21)

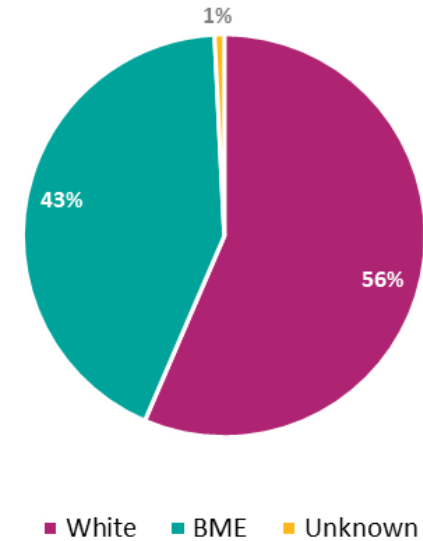
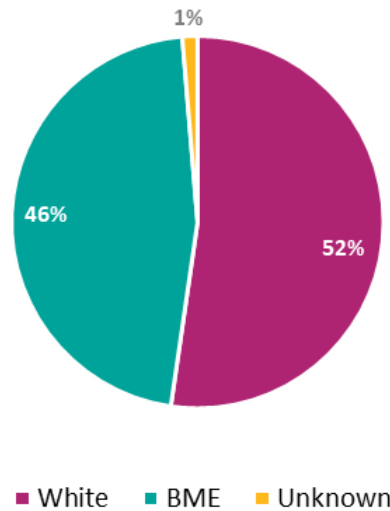


Figure 1: Breakdown (%) of Midwives in BHRUT by ethnicity (20/21)

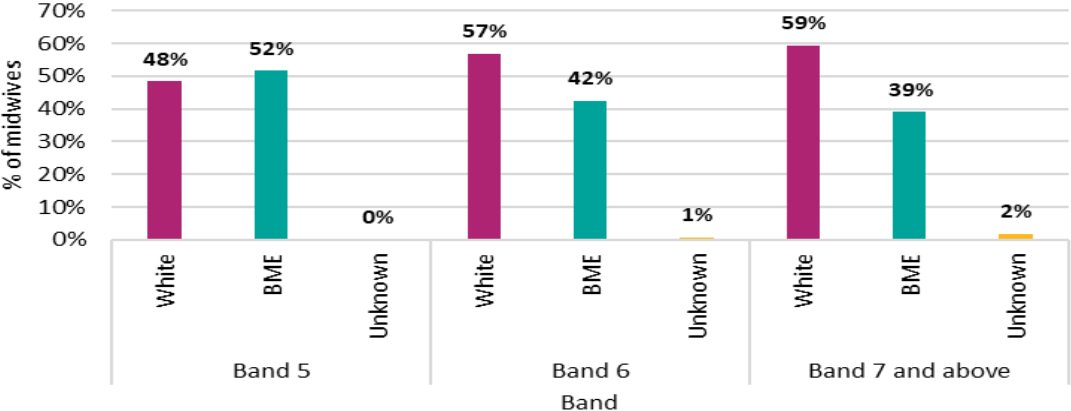


National distribution of Midwifery staff by ethnicity		
White	BME	Unknown
85%	11.7%	3%

- BME Midwives make up close to or more than half of the total number of midwives in NHS trusts, ranging between **43-64%**. Bart's is the only trust with White midwives as the minority (**32%**).

I1: Distribution of staff by ethnicity and Afc pay band (Midwifery only)

Figure 4: Breakdown (%) of midwives by pay band and ethnicity across Homerton (2020/21)



Key findings

- Relative to the overall distribution of staff across ethnic groups all ethnic minority staff are underrepresented at band 7 and above: e.g.
 - BHRUT – 39% of BME staff at band 7 and above compared with 46% BME staff overall
 - Homerton - 39% of BME staff at band 7 and above compared with 43% BME staff overall
 - Barts - 56% of BME staff at band 8a and above compared with 64% BME staff overall
- These differences are the opposite of what we observe at the national level – where BME staff were slightly overrepresented at band 8a and above in 20/21 (i.e. 16% at band 8a and above compared with 11% BME staff overall)
- Note that there are inconsistent groupings regarding pay bands. NHDS were unable to provide separate data at the more senior levels due to IG rules governing low numbers. For Barts, however, – from whom we also received data at the site level - we know they have no midwifery staff at the VSM level.

Figure 5: Breakdown (%) of midwives by pay band and ethnicity across BHRUT (2020/21)

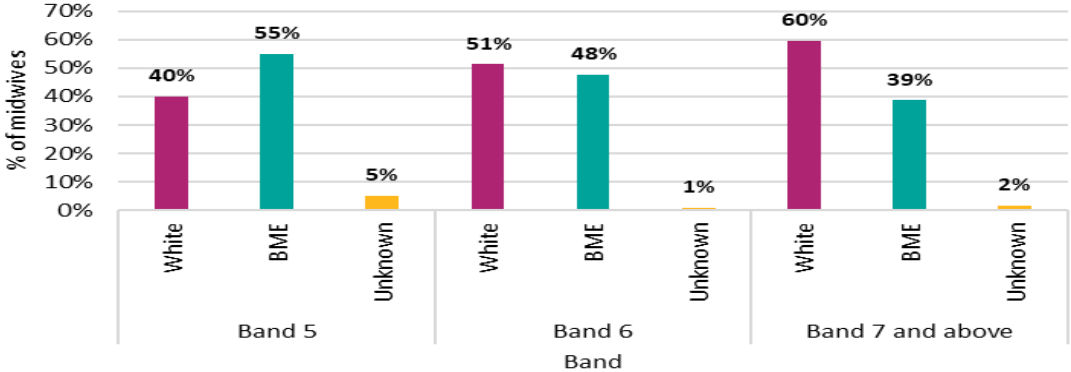
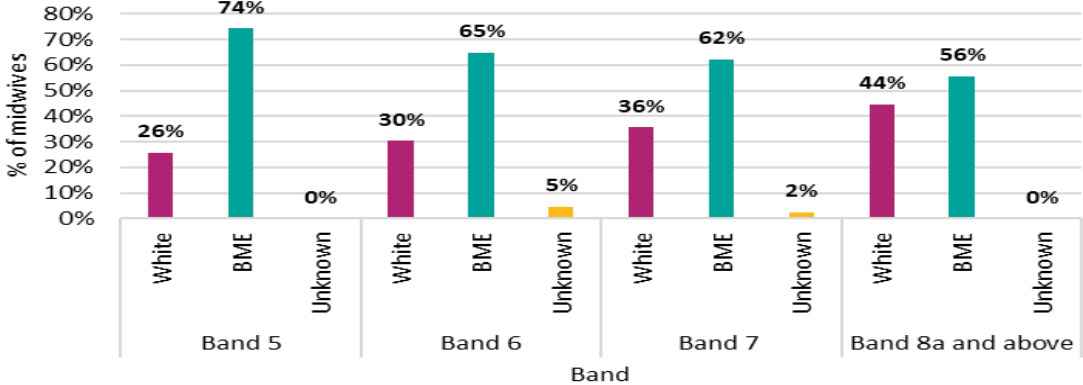
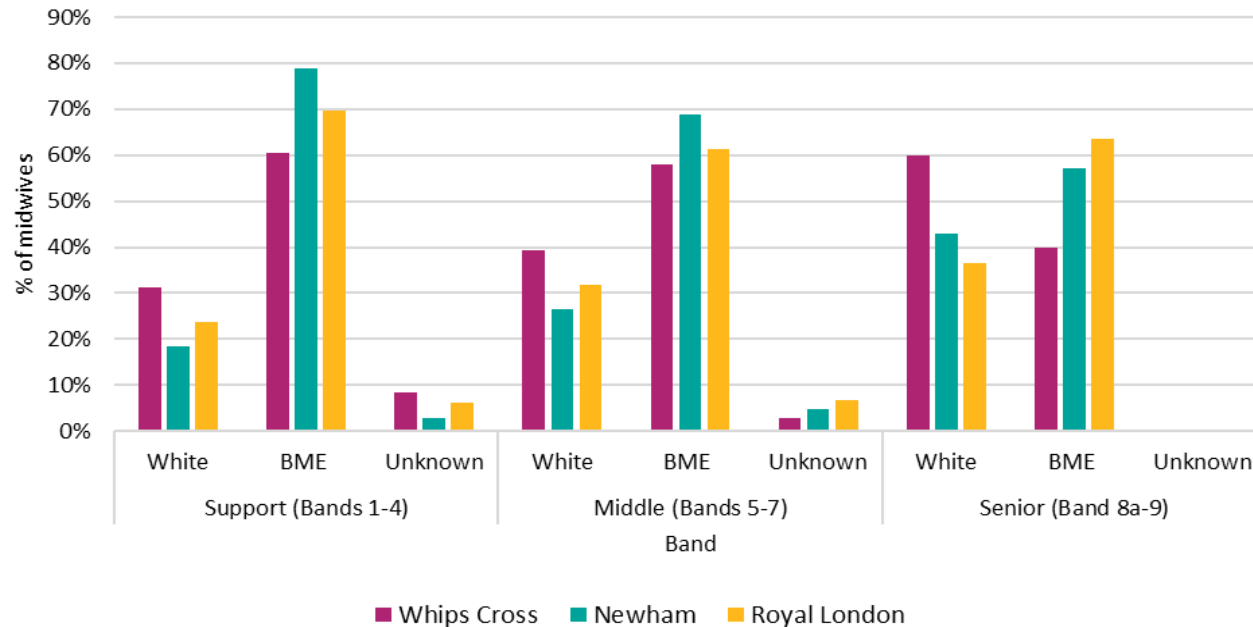


Figure 6: Breakdown (%) of midwives by pay band and ethnicity across Barts (2020/21)



I1: Distribution of staff by ethnicity and Afc pay band: Barts site level (Midwifery only)

Figure 7: Breakdown (%) of Barts clinical (non-medical) Maternity staff by pay band and ethnicity (2020)



Key findings

- Across all trust sites, there is a stark majority of midwives in ethnic minority groups in Bands 1-4 (between **60-79%**), compared to White maternity staff (**18-31%**)
- As pay band increases, the gap between proportions of ethnic minority and White midwives decreases i.e. the proportion of ethnic minority staff decreases as seniority increases.
- As pay band increases, the proportion of White midwives increases, although ethnic minority maternity staff still remain the majority. The exception is Whips Cross, where midwives in ethnic minority groups are the minority at **40%** in Band 8a-9, compared to White maternity staff at **60%**
- The following data refers to a different data source, data that we have received directly from Barts trust by their three sites, for 2020.
- **Note that we do not have the overall breakdown of staff by ethnicity at the site level to assess for over/under representation as we have done for the trust level data provide by NHSD.**

I2 & I3: Relative likelihood of being appointed from shortlisting & entering formal disciplinary process*

**Note: Data on I2&3 has not been provided for midwifery staff only and applies to staff groups across all specialties*

Table 1: Relative likelihood of White staff being appointed from shortlisting compared to BME staff across NEL boroughs (2020)

Trust	Relative likelihood of White staff being appointed from shortlisting compared to BME staff:
Homerton University Hospital NHS Foundation Trust	1.58
Barts Health NHS Trust	1.63
Barking, Havering and Redbridge University Hospitals NHS Trust	1.73

Table 2: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff across NEL boroughs (2020)

Trust	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:
Homerton University Hospital NHS Foundation Trust	1.18
Barts Health NHS Trust	1.25
Barking, Havering and Redbridge University Hospitals NHS Trust	1.26

Key findings:

- **Relative likelihood of White staff being appointed from shortlisting compared to BME staff (table 1):**
 - Across all NEL trusts, White staff are more likely to be appointed from shortlisting, compared to BME staff, varying between **58-73%** more likely.
 - This inequality is most present in Barking, Havering and Redbridge University Hospitals NHS Trust (**73%** more likely)
- **Relative likelihood of BME staff entering the formal disciplinary process compared with White staff (table 2):**
 - Across all NEL trusts, BME staff are more likely to enter formal disciplinary processes, compared to White staff, varying between **18-26%** more likely.
 - Although, these differences in relative likelihood is very small and according to the four-fifths rule**, only BHRUT has a difference large enough to conclude risks of adverse impacts on BME staff.

****Four-fifths rule:** It is important to note the NHSD report's use of the four-fifths rule in accessing inequalities. According to such guidelines, if a relative likelihood falls inside four-fifths i.e. **within 0.8-1.25**, it is concluded that the **difference is not big enough** for an organisation to have adverse effects on an identified group.

I4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff*

***Note: Data on I4 has not been provided for midwifery staff only and applies to staff groups across all specialties**

Table 3: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff across NEL boroughs (2020)

Trust	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:
Homerton University Hospital NHS Foundation Trust	1.25
Barts Health NHS Trust	0.98
Barking, Havering and Redbridge University Hospitals NHS Trust	0.74

Key findings:

- In both Homerton University Hospital NHS Foundation Trust and Barts Health NHS Trust, White staff were **slightly less likely** to access non mandatory training and CPD compared to BME staff.
- This is similar to London, where the relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff is **0.9**
- This is the reverse for Barking, Havering and Redbridge University Hospitals NHS Trust, where BME staff are more likely to access such training compared to White staff, by a more significant amount.
- According to the **four-fifths rule****, none of the NEL trusts show adverse inequality within likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.

****Four-fifths rule:** It is important to note the NHSD report’s use of the four-fifths rule in accessing inequalities. According to such guidelines, relative likelihood that falls inside four-fifths i.e. **within 0.8-1.25**, it is concluded that the **difference is not big enough** for an organisation to have adverse effects on an identified group

I5&I6: Staff experiencing harassment, bullying or abuse from patient, relatives, public or staff [Midwifery only]

Figure 8: % of midwives experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (2020)

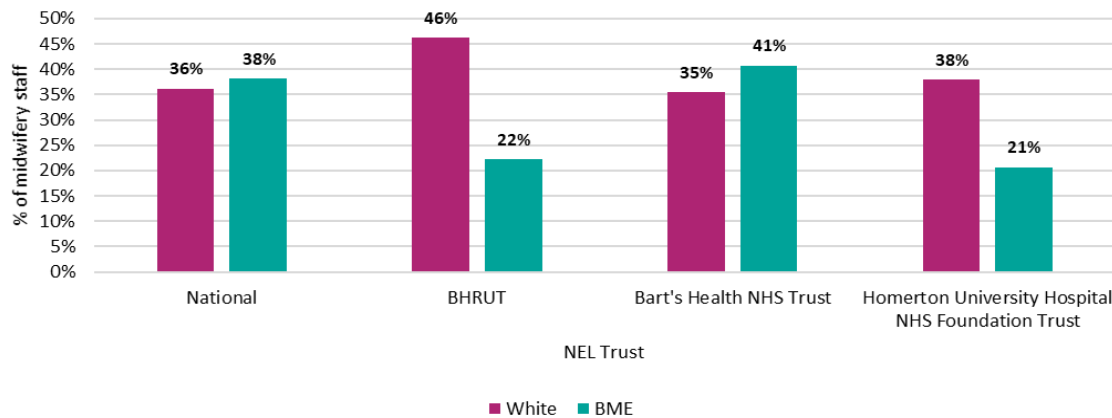
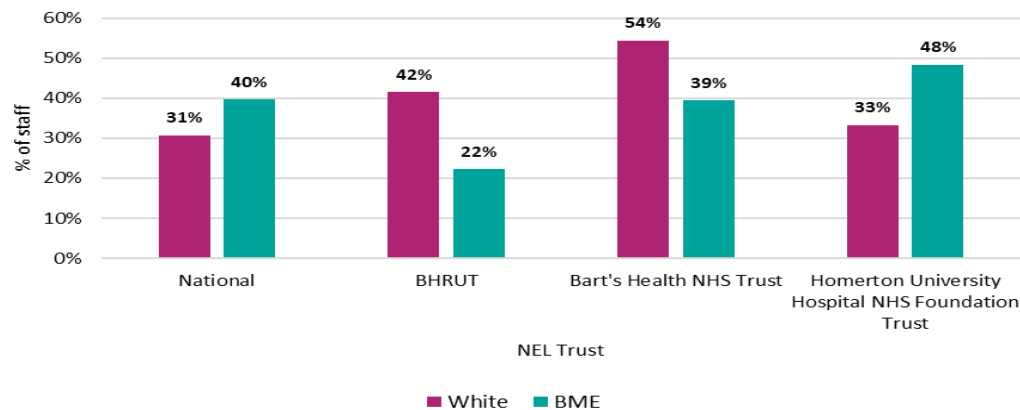


Figure 9: % of midwives experiencing harassment, bullying or abuse from staff in last 12 months (2020)



Key findings:

- **Staff experiencing harassment, bullying or abuse from patients, relatives or the public (chart 5)**
 - In BHRUT and Homerton, more White staff experience harassment, bullying or abuse from patients, relatives or the public (**46%** and **38%** respectively), compared to BME staff (**22%** and **21%** respectively)
 - The reverse is true for Barts (i.e. with BME staff being more likely to have experienced harassment) although the difference is much smaller, at around **6%**.
- **Staff experiencing harassment, bullying or abuse from staff (chart 6)**
 - Only Homerton has a larger proportion of BME staff experiencing harassment from other staff (**48%**) compared to White staff **33%**. This is also higher than the national rate for BME staff at **40%**.
 - There is a larger proportion of White midwives experiencing harassment from other staff in BHRUT (**42%**) and Barts (**54%**), compared to BME staff (**22%** and **39%** respectively).

I5&I6: Staff experiencing harassment, bullying or abuse from patients, relatives, public or staff: Barts site level [Midwifery only]

Figure 10: % of Barts midwives experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (2021)

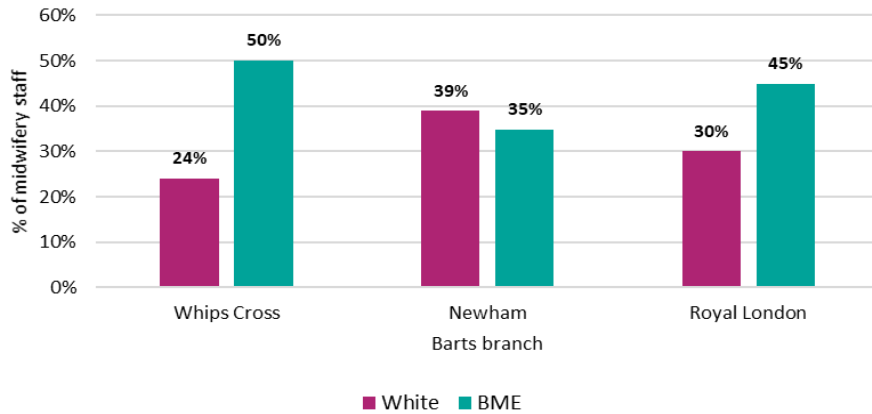
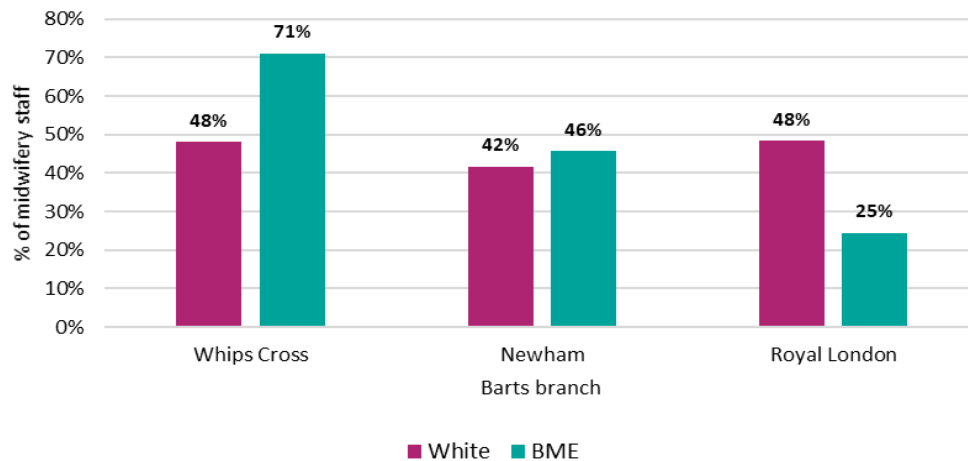


Figure 11: % of Barts midwives experiencing harassment, bullying or abuse from staff in last 12 months (2021)



Key findings:

- **Note: This site level data from Barts is based on 2021 survey responses and therefore not directly comparable to the 2020 survey results at the trust level that is presented in the previous slide**
- **Staff experiencing harassment, bullying or abuse from patients, relatives of the public (chart 14)**
 - For Whips Cross and Royal London, more BME maternity staff experienced harassment, bullying or abuse from patients, relatives or the public (**50%** and **45%** respectively) compared to White maternity staff (**24%** and **30%** respectively).
 - The reverse is true for Newham, although the difference is much smaller at **4%**.
 - The biggest inequality exists in Whips Cross, where there were **two times** as many BME maternity staff (**50%**) who experienced harassment from patients, relatives or the public, than White maternity staff (**24%**).
- **Staff experiencing harassment, bullying or abuse from staff (chart 15)**
 - Harassment, bullying or abuse from other staff varies across the Barts sites. For Whips Cross and Newham, more BME maternity staff experienced harassment from other staff (**71%** and **46%** respectively), compared to White maternity staff (**48%** and **42%** respectively)
 - The reverse was true for Royal London, where **48%** of White maternity staff experienced harassment from other staff, compared to **25%** of BME staff.
 - The biggest difference observed is at Whips Cross, where there were **71%** of BME maternity staff experiencing harassment from other staff, compared to **48%** of White staff.

I7&I8: Trust on equal opportunities for career progression and experience of discrimination (Midwifery only)

Figure 12: % of midwives believing trust provides equal opportunities for career progression or promotion (2020)

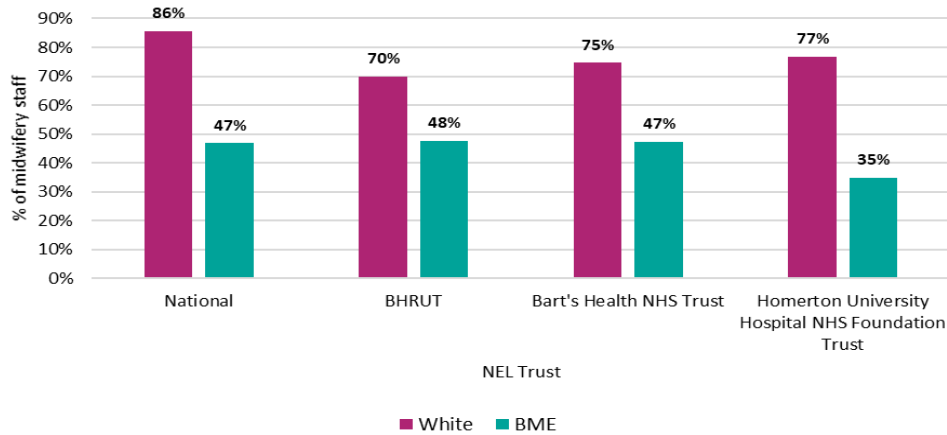
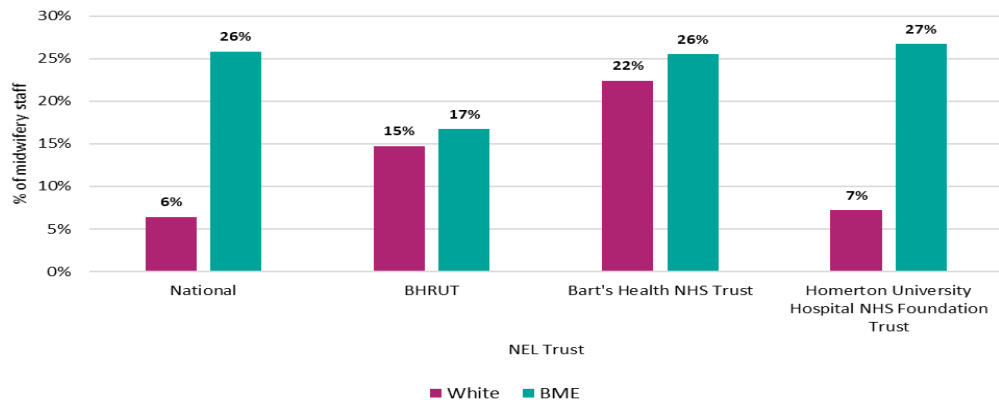


Figure 13: % of midwives personally experiencing discrimination at work from manager/team leader or other colleagues (2020)



Key findings:

- **Staff believing that the trust provides equal opportunities for career progression and promotion (chart 7):**
 - Across all three NEL Trusts, more White staff believed that their relative trust provides equal opportunities for career progression or promotion (**70-77%**), compared to BME staff (**35-48%**).
 - This trends are replicated nationally with a slighter bigger inequality, where **86%** of White midwives believed that their relative trust provides equal opportunities for career progression or promotion compared to **47%** BME midwives.
- **Staff personally experiencing discrimination at work (chart 8)**
 - Across all three NEL trusts, a greater proportion of BME staff have personally experienced discrimination at work from a manager/team leader or other colleagues, however there is significant variation between the trusts.
 - BHRUT and Barts have a small percentage difference (**2-4%** respectively) between White and BME midwives who have personally experienced discrimination at work from a manager/team leader or other colleagues
 - Homerton, however, has a significantly greater inequality, with **27%** of midwives who have experienced discrimination at work from a manager/team leader or other colleagues are BME compared to **7%** who are White.
 - This larger inequality is also replicated at national level, where **26%** of midwives who have experienced discrimination at work from a manager/team leader or other colleagues are BME compared to **6%** who are White.

I7&I8: Trust on equal opportunities for career progression and experience of discrimination: Barts site level (Midwifery only)

Figure 14: % of Barts midwives believing trust provides equal opportunities for career progression or promotion (2021)

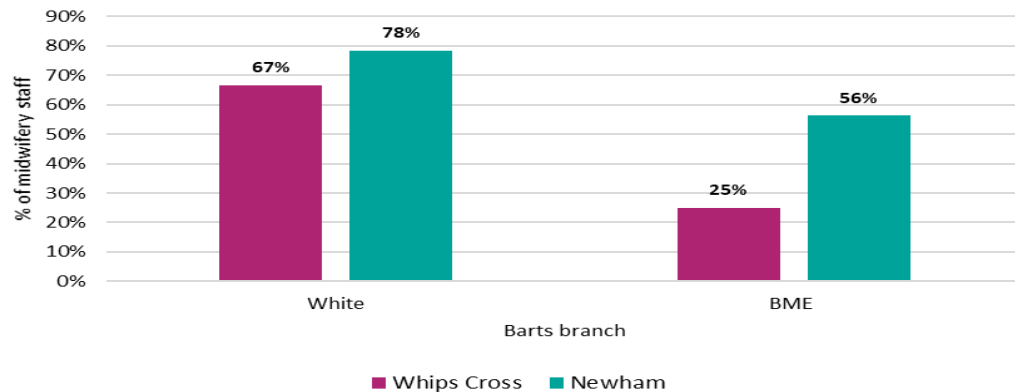
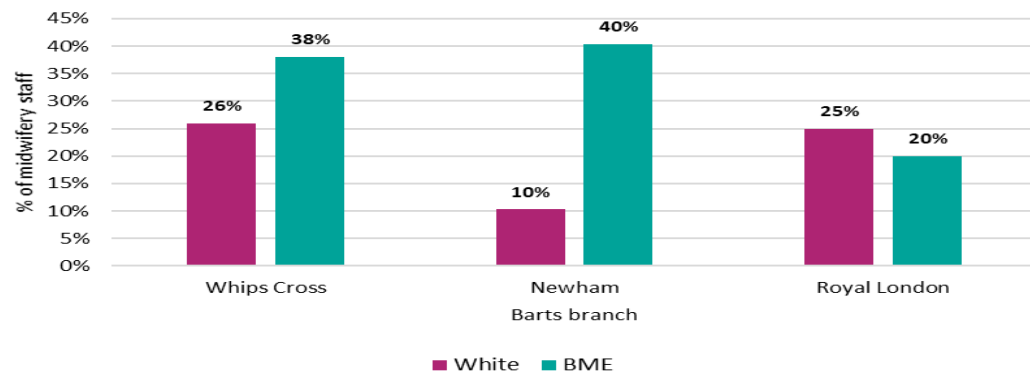


Figure 15: % of Barts midwives personally experiencing discrimination at work from manager/team leader or other colleagues (2021)



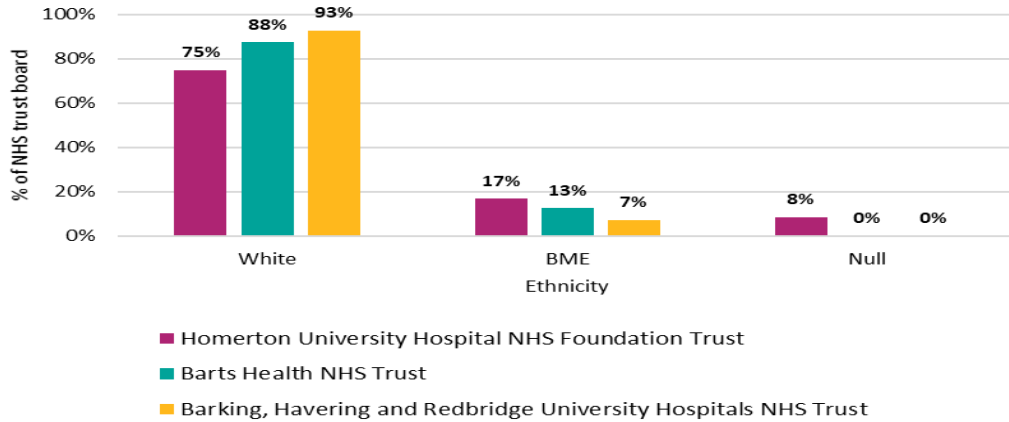
Key findings:

- **Note: This site level data from Barts is based on 2021 survey responses and therefore not directly comparable to the 2020 survey results at the trust level that is presented in the previous slide**
- **Staff believing that the trust provides equal opportunities for career progression and promotion (chart 16):**
 - Both Newham and Royal London have a greater proportion of White maternity staff believing trust provides equal opportunities (66.7% and 78.3% respectively) compared to BME maternity staff (25.0% and 56.3% respectively)
 - The biggest inequality exists at Whips Cross, where White midwives were **over two times** more likely to believe trust provides equal opportunities than BME midwives.
 - ****Due to too few survey responses, Royal London has been excluded from this chart.**
- **Staff personally experiencing discrimination at work (chart 17)**
 - For Whips Cross and Newham, more BME staff personally experienced discrimination at work from a manager/team leader or other colleague (38% and 40% respectively) compared to White staff (26% and 10% respectively).
 - The reverse is true for Royal London, but for a smaller percentage difference: more White midwives experiences discrimination (25%) compared to BME midwives (20%).
 - The biggest inequality exists in Newham, where there were four BME maternity staff personally experiencing discrimination, to every one White maternity staff.

I9: NHS Trust Board Representation by Ethnicity*

*Note : Data on I9 has not been provided for midwifery staff only and applies to staff groups across all specialties

Figure 16: Breakdown (%) of NHS Trust board representation by ethnicity (2020)



Key findings

- Across all three NEL Trusts, there is a significant majority of White representation (**75-93%**) and stark minority BME representation (**7-17%**) on NHS Trust boards. This difference is largest in BHRUT, where the Board is made up by approx. **93%** White staff and only **7%** by BME staff. The national figure of BME board representation is at **10%** and London figure at **20%**.
- Across all three NEL Trusts, there is a greater proportion of White executive members (**71-100%**) compared to BME executive members (**0-29%**). This inequality is again worst in BHRUT, where there are **no BME** board members who have executive membership.
- Across all NEL trusts, there is a significant greater proportion of White board members who have voting membership (**75-92%**) compared to BME staff (**8-17%**). This inequality is again worst in BHRUT, where only **8%** of voting board members are BME.
- **Note:** in contrast to the data on AFC pay band for which we are able to compare representation at pay band level with overall representation across the trusts – we do not have the equivalent data to compare in the same way for these data at the pooled staff level.

Figure 17: Breakdown (%) of NHS Trust board representation by ethnicity and executive/ non executive membership (2020)

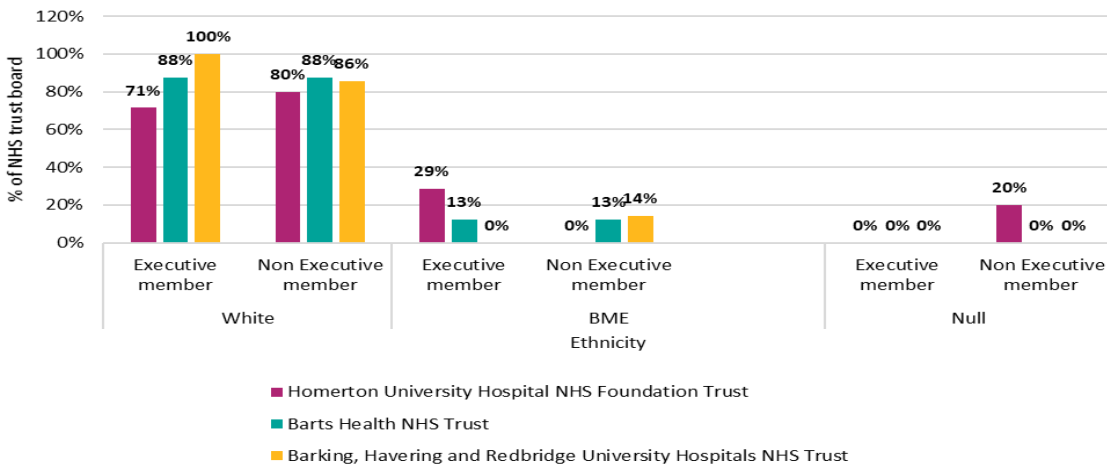
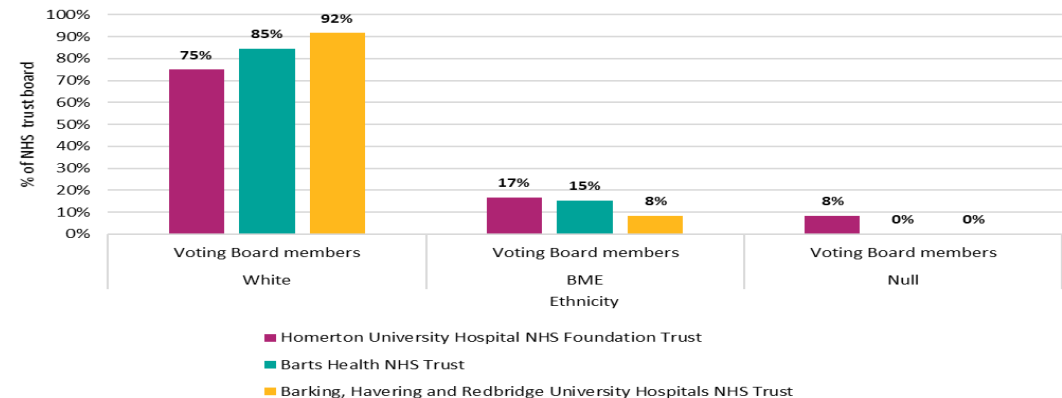


Figure 18: Breakdown (%) of NHS Trust board representation by ethnicity and voting/non voting membership (2020)





North East London
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9. Action Plan



9.1 Action Plan next steps

NEL LMS are committed to improving equity and equality for women from Ethnic Minority backgrounds, including staff within maternity services.

Action plan next steps are detailed in sections 9.2 and 9.3, relating to recommendations for further data analysis and further community asset mapping and co-production.

Summary of next steps:

1. Recommendations for further data analysis
2. Recommendations for further community asset mapping and co-production
 - This will include gathering and assuring data from wider sources by conducting a programme of outreach and participatory community co-production with local partners and women, to:
 - Determine the validity of our asset mapping by local women in their communities
 - Add less 'visible' assets seen as critical by local women
 - Understand women's direct experiences of engaging with these assets to determine quality, impact and cultural appropriateness
 - Create a comprehensive database supported by a digital map by borough for health professionals (this work will include ensuring that the database can be maintained and regularly refreshed to ensure the quality of the content).
3. To co-produce a five year strategy based on the needs of our population, aligning to the ICS planning guidance. This will include:
 - a presentation to our wider stakeholders on our findings
 - 2-3 workshops on how we will co-produce meeting the needs of women
 - a consultation and stakeholder and women's survey

9.2 Recommendations for further data analysis

- To support with **evidenced-base** decision making on the prioritisation and targeting of action plans, we proposed this initial analysis be supplemented by a further project that is split into **four phases** of work. **NOTE: these are indicative recommendations and would require further discussion and scoping before any work is commenced.**

Phase	Area of focus	What would we do?	What questions will this help answer?	Key issues
Phase 1	Confirming observed differences in health outcomes included in our initial analysis across ethnicities and deprivation status – and extending the analysis to cover more outcome measures	Carrying out a statistical analysis to estimate differences in health outcomes across : <ul style="list-style-type: none"> Ethnicity (controlling for differences in age and deprivation status) Deprivation status (controlling for differences in age and ethnicity status) <p>Explore make up of <i>Mixed</i> ethnic groups</p>	<ul style="list-style-type: none"> For which outcomes are there <i>genuine</i> differences across ethnicity and deprivation? Which outcomes are these differences the largest and for which category of women? How specific are these differences to individual boroughs? Which ones are NEL wide? 	<p>Data availability and quality for extended set of outcome measures</p> <p>Outcome measures with low numbers will need multiple years data to improve the reliability of findings.</p> <p>Time required by trusts to provide relevant data (if not currently reported on in SUS etc.) and quality checking by team may be considerable.</p>
Phase 2	Assessing the relative importance of health status, wider risk factors and access to maternity services in determining outcomes for women and babies	Carrying out statistical analysis to estimate the relative impact on outcomes of factors independent of ethnicity, deprivation and age - at NEL and borough level – including: <ul style="list-style-type: none"> LTCs (including type and number) and other risk factors (e.g. smoking rates) Access to maternity services The trust in which delivery takes place 	<ul style="list-style-type: none"> What other factors drive difference in outcomes regardless of ethnicity or deprivation? Which of these are potentially easier to prevent and/or mitigate against the adverse impacts than others? How much do trusts themselves influence outcomes (e.g. quality or care) 	<p>Data availability and quality on broader potential drivers on outcomes</p> <p>Unclear whether we can link PC data with secondary data for all boroughs</p> <p>Time required by trusts to provide relevant data (if not currently reported on in SUS etc.) and quality checking by team may be considerable.</p>
Phase 3	Confirming observed differences between ethnicities and deprivation status across the most 'important' drivers	Carrying out statistical analysis to understand whether any of the factors identified in Phase 2 vary by ethnicity or deprivation.	<ul style="list-style-type: none"> For the 'most' important drivers, are women of different ethnicity and/or deprivation status disproportionately affected? 	No major issues for this phase if those in P1&2 are addressed.
Phase 4	Analysis of (large sample) survey data (e.g. if commissioned by trusts) of lived experience which also records ethnicity and deprivation status	Assess themes in survey by women in different categories and whether differences in experience between them are statistically significant Triangulate findings with findings from the data analysis	<ul style="list-style-type: none"> To what extent do women's lived experience validate/confirm what we are seeing in the data? What does it tell us about other inequalities (e.g. in how women are treated) that data on outcomes alone cannot reveal but are very relevant to health, wellbeing and experience? 	Existing surveys on Maternity services do not split results by ethnicity/deprivation so likely that a more tailored survey would need to be commissioned by trusts.

9.3 Recommendations for further community asset mapping and co-production

The lenses and lived experiences of women and birthing people must be given precedence to reshape maternity and perinatal health services. We must provide an audience to ensure 'All voices must be heard' from all communities in the process of reshaping services.

Tasks	What would we do?	What questions do we want answered?	Key issues
<p>Stage 2 Community-engaged asset mapping</p> <p>January, early February 2022</p>	<p>Where</p> <ul style="list-style-type: none"> Children's Centres Community hubs and networks Stakeholder engagement events Online surveys Workshops to consolidate community assets <p>How</p> <ul style="list-style-type: none"> Workshops with stakeholders to consolidate community assets e.g. Social Prescribers, Early Years and children's services in each borough. Map assets onto deprivation maps for further co-production work. Outreach into each borough with local partners who provide culturally and gender centred support, access to language translations. Collaborating efforts across diverse stakeholders to improve equity and to tackle social determinants of health as part of an ICS, this will include housing opportunities, transport and infra-structure 	<ul style="list-style-type: none"> Which community assets listed have you used? What have we missed from our mapping that is important to you? Which ones do you have to travel outside of your borough to access? What transportation links are available to you to access these? Grade the assets based on personal experiences to determine quality of support? What else is missing from our community that would make a difference to you and your family Are there any other gaps in our asset mapping used by these teams? 	<ul style="list-style-type: none"> COVID 19 restrictions on stakeholder engagement Ensuring hard to reach voices are heard. Data viability Time to complete action plan Identify Resource to support Action plan
<p>Stage 3 Co-production of Five Year Strategy</p> <p>January, early February 2022</p>	<ul style="list-style-type: none"> Set up co-production opportunities for community representatives and other diverse stakeholders, ensuring barriers are removed – accessibility, digital divide, safe spaces, cultural appropriateness, language support and transportation. As part of the Core20PLUS5 approach to reducing health inequalities by ensuring continuity of care for 75% of women from Black, Asian and minority ethnic In addition to local communities, other stakeholders to be included: <ul style="list-style-type: none"> ICS Digital and data support ICS Workforce planning Early Years Steering Groups ICS Housing and Population plans Infrastructure and Transportation Population Health Children/family Hubs 	<p>What are the interventions and innovative solutions to:</p> <ul style="list-style-type: none"> Improving inequalities and equity to maternity care for ethnic minorities To achieving continuity of care for 75% of ethnic minority communities living in the most deprived areas of North East London Address the challenges – delivery, reach and access Staffing and workplace challenges to meet service demands, diversity and cultural competence 	<ul style="list-style-type: none"> COVID 19 restrictions on stakeholder engagement Ensuring hard to reach voices are heard. Data viability Time to complete action plan Identify Resource to support Action plan

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North East London
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