



LEAP Maternity Analysis

An exploration of maternity booking data in Lambeth: understanding the demographics and social factors of women booking onto maternity services in Lambeth.



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Key findings and messages

This analysis is a descriptive exploration of a large maternity dataset. When comparing the LEAP area with the full Lambeth population there are some similar trends to observe, such as the number of live births each year, as well as some differences, such as the ethnicity profile of pregnant women.

- There was a clear downward trend in live births from 2017/18 to 2019/20 across Lambeth and in the LEAP area.
- The average age of pregnant women between 2017/18 across Lambeth was 32 compared with 31 in the LEAP area.
- Maternity services see a more diverse group of women in the LEAP area compared with the rest of Lambeth: 58% of pregnant women from the LEAP area between 2017/18 and 2019/20 were non-White compared with 43% from non-LEAP areas.
- 25% of pregnant women from the LEAP area between 2017/18 – 2019/20 did not speak English as their first language.
- More than a fifth of pregnant women from LEAP and from Lambeth as a whole booked onto maternity services at or after 13 weeks of pregnancy, which is considered late.
- As part of the booking appointment, midwives ask women about past and current experience of domestic abuse. In 2019/20, the number of women who midwives were unable to ask about current domestic abuse increased for women from the LEAP area and Lambeth as a whole.

Introduction

Set up in 2015, Lambeth Early Action Partnership (LEAP) is made up of parents, early years practitioners, nurseries, children's centres, the National Children's Bureau, Lambeth Council, NHS trusts, community organisations and several local charities.

LEAP's mission is to:

- Give thousands of children aged 0-3 years a better start
- Use LEAP's learning and evidence to positively influence early years services across Lambeth and beyond.

LEAP aims to do this by demonstrating how children's life chances can be improved through a combination of enhanced early years investment and from knitting local services together through a multi-agency partnership.

The data explored covers the period of April 2017 – March 2020, therefore ending around the time COVID-19 began to have an effect on health services.

Analytical aims

This is an explorative descriptive analysis. The analytical aims are:

- 1) To understand more about women from Lambeth accessing maternity services via Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital NHS Foundation Trust

(KCH); comparing those living in the LEAP area with those living in non-LEAP areas of Lambeth, with a focus on trends over time.

- 2) Investigate evidence presented in LEAP service plans, with a focus on inequalities described within them in relation to our local population.
- 3) For service leads and the wider LEAP team to consider any changes that could be implemented to LEAP services in light of this analysis, such as the service offer or operational processes.

Further statistical analysis will explore some outcomes relevant for LEAP services.

Methodology

The timeframe for this analysis looked at a period of three years between 1st April 2017 and 31st March 2020 inclusively. Therefore, the effects of the pandemic will not be seen within this dataset. Unless otherwise stated, data presented in charts and tables throughout are from Badgernet.

Data was sourced from the Badgernet systems of GSTT and KCH. Badgernet is specialist perinatal data management software used to store pregnancy and neonatal health records. It captures information recorded during appointments and interactions with hospital maternity services - from the booking appointment to birth. The data analysed includes all women regardless of their birth outcome, in order to understand more about women who are booking at both hospitals during the antenatal period and therefore eligible for some LEAP services.

Sample data was extracted based on the delivery date for each woman, to ensure birth outcomes would be included in the dataset.

Non-Lambeth residents booking at either hospital were excluded from analysis and therefore all data relates to Lambeth residents only. The areas explored were:

- LEAP - Coldharbour, Stockwell, Vassall, Tulse Hill (ward boundaries as of 2021)
- Non-LEAP - all Lambeth wards excluding four LEAP wards noted above
- Lambeth – all Lambeth residents (LEAP and Non-LEAP combined)

This dataset is focussed on unique pregnancies, some women in the sample may have more than one pregnancy and be represented more than once. It is unlikely this will have had a significant impact on analysis.

Unless otherwise stated, nulls have been excluded from fields for analysis. Any inclusions of nulls are to minimise the data being skewed.

Sample size

The annual sample size can be found in Table 1 for each geographical area. To note:

- The number of women will differ from the number of live births due to multiple births and women experiencing neonatal deaths and still birth.
- Data on the number of births using a maternity services dataset will not include all registered births for a given area. This is most relevant when looking at data across Lambeth where those living on the boundary of the borough may choose to have their babies at

another hospital, for example. We estimate that data from the local Badgernet systems at GSTT and KCH account for over 75% (83% in 2020/21) of all Lambeth registered births, and over 90% (97% in 2020/21) of all LEAP registered births (source: comparison of the current dataset and ONS live births 2020).

Table 1 Annual sample size for each geographical area

Year	LEAP	Non-LEAP	Lambeth
2017/18	729	2356	3085
2018/19	798	2610	3408
2019/20	716	2250	2966

Live births

ONS data shows there were 613,936 live births in England and Wales in 2020, a decrease of 4.1% since 2019¹. Data from Badgernet shows that the number of live births to women booked at GSTT and KCH have decreased over the past three years within the LEAP area and across Lambeth. According to the current dataset, live births in the LEAP area saw a 21% decrease over the three years, while there was a 34% decrease in live births across the whole of Lambeth.

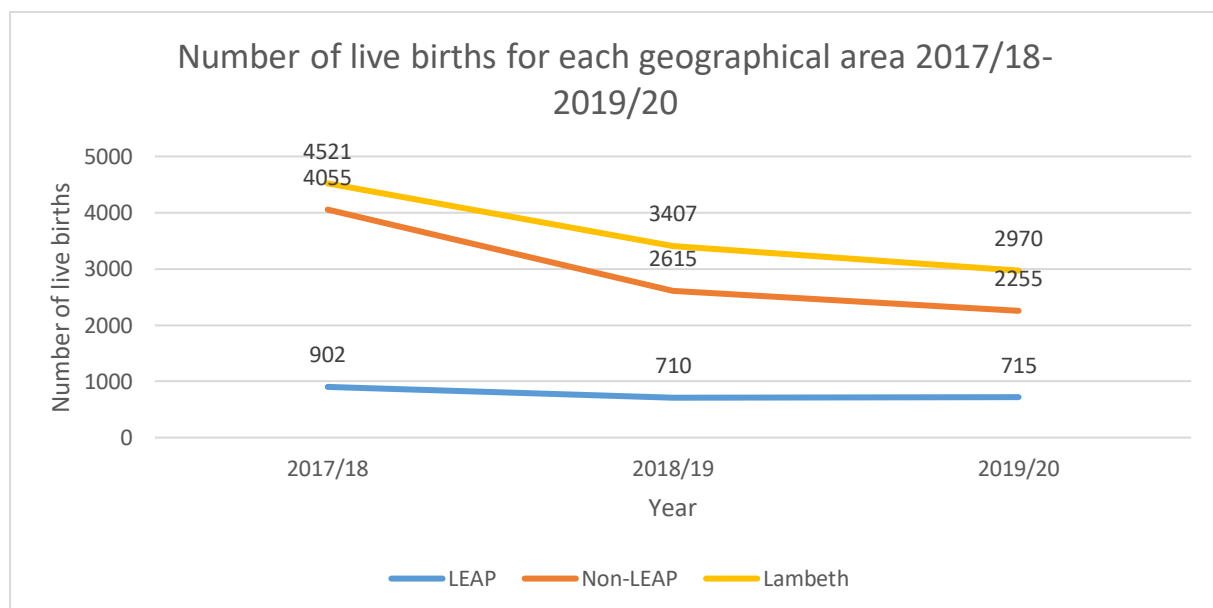


Figure 1 Number of live births for each geographical area 2017/18-2019/20

¹ [ONS Births in England and Wales: 2020](#)

In recent years, Lambeth’s fertility rate has decreased. The Office for National Statistics (ONS) suggests possible reasons for the decrease in Total Fertility Rate across the country²:

- Improved access to contraception
- The reduction in mortality rates of children aged under five years, resulting in women having fewer babies
- Lower levels of fertility, or difficulties conceiving because of postponement in childbearing

Live births in the LEAP area

Table 2 shows the number of live births broken down by each LEAP ward (relevant to ward boundaries pre-2022). The decline in the number of live births is reflected across all wards. Tulse Hill saw the greatest number of live births compared to other LEAP wards.

Table 2 Annual live births by LEAP Area

Year	Coldharbour	Stockwell	Tulse Hill	Vassall	Total LEAP area
2017/18	N=251	N=185	N=231	N=235	N= 902
2018/19	N=211	N=169	N=206	N=206	N= 792
2019/20	N=185	N=136	N=203	N=191	N= 715

There is currently ongoing work within the LEAP and Lambeth public health teams to understand Lambeth birth rates in more detail, using a dataset of all registered births in the borough.

Age at booking

The national standardised mean age of mother at the birth of a child during 2020 was 30.7³. Fertility rates for women aged under 30 years have generally been decreasing since 2013.⁴

The age breakdown of women at booking is shown in Figure 2. The most common age group across all geographies was 30-34 which echoes national findings. In 2019-20, 37% of live births across LEAP

²

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2020>

³

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2020#fertility-rates-by-geographic-area>

⁴

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2019>

were to women within this age category. The mean age at booking in 2019-20 was 31 for LEAP women and 32 for both non-LEAP and Lambeth-wide.

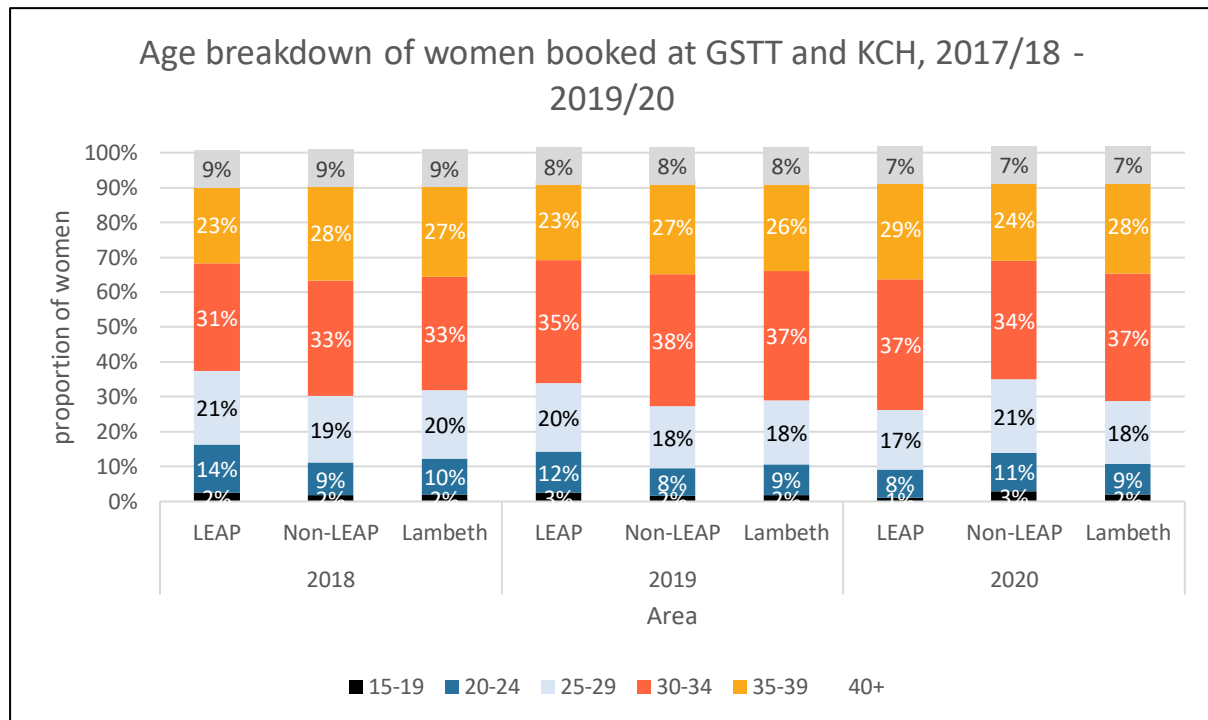


Figure 2 Age breakdown of women booked at GSTT and KCH, 2017/18-2019/20

Within this dataset, women aged over 37 during pregnancy were considered to be higher risk. This is noted under the medical risk factor column. 26% of women from the LEAP area were over the age of 37 during this period.

Ethnicity

LEAP’s Theory of Change includes the following indicator under domain 5: 5.4 Positive social/cultural norms and behaviour, and much of the evidence base for some of LEAP’s services includes exploring ethnic health inequalities in outcomes, therefore further statistical analysis to follow this document will look at outcomes broken down by ethnicity. Some more information about ethnicity categories can be found here:

<https://www.ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion>.

Ethnicity data is presented in five categories: Asian, Black, Other, Mixed and White to align with ONS categories. Although there are subcategories within each group where experiences will be different, in some cases numbers within the wider range of categories, the data are too small to analyse due to the risk of individuals being identified. To build a more nuanced picture, ethnicity may be looked at alongside a combination of other fields such as country of origin and primary language spoken. This is particularly the case for ‘other’ where it may become difficult to identify specific communities.

Table 3 shows the completion rates for the ethnicity data across years and geographical areas.

Table 3 Annual completion rates of ethnicity data

Year	LEAP	Non-LEAP	Lambeth
2017/18	80%	78%	79%
2018/19	82%	84%	83%
2019/20	79%	83%	86%

Ethnicity across Lambeth

Figure 3 shows ethnicity data from Lambeth DataNet, collected from patients registered with a GP across Lambeth as at April 2020. The data reflects the whole population of Lambeth, and is comparable to the maternity booking ethnicity breakdown; there is a higher proportion of residents from a Black background within the LEAP area compared to the non-LEAP area.

Lambeth has a transient population and not all residents may be registered with a GP, or they may be registered with a GP outside of Lambeth, therefore it is difficult to verify the accuracy of this data. Initial outputs from the 2021 Census are expected to be released in spring 2022, and may give a better understanding of the local ethnicity breakdown.

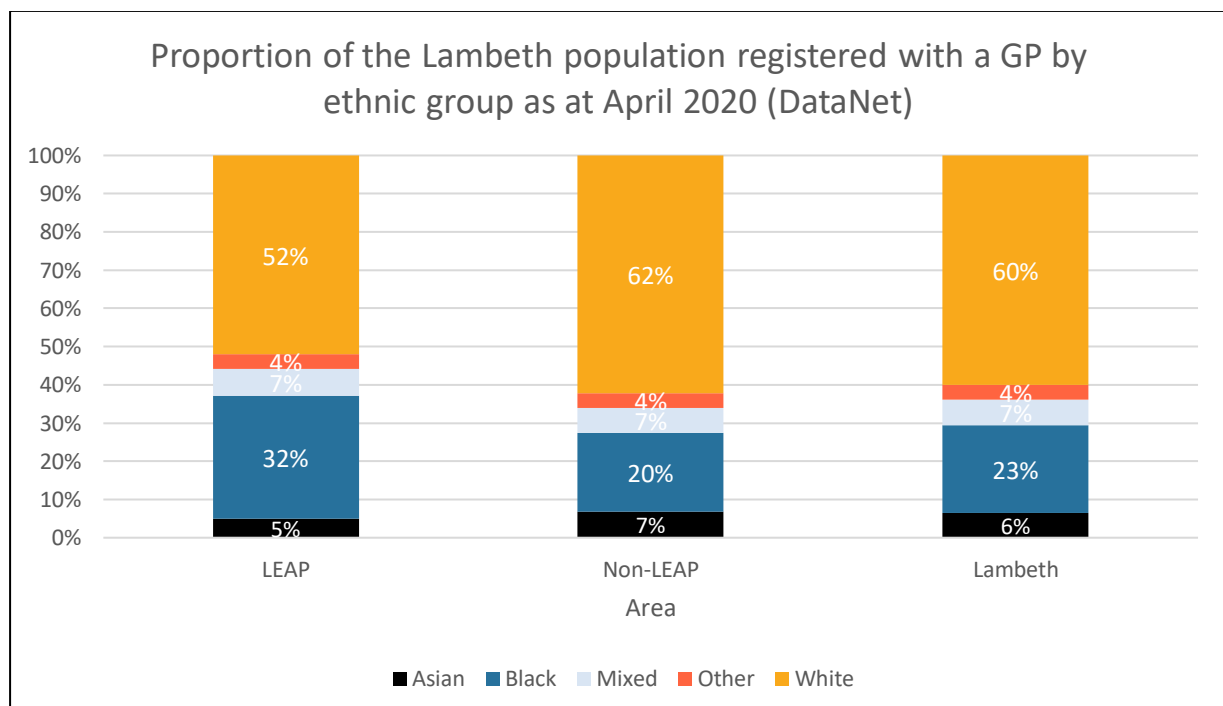


Figure 3 Proportion of the Lambeth population registered with a GP by ethnic group as at April 2020 (DataNet)

Ethnicity of women booked at GSTT or KCH

Figure 4 shows the ethnicity breakdown of women joining the maternity service at booking.

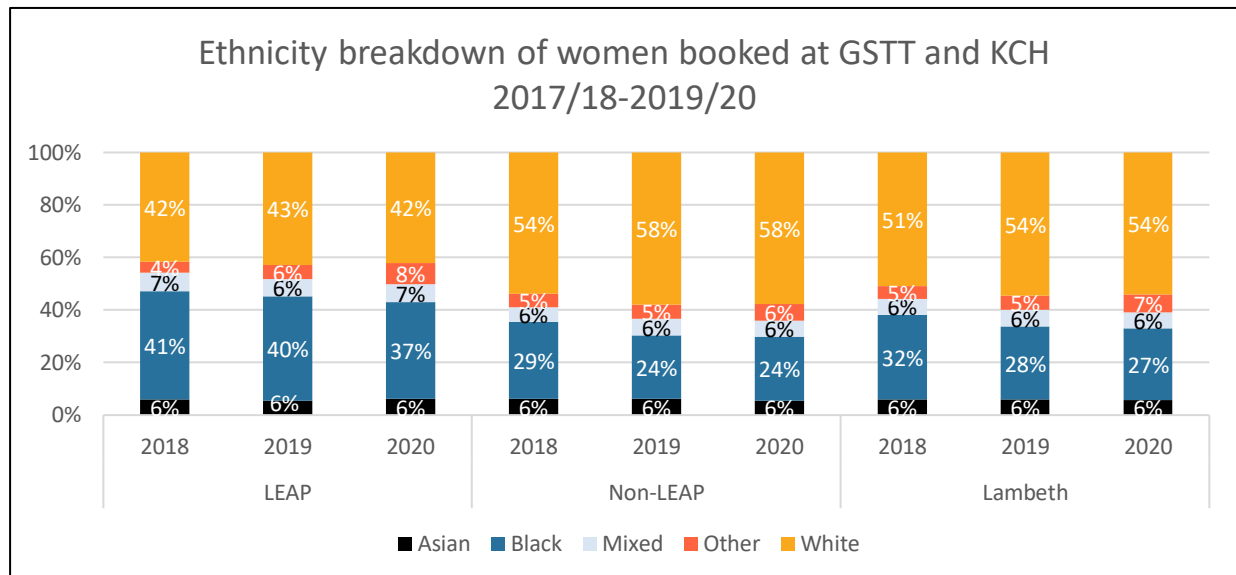


Figure 4 Ethnicity breakdown of women booked at GSTT and KCH, 2017/18 – 2019/20

The ethnicity breakdown of women booking onto maternity services in Lambeth is comparable to the breakdown of the local general population. In 2019/20 the most common group was White with 42% for the LEAP area, which is similar than the previous two years. The proportion of Black women booking on to maternity services has decreased between 2017/18 and 2019/20 across all geographies, from 41% to 37% in the LEAP area and from 32% to 27% across Lambeth. However, this is similar to the ethnicity breakdown of the local population from GP DataNet data. The LEAP area has a higher proportion of women from a Black background compared to Non-LEAP and Lambeth overall.

Figure 6 shows a full breakdown of ethnicity across the full 18 categories for women from Lambeth during 2019/20, which may be useful when thinking about cultural differences. This breakdown is not provided at lower geographical levels (i.e. LEAP and Non-LEAP) due to small numbers and the risk of individuals becoming identifiable.

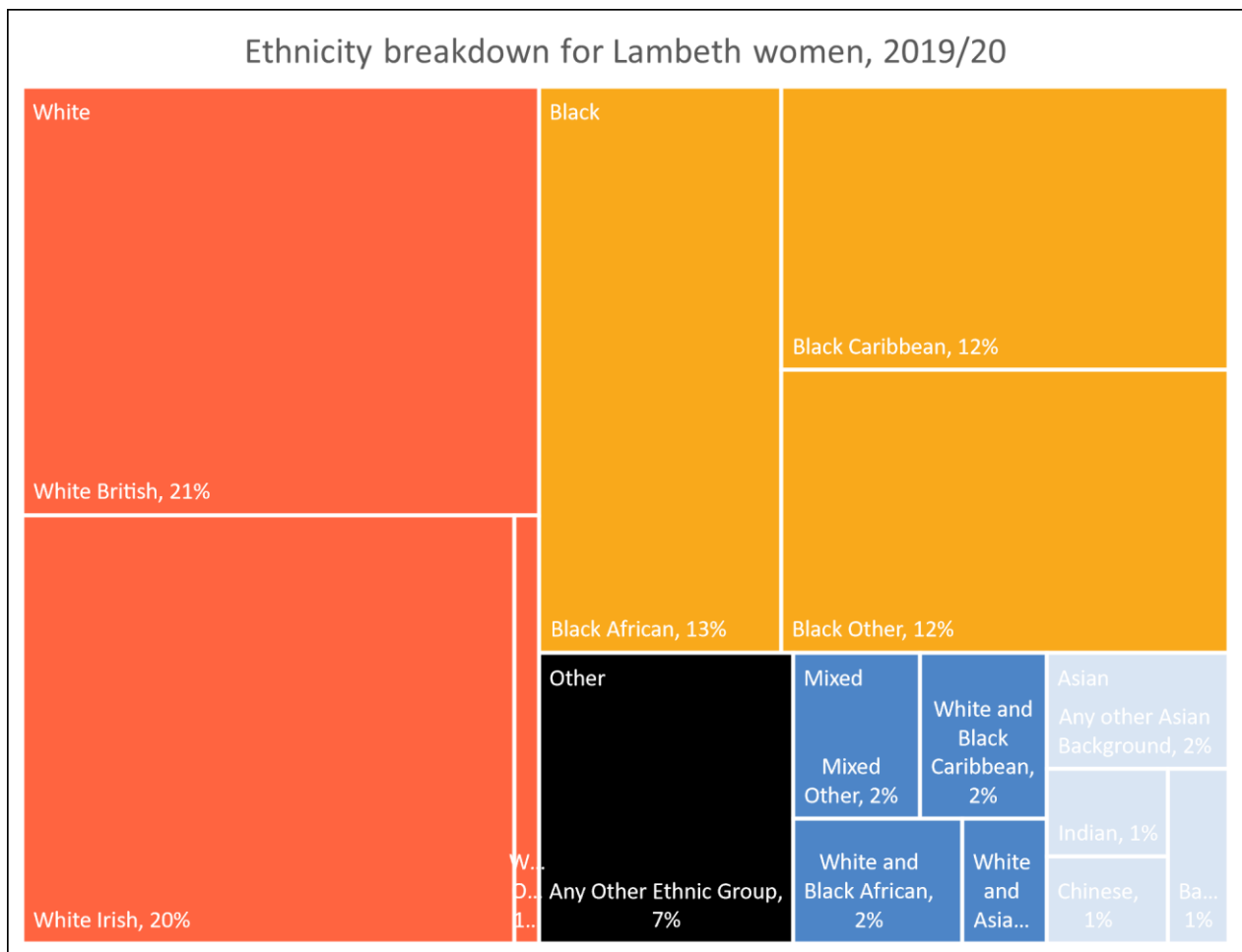


Figure 5 Ethnicity Breakdown for Lambeth Women 2019/20 (Badgernet)

Country of origin

Country of origin is defined as country of birth. Table 4 shows the most common countries of origin taking an average of all three years, ordered by the most common for Lambeth. Approximately 50% of women booked were not born in the UK across geographies on average.

The most common languages spoken Lambeth-wide were not reflected when analysing the LEAP area.

Country of origin along with language spoken at home may be useful when assessing cultural accessibility for LEAP and wider Lambeth services. It may also influence understanding of the UK healthcare system, specifically for maternity services, in terms of language and cultural accessibility.

Some women with a residence permit allowing them to live in the UK may be noted as having no recourse to public funds⁵. There is a section dedicated to no recourse to public funds on page 15.

⁵ <https://www.gov.uk/government/publications/public-funds--2/public-funds>

Table 4 Most common countries of origin, 3 year rolling average of 2017/18-2019/20

Country	LEAP	Non-LEAP	Lambeth
United Kingdom of Great Britain and Northern Ireland	47%	51%	50%
Jamaica	4%	2%	3%
Nigeria	4%	2%	3%
Portugal	4%	2%	3%
Somalia	3%	2%	2%
Eritrea	2%	-	-
France	1%	-	2%
Colombia	2%	-	-
Spain	1%	-	-
Ghana	2%	2%	2%
Ecuador	2%	1%	1%

Primary language

The primary language field contains a range of languages, as well as the option to specify 'Other'. For the purposes of this analysis, the first listed language has been included.

Table 5 shows the most commonly spoken languages in the most recent year - 2019/20 - across all geographies starting with the most recent year (ordered by most common for Lambeth-wide population).

25% of women from the LEAP population do not speak English as a primary language, although insights from LEAP suggest women who have a good level of proficiency in English note their primary language as English, so there may be some underrepresentation of other languages.

Table 5 Most common primary language spoken

2019/20	LEAP	Non-LEAP	Lambeth
English	75%	69%	74%
Spanish	4%	7%	5%
French	2%	3%	2%
Portuguese	3%	4%	3%
Polish	*%	1%	1%
Arabic	*%	1%	1%
Italian	*%	1%	1%
Somali	2%	2%	2%

*numbers too small to present

Although organisations typically translate materials into languages which are most commonly spoken, there were over 170 women across Lambeth in 19/20 whose primary language would not be considered common, and therefore may not have (regular) access to translated materials or information should they need them. If this is the case, it could result in women not feeling fully informed about what to expect from services during their pregnancy, the support available to them and increase the risk of women not engaging with vital services. Without the right information available to all women, informed choices may be impacted.

The numbers of less commonly spoken languages are small when broken down by LEAP and non-LEAP and therefore not presented. English proficiency is not captured as a data item on its own, but may be found in 'communication notes' where 'difficulty understanding English' is sometimes noted.

During 2019-20, 9% of LEAP women reported they had difficulty understanding English, and 7% Lambeth-wide had difficulty understanding English, therefore without access to translated materials it may be difficult to understand if women feel fully informed about the pregnancy journey and support available to them throughout.

Communication and learning difficulties

Data around communication is not collected consistently and therefore will not be presented in charts or tables, but there remain some useful insights.

For Lambeth women in 2019/20, fewer than 10 women reported a hearing impairment, fewer than 10 reported they required another communication method, and fewer than 10 reported needing a sign language interpreter.

Other communication methods included sign language and lip reading. Lip reading in particular is something that may need to be considered where blended delivery offers include a virtual element.

2% of LEAP women reported learning difficulties during 2019-20.

Access to public funds

There was around 50% completion for this field which indicates poor/substandard data quality. Therefore, nulls and blank records have been included for this field.

Figure 5 shows the proportion of women living in the LEAP area reporting no access to public funds increased from 2017/18 - 2018/19 before remaining similar during 2019/20. No further details are provided about reasons for not having access to public funds. During 2019-20, 49% of people from the LEAP area who reported no access to public funds listed their country of origin as outside of the UK. 3% of women from the LEAP area who reported no access to public funds also reported their employment status as unemployed, with no access to benefits. [Information from London Councils about No Recourse to Public Funds and support for these groups](#) can be found here.

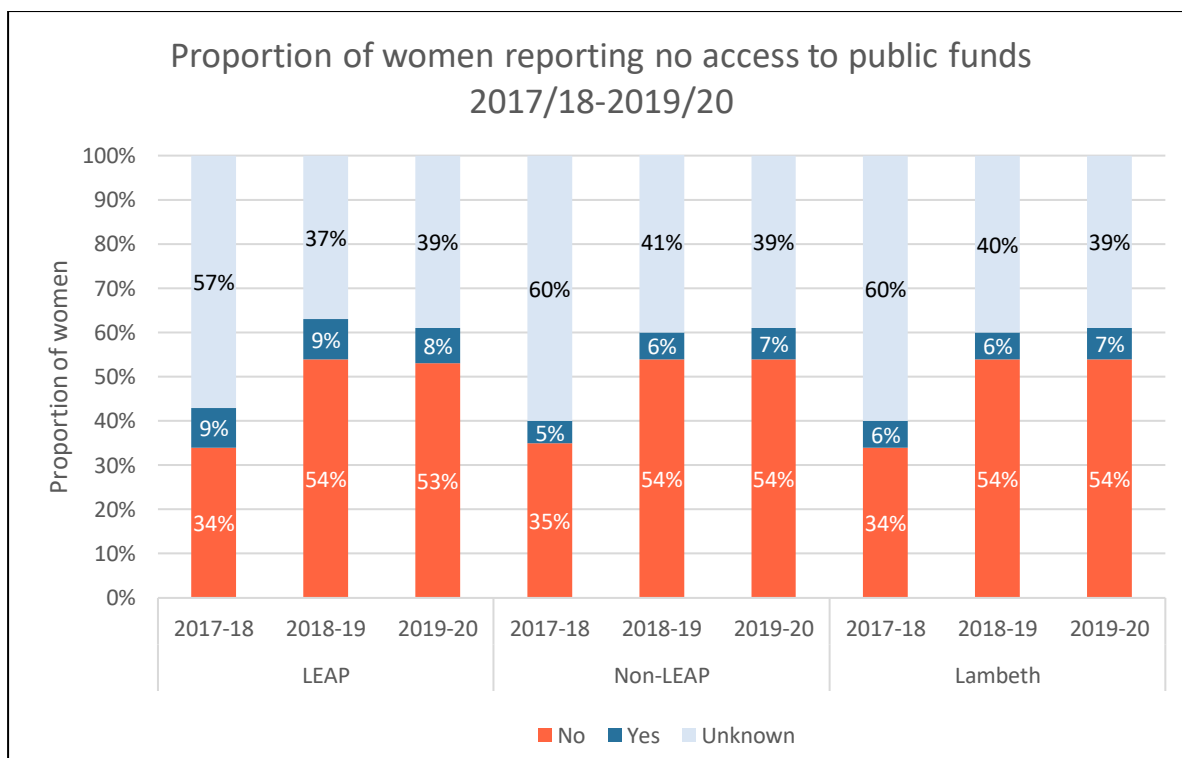


Figure 6 Proportion of women reporting no access to public funds for each geographical area, 2017-18 – 2019-20

Employment status

The employment field has not been completed consistently, with a number of records reported as ‘Other’ which is a free text field. In some cases, this lists the type of employment area or trade, but does not specify the current employment status, or further details such as “just lost job/started maternity”. Therefore, those listed as other have been excluded from the analysis.

Table 6 shows the most common categories for the most recent year 2019/20.

Table 6 Employment status for women 2017/18-2019/20

19/20	LEAP	Non-LEAP	Lambeth
Employed*	29%	33%	32%
Employed – Full time	22%	28%	27%
Employed – part time	14%	12%	12%
Full time Parent	8%	7%	8%
Unemployed – no benefits	7%	7%	7%
Unemployed - with benefits	10%	5%	6%
Self-employed	3%	4%	4%
Higher Education	2%	1%	1%

*Status is recorded as employed, with no indication as to whether employment is part time or full time

Although there are no further details consistently given for reasons of unemployment, there are a small number of women who have no right to work, have opted for a career break or are medically

unfit. In 19/20 7% of women across all geographies were unemployed with no benefits, although it is not possible to understand whether they are being financially supported through other means.

Claimant count data shows 9,140 women and 12,290 men were claiming Universal Credit across Lambeth for 2019. Claimant count data shows 8.2% of Lambeth population were claiming Jobseeker's Allowance during June 2021.⁶

Support available

At the maternity booking appointment, women are asked about their support status and whether they feel supported.

Support Status: although this field is well completed, 'lived alone supported' and 'Other' has an element of free text detailing which family members and how many other people may be in the household. This data therefore has not been presented as a trend across years.

Feel supported: across all years, 72% of women Lambeth-wide reported that they felt supported. Nulls have been included for the analysis of this field. Numbers become too small to enable reporting for the LEAP area.

Biological father

Few details are gathered on biological fathers within the Badgernet system. The only field with good quality data about fathers is biological fathers' ethnicity and is presented in Figure 7.

It is comparable to Lambeth-wide data about the general population on Page 11. The data shows an increase in the proportion of biological fathers who are from a Black background in 2018/19, although this slightly decreases the following year for LEAP and across Lambeth. However, this trend differed marginally for non-LEAP residents.

⁶ <https://www.nomisweb.co.uk>

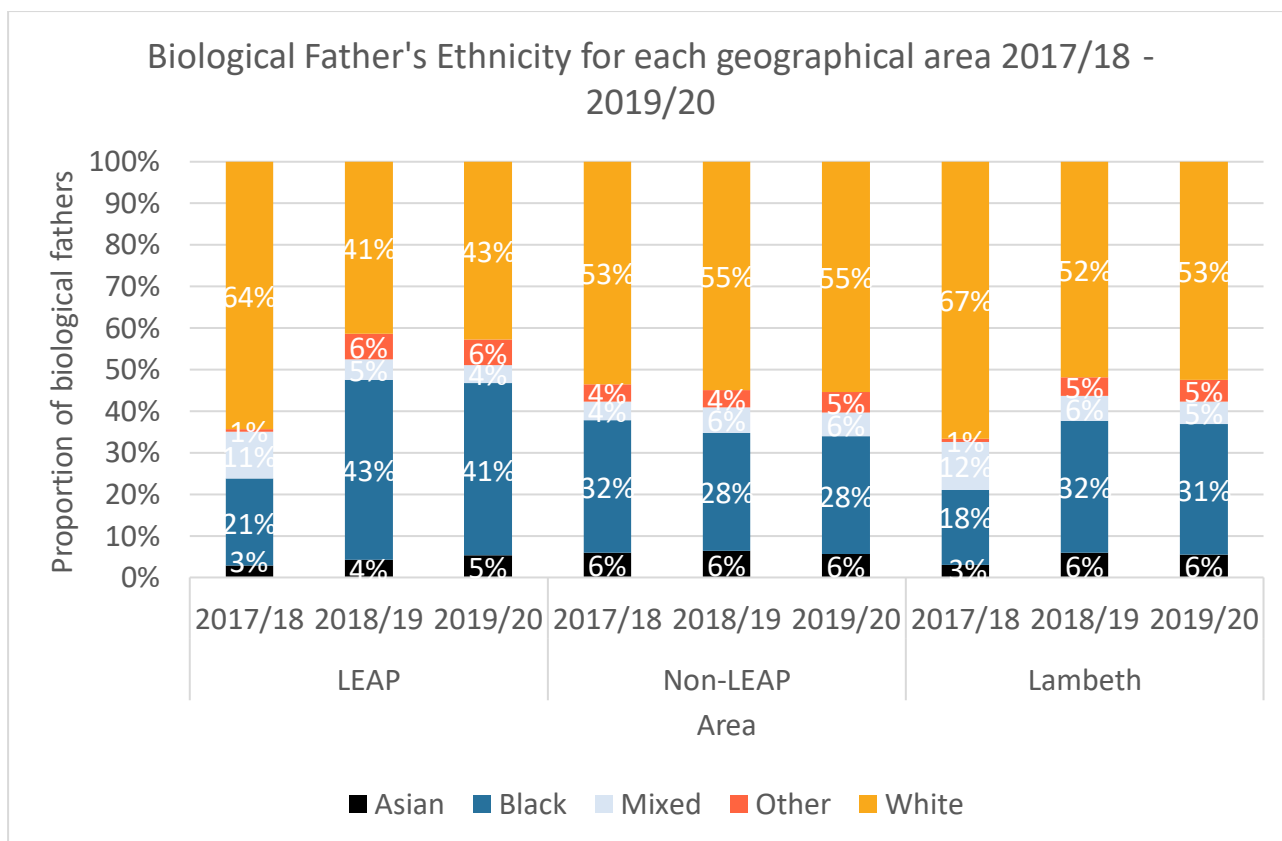


Figure 7 Biological father's ethnicity for each geographical area, 2017/18 – 2019/20

Booking process

This section looks at three fields related to the maternity booking process: referral route; whether the GP was informed; and late booking.

There are several fields which explore the booking process for women, however some are of poor data quality. There was a completion rate of just over 10% for the field that collected information on whether a woman's GP was informed of their pregnancy.

At the time of writing, the process in Lambeth supports women to self-refer on to maternity services at GSTT and KCH for their antenatal care using an online form. GPs can refer women, but this is no longer the primary referral route (Fig. 9). This is not unusual - there is a general shift nationally from GPs referring women to maternity services, to women having the ability to self-refer.

NHS guidelines state that the first midwife appointment (the booking appointment) should happen before a woman is 10 weeks pregnant in order that screening can be offered at an appropriate time and timely antenatal advice provided. The World Health Organization (WHO) recommends that pregnant women should have an early ultrasound scan before 24 weeks of gestation to estimate gestational age, improve detection of foetal anomalies and multiple pregnancies, reduce induction of labour for post-term pregnancy, and improve a woman's pregnancy experience.

GSTT and KCH both consider a booking appointment at or after 13 weeks' gestation to be late.

Referral route into maternity service

Figure 8 shows the proportion of women who self-referred, were referred by a GP practice, or referred via another route.

The proportion of self-referrals has increased over time – between 65% and 69% women self-referred across all geographies in 2019/20, compared with a range of 17% - 24% in 2017/18. The proportion of referrals from GPs has decreased over time with 33% for LEAP women, 28% non-LEAP and 29% across Lambeth in 2019/20. The increase in self-referrals is to be expected due to the change of process in Lambeth, as noted above.

2017/18 saw a higher proportion of referrals from other professionals and family members than the following years. This includes referrals from Early Pregnancy Units, diabetics team, and other healthcare departments.

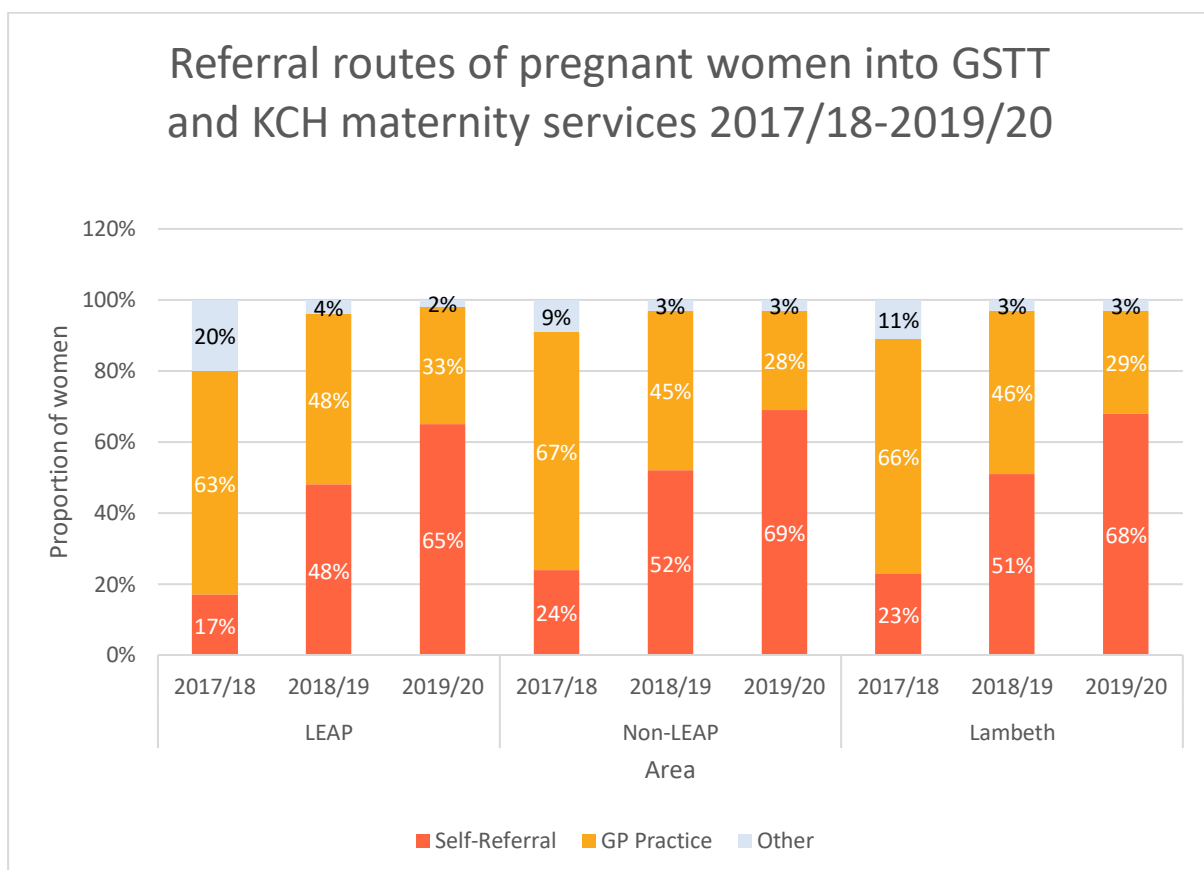


Figure 8 Referral routes of pregnant women into GSTT and KCH maternity services 2017/18 – 2019/20

GP informed of pregnancy

18% of all women booked who live in Lambeth had not had information about their pregnancy passed onto their GP in 2019/20.

There were a large proportion of self-referrals to the maternity booking unit in the same year. This corresponds with the change to the antenatal referral process in Lambeth in recent years. It is possible that this change of process has led to some women’s GPs not being notified about their

pregnancy after the booking appointment, as would be expected. If a GP is not informed of a patient’s pregnancy, they are unable to pass on medical or safeguarding information about a woman that could be relevant to their care.

Figure 9 shows the proportion of women whose GP was not informed of their pregnancy. Data quality is relatively poor, with 21% completion across all geographies in 2019/20, although this has increased from 13% in 2017/18.

Where data was recorded, 82% of women’s GPs were informed of their pregnancy in 2019/20 across all areas. When looking at referral routes into the maternity services, the majority are self-referrals. This may reflect the completion of this field as 65% of LEAP women self-referred in 2019/20.

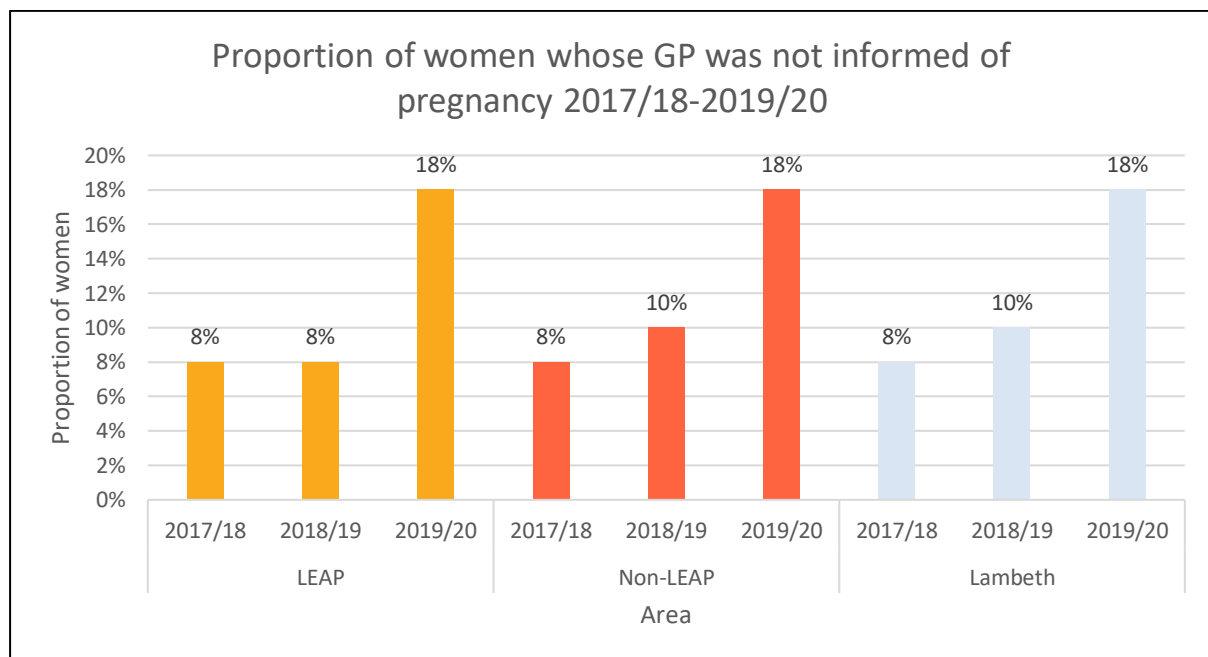


Figure 9 Proportion of women whose GP was not informed of pregnancy 2017/18-2019/20

Late booking

Each year a number of women are booked onto the maternity service late into their pregnancy. The proportion of late bookings increased from 2017/18 to 2018/19 and decreased the following year, this is presented in figure 12.

During 2019/20, 23% of women from the LEAP area and 19% Lambeth-wide booked late for their antenatal care. Most of the reasons are listed as free text, therefore only those for LEAP women have been analysed and grouped into categories. There were a variety of reasons for late bookings, reasons across all three years have been combined and most common presented in Table 7.

Table 7 Reasons for late bookings 2017/18-2019/20

Reason	Percentage between 2017/18-2019/20
Unaware of pregnancy	16%
Transfer of care	14%

Moved or out of the country	13%
Late referral	11%
Missed appointment	4%
Appointment delayed/lack of availability/process issue	4%

Other reasons are related to their views and decisions around their pregnancy journey, and in some cases related to previous experiences (wanting to be sure, or feeling that support wasn't necessary, or concealing their pregnancy), or not being fully informed of the maternity process in the UK.

A number of women were booked late due to issues with the hospital not receiving the GP referral (where the GP was the referral route into antenatal care), delays to GP referrals and other communication issues resulting in women not receiving their appointment letters, as well as delays due to appointment availability.

The maternity booking dataset does not include information about whether women are currently registered with a GP or not, but it might be reasonable to assume that some women who book onto maternity services are not registered with a GP given some reasons provided for late booking include a recent move to the country or a move from a different area within the country.

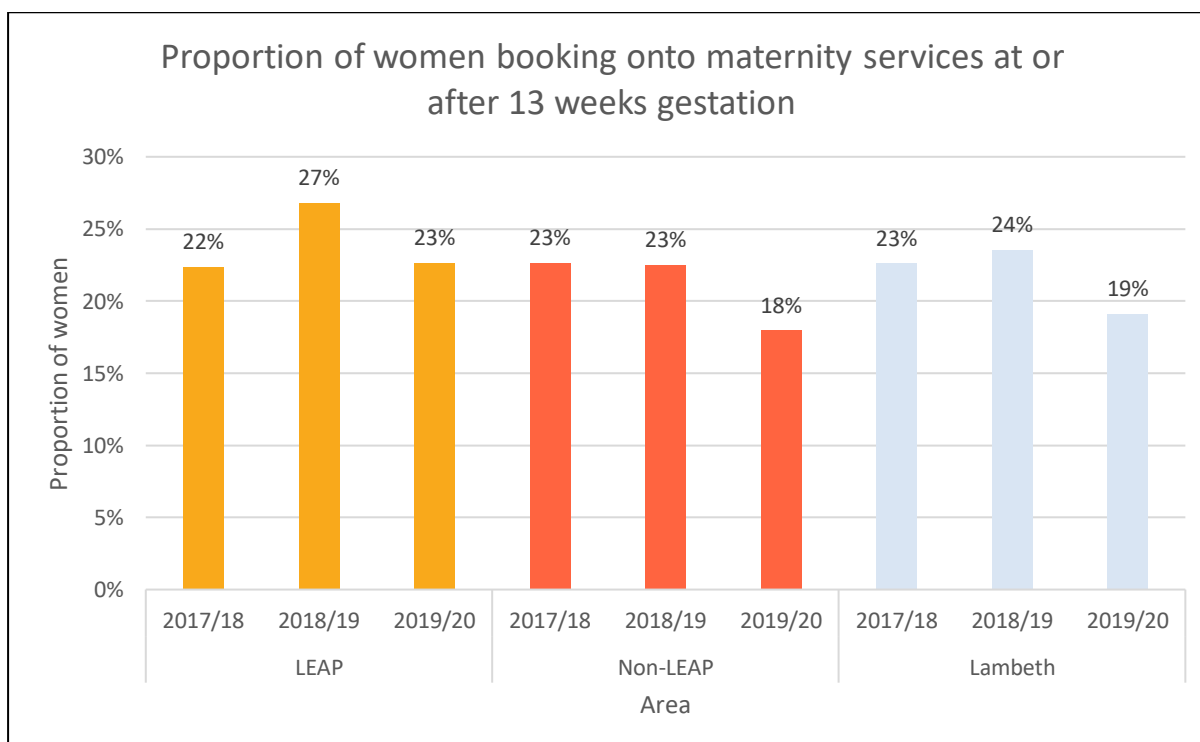


Figure 10 Proportion of women reported as having booked late onto maternity services, 2017/18 – 2019/20

Previous pregnancies

Figure 11 shows the proportion of women who have been pregnant before. No details about previous pregnancies, term or birth outcome (including terminations or miscarriages) are recorded in the Badgernet system. Therefore, conclusions cannot be drawn about any level of support received, either medically or socially, throughout any previous pregnancies.

Approximately two thirds of women booked across all geographies reported they had been pregnant before, therefore for a third of women in the dataset this was their first pregnancy.

Of those who reported previous pregnancies, 50% of LEAP women had only one previous pregnancy with the remaining 50% ranging between two and 13 pregnancies in 2017/18. 46% of non-LEAP women had only one previous pregnancy, with the remaining 54% ranging between two and 13 pregnancies.

In 2019/20, of those women who had not been pregnant before:

- 55/872 (6%) Lambeth-wide reported difficulty understanding English
- 67/872 (8%) Lambeth-wide were reported as requiring an interpreter at their appointment(s)

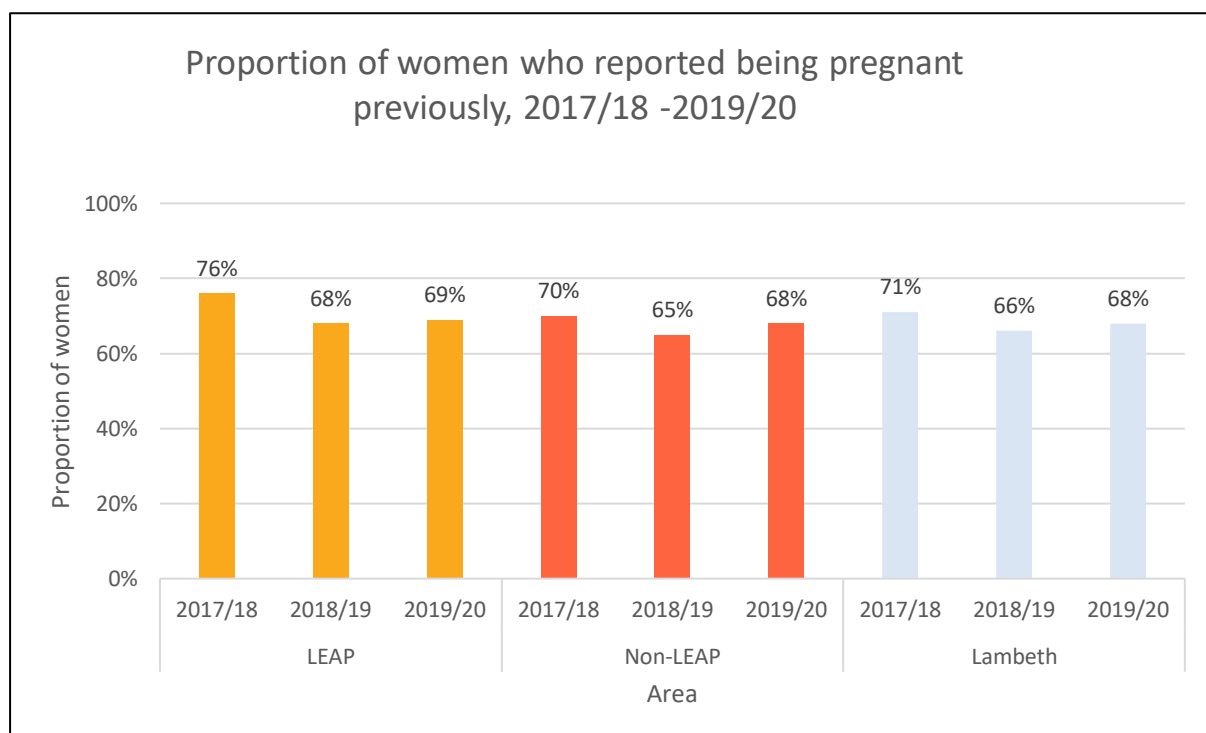


Figure 11 Proportion of women who reported being pregnant previously, 2017/18 – 2019-20

Was the pregnancy planned?

Around a third of women reported their pregnancy was not planned. The proportion of women reporting unplanned pregnancies is higher for women in the LEAP area compared to non-LEAP or

Lambeth-wide in all years. There is a slight increase in the proportion of planned pregnancies over the years.

26% (198/770) of those who reported an unplanned pregnancy across Lambeth in 2019/20 had not been pregnant before.

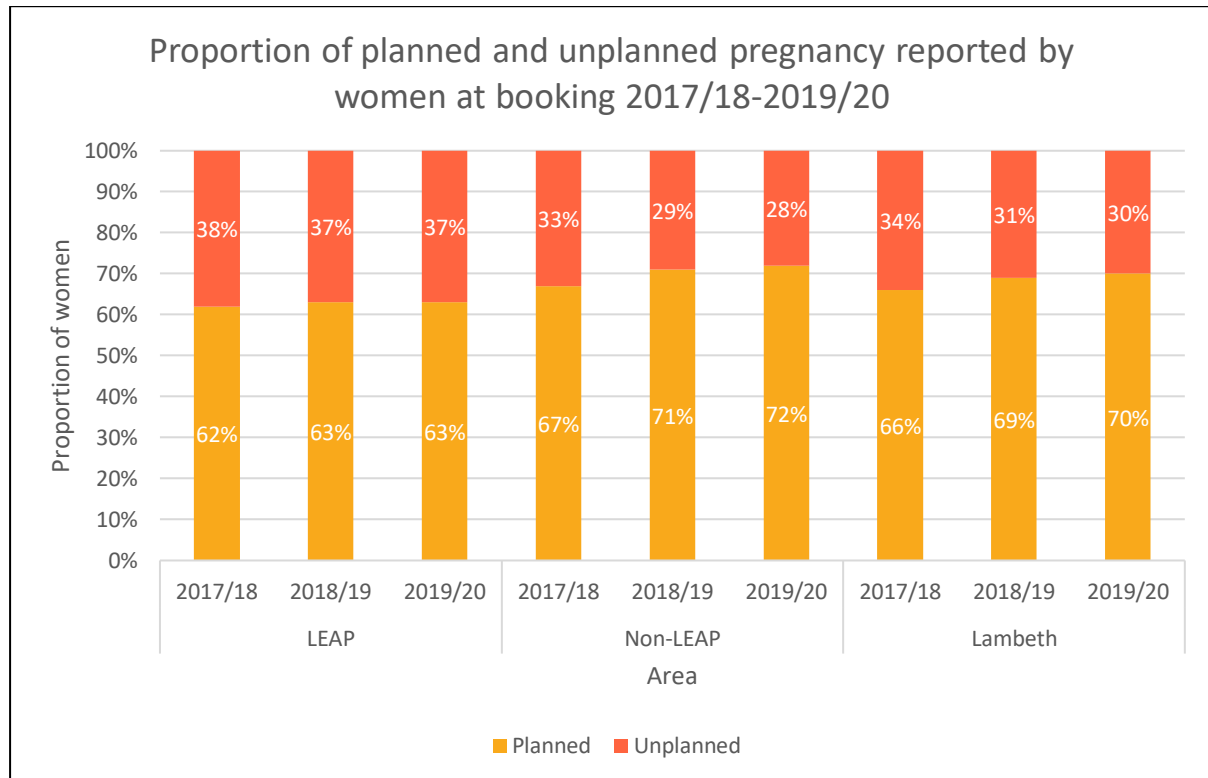


Figure 12 Proportion of planned and unplanned pregnancies reported by women at booking, 2017/18 – 2019/20

Gestational diabetes

Diabetes display

This field is completed differently for some women, either detailing current or previous gestational diabetes, and possibly noting whether type 1 or type 2 diabetes is present.

The chart below shows the proportion of women where gestational diabetes has been noted, and shows an increase in 2019/20. Women may additionally present with type 1 or type 2 diabetes as well as gestational diabetes.

Diabetes control

53 out of 269 women with diabetes across Lambeth were recorded as having had their diabetes controlled, either through medication (Insulin, metformin) or diet.

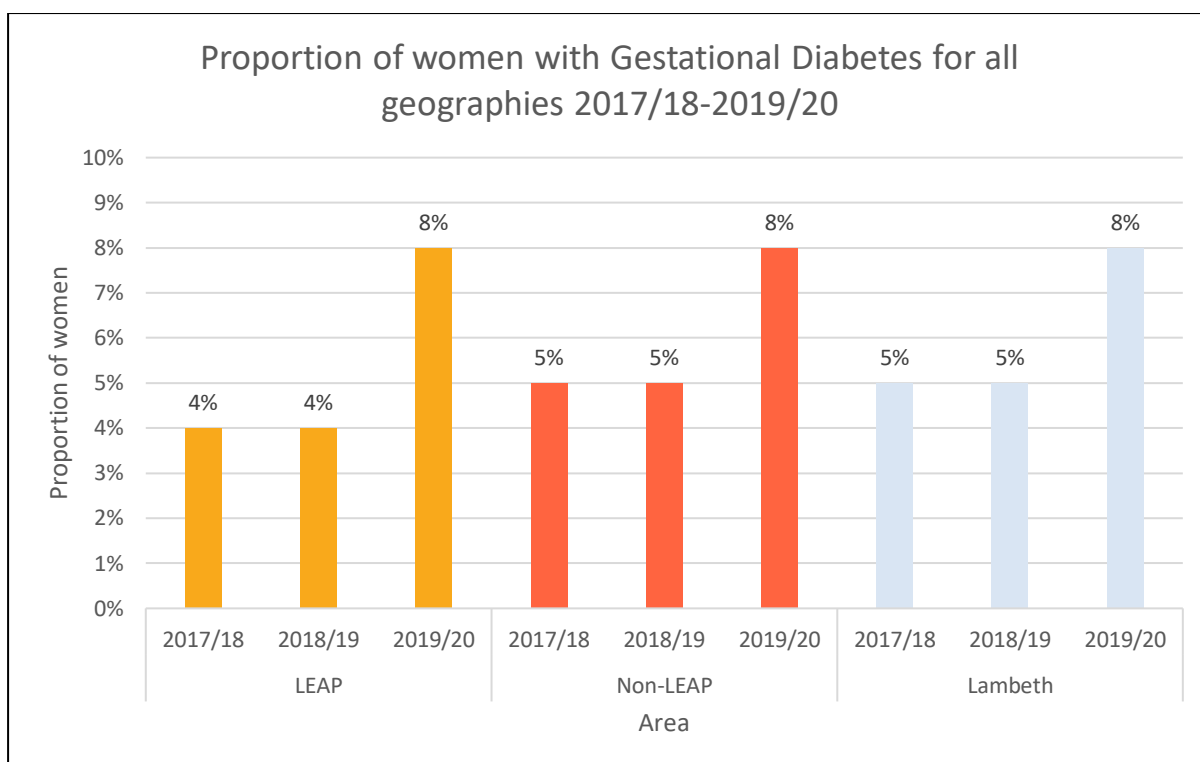


Figure 13 Proportion of women with gestational diabetes 2017/18 – 2019/20

Domestic abuse

When possible, women are asked about current or previous domestic abuse at their maternity booking appointment. According to the dataset, very few women from Lambeth declined to answer this question.

There were a number of women whose midwives were unable to ask about domestic abuse at booking. Data received does not inform us whether there was an opportunity to do so at a later date.

The proportion of women midwives were unable to ask about previous and current domestic abuse increased during 2019/20.

The number of women reporting current domestic abuse was small and therefore not included in this analysis due to the risk of identification. This does not mean however that domestic abuse is not happening, and there are a number of reasons why a woman may choose not to disclose abuse. It is likely that the number of women actually experiencing abuse during pregnancy was significantly higher than can be seen in the dataset. In the ‘Supporting women and babies after domestic abuse’ report, Women’s Aid state: *Prevalence studies suggest that between 20% and 30% of women will experience physical violence at the hands of a partner/ex-partner during pregnancy. There are many risks involved in domestic abuse during pregnancy, and it can impact both mother and baby in short-term and long-term ways. Risks are both emotional and physical.*

Data quality for ‘Current contact with perpetrator’ was poor, therefore not included in this analysis.

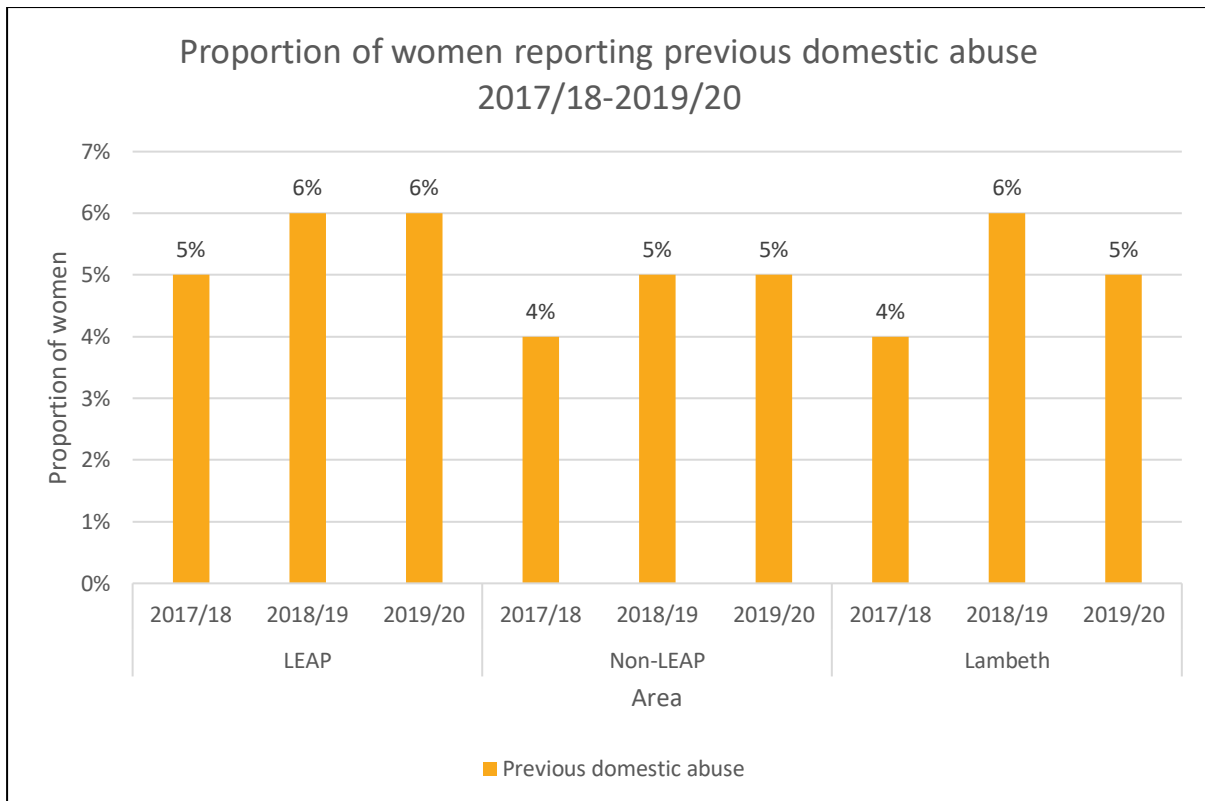


Figure 14 Proportion of women reporting previous domestic abuse 2017-18 – 2019-20

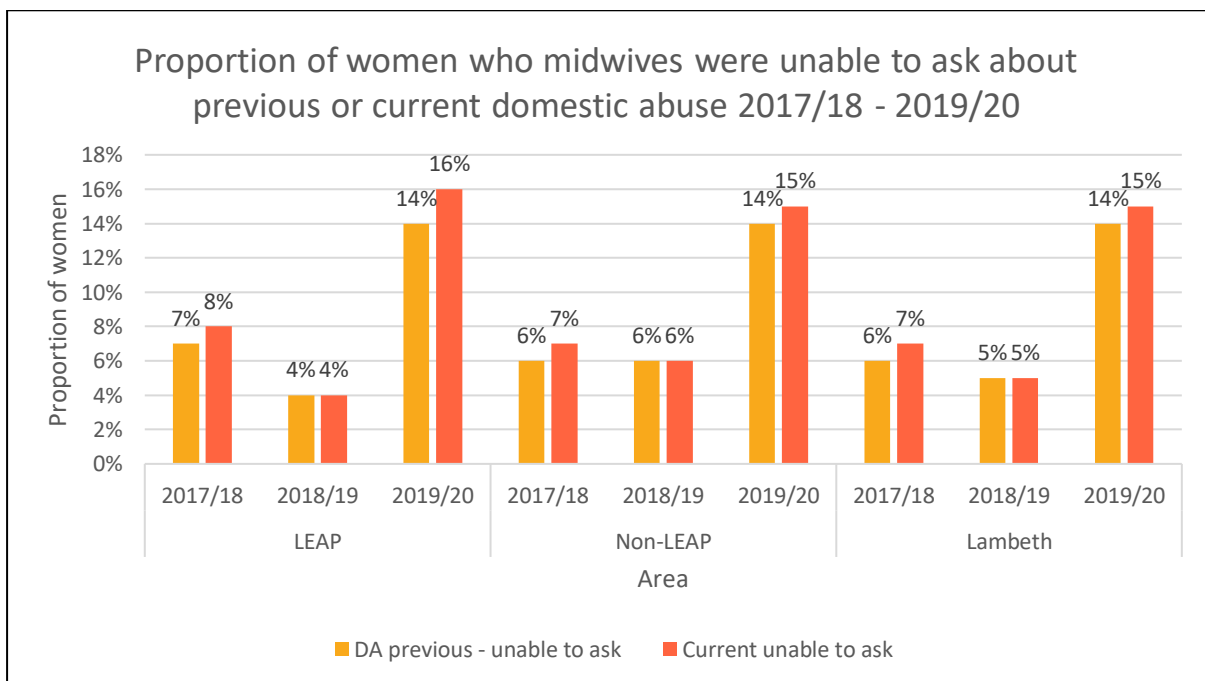


Figure 15 Proportion of women who midwives were unable to ask about previous or current domestic abuse 2017/18-2019/20

Risk factors

Data on various types of risk factors has been collected, with multiple factors recorded within one field. Some of the risks noted may also be recorded in a dedicated field elsewhere in the dataset (e.g. diabetes, daily number of cigarettes smoked where smoking is reported). The general risk factor fields are:

- **Medical risk factor:** details any medically related risk factors, for example diabetes, gastrointestinal disorder, autoimmune disease, blood related conditions
- **Mental health risk factor:** details any current or previous mental health conditions, for example, depression, eating disorders, anxiety
- **Obstetric risk factor:** includes information on obstetric risks such as previous pre-eclampsia, previous tears or previous caesarean section
- **Sensitive risk factor:** includes risks such as substance abuse or sexually transmitted infections
- **Social risk factor:** includes risks such as learning disabilities, difficulty speaking English and involvement of social services
- **Current pregnancy risk factor:** gestational diabetes, infertility treatments, multiple babies, travel to Zika infected country

The list of categories is not exhaustive.

Detailed breakdown of the types of risks or number of risks are not included in this analysis but this could be a further piece of work to explore.

Figures 16 and 17 show the proportion of women with at least one risk noted for each risk type. Medical, obstetric and current risk factors are presented together in figure 16, and mental health, sensitive risk factors and social risk factors are presented together in figure 17.

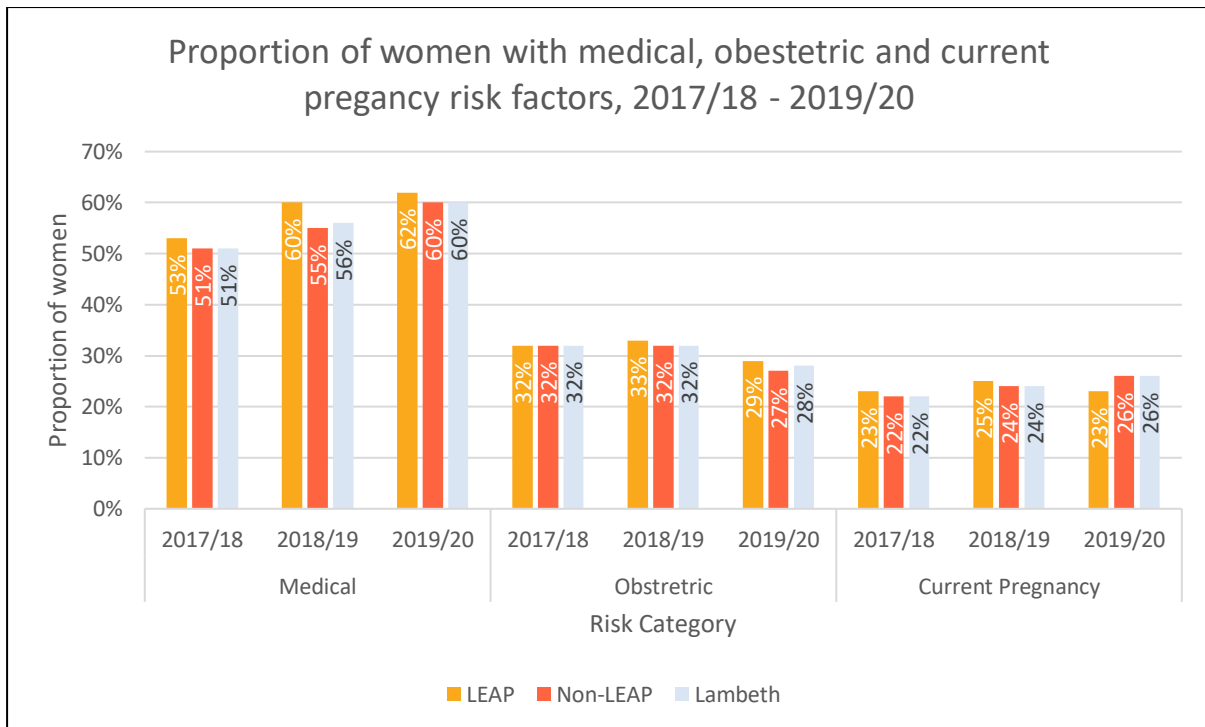


Figure 16 Proportion of women with medical, obstetric and current pregnancy risk factors, 2017/18 – 2019/20

The proportion of women with at least one medical risk factor increased since 2017/18 across all geographies. At least 50% of women had a minimum of one medical risk factor.

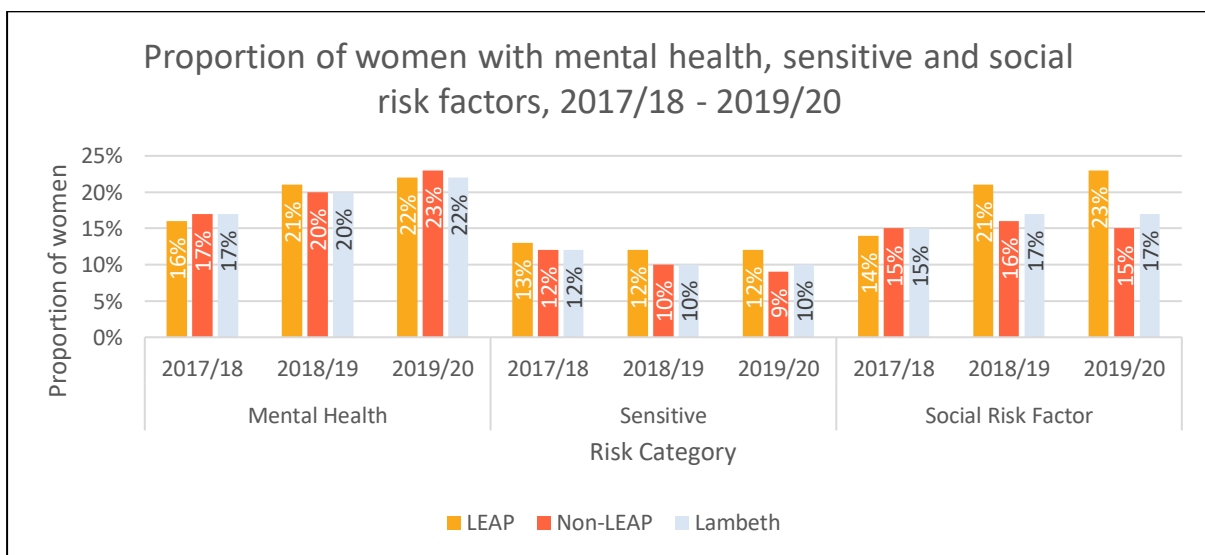


Figure 17 Proportion of women with mental health, sensitive and social risk factors, 2017/18 2019/20

The proportion of women with at least one mental health risk factor and one social risk factor has increased over the years across all areas (see figure 17).

Substance use: drugs

Between 8 and 11% of women have reported having ever used drugs over the three years.

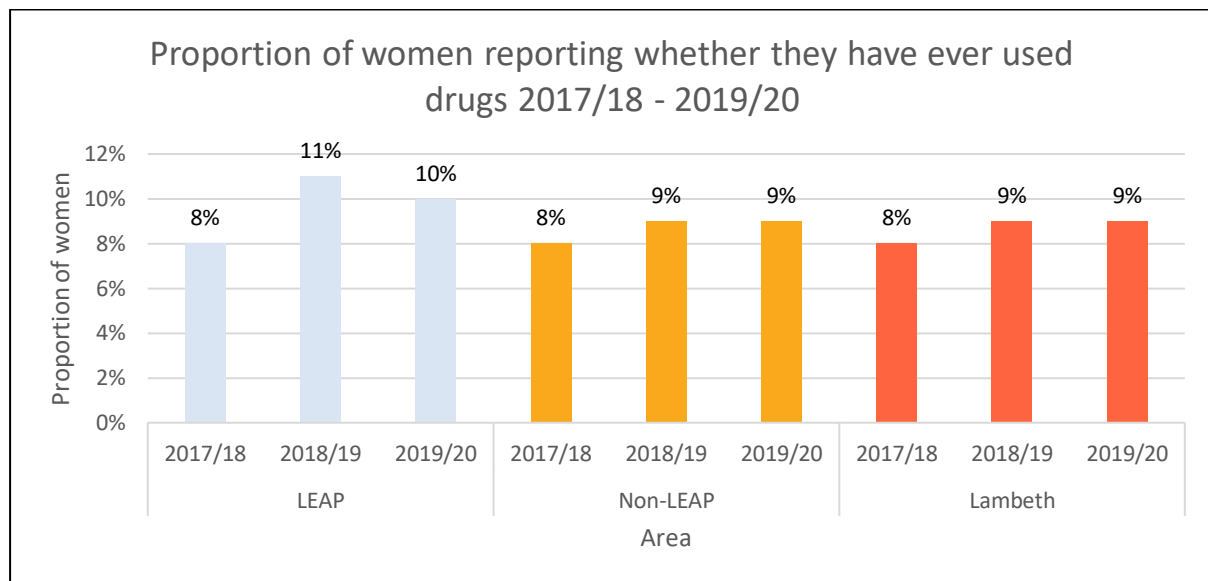


Figure 18 Proportion of women reporting whether they have ever used drugs 2017/18 - 2019/20

Social factors for women: housing and accommodation

Data is collected on whether women have existing housing problems. However, the problems are not subsequently detailed. The 'accommodation' or 'supported' field may provide more details about housing situations and can include details about women who may be homeless, or in temporary accommodation. Up to 7% reported having housing problems across all geographies.

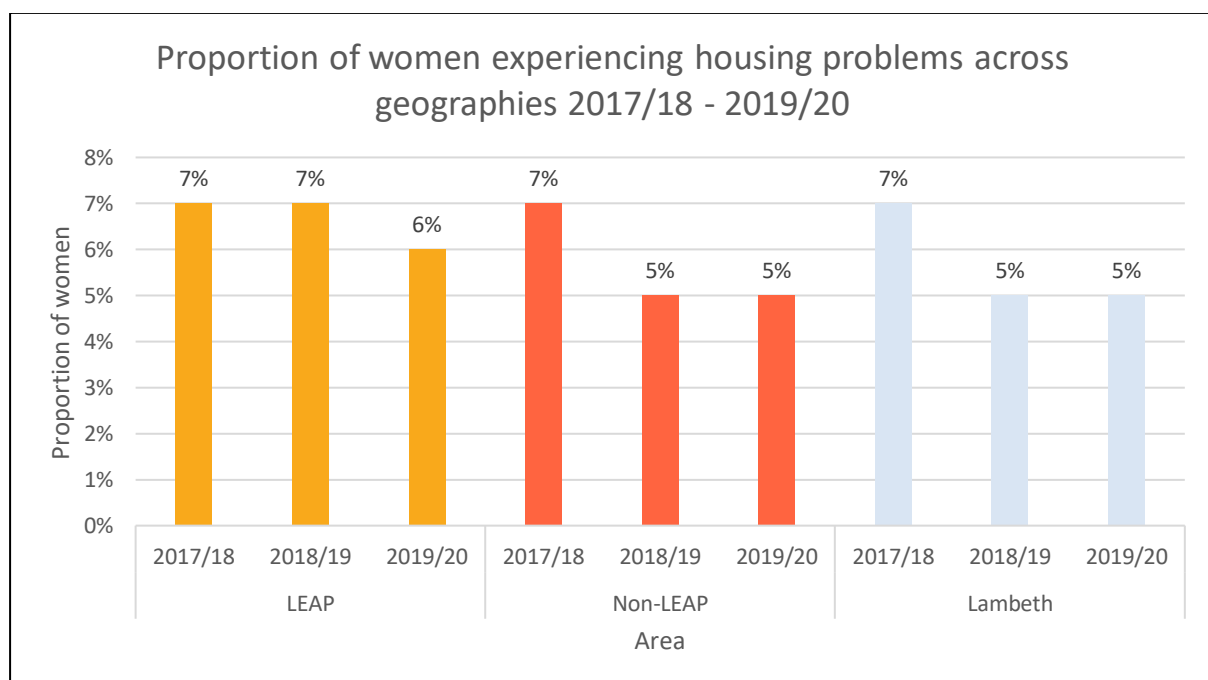


Figure 19 Proportion of women experiencing housing problems across geographies 2017/18- 2019/20

The accommodation field allows for some free text entry under ‘other’ as well as pre-set categories and often details the type (shared housing, hostel). Further details around the living arrangements are not included. In 2019-20, 60% of LEAP women were renting, with 21% renting privately compared to 25% who owned their home. There are a small number of women in temporary accommodation, ‘sofa surfing’, or living with friends.

Social factors for women: female genital mutilation (FGM)

Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, but there is no medical reason for this to be done (NHS.uk). Illegal in the UK, FGM is usually carried out on young girls. It is very painful and can seriously harm the physical and mental health of women and girls, including long-term problems associated with childbirth.

FGM is categorised into four types, these are defined in the annex.

Data is collected about FGM and is identified either via an examination or is self-reported. Type and subtype are also recorded but numbers are small and therefore will not be presented due to the sensitive nature of this field. Trust FGM leads were not always notified where FGM was reported, though processes or reasons for this were not detailed. Figure 20 shows the proportion of women who reported FGM. Nulls have been included in this field.

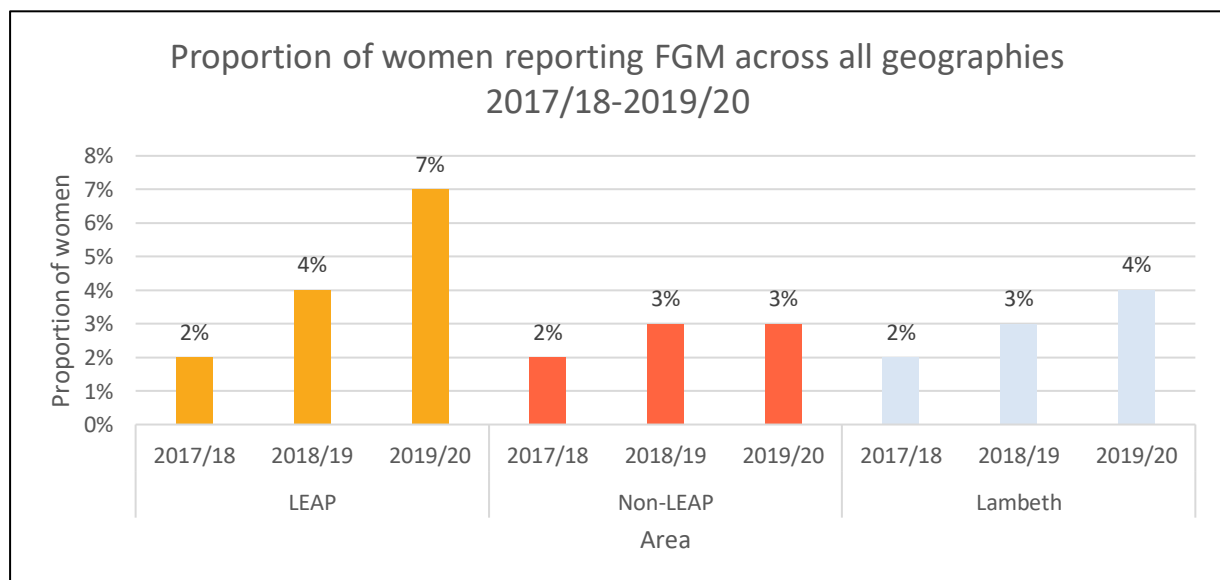


Figure 20 Proportion of women reporting FGM across all geographies 2017/18 - 2019/20

Data is also collected about family history of FGM in a separate field. There were a number of women who reported FGM who also reported a family history of FGM. 86% cent of women across Lambeth who reported FGM also reported a family history of FGM.

Annex

There are several data items that have been explored across all geographies and years, but due to data quality, and/or small numbers of free text fields, have not been presented as a trend. These are noted below.

Congenital abnormalities and infectious diseases

Congenital abnormalities can be defined as structural or functional anomalies that occur during intrauterine life. These conditions develop prenatally and may be identified before or at birth. Less than 20 babies Lambeth- wide were identified as having a congenital abnormality therefore data across years and geographies has not been presented.

Infectious disease

Infectious disease includes Hepatitis B, Herpes and HIV, however numbers are too small to be included therefore have not been presented in this analysis.

Social care status

Although data is collected for a number of fields (listed below) relating to the social care status of previous children and the unborn child, numbers are too small across all geographies to be included in this analysis or to draw conclusions from.

This data includes the following:

Previous child:

Child protection plan

Child in need

Foster care

Adoption

Living elsewhere

Unborn Child:

Child protection plan

Child in need

Foster care

Adoption

The dataset included other fields where data quality was poor and therefore were also excluded from analysis. These were: surrogate mother and relationship problems.

Drug use

In addition to 'Ever used drugs' presented above, the following fields are included in the dataset, however will not be presented due to poor data quality/small numbers:

- Current drug use
- Receiving treatment
- Current partner using drugs
- Ever overdosed

FGM types, as defined by the NHS Health A to Z

- type 1 (clitoridectomy) – removing part or all of the clitoris
- type 2 (excision) – removing part or all of the clitoris and the inner labia (the lips that surround the vagina), with or without removal of the labia majora (the larger outer lips)
- type 3 (infibulation) – narrowing the vaginal opening by creating a seal, formed by cutting and repositioning the labia
- other harmful procedures to the female genitals, including pricking, piercing, cutting, scraping or burning the area

Further analysis

Additional analysis is currently in development, with statistical outputs focussing on outcomes relevant to LEAP services, such as: birthweight, anxiety and depression.