

INFANT MORTALITY IN ENFIELD

Annual Public Health Report: 2015





WELCOME



I would like to welcome you to the Annual Public Health Report for 2015/16. This report focuses on infant mortality and what can be done to reduce it as well as ensuring all children in Enfield have the best chances for a long and healthy life.

Infant mortality has been a long standing concern for Enfield. Despite recent improvements, it remains a priority for the Health and Wellbeing Board. It is associated with a number of risk factors; low socio-economic status, late booking for antenatal care, smoking during and/or after pregnancy, alcohol and/or substance misuse during and after pregnancy, maternal obesity, domestic violence, low birth weight, not breastfeeding and inappropriate infant sleeping position. Enfield has been able to consider these factors and has, in collaboration with partners, developed interventions and campaigns to tackle them including the “Back to Sleep” campaign promoting safe sleep practices for babies, breastfeeding support programmes, and the “ASAP – As Soon As you are Pregnant” campaign aimed at encouraging pregnant women to notify health services as soon as they find out they are pregnant.

This Annual Public Health Report highlights the importance of evidence-led interventions that can impact on improving infant mortality rates. It includes examples of work across the borough that contributes to reducing infant mortality. This includes joint working with Children’s Centres, Teenage Pregnancy Unit, with the Health Visitor and Family Nurse Partnership services, and Perinatal Mental Health services. Ultimately, it is only by engaging fully with our partners and especially with the Enfield community that we can have an impact on reducing the rate of infant mortality in Enfield further.

I would like to thank the Public Health team for their hard work in producing this report which will help to guide and shape future work in reducing infant mortality and ensuring all children have the best start in life.

Cllr Nneka Keazor
Cabinet Member for Public Health and Sport

FOREWORD



My report this year focuses on infant mortality and what is being done in Enfield to address it. In 2010, Enfield had the worst infant mortality rate in London (5.76 per 1,000 live births). Whilst I am pleased to say that the rate has decreased (4.56 per 1,000 live births) we cannot afford to be complacent especially as Enfield's rate is still higher than the London average (3.8).

We know that a number of factors are associated with a higher risk of infant mortality and Enfield has developed a number of campaigns to address these factors. However, it is important that we continually promote messages to protect both babies and unborn children, for example, encouraging women to make sure they make contact with health services as soon as they think they are pregnant and see a midwife preferably within 10 weeks but certainly within 12 weeks of becoming pregnant, supporting women to access smoking cessation services, give advice regarding healthy eating in pregnancy, raising the awareness of the importance of breastfeeding and safe sleep positions, and promoting the antenatal screening programmes available to all pregnant women. I am also delighted that North Middlesex University Hospital NHS Trust is planning a programme for monitoring foetal growth with ultrasound.

This report highlights the relationship between child poverty and levels of infant mortality. Reducing both child poverty and infant mortality are key priorities for Enfield Council and feature in Enfield's Health and Wellbeing strategy (2014-2019), there are a number of work streams associated with this aimed at ensuring all children in Enfield have the best start in life.

I would like to thank Dr Allison Duggal, her team and partners for their work on tackling infant mortality. I would also like to thank Dr Cath Fenton and her team for the work they carried out prior to transition on moving this agenda forward. Finally I would like to thank those who produced this report; Dr Allison Duggal, Dr Chinelo Nwajiobi, Estella Makumbi, Miho Yoshizaki, Emily Rainbow, Lisa Luhman and all the Enfield Public Health Team for their clear description of the situation.

Dr. Shahed Ahmad
Director of Public Health

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EXECUTIVE SUMMARY

This year's Annual Public Health Report focusses on infant mortality and what is being done in the borough to ensure that all children in Enfield have the best chance for a long and healthy life regardless of the circumstances of their births.

Infant mortality refers to the death of a live-born baby in the first year of life. It does not include stillbirths, miscarriages or terminations and is more common in the first eight months of life. Infant mortality is usually expressed as a population rate (the number of infant deaths per 1,000 live births) which allows comparison with other populations or areas. Common causes of infant death include physical immaturity e.g. in premature births; low birth weight; congenital anomalies; maternal complications; infections; SUDI or "cot deaths".

In England and Wales, 130 out of every 1,000 children born in 1911 died before their first birthday. Now, the infant mortality rate is a fraction of this (4.1 per every 1,000 live births in 2011-13). The decrease in infant deaths is due to advances in public health and healthcare, including the control of infectious diseases and improved public health infrastructure, as well as specific improvements in midwifery and neonatal intensive care. However, infant mortality levels in Enfield were the sixth highest in London for the years 2011-13 (4.6 per 1,000 live births), this was a reduction from the 2010-12 rate of 5.76.

This report explores some of the contributing factors to infant mortality and the interventions that Enfield are delivering with partners to tackle infant mortality.

The first section describes infant mortality, current data and why early years are important to the health of a child. This section also explores the relationship between child poverty and inequalities; it identifies the risk factors associated with infant mortality and describes the current antenatal, maternity and screening services available to all women in Enfield.

There is a body of evidence, both national and international, that demonstrates that infant mortality rates can be successfully reduced. The next section of the report explores this evidence and how it has been used to inform our services, interventions and campaigns.

This is followed by a section which describes how services are working in partnership to tackle infant mortality. This includes examples from Children's Centres, Health Visitors, Family Nurse Partnership, Perinatal Mental Health services, Enfield Safeguarding Children Board and the Teenage Pregnancy Unit.

The final section of the Annual Public Health Report illustrates how Enfield will know it is making a difference, and describes the various data sources and tools available that can be used to measure the difference Enfield is making.



A newborn baby is lying in a wooden crib. The baby is partially covered by a white sheet and several white crocheted blankets. The crib has wooden slats. The background is a plain, light-colored wall.

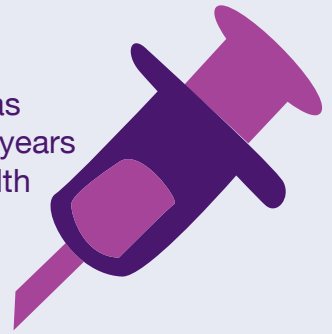
INFANT MORTALITY

INFANT MORTALITY: KEY MESSAGES



Every year in England about **3,000 babies die** before their first birthday.

Infant mortality has reduced over the years due to public health efforts such as **immunisations**.



Babies born to **mothers who smoke** (or have partners that smoke) during pregnancy are more likely to die during the first weeks of life.

Depression and anxiety are common in pregnancy and once the baby has arrived. Current data suggest that **10-20%** of maternities in Enfield are affected by **mental health issues**.

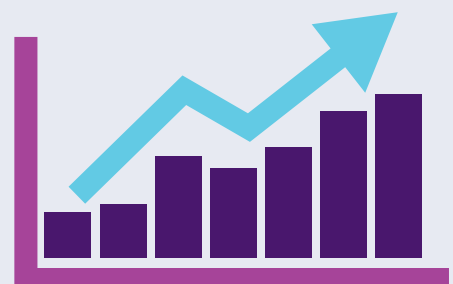


Breastfeeding is known to reduce the chances of a child suffering from diarrhoea and vomiting, chest infections, ear infections, constipation, and obesity.



In 2013, **8.5%** of babies born in Enfield were identified as being of a **low birth weight**. Low birth weight infants are at higher risk of mortality than babies of normal weight at birth.

Infant mortality levels in Enfield were the **sixth highest** in London for the years 2011-13 (4.6 per 1,000 live births), this was a reduction from the 2010-12 rate of 5.76.




The following factors can help to reduce infant mortality:



Routine enquiry and support regarding domestic violence and mental illness



Ensuring early access to antenatal care



Providing information and education on the antenatal and newborn screening programme



Promoting healthy and maternal nutritional status



Provision of specialist services for obese pregnant women




Reducing smoking before during and after pregnancy



Promotion of safe sleeping



Promotion and support of breastfeeding



Ensuring high coverage of childhood immunisations

Enfield has, in collaboration with partners, developed interventions and campaigns to tackle infant mortality including:



the “Back to Sleep” campaign promoting safe sleep practices for babies



breastfeeding support programmes



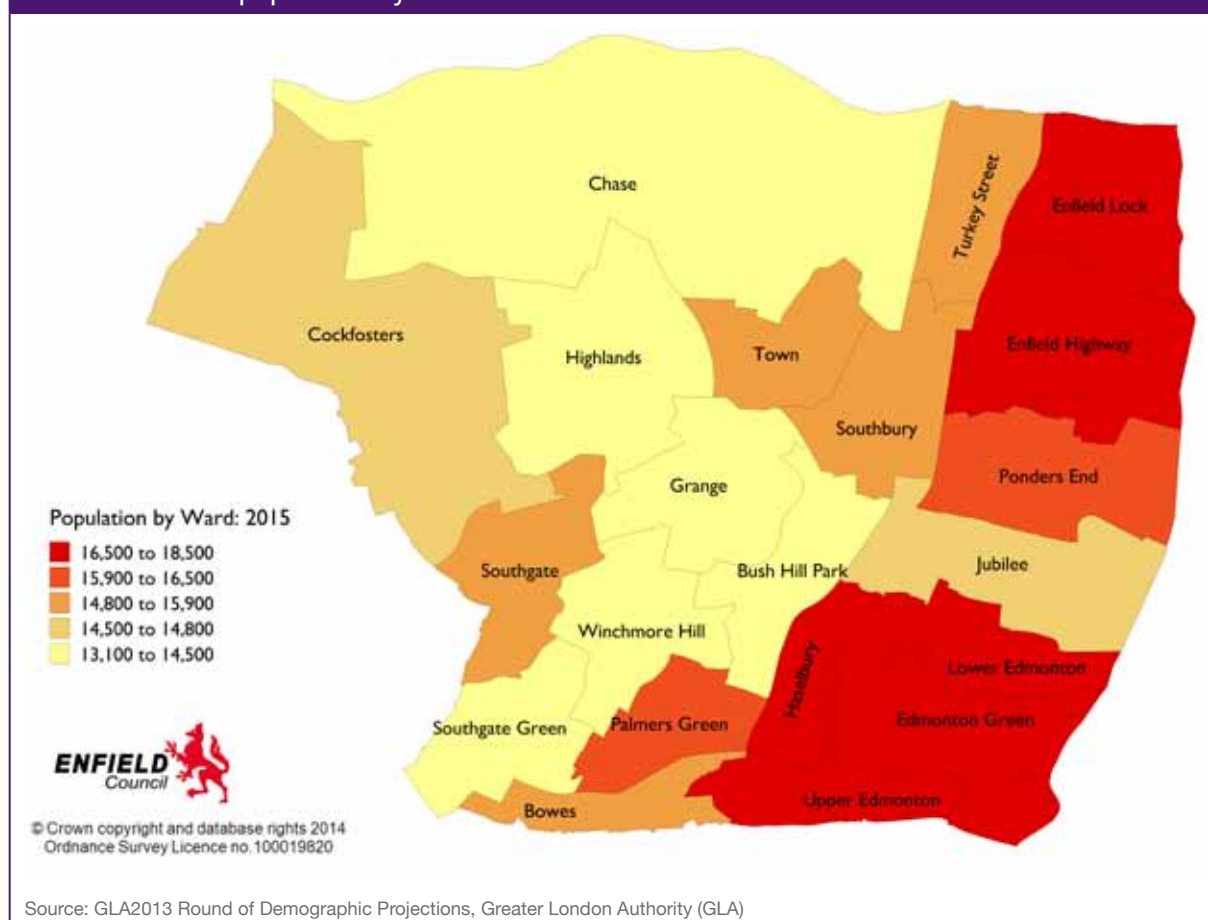
the “ASAP – As Soon As you are Pregnant” campaign aimed at encouraging pregnant women to notify health services as soon as they find out they are pregnant

CHILDREN AND YOUNG PEOPLE IN ENFIELD

Enfield is a very diverse borough with over 324,000 residents (Mid-2014 population estimates, Office for National Statistics (ONS), around two thirds of whom were born in the UK (2011 Census, ONS). In 2010 it was estimated that new community groups made up about 12% of the total population. These included Somalis, Nigerians, Ghanaians, Congolese, Turkish, Kurdish, Albanian and migrants from the A10 accession countries following the 2004 enlargement of the European Union (EU)¹.

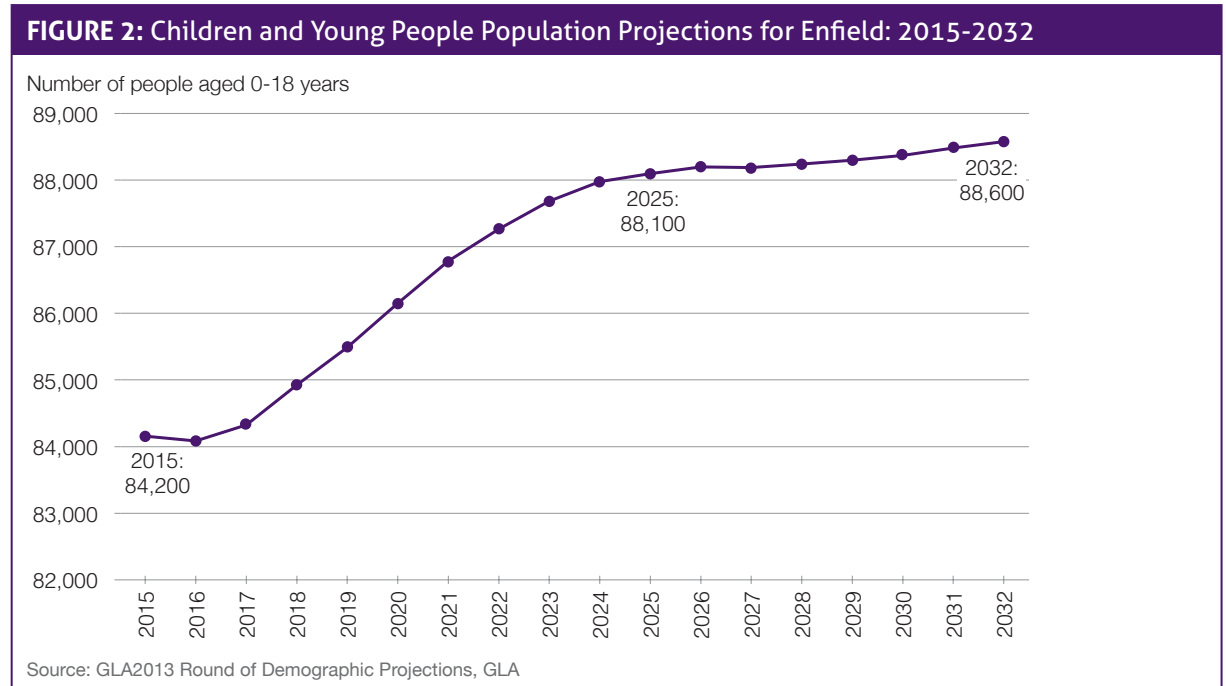
Enfield has a mobile population with many residents moving in from other parts of London and moving out to other UK locations. There is also net inward migration from outside the UK. The population is higher on the eastern side of the borough than the west, particularly in Enfield Lock, Enfield Highway, Lower and Upper Edmonton, Edmonton Green and Hazelbury.

FIGURE 1: Enfield population by Ward

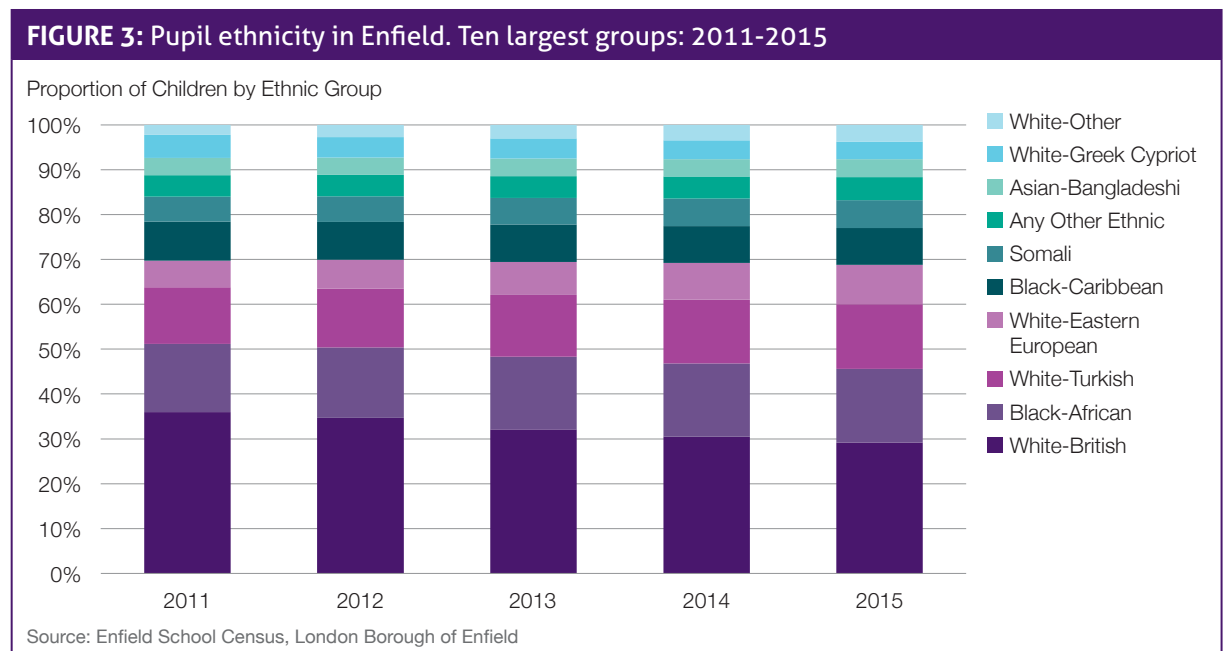


¹ Source: Office for National Statistics

An unusually large proportion of the Enfield population is made up by younger people. In 2013, just over one fifth (21.3%) of residents were aged under 15, the 4th highest proportion in England and well above the England average of 17.8%. Current estimates suggest that the total number of people under 18 years old and resident in Enfield was 84,200 in 2015. This is predicted to increase to 88,100 by 2025 and 88,600 by 2032.



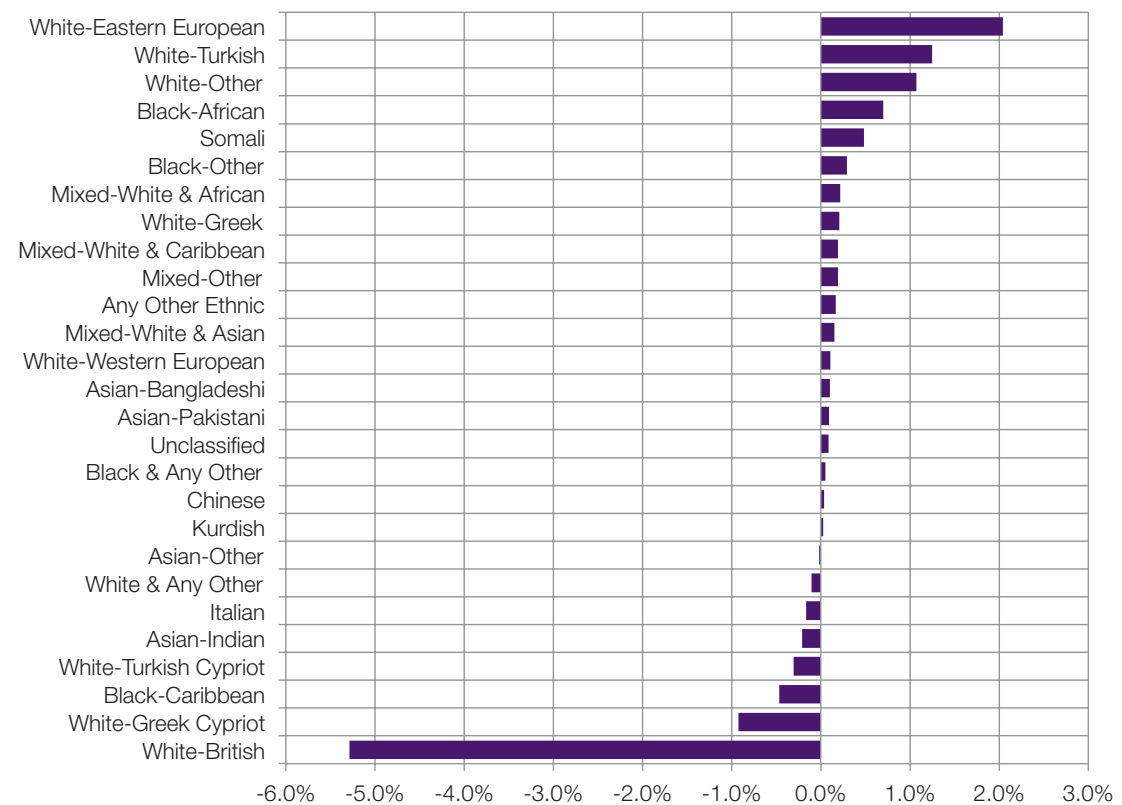
Between 2011 and 2015, the largest ethnic group amongst Enfield school pupils was White British (21.5%). The second largest group was Black-African (12.1%). There is a large Turkish community in Enfield and more than 10% of pupils are White-Turkish.





The proportion of pupils belonging to the White British group fell substantially by 5.3% between 2011 and 2015. In contrast, the proportion of pupils identified as White Other, White Turkish and White Easter European increased (7%).

FIGURE 4: Change in size of pupil ethnic groups: 2011-2015



Source: Enfield School Census, London Borough of Enfield

THE IMPORTANCE OF THE EARLY YEARS IN THE HEALTH OF A CHILD

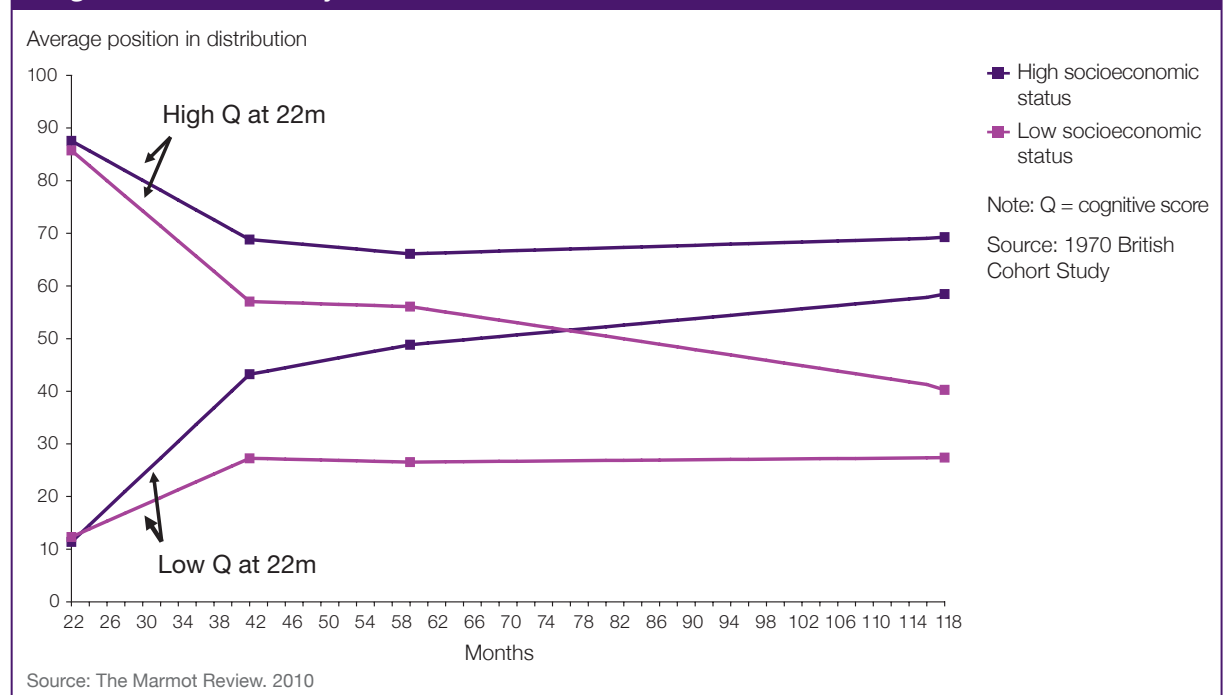
Pregnancy, birth and the first 24 months of a baby's life are seen as critical to the health of the child. It is a time when parents are very busy, but are receptive to help and advice from different sources.

A baby's brain is developing at an incredible rate during this period. From birth to 18 months, the synapses (connections in the brain) are forming at a rate of 1-2 million per second. It is this rapid and incredible brain development that makes the early years such an important time to ensure that a child lives a healthy, happy and successful life.

The attachment between babies, parents caregivers is crucial and there is long-standing evidence that the baby's social and emotional development is strongly affected by the quality of this attachment².

It is crucial that help and support are available to families with children under two years old. If a child falls behind in the first year, there is good evidence that they are more likely to fall further behind in subsequent years. Figure 5 shows the differences in changes to cognitive development in children according to socioeconomic differences. This shows that where a child has a higher cognitive score at 22 months, then those children who have low socioeconomic status (i.e. poorer children) start to lag behind their peers with higher socioeconomic status (richer children) by 42 months. Where children have a lower cognitive score at 22 months, there is again a difference according to socioeconomic status. In this case, the richer children show increases in cognitive status whereas the poorer children do not see any gains past 42 months.

FIGURE 5: Inequality in early cognitive development of children in the 1970 British Cohort Study at ages 22 months to 10 years³



2 1001 Critical Days – web

3 Fair Society, Health Lives. The Marmot Review. February 2010.

WHAT IS INFANT MORTALITY?

Introduction

Infant mortality refers to the death of a live-born baby in the first year of life. It does not include stillbirths (a stillborn baby is a baby who is born dead after 24 completed weeks of pregnancy), miscarriages (the loss of the pregnancy in the first 23 weeks) and terminations (abortions) and is more common in the first eight months of life. Infant mortality is usually expressed as a population rate (the number of infant deaths per 1,000 live births) which allows comparison with other populations or areas. Common causes of infant death include physical immaturity e.g. in premature births; low birth weight; congenital anomalies; maternal complications; infections; injury and Sudden Unexpected Death in Infancy (SUDI or 'cot death').

Although infant mortality refers to the death of a live born baby in the first year of life, a variety of infant mortality statistics are available. The most common ones are:

- Perinatal Mortality (still births and deaths less than seven days after birth)
- Neonatal Mortality (infant deaths less than 28 days after birth)
- Post-neonatal Mortality (infant deaths 28 days to one year after birth)

In England and Wales, 130 out of every 1,000 children born in 1911 died before their first birthday. Now, the infant mortality rate is a fraction of this (4.1 per every 1,000 live births in 2011-13). The decrease in infant deaths is due to advances in public health and healthcare, including the control of infectious diseases and improved public health infrastructure, as well as specific improvements in midwifery and neonatal intensive care. Infant mortality is often used as a proxy for population health as there is good correlation between infant mortality and the health of a population worldwide⁴.

The factors that are associated with a higher risk of infant mortality include:⁵

- Low socio-economic status (usually associated with living in a more deprived area)
- Maternal age (under 20 years and 35 years and over)
- Birth outside marriage/sole parental registration
- Late-booking for antenatal care
- Smoking during and/or after pregnancy
- Alcohol and/or substance misuse during and after pregnancy
- Maternal obesity
- Maternal morbidity, for example diabetes, mental illness
- Domestic violence
- Low birth weight (<2,500g)
- Not breast feeding
- Inappropriate infant sleeping position and environment
- Congenital abnormalities

In addition to addressing the factors listed above, infant mortality rates can be decreased by: reducing child poverty; reducing the levels of obesity in pregnancy; increasing breastfeeding rates; reducing smoking in pregnancy; reducing sudden unexpected death in infancy (cot deaths); and reducing unwanted teenage conceptions.

4 Infant Mortality Rate as an Indicator of Population Health. D. D. Reidpath and P. Allotey. *Journal of Epidemiology and Community Health* Vol. 57, No. 5 (May, 2003), pp 344-346

5 Tackling health inequalities in infant and maternal health outcomes – report of the infant mortality national support team. December 2010



Why is it important?

Every year in England, about 3,000 babies die before their first birthday and many more are stillborn or have long-term disabilities. The death of a baby is a devastating experience for families and many of these deaths are preventable. Infant mortality varies considerably between countries, particularly between developing countries and the more developed world such as North America and the UK. In 2010, the infant mortality rate for England and Wales was 3.2 per 1,000 live births after 24 weeks gestation,

compared to 2.1 per 1,000 in Finland and Sweden and 2.5 in Norway. The infant mortality rate was higher in Scotland (3.3 per 1,000), the USA (4.2 per 1,000) and Northern Ireland (4.5 per 1,000).

Infant mortality is an important indicator of the health of pregnant women, infants and children. These statistics are also an important measure of the overall health of a population, in part because the risk factors for infant mortality are likely to be the same influence the health status of the population⁶. Further, there is a growing body of evidence that shows the importance of health and wellbeing in the early years, and in particular the first two years of life, and the long-term benefits of ensuring all children have access to the best start in life.

The main causes of infant deaths are immaturity related conditions (babies born less than 37 weeks gestation), congenital anomalies (conditions or malformations present before or at the time of birth) and sudden and unexpected death in infancy, normally occurring within the first eight months of life (Oakley et al. 2009). Most causes of infant deaths show a socio-economic gradient.

Infant mortality and inequalities

Infant mortality has reduced over the years due to public health efforts such as immunisations, but not everyone in society benefits equally and significant health inequalities persist. There are higher rates of infant mortality in some population groups, including those working in routine and manual occupations, births registered by the mother alone, and births where the registered occupation group is 'other'; which includes people who are unemployed⁷. Infant mortality is strongly linked with lower socio-economic status, and hence with child poverty, both nationally and internationally.

Infant mortality has reduced over the years due to public health efforts such as immunisations

6 Health Inequalities Unit. Review of the Health Inequalities Infant Mortality PSA Target. Department of Health February 2007 see <http://tinyurl.com/o86acry> (accessed 22 July 2013)

7 Fair Society, Health Lives. Marmot M. 2010. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

INFANT MORTALITY IN ENFIELD

Infant mortality levels in Enfield were the sixth highest in London for the years 2011-13⁸ (4.6 per 1,000 live births), the most recent period for which data are available. This is shown in Figure 6.

The numbers of deaths are relatively small, but an average of 27 babies are still dying before their first birthday each year in Enfield and the rate each year has dropped very little.

FIGURE 6: Infant mortality rates in Enfield, London and England. Three-year rolling averages from 2003-05 to 2011-13

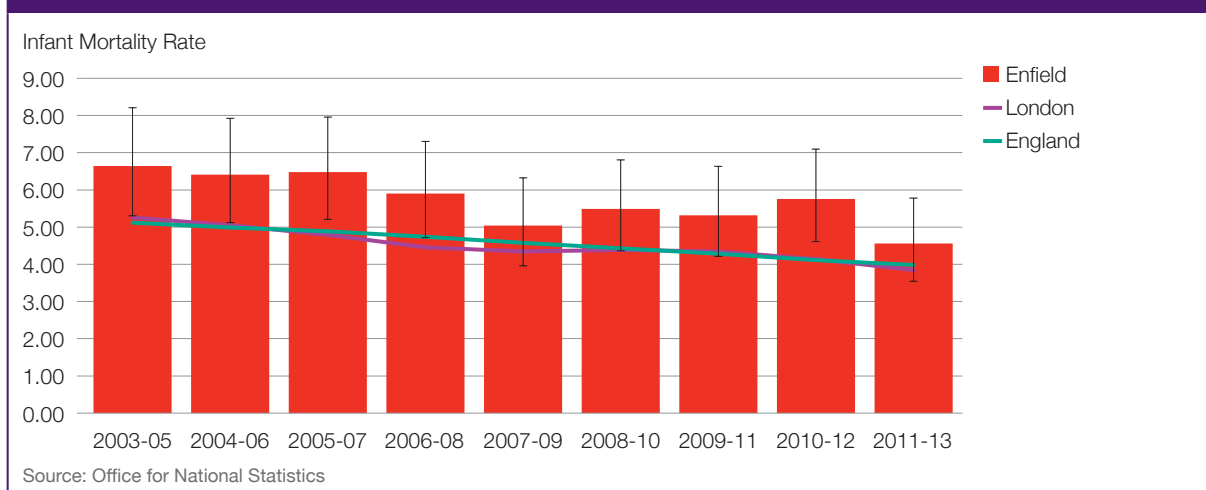
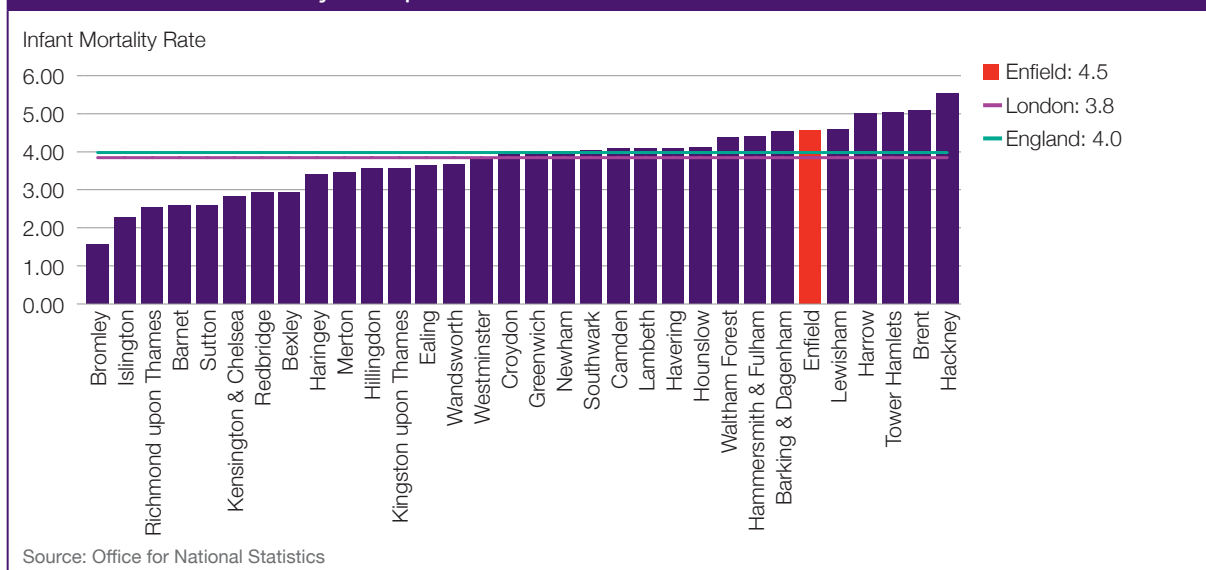


FIGURE 7: Infant Mortality Rate, per 1,000 Live Births: 2011-13 Pooled

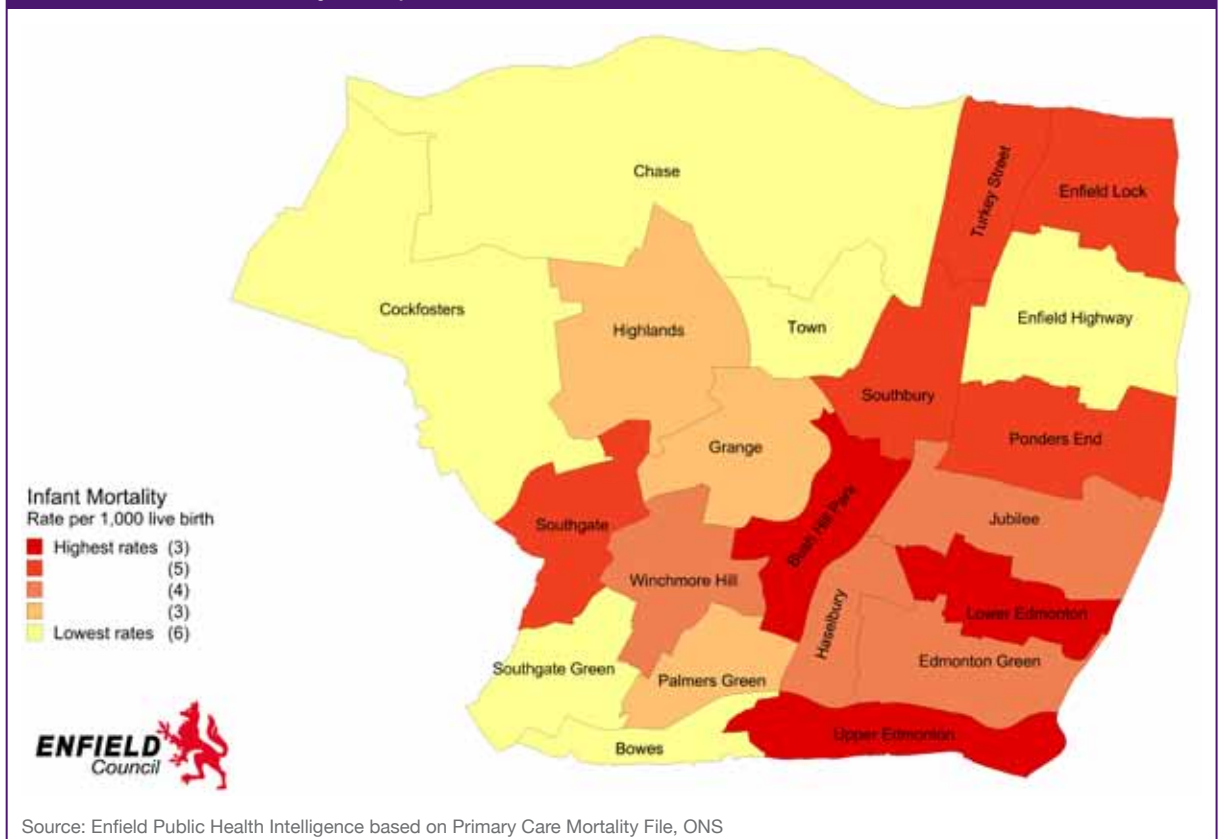


⁸ Infant mortality data is calculated as a 3-year average. This is because the numbers of deaths is small and so small changes can seem significant. By averaging these out over 3 years, the data is more meaningful.



Within Enfield, the highest rates of infant mortality are in the east of the borough, particularly in Upper Edmonton, Lower Edmonton and Bush Hill Park. However, it should be noted that these are based on small numbers of events and the data should be treated with caution.

FIGURE 8: Infant Mortality Rate per Ward, Enfield, 2006-2013



Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected Death in Infancy (SUDI) refers to all unexpected deaths in infants of up to one year of age without a clear diagnosis of cause of death. All deaths in the first year of life are investigated and categorised, these are usually divided into those deaths for which there is a clear diagnosis and those for which there is no diagnosis. Those deaths without a diagnosis after investigation are referred to as Sudden Infant Death Syndrome (SIDS).

Sudden unexpected death in infancy (SUDI)⁹ is a significant cause of infant mortality and usually occurs within the first eight months of life. There is a higher risk of SUDI for male, preterm and/or low birth weight babies and for babies sleeping on their fronts or sides (that is, not sleeping on their back). Although SUDIs occur in all socioeconomic groups, it is more common amongst people living in deprived areas (Gray et al., 2009). Overcrowded living conditions are associated with health problems such as stress and depression, poor educational achievement of children and family breakdown. Although the exact mechanisms are unknown, there appears to be a link between overcrowding and SUDI; but it should also be noted that smoking and obesity and teenage pregnancy are also more common in more deprived areas.

In Enfield there were 4.3 homeless households with dependent children or pregnant women per 1,000 total households. This compares to 1.7 nationally.

In Enfield there were 4.3 homeless households with dependent children or pregnant women per 1,000 total households. This compares to 1.7 nationally

FIGURE 9: Rate of unexplained deaths in infancy per 1,000 live births 2004-2012



⁹ SUDI refers to sudden infant death syndrome. When the death has been investigated and no cause can be found, it will be recorded as Sudden Infant Death Syndrome and known colloquially as a cot death.

RISK FACTORS FOR INFANT MORTALITY

Child Poverty

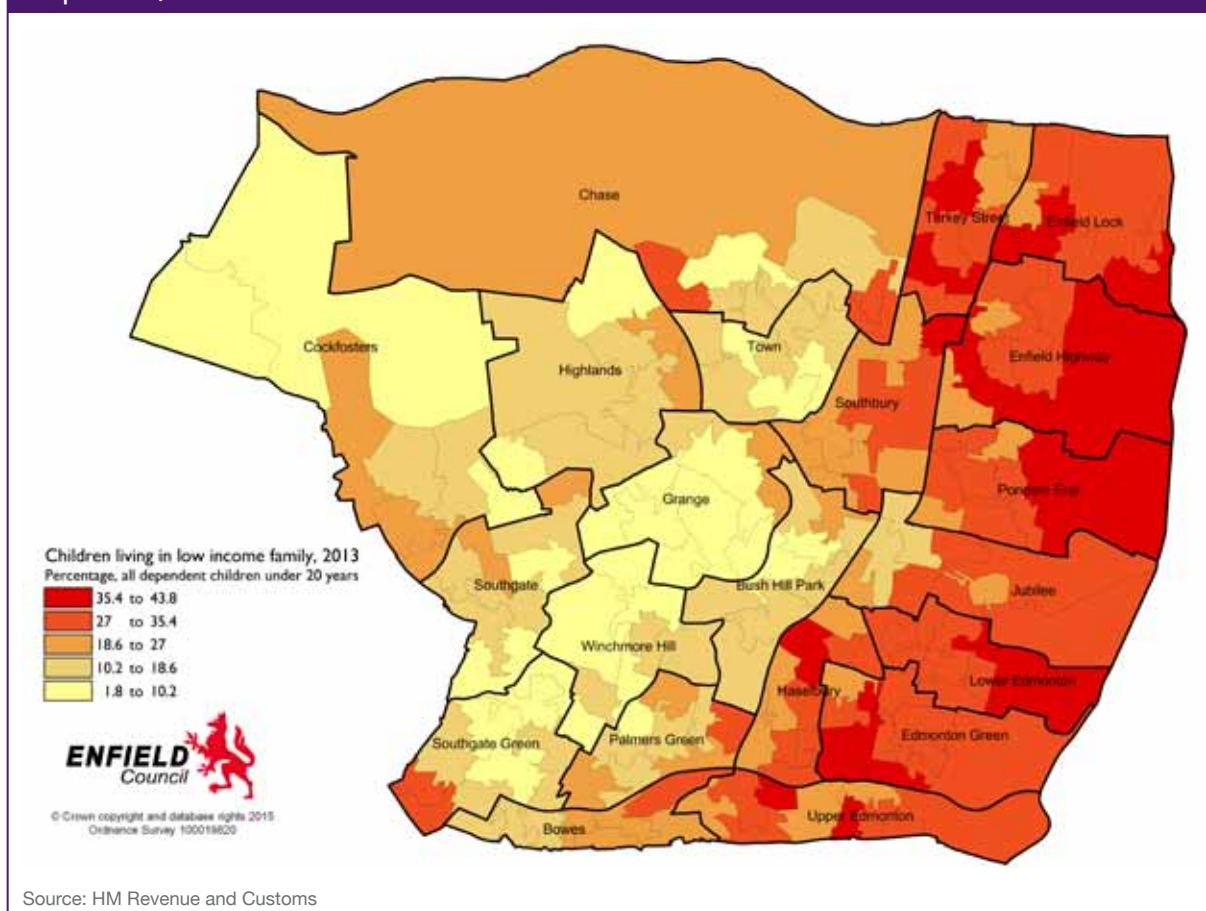
Enfield is a borough of contrasts. The Western side of the borough is affluent, but almost one in four (24.9%) children in Enfield live in poverty – the 11th highest rate in London – and over 21,000 children live in houses blighted by poverty. The large number of children living in poverty in Enfield is set against a backdrop of significant demographic changes in the borough. The population of 0-4 year olds has risen over 30% in the last 10 years, child poverty rates are constantly above London and England averages and the number of lone parents claiming benefits rose by 14% between 2,000 and 2010, bucking the trend for the rest of London where it fell by a quarter.

The child poverty rate varies widely within Enfield, with the highest rates in the east of the borough as Figure 8 shows. It is worth comparing this to Figure 10 which shows the rates of infant mortality by ward and shows the relationship between poverty and infant mortality.

The wards with the highest rates of child poverty are Edmonton Green, Turkey Street, Enfield Lock, Lower Edmonton, Ponders End, Enfield Highway, Haselbury and Upper Edmonton.

More than two in five children are living in poverty in the following wards: Edmonton Green, Turkey Street, Enfield Lock, Lower Edmonton, Ponders End, Enfield Highway, Haselbury and Upper Edmonton. Even in the wards with the lowest child poverty rates, more than one in ten children live in poverty.

FIGURE 10: Percentage of dependent children under 20 year olds living in poverty, by lower super output area, 2013





Children from low-income families are more likely than those from higher-income families to live in inadequate housing. Poor housing has been shown to have an adverse impact on childhood health and has been associated with:

- An increased risk of contracting respiratory infections, asthma and hypothermia;
- Reduced immunity;
- An increased likelihood of developing skin conditions;
- Developmental delay; and
- Stress and depression.

As of May 2014, more than 35,000 households in Enfield were claiming housing benefit. More than half of these households (54.3%) had at least one dependent child – this is above both the London (42.4%) and England (37.3%) averages. Around half of households claiming housing benefit are renting from the private rental sector. These tenants are at a higher risk of living in poor housing conditions than those who rent from the Council.

Enfield also has a higher proportion of households with children living in temporary accommodation than the London average. This is partly because of increased demand in the borough – other local authorities place households in Enfield due to the relatively cheaper housing market. As of March 2014, Enfield had by far the highest number of households placed by other local authorities (1,659 households) among London boroughs. Redbridge was the second highest with only 1,092 households.

The number of children living in temporary accommodation in Enfield was 4,362 in June 2014

The number of children living in temporary accommodation in Enfield was 4,362 in June 2014. This equates to almost two children per household in temporary accommodation, compared to 1.5 in other London boroughs.

FIGURE 11: Number of children per all households living in temporary accommodation

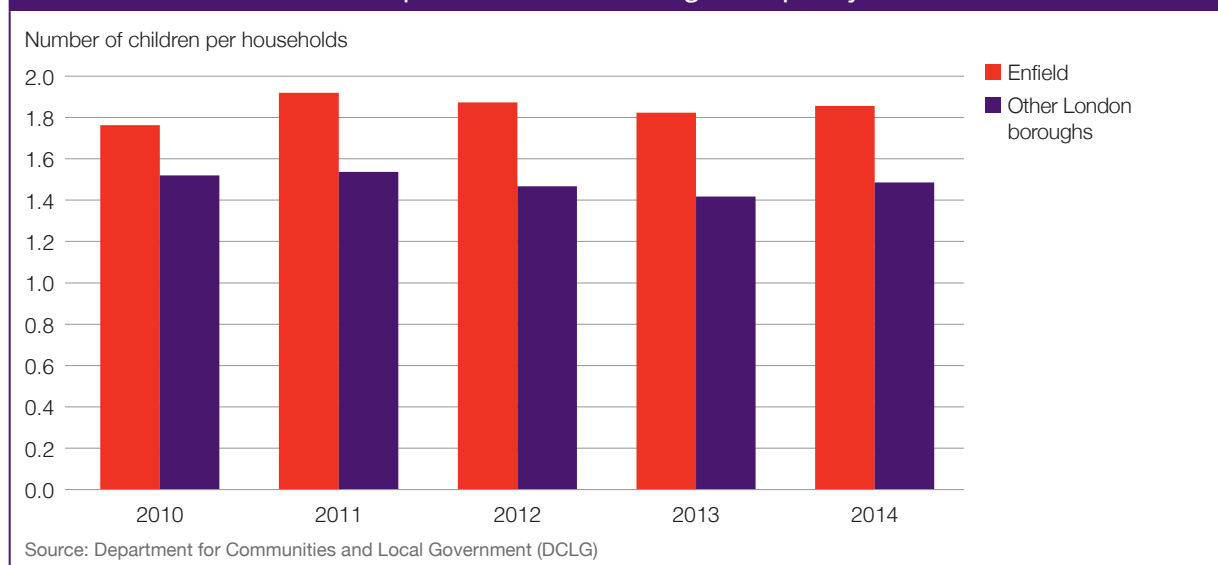
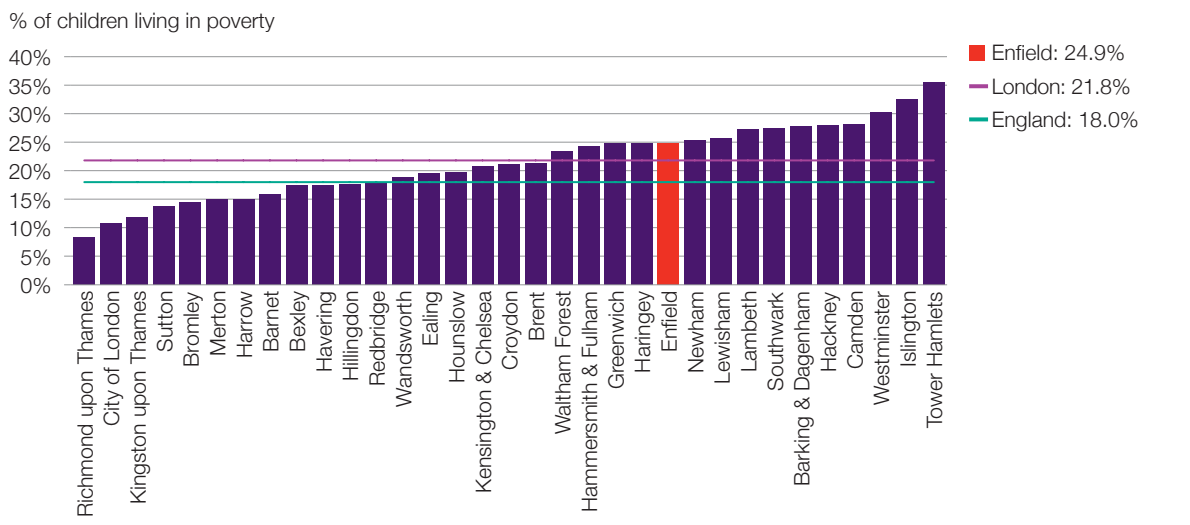
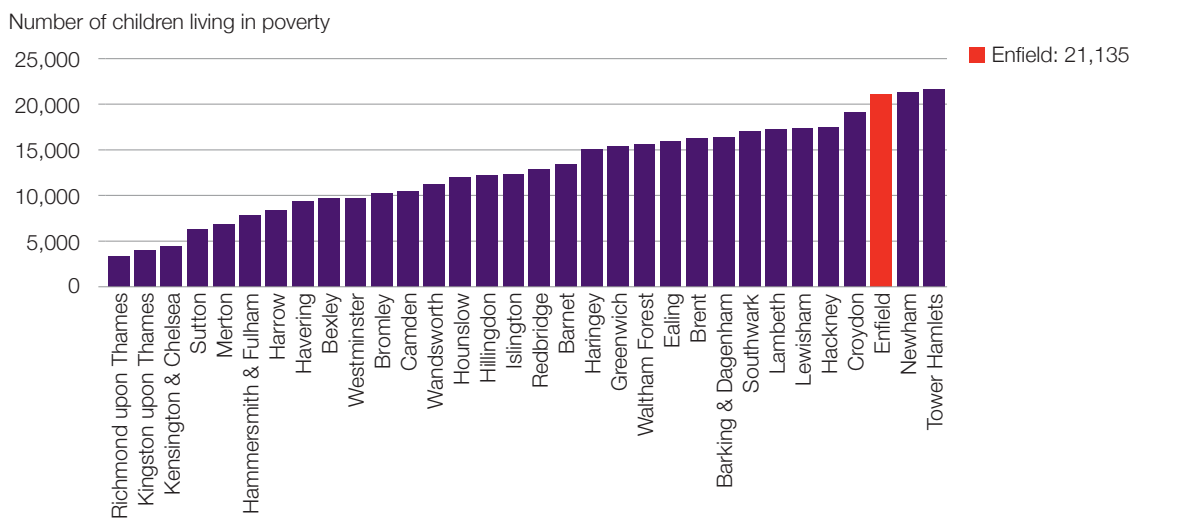


FIGURE 12: Percentage of children living in a low-income family, all dependent children aged less than 20 years, London Boroughs, 2013



Source: HMRC

FIGURE 13: Number of children living in low-income family, all dependent children aged less than 20 years, London Boroughs, 2013



Source: HMRC



Smoking and tobacco use

Smoking in pregnancy is the single greatest modifiable risk factor for adverse outcomes in pregnancy, including miscarriage and stillbirth. This includes passive smoking by the mother or infant if their partner smokes. Smoking during pregnancy increases the risk of infant mortality and can lead to chronic conditions in later life.

Babies born to mothers who smoke (or who have partners that smoke) during pregnancy are more likely to die during the first weeks of life than babies of mothers who do not smoke. Smoking exposes the baby to more than 4,000 chemicals present in cigarette smoke¹⁰ and the babies of mothers who smoked during pregnancy are more likely to be born prematurely, twice as likely to have a low birth weight and are up to three times as likely to die from sudden unexplained death (Green et al., 2005). Smoking is associated with inequalities; smoking in pregnancy is much higher in routine and manual socio-economic groups. Nationally, 38% of mothers in England lived in a household where at least one person smoked during their pregnancy¹¹.

NHS maternity services record the smoking status of women when they book for antenatal care and women that smoke are offered a referral to smoking cessation services. Enfield's rate of smoking amongst pregnant women at the time of delivery has fallen steadily over the course of the last five years, mirroring the regional trend. In Enfield, the levels of smoking during pregnancy are low at 5.5% of pregnant women compared to 12% in England. There are, however, likely to be considerable inequalities in the prevalence of tobacco use during pregnancy, as recent local evidence suggests high levels of tobacco use in the Turkish community.

Babies born to mothers who smoke (or who have partners that smoke) during pregnancy are more likely to die during the first weeks of life

¹⁰ See <http://tinyurl.com/8araqzz> (accessed 23 July 2013)

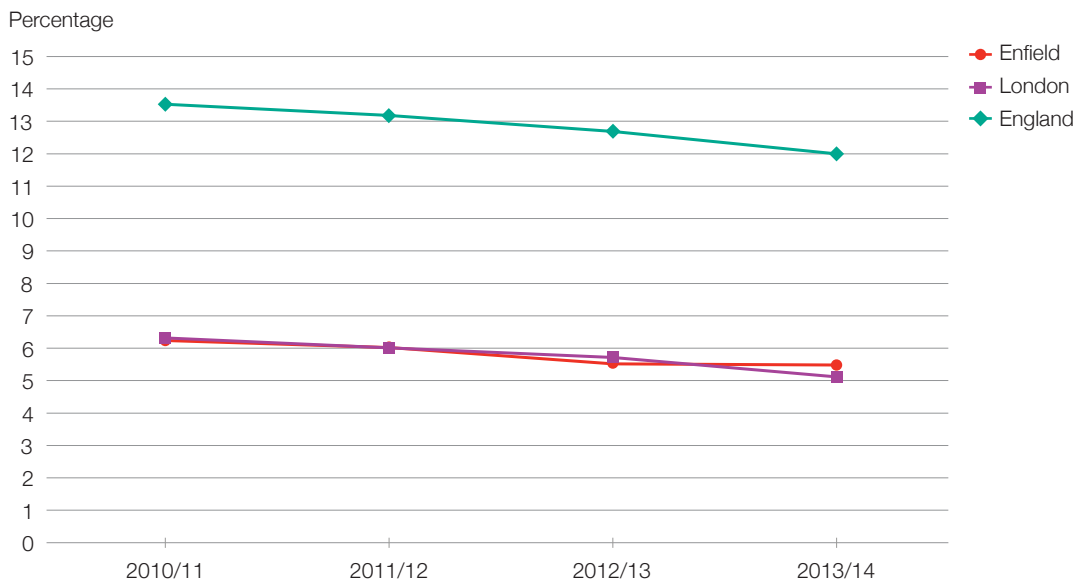
¹¹ NICE Smoking: stopping in pregnancy and after childbirth. NICE guidelines [PH26] Published date: June 2010

The Department of Health's Tobacco Control Plan sets out a target that the proportion of mothers smoking at the time of delivery should fall below 11% by the end of 2015. In 2013/14, Enfield's rate was already half this, at 5.5%. This was marginally above the London average of 5.1% but well below the national average of 12%.

Ensuring this figure remains low is key to promoting child health and reducing the chances of issues such as premature births and low birth weights, both of which can significantly affect rates of infant mortality and the long-term health and educational attainment of a child. As can be seen in Figure 14, smoking prevalence amongst women at delivery in Enfield is low compared to the English prevalence. However, it should be noted that these data refer to women that self-report smoking and are not based on an objective measurement such as nicotine metabolites.

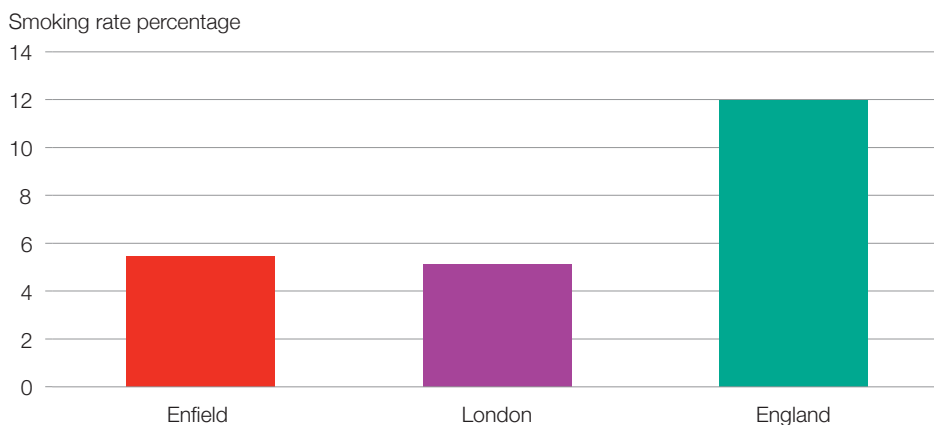
E-cigarettes are increasingly being used by people trying to stop smoking. E-cigarettes are not risk free and although the vapour contains fewer toxins, they are not recommended for pregnant women as they are not regulated and the effects on the unborn child are not known. If a pregnant woman wants to stop using e-cigarettes or smoking there are a number of sources of support they could use including the national quitline and a local stop smoking service that can help and prescribe nicotine replacement therapy if appropriate.

FIGURE 14: Smoking at time of delivery – Enfield



Source: Public Health Outcomes Framework

FIGURE 15: Smoking at time of delivery 2013/14



Source: Public Health Outcomes Framework

Maternal Obesity

Maternal obesity is associated with greater health risks to both the mother and baby. For the baby, there is a higher risk of stillbirth, congenital abnormality and prematurity.

Obesity is linked to socioeconomic group, and is more common in those working in routine and manual work than in professional and managerial groups and some BME communities. Maternal obesity is associated with many issues for the baby, including:

- stillbirth
- neonatal death
- congenital anomalies, including neural tube defects and cardiovascular anomalies
- prematurity.

There are issues for the mother as well. It can be difficult to perform ultrasound examinations on obese women, blood pressure cuffs might not fit the larger arms of obese women and there may be issues if the woman needs to have an anaesthetic.

In the Confidential Enquiry into Maternal and Child Health (CEMACH) maternal death enquiry, it was found that 30% of the 261 maternal deaths in the UK between 2000 and 2002 were in obese women (BMI of at least 30kg/M²). In the period 2003-2005, 22% of the 295 maternal deaths involved women who were obese and of those women, 19 were morbidly obese (BMI greater than 40kg/M²). In 2003-2005 there were 48 maternal deaths due to heart disease and 60% of those women that died from heart disease during their pregnancy were overweight or obese¹².

The same enquiry found the following risks related to maternal obesity in pregnancy:

- maternal death or severe morbidity
- cardiac disease
- spontaneous first trimester and recurrent miscarriage
- pre-eclampsia
- gestational diabetes
- thromboembolism
- post-caesarean wound infection
- infection from other causes
- postpartum haemorrhage
- low breastfeeding rates.

Maternal obesity can lead to complications associated with pregnancy including:

- increases in caesarean and operative deliveries
- admission to hospital for complications
- length of hospital stay
- requirements for neonatal intensive care
- a need for appropriate equipment to manage safely the care of obese mothers.

There is a clear need for care pathways for the management of obese pregnant women and women at clear risk of obesity. Such care is likely to result in improved life chances for the child and improved health and wellbeing for the mother.

¹² CEMACH – http://www.noo.org.uk/NOO_about_obesity/maternal_obesity/maternalhealth

ANTENATAL AND MATERNITY SERVICES AND SCREENING

Access to antenatal and maternity services

Early access to antenatal care is particularly important for women as it provides various opportunities to identify and manage potential problems, such as gestational diabetes or smoking during pregnancy, before they become serious issues.

Late access to antenatal care can be more common amongst some minority ethnic groups because of deeply-held cultural beliefs and multi-generational teaching. For example, there is evidence that irrespective of educational background, a sizeable proportion of women from Black African ethnic groups deliberately do not reveal that they are pregnant until sometime after 12 weeks of pregnancy¹³. A number of immigrants, especially refugees and asylum seekers, are reluctant to engage with any people or organisations they associate with 'state control' because of experiences that they may have had elsewhere, and thus often substantially delay seeking help with pregnancies. In addition, pregnant women who have complex social factors (for example, housing problems, not being fluent in English, being unfamiliar with the NHS system) have been found to be deterred from using antenatal services for a range of reasons, including:¹⁴

- feeling overwhelmed by the involvement of multiple agencies
- not being familiar with ante-natal care services
- having practical problems which prevent them attending antenatal appointments
- finding it hard to communicate with healthcare staff
- feeling anxious about the attitudes of health care staff, especially if they already have a number of children.

Despite some seasonal variation, over the last two years the proportion of expectant mothers being seen by 12 weeks six days of pregnancy has gradually increased. However, as can be seen in Table 1, North Middlesex Hospital was not performing as well as other maternity units in the sector. In 2014/15 67% of women booked for maternity care were less than 12 weeks pregnant at North Middlesex University Hospital. Of those bookings that took place over 12 weeks gestation, 5.2% were due to a late referral from the GP and 6% were due to patient choice. For the same timeframe, in Barnet and Chase Farm Hospital NHS Trust (now Royal Free Barnet General) 81.6% of those booked for maternity care before 12 weeks. Since these data were released, there have been changes to maternity services in Enfield, including the closure of the maternity unit at Chase Farm Hospital.

TABLE 1: Early Booking at Maternity Services – Enfield CCG 2014/15

	Number of Maternities	% booked before 12 completed weeks of pregnancy
Barnet and Chase Farm	914	79.1
North Middlesex	2,192	67.0
Royal Free	54	96.4
UCLH	174	76.0
Whittington	140	73.3
Total Enfield Maternities	3,474	70.9

¹³ Chinouya M, Madziva C. *Black African women and the antenatal booking appointment in Haringey*. Public Health Department. Haringey Council. London. 2013

¹⁴ NICE CG 110, 2010

Antenatal and Newborn Screening

When a woman is pregnant and accesses antenatal and maternity services, she will be offered a number of screening tests. Every woman can choose which maternity service she uses and all maternity units provide the same screening tests and employ a screening coordinator.

There are six antenatal and newborn screening programmes, which screen for a total of 30 conditions:

1

Infectious Diseases in Pregnancy (HIV and Hepatitis B)

Early diagnosis of these infections in the expectant mother allows the mother to be treated. Some of the treatments reduce the chances of the unborn child being infected in the womb.

2

Sickle Cell and Thalassaemia Testing

Early screening for sickle cell trait or thalassaemia in the pregnant woman allows the risk of the baby having these serious blood disorders to be calculated and appropriate action taken.

3

Foetal Anomaly Screening including Down's Syndrome

Screening for foetal anomalies includes screening for problems with the baby's heart, kidneys or other organs. It also allows identification of syndromes such as Down's. This allows the medical team to be prepared to treat the baby appropriately during and after birth and reduces the risks to both mother and child.

4

Newborn Hearing Screening

Identification of hearing problems as soon as possible allows appropriate actions to be taken to ensure that the baby can develop properly.

5

Newborn Infant Physical Examination (NIPE)

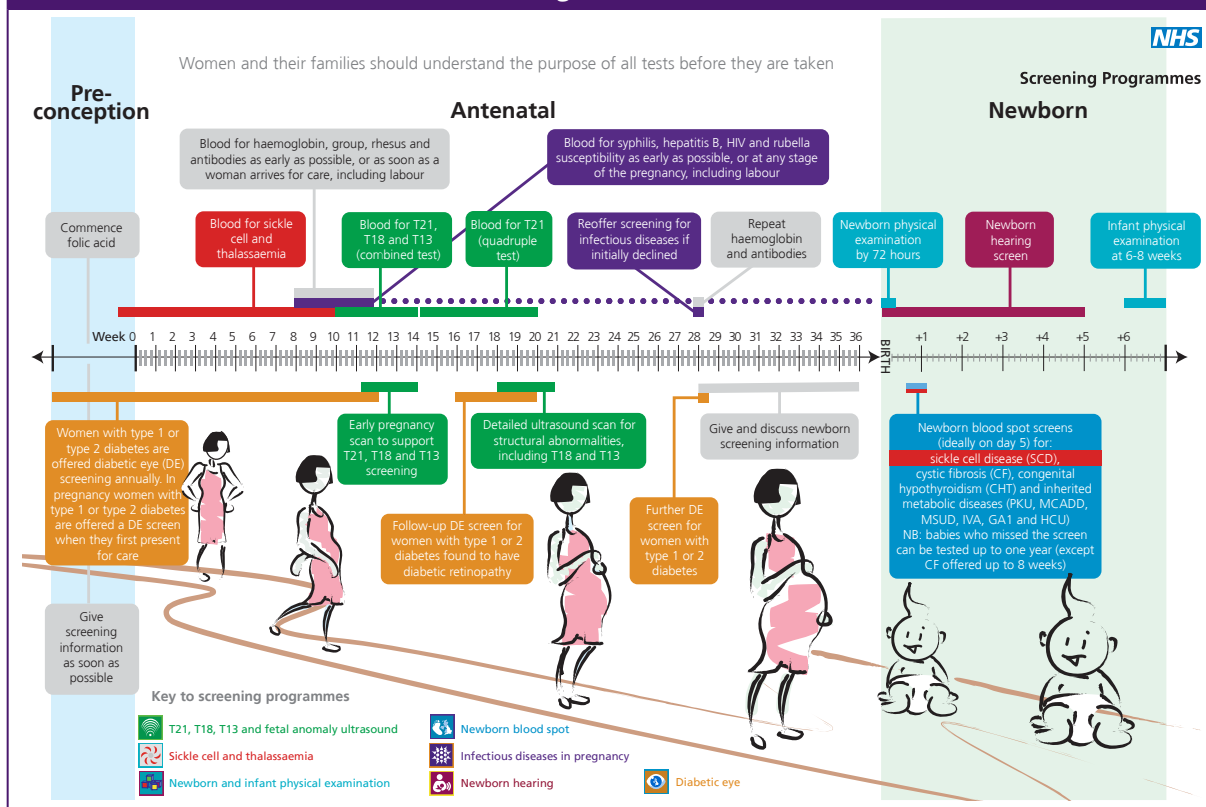
The Newborn Infant Physical Examination takes place within 72 hours of birth and then again at 6-8 weeks. The examination checks the baby's hearing, hips, eyes and boys' testes.

6

Newborn Bloodspot Testing

Newborn Bloodspot testing tests for Phenylketonuria (PKU), congenital hypothyroidism (CH), sickle cell diseases, cystic fibrosis (CF), medium-chain acyl Co-A dehydrogenase deficiency (MCCAD), maple syrup urine disease (MSUD), homocystinuria (HCU), glutaric aciduria Type 1 (GA1) and isovaleric acidemia (IVA). Early diagnosis of these conditions allows treatment before the baby's health is damaged. For instance, congenital hypothyroidism (being born without a thyroid gland) can lead to poor growth and learning disabilities, but if it is identified early the baby can be given thyroxine (the hormone produced by the thyroid).

FIGURE 16: Antenatal and Newborn Screening Timeline



Breastfeeding

Exclusive breastfeeding is recommended for the first six months of life. This is based on international evidence and has numerous benefits for both mother and child.

Maternal age, educational attainment and socio-economic position have a strong impact on patterns of infant feeding. The NHS infant feeding survey 2010 showed that breastfeeding was most common among mothers who were aged 30 or over from minority ethnic groups, left education aged over 18, in managerial and professional occupation and living in the least deprived areas. While association between maternal breastfeeding for four months or more is independent of family income level, low income mothers breastfeed less often and for shorter periods of time¹⁵.

It was also noted that Infants who were breastfed longer had fewer bouts of sickness and reported use of fewer medications¹⁶.

TABLE 2: Advantages of Breastfeeding

Advantages for mother	Advantages for Baby
Cheap	Lower risk of GI infections
Convenient	Lower risk of respiratory infections
No risk of error in preparation of milk	Lower risk of atopic disorders (allergy)
Promotes weight loss	Lower risk of SIDS
Lower risk of breast cancer and possibly some other diseases	Lower risk of heart disease in later life
Promotes bonding	Lower risk of obesity

15 Maternal childbirth J 2006, Nov; 10(6) 537-543

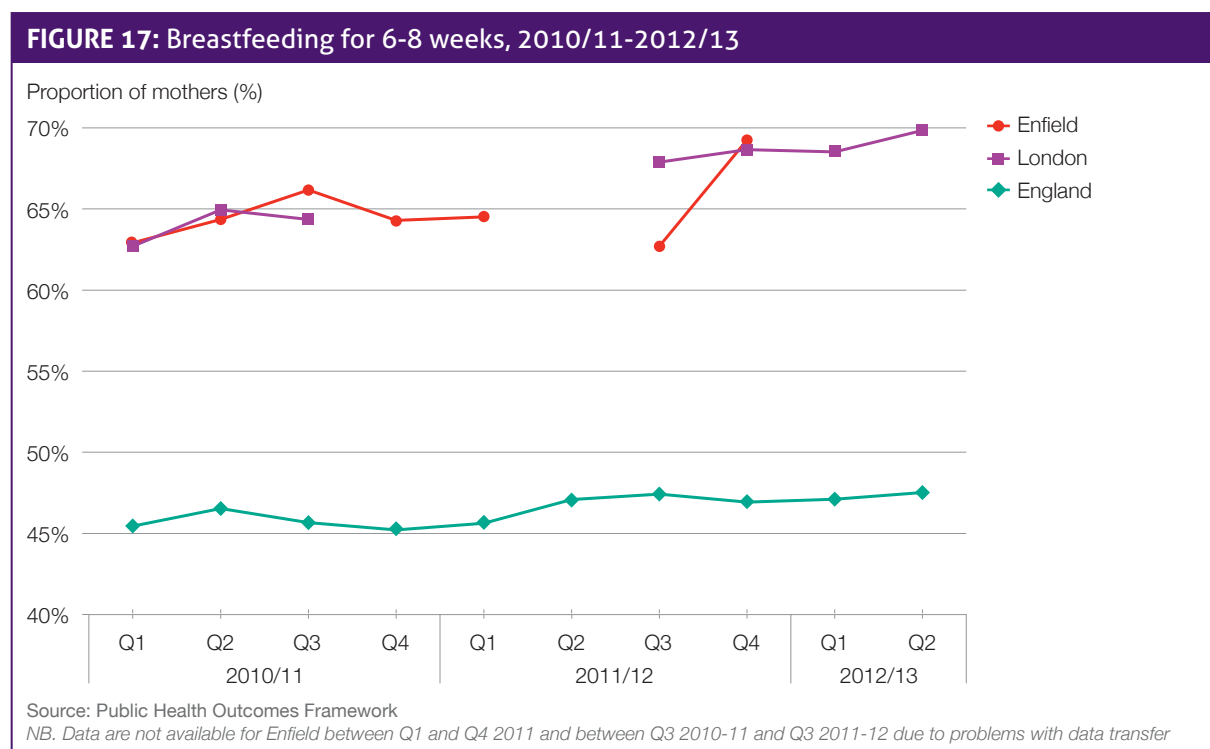
16 Birth 2002 June29 (2) 95-100

Historical prevalence data for breastfeeding rates at 6-8 weeks after birth – accepted as good practice in reducing the chances of poor health in infants across a number of conditions – suggest that mothers in Enfield continue to breastfeed at a level in line with the London average and significantly above the England average. In the fourth quarter of 2011/12 (the latest available local data), 69.26% of mothers were breastfeeding at 6-8 weeks after birth. This compared with a London figure of 68.55% and an England figure of 46.88%.

At a national level, there has been a significant improvement in breast feeding initiation and prevalence at six weeks to eight weeks as shown in Table 3 below.

TABLE 3: Breastfeeding in UK		
Indicator	2005	2010
Proportion of babies breastfed at birth	76%	81%
Mothers breastfeeding exclusively at three months	13%	17%
Breastfeeding rates at six weeks	48%	55%
Introducing solids by four months	51%	30%

Source: NHS infant feeding survey 2010



By breastfeeding their new-borns, mothers contribute to the health of both their child and themselves in the short and long term. Breastfeeding is known to reduce the chances of a child suffering from diarrhoea and vomiting, chest infections, ear infections, constipation, and obesity and, consequently, Type 2 Diabetes in later life.

Maternal morbidity e.g. diabetes or mental illness

Perinatal mental health

Having a baby is very rewarding but can be hard, physically and emotionally. Parents are often deprived of sleep and have to adjust to a very different way of life. This is always a challenge, but for some parents it is more challenging and the chemical changes taking place in the body, along with emotional upheaval can lead to mental health problems.

Depression and anxiety are common in pregnancy and once the baby has arrived. Current data suggest that 10-20% of maternities in Enfield are affected by mental health issues¹⁷. The majority of these would be expected to be mild to moderate depression and estimates based on national prevalence data would suggest a minimum of 470 cases per year in the borough. In addition, over 100 women would be expected to be suffering from post-traumatic stress disorder and severe depression and we would expect 10 cases of post-partum (puerperal) psychosis, a severe mental illness and psychiatric emergency, per year in the borough. Whilst some women may develop a psychotic illness during the perinatal period, some women with severe mental health illness such as bipolar disorder or schizophrenia may suffer relapses and suicide is one of the leading indirect causes of death in the perinatal period¹⁸.



10-20% of
maternities in
Enfield are affected
by mental health
issues

TABLE 4: Estimated numbers of women in Enfield affected by mental illness during pregnancy and the postnatal period

Condition	Estimated number of Women
Postpartum psychosis 2013/14	10
Serious Mental Illness (SMI) 2013/14	10
Mild-moderate depressive illness and anxiety (lower and upper estimates) 2013/14	470-700
PTSD 2013/14	140
Adjustment disorders and distress (lower and upper estimate 2013/14)	700-1400

Source: Hospital Episode Statistics, Health and Social Care Information Centre

Recently, the Department of Health and Public Health England released Future in Mind¹⁹ which set out proposals to support improvements in children and young people's mental health and had recommended that all maternity units should have a specialist mental health clinician. This has been echoed by the Royal College of Midwives. Currently, in North Central London, only the Whittington Hospital can offer a comprehensive specialist perinatal mental health service.

Most mental health services in the borough are provided by Barnet Enfield and Haringey Mental Health Trust.

¹⁷ Mental health in pregnancy, the postnatal period and babies and toddlers. CHIMAT

¹⁸ Centre for Maternal and Child Enquiries (CMACE) 2011

¹⁹ Future in Mind: <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>

Low birth weight

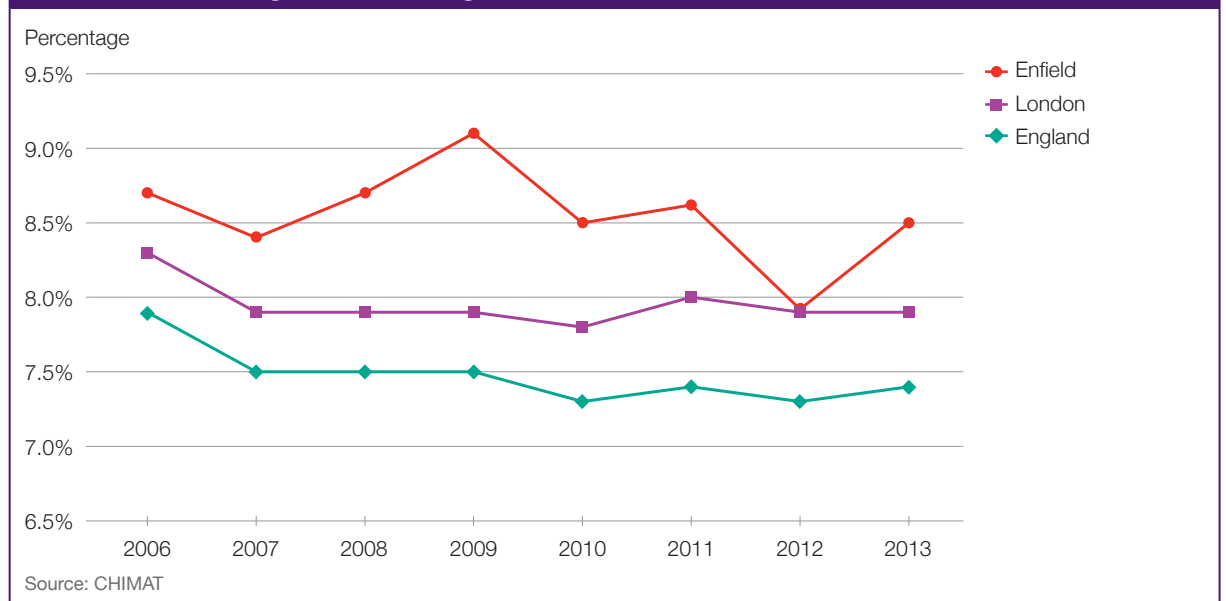
Low birth weight infants (defined as <2,500g weight and birth at term) are at higher risk of mortality than babies of normal weight at birth. Most of the deaths in these children are in the neonatal period, but low birth weight children remain at higher risk into infancy and early childhood.

There are many risk factors for low birth weight, but the most important ones are smoking in pregnancy, ethnicity and socioeconomic factors. Prematurity is also associated with low birth weight.^{20, 21}

In 2013, 8.5% of babies born in Enfield²² were identified as being of a low birth weight.

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FIGURE 18: Percentage low birth weight babies 2006-2013



20 N Engl J Med. 1985 Jan 10;312(2):82-90. Mc Cormick

21 Public Health Rep. 1987 Mar-Apr;102(2):182-92.Sappenfield et al.

22 CHIMAT – % Live births and stillbirths with a low birthweight

Stillbirths

A stillbirth is a baby born dead after 24 completed weeks of pregnancy. There are more than 3,600 stillbirths every year in the UK, and one in every 200 births ends in a stillbirth.

What causes stillbirth?

- About 50% of all stillbirths are linked to complications of the placenta (the organ that links the baby's blood supply to the mother's and nourishes the baby in the womb).

Other conditions that can cause stillbirth or may be associated with stillbirth include:

- Bleeding (haemorrhage) before or during labour
- Placental abruption – where the placenta separates from the womb before the baby is born
- Pre-eclampsia – a condition that causes high blood pressure in the mother
- the umbilical cord slipping down through the entrance of the womb before the baby is born (cord prolapse) or wrapping around the baby's neck
- Genetic disorders
- Diabetes
- Infections – these include bacterial and viral infections
- A liver disorder, intrahepatic cholestasis of pregnancy (ICP) or obstetric cholestasis
- Multiple pregnancies
- Mother's age – those aged 35 years and above are more at risk
- Maternal obesity – those with a body mass index (BMI) over 30 are more at risk
- Smoking, drinking alcohol or substance misuse.

The Enfield stillbirth rate pooled between 2011 and 2013 is 6.0 (per thousand total births) compared to an England rate of 4.9.

The earlier a woman accesses maternity services, the earlier they can be assessed and referred or treated for some of these conditions. In 2013, only 65.7% of women in England who had a stillbirth booked by 12 weeks gestation²³. In the UK, women are recommended to engage with maternity services and establish a plan of care prior to the 12th completed week of pregnancy²⁴, and ideally by 10 weeks²⁵.

Reducing stillbirths

Maternity services record the smoking status of women at the time of booking for antenatal care. Those that smoke are offered referral to smoking cessation services.

Pregnant women are also offered at least 2 ultrasound scans during their pregnancy:

- at 8 to 14 weeks, and
- between 18 and 21 weeks

In Enfield the North Middlesex Hospital is planning a programme for monitoring foetal growth with ultrasound.

23 Health Equity Audit of Booking for Antenatal Care in London. Neil S P Smith. 2015.

24 Predictors of the timing of initiation of antenatal care in an ethnically diverse urban cohort in the UK. Cresswell et al. BMC Pregnancy and Childbirth 2013, 13:103.

25 National Institute for Health and Care Excellence. Antenatal Care: NICE Clinical Guideline 62. 2008. <https://www.nice.org.uk/guidance/CG62>



Immunisation coverage

Immunisation ranks only just below clean water as the most important intervention for children's health. This is reflected in the national schedule of immunisations, which begin at just eight weeks old and continue for the rest of life.

Enfield has had challenges trying to maintain immunisation rates and although they are still generally low compared to National rates, there have been general improvements. There are a number of reasons for this. As in the rest of London, there is a growing 0-5 population and this is likely to put pressure on existing resources such as GP practices. The mobility of the local population also contributes to difficulties contacting families and arranging immunisations.

In recent years there have been further challenges for Enfield due to problems with the reporting system for immunisation data. This resulted in the rates of immunisation in the borough being under-reported. These technical difficulties in reporting have now been resolved and the interim data show that reported Enfield immunisation rates have improved even if rates are not yet up to the 95% recommended by the World Health Organisation (WHO).

TABLE 5: Enfield Immunisation Coverage 2014/2015

Immunisation	Number immunisations given	Coverage (%)
Primary immunisations at 12 months ²³	3,962	90.5
PCV at 12 months	3,954	90.4
MMR (second dose)	3,723	86.1
HiB/MenC booster by 24 months	3,964	91.2
PCV booster	3,895	88.6
DTaP/IPV booster	4,063	93.6

Source: HSCIC NHS Immunisation Statistics England, 2014-15

²⁶ Diphtheria, Tetanus, Pertussis, Pneumococcal and Haemophilus influenza (DTaP/IPV/HiB)

Teenage pregnancy

Children born to teenage mothers are more likely to experience negative outcomes in life. Pregnant teenagers are less likely to access antenatal services early in the pregnancy, more likely to smoke and less likely to breastfeed. Teenage mothers are three times more likely to develop post-natal depression, more likely to end up in poverty, poor housing and poor health. Nationally, infant mortality rates are 60% higher for teenage mothers than they are for women aged 20-39 years²⁷. There is also a 25% greater likelihood of prematurity and low birth weight amongst teenage mothers compared with older mothers.

Enfield's Teenage pregnancy rate in 2013 was 23 per 1,000 females aged 15-17 years. This was higher than the London rate of 21.8 but lower than the England rate of 24.3. It was a 12.9% reduction from the Enfield rate in 2012 of 26.4 and a 50.4% reduction from the baseline rate in 1998 of 46.4 per 1,000 females aged 15-17 years. Teenage pregnancy rates in Enfield have been decreasing since 2007.

In Enfield, 35.8% of abortions for women under-25 years were repeated abortions in 2014, the 8th highest rate amongst 32 London boroughs and significantly higher than the England average of 27%.



FIGURE 19: Percentage of all deliveries that were to mothers aged under 18 years



Even though the teenage pregnancy rates in Enfield have been reducing, there is still a disproportionate rate of teenage conceptions taking place in Upper Edmonton, Lower Edmonton and Haselbury which are within the most deprived areas of Enfield. The rates in these areas are more than five times higher than the teenage conception rates in the areas of the borough with the lowest rates. This geographical variation across the borough mirrors the geographical variation of child poverty and this is in line with national evidence which demonstrates that young women from the poorest backgrounds are more likely to become teenage mothers.

²⁷ Department for Children, Schools and Families and Department of Health, 2010. Teenage Pregnancy Strategy: Beyond 2010. [online] Available at Teenage Pregnancy Strategy Beyond 2010

FIGURE 20: Map showing teenage conception rate by Ward in Enfield, 2011-2013

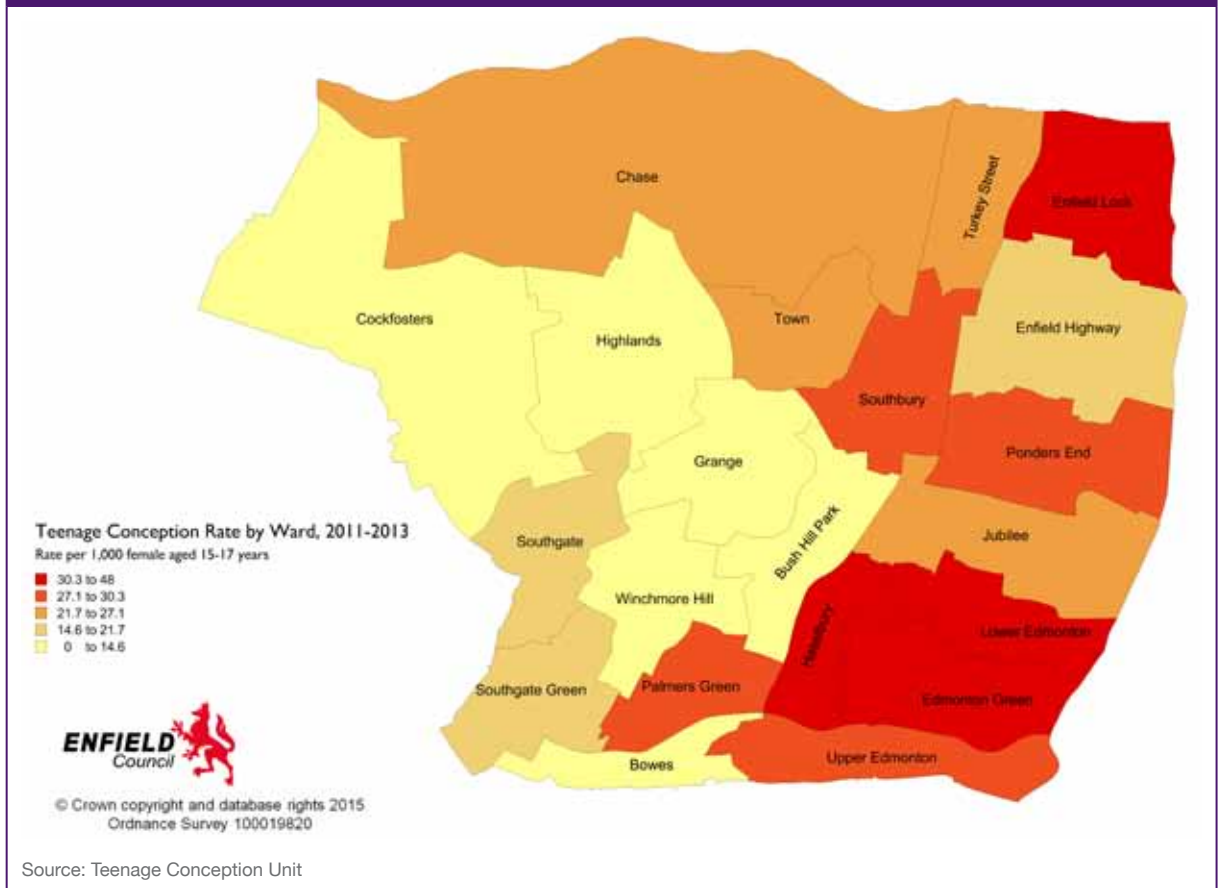
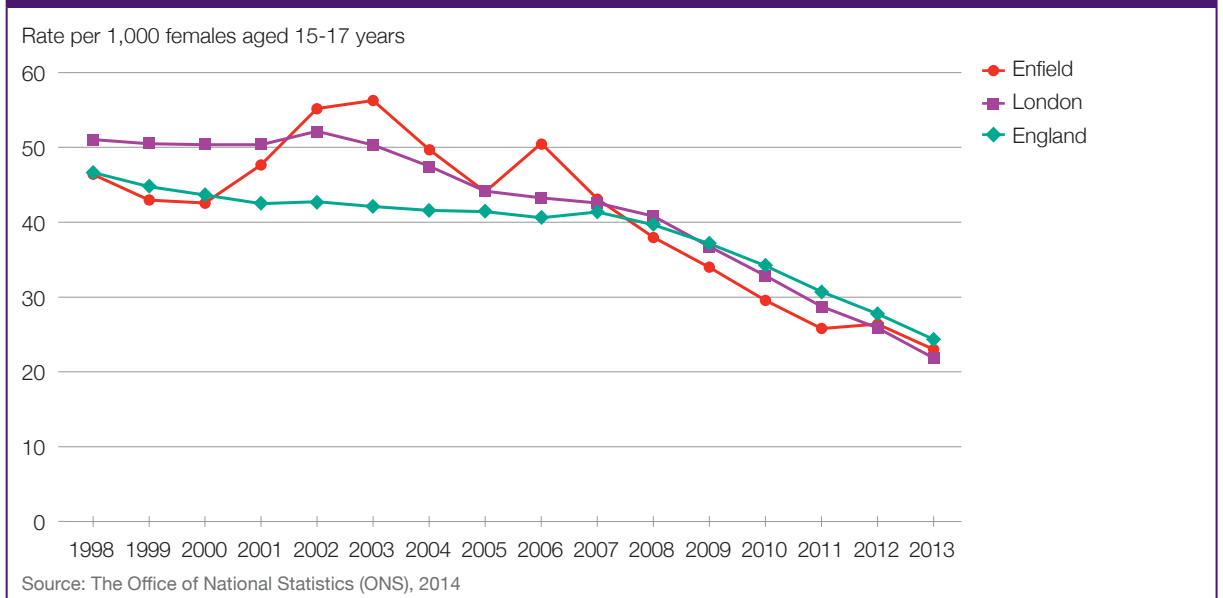


FIGURE 21: Under-18 Conception Rate in Enfield, London and England: 1998 to 2013



Older mothers

The percentage of births to mothers over the age of 35 years in Enfield (22.6%) is higher than the national average (19.2%), but lower than the regional average (24.9%). This may be in part due women waiting to start a family due to the extra cost of working and living in Greater London.

FIGURE 22: Percentage of all deliveries that were to women aged 35 years and above



Female Genital Mutilation

Female Genital Mutilation (FGM) is a form of child abuse and violence against women and girls. It is illegal in the UK and is prohibited in 24 of the 29 countries in Africa and the Middle East where it is most prevalent.

FGM is a cultural practice and can be performed at different times in a woman's life depending on which culture she was born in to: it can be performed on newborns, during childhood, adolescence, just before marriage or during first pregnancy. The majority of cases are thought to be performed when the girl is between five and eight years of age. FGM involves procedures that include the partial or total removal of the external female genital organs for non-medical purposes.

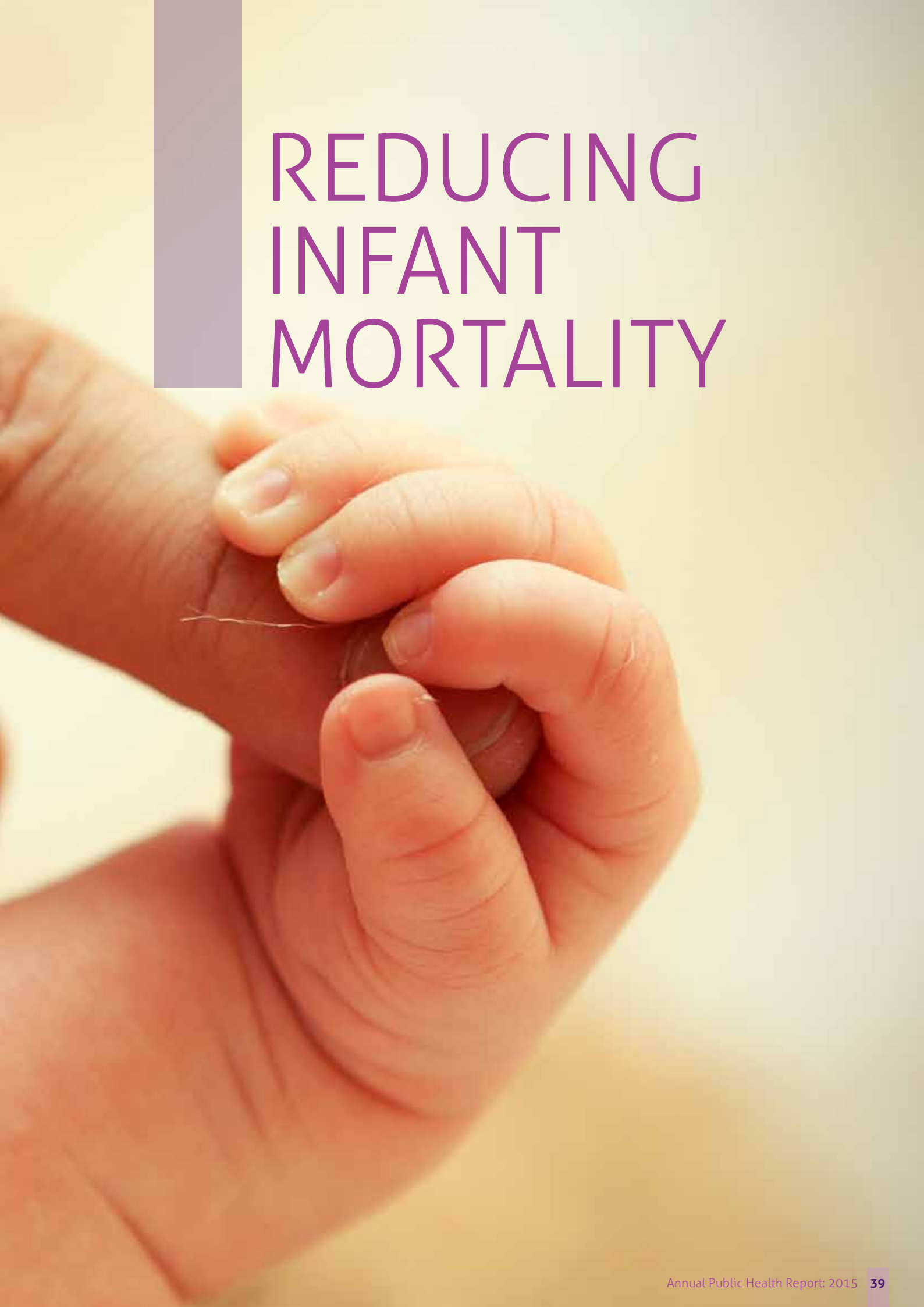
FGM is a practice that is medically unnecessary, painful and often results in serious physical and mental health consequences. Women are often cut with crude implements such as razor blades, glass or scissors. Needless to say, this is done by lay cutters with no anaesthetic and the articles used are not sterile. Infection is a major problem, including lifelong problems such as hepatitis and HIV infections.

Women that have been victims of FGM may have difficult pregnancies and deliveries due to the damage done by FGM. This puts the life of the woman and her child at risk.

TABLE 6: The Health Consequences of FGM

In the short term the consequences may include:	In the longer-term, the consequences may include:
■ Death	■ Chronic vaginal and pelvic infections
■ Shock and severe pain	■ Difficulties passing urine and chronic urinary tract infections
■ Haemorrhage	■ Kidney disease
■ Wound infections, including tetanus, HIV, hepatitis B, hepatitis C	■ Damage to the reproductive system including infertility
■ Urinary retention	■ Infibulation cysts, neuromas and keloid scars
■ Fractures or dislocations as a result of the girl being restrained	■ Psychological damage including depression, anxiety and sexual dysfunction
■ Injury to other tissues	■ Increased risk of HIV and other infections
■ Damage to other organs	■ Fistula formation
	■ Complications in pregnancy
	■ Maternal or foetal death



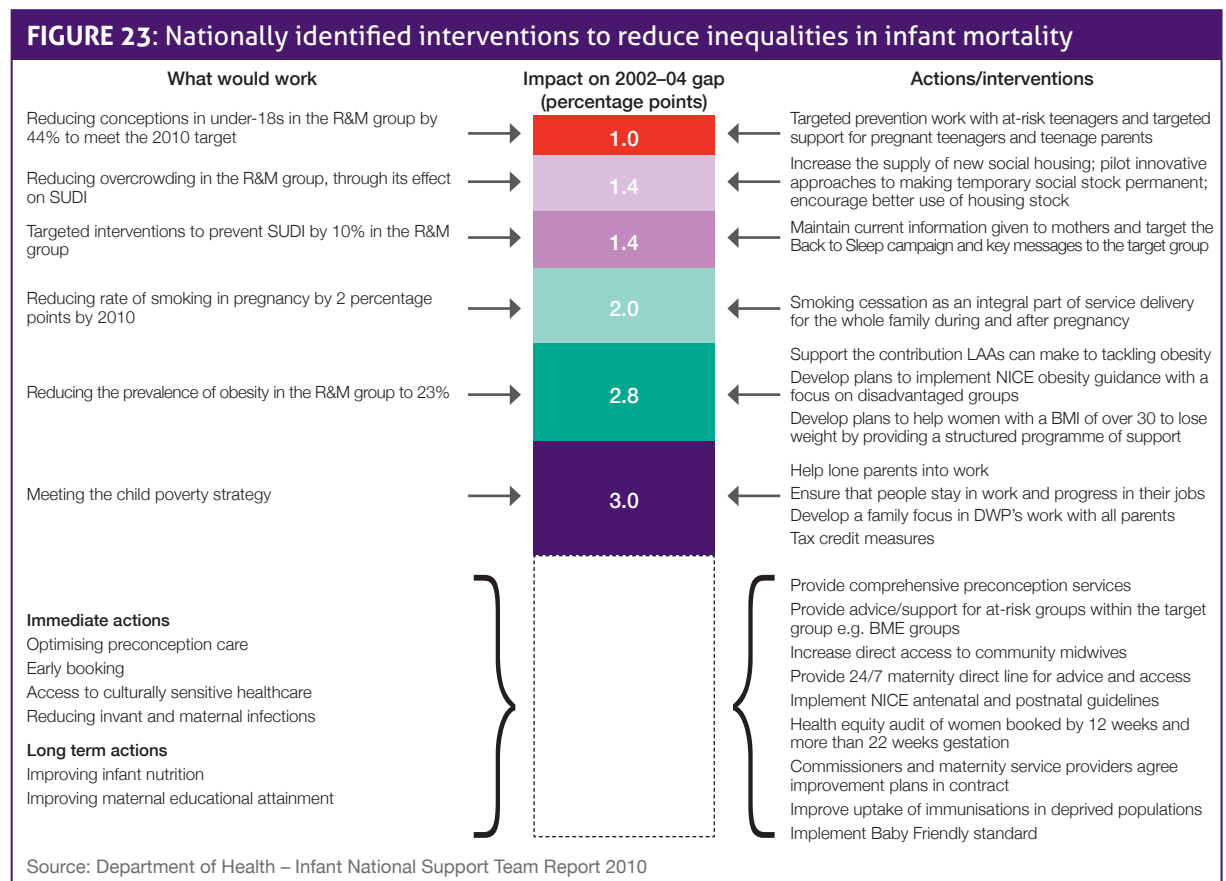


REDUCING INFANT MORTALITY

WHAT DOES THE EVIDENCE TELL US ABOUT HOW TO TACKLE INFANT MORTALITY?

There is a body of evidence, both national and international, that demonstrates that infant mortality can be successfully reduced.

The figure below shows which interventions have evidence that they work and what the impact would have been in 2002-2004 if they had been implemented nationally. This gives us a useful guide as to what we should do locally to address infant mortality rates.



In addition to the points in Figure 23, the Department of Health has identified the following additional factors that can help to reduce infant mortality:

- Improving maternal educational attainment
- Routine enquiry and support regarding domestic violence and mental illness
- Providing more intensive parenting support for women with complex needs
- Ensuring early access to antenatal care
- Providing information and education on the antenatal and newborn screening programme
- Promoting health and maternal nutritional status
- Provision of specialist services for obese pregnant women
- Reducing smoking before during and after pregnancy
- Reducing exposure of infants to environmental tobacco smoke
- Providing information and education on risks associated with consanguinity²⁸
- Promotion of safe sleeping
- Promotion and support of breastfeeding
- Ensuring high coverage of childhood immunisations

More recently Sir Michael Marmot published a review 'Fair society, healthy lives (2010)' in which six policy objectives were identified which would reduce health inequalities. The first of these was the need to give every child the best start in life. This influenced national policy and in recent years public health has adopted a life course approach. This approach stresses the impact that early experiences can have on the entire life of an individual.



²⁸ Everybody carries rare 'recessive' genes in their cells that can cause serious diseases and/or congenital abnormalities, some of which are incompatible with life. (It is important to remember that the most common direct cause of infant death is congenital abnormality). These recessive genes are usually rendered inoperative by the presence of other genes which 'override' them. However, if a couple who are closely related (such as first cousins, who share a set of grandparents) have a baby together there is an increased risk of each giving the baby the same recessive gene and these two genes together can cause a congenital abnormality or rare, serious disease. Normally, relationships between more distant relatives leading to pregnancy carry lower risks. However, some families carry specific genetic disorders and the risk of a relationship between more distant relatives (such as third cousins) in such circumstances carries a much higher risk of any consequential child suffering from that condition.



A young child with dark skin and short hair is shown in profile, wearing a red, white, and blue plaid shirt and denim shorts. The child is being held by an adult, whose hands are visible at the bottom. The background is a soft, out-of-focus light blue. A vertical purple bar is on the left side of the page.

DELIVERY THROUGH PARTNERSHIP WORKING

PARTNERSHIP WORKING WITH CHILDREN'S CENTRES

Children's centres in Enfield

Enfield has five hub children centres which deliver stay and play sessions known as the 'Universal Core Offer'. These central 'hubs' also deliver sessions from other local venues like schools, churches and other community buildings. These universal programmes will be widely used by the community; especially families with children aged 0-2. This approach will enable centres to identify families with particular needs, in a non-stigmatising way. They will then be able to offer timely support or signpost to other more targeted individual services, 'The Target Core Offer' as required. There are three stay and play sessions which are a balance of both play and communication focused sessions. These include:

- **Baby Talk** for first time parents with babies aged three months to 12 months. Health visitor will write to all parents when their child is approximately eight weeks old and invite them for a session at their local centre. The programme will be delivered by children centre staff but supported from a range of different professionals. Each session will have a different theme like safe sleeping, baby massage etc. and it will be followed by health advice like breastfeeding, weaning, healthy snacks and others. There will be opportunities for baby weighing and meeting other professionals.
- **Toddler Talk** for families with two or more children aged three plus months. This is a 12-week rolling programme. Parents will be invited to attend six weeks prior to the start of the session each school term. The session starts with interactive play where parents will be encouraged to use the Enfield Play and Communication profile to assess their own child's personal, social and language development. This will be followed by health advice and support. Those families who may need additional access to services from speciality professionals like speech therapists, educational psychologists or family workers will have the opportunity to book an appointment to meet a specialist or attend other activities. Information about local adult learning, volunteering and employment support will be available.
- **Child Talk** for families with children who will be starting nursery or school within the next 12 months. This a six-week programme where the early intervention workers will work with parents to complete a play and communication profile of what their child is able to achieve. This aims at helping parents to understand and explore what the anticipated next steps are for their child.

Other significant services include support from volunteer community health workers, who are part of Enfield Parent Engagement Panel (PEP). These are community members who act as a link between their communities and the children's centres. They reach out to their communities and chaperone individuals who may need to be supported while in the centres to ensure that they get a good experience and continue to access the service. They raise awareness of the services offered by the children's centres and encourage parents to use the service. They have been trained to support, sign post and offer basic health advice to members of the community. They are stationed in some of the children's centres on specific days and they also work with individuals in their respective communities. They also support health promotion events.

Volunteer breastfeeding peer support workers are placed in the different centres. They are National Childbirth Trust (NCT) trained to support breastfeeding without putting pressure on mothers who do not wish to breast feed. They also support families through weaning and introducing solid food. They empower women to make the best decisions for their babies. The infant mortality review and action plan (which was developed in 2015) identified breastfeeding as a key factor in reducing Infant mortality. Increasing the rate of breastfeeding initiation in the (Routine and Manual) R&M group to those of the non-R&M group from 67% to 83% – would contribute four percentage points. (Tackling health inequalities in infant and maternal health outcomes, 2010)²⁹

29 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215869/dh_122844.pdf



Outreach and Home Visit

Some families need more convincing and encouragement than others to use Sure start services. Reaching out into the community is essential if Sure Start children's centres are to support the most disadvantaged families. Outreach and home visiting can involve staff from the whole spectrum of Sure Start services including health professionals, family support workers and a range of specialists targeting specific issues. A structured programme of outreach of work enables centres to:

- Inform families about support available to help them
- Make services easier to reach and use
- Provide a gateway to persuade families to access services
- Deliver services through home visit particularly relating to child health and communication and social and emotional development
- Target resources at the families who need the most support and so improve outcomes for the most disadvantaged children.

Conclusion

All five Enfield hubs have access to the following professionals who are part of the stay and play sessions. These give general information, advice and guidance and sign post to targeted offer where necessary. They can all contribute to early detection and intervention as well as resilience, health and wellbeing of families which mitigates the risks linked to Infant mortality and contributes to better outcomes for children and their families. These include:

- Speech therapy
- Social workers
- Educational Psychologists for under 5's
- Health visitors
- Special Educational Needs advisors
- Family support workers
- Jobcentre Plus or Benefit workers

PARTNERSHIP WORKING IN HEALTH PROTECTION

Immunisation

Newborn children are at higher risk from infection than older children and adults. This is partly due to the immaturity of their immune systems, which rely for the first few months on immunity passed on from their mother. This is one of the reasons that immunisation against childhood illnesses is so important and indeed, after clean water and sewage, immunisation is the most important public health measure that can be taken to protect a population.

Following the transition of public health to the local authority, the arrangements for immunisation and screening have changed. NHS England commissions both screening and immunisations, with public health advice from Public Health England (PHE), while local authorities provide an assurance function.

The Enfield Public Health team have excellent working relationships with both the NHSE Immunisation Commissioner for London region and the Child Health Information Team at Barnet, Enfield and Haringey Mental Health Trust (BEH MHT). This has enabled the team to receive regular data on the uptake of all childhood immunisations. The team also receive quarterly uptake data on the entire immunisation programme via PHE.

There has been a recent policy change and universal BCG vaccination for newborns is being made available across London. This has been implemented at North Middlesex Hospital and The Royal Free Hospital Trust has recently agreed to implement this at Barnet Hospital as well as providing flu and pertussis vaccinations to pregnant women. It is hoped that this will start in 2016.





Recent PHE data indicates that the take up of ‘flu and pertussis vaccination amongst pregnant women is low in Enfield compared to national and regional levels. This results in their newborn children not being protected from these infections and there are current plans to promote these vaccinations in maternity units and in the community. It appears that Enfield does not perform as well as London or England in either prenatal pertussis vaccination or influenza vaccination. Published provisional flu vaccine data show that 30.3% of pregnant women in Enfield received ‘flu vaccination compared to 37.2% in London and 41.4% for England. Pertussis vaccination data are shown in Table 7.

TABLE 7: Prenatal pertussis vaccine coverage Enfield Clinical Commissioning Group as of November 2015

	1 April 2015 to 31 September 2015					
	April	May	June	July	August	September
NHS Enfield CCG	32.0	34.1	32.4	31.4	33.2	28.2
London Area Team	46.0	45.8	44.3	45.4	46.8	46.6
England	56.1	55.2	55.1	55.6	56.6	57.7

Source: NHS England

Communicable disease

The control of communicable disease is provided in partnership between Public Health England (PHE), local authorities and the NHS. In Enfield we have a Health Protection Forum which is attended by representative from many teams in the local authority including environmental health and emergency planning, plus representatives of NHS England, the Clinical Commissioning Group (CCG) and PHE. The forum provides a mechanism for sharing information on communicable diseases including any local incidents and outbreaks.

PARTNERSHIP WORKING ON TEENAGE PREGNANCY

Enfield's teenage pregnancy unit works to implement the national teenage pregnancy strategy. It is funded from Enfield's Public Health grant and works in partnership with services such as the sexual health service, schools and youth services to reduce the overall borough rate of teenage pregnancies while specifically targeting the areas with high and increasing rates.

Accountability for achieving the reduction in teenage conceptions lies with the Enfield Targeted Youth Engagement Board (ETYEB) through the work of the Teenage Pregnancy Partnership Board (TPPB). Achieving reductions in the rates of teenage pregnancy depends on effective partnerships between key agencies such as Enfield Council, Enfield CCG, other NHS bodies and the voluntary sector. Local and national data are used to identify and prioritise programmes of work and groups to support with targeted services within the borough. The two measures for which there is the strongest evidence of impact on teenage pregnancy rates are: comprehensive information advice and support – from parents, schools and other professionals – combined with accessible, young people-friendly sexual and reproductive health (SRH) service³⁰.

In order to reduce teenage pregnancy in Enfield, the following schemes have been put in place:

- **Enfield Young People's Project (EYPP)** is a youth development programme designed to support young people at high risk of social exclusion or disengagement from education, low attainment, behavioural and/or emotional problems, teenage pregnancy and poor sexual health. The programme is also designed to empower young people with low self-esteem to make positive decisions for themselves. To date 222 selected students have participated in the programme since 2011.
- **Txtm8** – Offered a completely free text messaging service for young people aged 13-19. They could text in with any question about sex and relationships to 89868 and a trained team of operators would respond within 30 minutes. Young people could text as many times as they wanted and could carry out 'conversations' via text with operators to get more information and advice³¹. This service was available to all young people in Enfield 24 hours a day, seven days a week, but has recently been discontinued as a new, improved service – the Well Happy telephone app is about to be introduced.
- **Dedicated sexual health outreach nurses for under 19s** – There is a dedicated team of two highly experienced sexual health nurses, who deliver service for young people branded as SHOUT 4YP. They work in schools and colleges in the borough in addition to running the 4YP clinics for young people. They offer advice including contraception to help young people make healthy choices and reduce the risk of unplanned pregnancies and sexually transmitted infections (STIs). The programme also offers free condoms, free pregnancy testing and free Chlamydia testing. The sexual health nurses also train providers and run two young people friendly clinics in Edmonton and Chase Side, which are close to the teenage pregnancy hot spot areas in the borough.
- **Sexual Health Clinics** – The two sexual health clinics in Enfield provide young people specific clinics (4YP) clinics. In addition, the clinics have good accessibility with a clinic available every week day, with late opening hours and Saturday opening.
- **Condom distribution scheme** – Young people can access free condoms and advice via a C-Card scheme³².
- **Emergency contraception scheme and Chlamydia testing** – Selected 4YP pharmacies in Enfield provide free emergency hormonal contraception (morning after pill). This service is free and confidential for all females aged 24 and under. They also provide free Chlamydia testing services³³.

30 Department for Children, Schools and Families and Department of Health. (2010) Teenage Pregnancy Strategy: Beyond 2010. [online] Available at www.yor-ok.org.uk/Teenage-Pregnancy/Teenage%20Pregnancy%20Strategy%20Beyond%202010.pdf

31 www.txtm8.com

32 www.enfield.gov.uk/youth/info/64/free_condoms_and_txtm8

33 www.enfield.gov.uk/youth/info/61/emergency_contraception

- **Social networking** – 4YP also has an Enfield Facebook page³⁴ as well as a twitter page³⁵ to ensure that young people can access the latest Sex and Relationships Education (SRE) information as well as local information about teenage pregnancy.
- **Youth Enfield website** – This has a dedicated section for information on sex and relationships³⁶.
- **Training** – Workforce training is provided for professionals and volunteers working with young people. A variety of training is offered to professionals to ensure that everybody working with children and young people are equipped with the knowledge, understanding, skills and confidence to support the SRE needs of young people and therefore contribute towards the Teenage Pregnancy Prevention Strategy.

Many of the services for young people such as local contraception services and sexual health services gained You're Welcome accreditation this year and the certificates were given to the services by Cllr Nneka Keazor at a ceremony in September 2015.

FIGURE 24: Partners receiving their certificates for You're Welcome accreditation from Cllr Keazor, Cabinet Member for Public Health, Autumn 2015



34 www.facebook.com/pages/4YP-Enfield/115709038492949
 35 www.twitter.com/4ypenfield
 36 www.enfield.gov.uk/youth

PARTNERSHIP WORKING WITH HEALTH VISITING AND FAMILY NURSE PARTNERSHIP

Introduction to health visiting

Health visiting is a universal service that provides a platform from which to reach out to individuals and vulnerable groups, taking into account their different dynamics and needs. Health visitors provide a professional public health service based on evidence of what works for individuals, families, groups and communities, enhancing health and reducing health inequalities through proactive universal service for all pre-school children and vulnerable population targeted according to need. The different national policy drivers give them the mandate to undertake antenatal visits and do health promotion at this stage, visit new born babies between 10 and 14 days, undertake a 6-8 week review followed by another review at one year. This facilitates regular contact with families and their children at the most challenging times of their life and plays a key role in early detection of potential risk factors of infant mortality.

Why health visiting matters

The period from pre-natal development to age three is recognised as a key determinant of health and health inequalities³⁷. Health visitors have always focused primarily on this age range, and still use this base to reach out to the wider community in which children and their parents and families live in order to influence the structural determinants of health³⁸. Health visitors influence the wider determinants of health through their work with parents who have new babies, offering support and informed advice from the ante-natal period until the child starts school. They play an important role in supporting families to make informed decisions about safer sleeping³⁹. They visit parents at home, invite them to join groups, clinics and networks run by the health visitors or colleagues like nursery nurses or community mothers. They can also have a role in community asset mapping, identifying whether a particular community has any specific needs.

Health visitors are highly trained specialist community public health nurses, skilled at spotting early issues, which may develop into problems or risks to the family if not addressed. The wider health visiting team may also include nursery nurses, health care assistants and other specialist health professionals. They offer a universal family service which means that all new parents are entitled to health visiting services irrespective of their situation and number of children. The service will vary according to the personalised assessment of each particular family and what will work for them. They lead the delivery of the 0-5 elements of the Healthy Child programme in partnership with other social care colleagues which places them in a strategic position to tackle and reduce infant mortality because they work closely with the parent and family from pre-natal, during pregnancy, post-natal until the child starts school at five years. It is therefore imperative to have a strong health visiting service that can effectively identify risks and early intervention which is critical in reducing infant mortality.

Through regular contact and with appropriate training, health visitors can influence mothers, fathers and family members to develop healthy behaviours (including not smoking, increasing physical activity and maintaining a healthy weight) associated with improved wellbeing. In addition, health visitors can encourage greater physical activity among children by providing relevant information to families and working with partners to develop greater opportunities to be physically active.

37 Irwin L, Siddiqi A, Hertzman C, 2007

38 Cowley S, Caan, W, Dowling S, Weir, H 2007

39 Journal of health visiting, vol 3, Issue 3, 17 Mar 2015 pp 152-158

The Health Visiting Programme

The Health Visiting Programme which started in 2011 is a national programme of work to deliver the government's commitment of transforming the health visiting service by 2015. The programme sought to increase the number of health visitors by 4,200 and create a transformed, service providing improved outcomes for children and families, with more targeted and tailored support for those who need it. This meant moving from 8,092 health visitors in May 2010 to 12,292 health visitors by April 2015.

Breastfeeding initiation and duration rates can be improved by health visitor intervention. They can ensure whole system approach to promoting breastfeeding by implementing the UNICEF baby friendly standards and supporting other settings such as children's centres to become baby friendly and training for early year staff. Health visitors are well positioned to support mothers with breastfeeding as they continue active engagement with mothers after birth. There is evidence that not breastfeeding is one of the risk factors of infant mortality.

Health visitors can provide help and support to new parents on a range of minor childhood illness such as fever, cold and coughs as well as guidance on the signs of more serious diseases such as meningitis, bronchitis and chicken pox, both to families and in settings such as children's centres. Health visitors are in a strong position to raise awareness of the biggest risks and offer practical and accurate safety advice at universal contacts such as child developmental checks and during targeted follow up after A & E attendance.

Changes in commissioning

To support the transformation, from 1 October 2015, the responsibility for commissioning health visiting services will transfer from NHS England to Local authorities. This is because of the overall change in arrangement to transfer commissioning of public health services for children aged 0-5. The 0-5 Healthy Child Programme is led by the health visiting services. The rationale behind this move is that local authorities know their communities and understand local needs so they are in a better position to commission the services. Funding for the 0-5 budget will sit within the overall ring-fenced public health budget. A review at twelve months, involving PHE will inform future commissioning arrangements. Child health information systems and the 6-8 week GP check (Child Health surveillance) will not transfer to local authorities.

Work has been done to ensure local authorities are well prepared to take on their new commissioning role and understand the leadership role of health visitors, the new service model for health visiting and the Healthy Child Programme. At national level, the Department of Health, NHS England, Public Health England and Health Education England are working with key partners including Local Government Association, Society of Local Authority Chief Executives (SOLACE), The Association of Directors of Children's Services (ADCS), The Association of Directors of Public Health (ADPH) and others to ensure a smooth transition. Only the commissioning responsibility will transfer. Health visitors will continue to be employed by their current provider, the NHS.

Conclusion

Infant mortality has declined significantly in recent years; yet many preventable deaths still occur (Child mortality statistics: childhood, infant and perinatal, 2012 Office for National Statistics 2014). A number of factors affect risk of infant mortality and contribute to health inequalities. These include poverty and housing quality as well as maternal smoking and obesity and teenage pregnancy⁴⁰.

Two causes of premature deaths and illness are unintentional injuries and less commonly, infectious disease ('Chief Medical Officer's annual report 2012: our children deserve better: prevention pays'). Health visitors have an important role to play in educating families on assessing and maximising their home safety and working with other agencies (for example the fire and rescue service) to prevent unintentional injuries. They can also help improve local uptake rates of immunisations to reduce the occurrence of vaccine-preventable illness. They can also be instrumental in safeguarding children from harm within the home (such as maltreatment and neglect), allowing early identification and intervention for those at risk.



Family Nurse Partnership

The Family Nurse Partnership (FNP) is an evidenced based, preventative programme offered to vulnerable young mothers having their first baby. It is a nurse led intensive home-visiting programme from early pregnancy to the age of two. The aims are to:

- improve pregnancy outcomes;
- improve child health and development;
- improve parents' economic self-sufficiency.

It is a 'licensed' programme with structured inputs and well-tested theories and methodologies. It has a strong and rigorous US evidence base, developed over the last 30 years and has been shown to benefit the most needy young families in the short, medium and long term across a wide range of outcomes, helping to improve social mobility and break the cycle of inter-generational disadvantage and poverty⁴¹.

41 Department of Health., 2012. The Family Nurse Partnership Programme – Information Leaflet. [online] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf

The criteria for eligibility to be offered the programme are:

- All first time mothers aged 19 and under at conception;
- Enfield residents;
- Eligible if previous pregnancy ended in miscarriage, termination, still birth;
- Enrolment should be as early as possible in pregnancy and no later than the 28th week of pregnancy. 60% should be enrolled by the 16th week of pregnancy.

Women who plan to have their child adopted or have had a previous live birth are excluded from the programme.

The programme shows:^{42, 43}

- Improved prenatal health
- Fewer childhood injuries and reduced child neglect and maltreatment
- Fewer subsequent pregnancies
- Greater intervals between births
- Increased maternal employment
- Improved school readiness
- There are also effects on child and maternal mortality^{44, 45, 46}

FNP Teams have caseloads of up to 25 families per practitioner, and therefore the work is much more intense, and relies heavily on the ability of the practitioner to build a trusting and lasting therapeutic relationship with the mother. The FNP programme in Enfield commenced enrolling clients on 1st November 2013 and has one WTE supervisor, four WTE family nurses and one WTE quality support officer (job share). They offer 'show and tell' sessions to individuals, teams, other professionals and agencies and including invitations to attend their team meetings in order to showcase their practice and promote the programme to a range of services.

As of June 2015, Enfield FNP had a caseload of 70 cases. In the last 12 months 37 clients were enrolled, of whom 41% were enrolled by the 16th week of pregnancy (the target is 60%). In the same period, 75% of those who were offered the programme enrolled, which meant that the target of 75% was achieved. In addition, 44 pregnancies, 19 infancies and five toddlers were completed within the FNP programme. The percentage attrition for pregnancy was 0%, for infancy 10.5% and for toddlerhood 60%.

There are an increasing number of vulnerable, complex and safeguarding issues within the families enrolled onto the programme.

FNP will be fully funded for the first two years during which time commissioners will be expected to develop a strategic vision for FNP in Enfield as part of wider maternity and children's services. FNP aligns with the Healthy Child Programme and will be included in future commissioning plans for the wider Health Visiting service. An early years needs assessment, which includes the FNP programme is due to be carried out in the autumn of 2016.

42 Social Programs That Work – Family Nurse Partnership. *Social Programs that Work*

43 Intervention Summary – Family Nurse Partnership. *National Registry of Evidence-based Programs and Practices*

44 Olds, D. L. et al. Effects of Nurse Home-Visiting on Maternal Life Course and Child Development: Age 6 Follow-Up Results of a Randomized Trial. *Pediatrics* 114, 1550–1559 (2004).

45 Olds DL, Eckenrode J, Henderson CR, Jr & et al. Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. *JAMA* 278, 637–643 (1997).

46 Olds, D. L. et al. Effect of Home Visiting by Nurses on Maternal and Child Mortality: Results of a 2-Decade Follow-up of a Randomized Clinical Trial. *JAMA Pediatr.* 168, 800 (2014).

PARTNERSHIP WITH THE NHS – PERINATAL MENTAL HEALTH

There is current, ongoing, work in North Central London to ensure that all women in the region have access to appropriate timely, high quality, universal and specialist mental health services. One recent initiative is the new service in Enfield to improve the development of strong and positive bonds between parents and their babies. This service is called EPIP (Enfield Parents and Infant Partnership) and is available for the first 18 months of baby's life. This service is funded by the Council, the NHS, Enfield Parents and Children, Enfield Children's Centres and PIPUK (Parent and Infant Partnership UK)⁴⁷.

The team is made up of a number of specialist staff including a health visitor and counselling therapist who can help if parents are worried about their relationship with their babies, have difficult feelings about parenthood and might be finding parenthood difficult, or who have concerns about baby's development and behaviour. Therapeutic support available might include Parent Infant Psychotherapy sessions, Specialist Health Visitor support, Group Work with other parents and babies, Individual Counselling.

This does not have to be the first child, if difficulties have been experienced with the antenatal and postnatal period of other pregnancies, then the family can be referred. The service is based at the CAMHS premises in Edmonton, but families can also be seen at children's centres and sometimes at their own home. The team is made up of parent infant psychotherapists, a specialist health visitor and a counselling therapist. They can advise on concerns such as worries about baby's development, bonding with baby and where families are finding parenthood difficult.

Parents need a referral to access EPIP and this can be done by a variety of professionals such as midwives, health visitors and GPs, social care and some voluntary organisations. Once referred, parents can be offered a range of therapeutic support such as parent infant psychotherapy sessions, specialist health visitor therapeutic support and guidance, group work and individual therapeutic counselling support.

The new health visiting guidance includes an antenatal visit for all pregnant women so that they have met a health visitor, know what to expect and can answer questions and highlight any issues. This is addition to the service available across North Central London offering targeted antenatal visits to women with mental health concerns.

In Enfield there is a specialist Health Visitor for perinatal and infant mental health (PIMH) who is also part of the Enfield Parent Infant Partnership (EPIP) team. The SpHV PIMH offers consultation and support to the HVs in their work with families who have mental health issues and challenges to the earliest relationships with their infants.

The Enfield HV PIMH working group have developed an antenatal and postnatal PIMH pathway with additional guidance on identification and risk assessment of parental mental health illness. All the Health Visitors, Early Years Practitioners and Health Visiting Assistants are trained in the Solihull Approach and Health Visitors have had the Institute of Health Visiting perinatal mental health training.

⁴⁷ www.pipuk.org.uk A charity that provides services to local communities to babies who are struggling to develop a secure attachment relationship with their primary caregiver (usually the mother)

PARTNERSHIP – BEREAVEMENT SUPPORT

Parents who have suffered a sudden and unexpected death of a baby often feel anxious when they have another child. The Lullaby Trust runs the Care of Next Infant (CONI) programme with the NHS. The CONI programme can be run from hospitals and community health centres and involves many professionals such as paediatricians, GPs, health visitors and specialist midwives.

Each area has a CONI co-ordinator and a CONI paediatrician. The family will have regular contact with their health visitor and any concerns about the baby can be fast-tracked for expert advice. Parents receiving CONI can choose to receive a symptom diary, weighing scales, a breathing monitor, resuscitation training, a room thermometer and a baby check book.

Parents that have lost an older child can access bereavement support by speaking to their GP. There are also a number of charities that can assist and these are listed in the Appendix 2.

Where a child or young person has lost a sibling, specialist services can be accessed via an NHS referral or via one of the bereavement charities.



HEALTH IMPROVEMENT AND HEALTH PROMOTION

Smoking cessation

There is a smoking cessation advisor in maternity services and all maternity staff are able to refer pregnant women for smoking cessation advice and (where appropriate) for nicotine replacement therapy. Often women are not willing to admit that they use tobacco when pregnant and so there is ongoing partnership work with local hospitals to better identify pregnant women that smoke and on getting a better estimate of the prevalence of tobacco use in pregnant women.

Healthy eating and pregnancy

Women are often confused about eating healthily in pregnancy. There are a number of foods that should be avoided such as soft cheeses and there are a number of confusing messages about how many extra calories a woman needs during pregnancy and which vitamins she should take. Being overweight or obese before and during after pregnancy are associated with poorer outcomes for both the mother and baby. We are working in partnership with a local maternity unit to provide health trainer support to obese pregnant women.

Early Access to Maternity

The Early Access to Maternity campaign was launched earlier this year with displays on the back of buses, in telephone booths and around the borough on billboards. This was accompanied by a press release in local papers.

In July 2015, a one week roadshow was held in Edmonton Town Centre where a commercial on early access to maternity and breastfeeding was shown to the public, leaflets were distributed and a questionnaire was randomly given out to people to evaluate the effectiveness of our campaigns. Local volunteers from the Parent Engagement Panel helped with the campaign and we received positive feedback from both people approached at the roadshow and the volunteers participating.

300 copies of the commercial used at the roadshow have been produced and have been distributed to all GP surgeries, children's centres and relevant community groups and relevant children's services.

**As
Soon
As you're
Pregnant**

Healthy Enfield

Tell your local maternity unit:

North Middlesex Hospital
Maternity Services
020 8887 3055

Barnet and Chase Farm
Hospital Maternity
Services
020 8375 1254

www.enfield.gov.uk/asap

Get the best care for
you and your baby –
contact your local
maternity service
as soon as possible

To find your local maternity service
go to our website.
www.enfield.gov.uk/asap

ENFIELD
Council

PARTNERSHIP WORKING ON BREASTFEEDING

Enfield Public Health continues to raise awareness of the importance of breastfeeding, its benefits and how to overcome barriers to breastfeeding using social marketing campaigns. One of our main commissioning challenges is recruiting peer supporters as part of a multi-disciplinary team and ensuring that they are integrated within the health care setting and the community.

Enfield Public Health has embarked on delivering a coordinated programme of interventions across different settings to improve breastfeeding rates. The National Child birth Trust (NCT) were commissioned to train a cohort of 12 breastfeeding peer supporters who graduated on 25 February 2015 and have been given volunteer placements in children's centres across Enfield, to support mothers who need help. An award ceremony was held and was led by Cllr Ayfer Orhan, the Cabinet member for Children and Young People and attended by health professionals from maternity, universal health visiting services and senior managers from both public health and children's services.

We have launched the Parent Engagement Panel (PEP) Antenatal project which is a strategic partnership project across a number of different services. Twelve PEP members formed our first cohort of volunteers and now work as Community Health workers to engage parents and families from pregnancy, through the pregnancy and child birth and in the development of children from the onset in order to improve life opportunities for children and their families. We are currently training further volunteers and exploring ways that the breastfeeding volunteers can deliver support to women in children's centres.



PEP volunteers support, advise and give information as well as signposting families to relevant services. They will work closely with children's centres, health visitors, midwives and education services. The group undergoes an intensive training programme which will enable them to work effectively and safely with both health professionals and people in the community, using the health trainer model of delivery. This will enable us to provide sustainable universal support as well as targeted support for mothers who are least likely to breastfeed and who are at risk of poor health outcomes.

The programme is designed to give them skills to move on into paid employment hence we have to recruit new recruits each year if the service is to be sustainable. We also face the challenge of ensuring that we target the women who are least likely to start and continue breastfeeding and engage them from the onset of pregnancy. This requires innovative outreach work to ensure we are not 'preaching to the converted'. This project is one of the initiatives laying the foundation for delivering the UNICEF Baby Friendly Initiative in the community in Enfield.

The Breastfeeding welcome scheme is in progress and the number of businesses that have signed to the scheme has increased to 200. We have rolled out a new sticker for businesses to display at their counters and in their windows, to let customers know that they are welcome to breastfeed whilst on those premises. We have developed, with NHS Wirral, a 'Breastfeeding App' which will carry the details of Enfield businesses that welcome breastfeeding and list the sources of breast feeding support available Enfield. It also includes general information about breastfeeding and its benefits. The app will target mainly young parents and those who wish to breastfeed whilst out and about in the borough.

FIGURE 25: Breastfeeding Health Promotion at All Saints Church, Edmonton



PARTNERSHIP WITH ENFIELD SAFEGUARDING CHILDREN BOARD AND THE CHILD DEATH OVERVIEW PANEL

Enfield Safeguarding Children Board

Babies are particularly vulnerable to abuse and neglect. Children under one years old have eight times the average risk of child homicide⁴⁸ and around 26% of babies in the UK are estimated to be living within complex family situations that may increase the risk e.g. parents misusing drugs or alcohol or domestic violence in the family⁴⁹.

The Children Act 2004 placed a statutory duty on Local Authorities to establish a Local Safeguarding Children Board (LSCB) and the Enfield Safeguarding Children Board was set up in 2006. The Board meets every two months and is made up of partners including health, social services, voluntary sector and the police, along with two lay members. The Board brings together local agencies to promote the health and wellbeing, and ensure the safety of children in the Borough.

Enfield Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) meets to review the deaths of Enfield infants and children. The panel is chaired by a Consultant in Public Health and attended by Consultant Paediatricians, Social Workers, Police and midwifery staff.

Child deaths are reviewed and assessed as to whether there are any modifiable factors i.e. could anything have been done or be done in the future to prevent such deaths. As a result of this, annual professional update sessions are held, for example to discuss the evidence around sudden unexplained deaths in infancy (SUDI) and safer sleeping.

Each local authority will have a CDOP, and learning from meetings is coordinated between authorities. There is also current work exploring the production of a national system to allow shared learning and better analysis of risk factors for sudden unexpected death in infancy.

FGM group

There is a Council-led FGM group which aims to help survivors access appropriate services and prevent FGM. The group held a successful conference – ‘Standing up to FGM’ in March 2015, has engaged in community development with the Somali community and helped train social workers on this issue.

There is an action plan for the group which includes health promotion work, clinical pathway development and further community development. Members of the group also operate at a regional, national and international level.

48 NSPCC. All Babies Count. Chris Cuthbert, Gwynne Rayns and Kate Stanley 2011.

49 1001 Critical Days – website

HOW WILL WE SEE THE RESULTS?

Infant mortality is a multifactorial issue and there are a number of outputs and outcomes that need to be monitored to ensure that we are having a true effect on infant mortality rates. This will be achieved by using strategies and functions already in place across the Council and the health economy.

Nationally, the following can be used to track progress towards reducing infant mortality:

- Deaths of infants under the age of one year per 1,000 live births
- Breastfeeding at six to eight weeks
- Smoking at time of delivery
- Teenage conceptions
- Sudden unexpected deaths in infancy
- Booking by 12 weeks and six days.

Additionally, we will also be locally monitoring progress in the following areas:

- Breastfeeding initiation
- Body Mass Index at booking.

JSNA and Public Health Intelligence Function

Public Health Enfield has a small Health Intelligence Team which produces various intelligence products and reports as part of the statutory Public Health function to support the local authority and the NHS, and to support the Public Health priority of reducing health inequalities and improving the outcomes of Long Term Conditions.

In addition, the team supports the Health and Wellbeing Board and can provide local data to support the implementation of the infant mortality action plan and can help source national data such as the child health profiles available from Public Health England.

The team also leads on the update and maintenance of the statutory Joint Strategic Needs Assessment (JSNA). Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (JHWSs), through the Health and Wellbeing Board. The purpose of the JSNA is to inform the way in which decisions about health, wellbeing and social care services are planned and arranged. It holds all the health and demographic information needed to assess local health and plan services. The contents are continually reviewed and updated to ensure the document remains a relevant and useful tool and resource for commissioners, policy makers, local people and other key stakeholders.

The maintenance of Enfield JSNA is led by the Public Health Intelligence team, and the maintenance process is overseen by the JSNA steering group which includes Local Authority, CCG and Community and Voluntary sector colleagues. The Enfield JSNA is available on the Enfield Health and Wellbeing website at www.enfield.gov.uk/healthandwellbeing/jsna



Enfield Joint Health and Wellbeing Strategy

Enfield Health and Wellbeing Board developed the Enfield's Joint Health and Wellbeing Strategy (JHWS), providing a strategic steer to encourage integrated working between health and social care commissioners, as well as between other health-related services such as housing, transport, the economy and environment. The JHWS also sets out outcomes and high-level actions for the period between 2014 and 2019.

Outcomes in the strategy that require close monitoring include:

- Child immunisation coverage
- Childhood obesity
- Excess weight (overweight and obesity) in adult
- Reducing smoking prevalence
- Increasing levels of physical activity

National data sources

The Child and Maternal Health Intelligence Network (CHIMAT) has a number of tools allowing professionals to interrogate national and local data to improve decision making. The data supports policy makers and commissioners in all areas of children's health and the team at CHIMAT produce a number of benchmarking tools and health profiles.

Additional data are available from Public Health England via the Public Health Outcomes Framework and data are available on maternity services through the performance management of the service by the local Clinical Commissioning Group. There are also data available from the Office for National Statistics, and this is a particularly important source for national statistics such as births and deaths.



A close-up, shallow depth-of-field photograph of a person's hands holding a white smartphone. The person is wearing a dark red, textured sweater. The background is a blurred indoor setting with a light-colored wall and a wooden surface. A teal vertical bar is positioned on the left side of the page, partially overlapping the word 'APPENDICES'.

APPENDICES

APPENDIX 1

COMPLETE

IMMUNISATION SCHEDULE

The safest way to protect children and adults

The routine immunisation schedule				
Age due	Diseases protected against	Vaccine given and trade name		Usual site ¹
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio and <i>Haemophilus influenzae</i> type b (Hib)	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB) ²	MenB ²	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Meningococcal group C (MenC)	MenC	NeisVac-C	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	MenB ²	MenB ²	Bexsero	Left thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
One year old	Hib and MenC	Hib/MenC booster	Menitorix	Upper arm/thigh
	Pneumococcal (13 serotypes)	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO ³ or Priorix	Upper arm/thigh
	MenB ²	MenB booster ²	Bexsero	Left thigh
Two to six years old (including children in school years 1 and 2)	Influenza (each year from September)	Live attenuated influenza vaccine LAIV ⁴	Fluenz Tetra ³	Both nostrils
Three years four months old	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO ³ or Priorix	Upper arm
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-12 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal polysaccharide vaccine (PPV)	Pneumovax II	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax ³	Upper arm (subcutaneous)

¹ Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All injected vaccines are given intramuscularly unless stated otherwise.

² Only for infants born on or after 1 May 2015

³ Contains porcine gelatine

⁴ If LAIV (live attenuated influenza vaccine) is contraindicated and child is in a clinical risk group, use inactivated flu vaccine

Selective immunisation programmes

Target group	Age and schedule	Disease	Vaccines required
Babies born to hepatitis B infected mothers	At birth, four weeks, eight weeks and Boost at one year ¹	Hepatitis B	Hepatitis B vaccine (Engerix B / HBvaxPRO)
Infants in areas of the country with TB incidence \geq 40/100,000	At birth	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country ²	At birth	Tuberculosis	BCG
Pregnant women	During flu season At any stage of pregnancy	Influenza	Inactivated flu vaccine
Pregnant women	28-32 weeks of pregnancy	Pertussis	dTaP/IPV (Boostrix-IPV or Repevax)

¹ Take blood for HBsAg to exclude infection

² Where the annual incidence of TB is \geq 40/100,000 – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/393840/Worldwide_TB_Surveillance_2013_Data_High_and_Low_Incidence_Tables____2_.pdf

Additional vaccines for individuals with underlying medical conditions

Medical condition	Diseases protected against	Vaccines required ¹
Asplenia or splenic dysfunction (including sickle cell and coeliac disease) ³	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Cochlear implants	Pneumococcal	PCV13 (up to five years of age) PPV (from two years of age)
Chronic respiratory and heart conditions ³ (such as severe asthma, chronic pulmonary disease, and heart failure)	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Chronic neurological conditions ³ (such as Parkinson's or motor neurone disease, or learning disability)	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Diabetes ³	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Chronic kidney disease (CKD) ³ (including haemodialysis)	Pneumococcal (stage 4 and 5 CKD) Influenza (stage 3, 4 and 5 CKD) Hepatitis B (stage 4 and 5 CKD)	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine Hepatitis B
Chronic liver conditions ³	Pneumococcal Influenza Hepatitis A Hepatitis B	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine Hepatitis A Hepatitis B
Haemophilia	Hepatitis A Hepatitis B	Hepatitis A Hepatitis B
Immunosuppression due to disease or treatment ³	Pneumococcal Influenza	PCV13 (up to five years of age) ² PPV (from two years of age) Annual flu vaccine
Complement disorders ³ (including those receiving complement inhibitor therapy)	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (to any age) PPV (from two years of age) Annual flu vaccine

¹ Check relevant chapter of green book for specific schedule

² To any age in severe immunosuppression

³ Consider annual influenza vaccination for household members and those who care for people with these conditions

APPENDIX 2

BEREAVEMENT SUPPORT LEAFLET

Useful contacts:

Bliss – Bereavement support for families following the death of a premature baby.
Tel: 0500 618140 www.bliss.org.uk

Child Bereavement UK – Supporting families and educating professionals when a baby or child dies, or when a child is facing bereavement. Tel: 01494 446648
www.childbereavement.org.uk

Child Death Helpline – For anyone affected by the death of a child, from pre-birth to adult, under any circumstances.
Tel: 0800 282986
www.childdeathhelpline.org.uk

Childhood Bereavement Network – Information and advice about local and national services for bereaved children and young people. Tel: 020 7843 6309
www.childhoodbereavementnetwork.org.uk

The Lullaby Trust – Support for families bereaved through a sudden infant death
Tel: 0808 802 6868 www.lullabytrust.org.uk

Sands (Stillbirth and Neonatal Death Charity) – Support for families bereaved through a sudden infant death.
Tel: 020 7436 5881 www.uk-sands.org.uk

Winston's Wish – is the largest childhood bereavement charity and the largest provider of services to bereaved children, young people and their families in the UK.
Tel: 08452 030405 www.winstonswish.org.uk

Grief Encounter – Support for kids, teens, parents and professionals when someone dies. Tel: 020 8371 8455
www.griefencounter.org.uk



Enfield Child Death Overview Panel
Enfield Safeguarding Children Board
PO Box 59 Civic Centre
Enfield EN1 3SR
Tel: 020 8379 3012 or 2722
Email: CDOP@enfield.gov.uk



Enfield Safeguarding
Children Board

When a child dies

Information for
Families and
Professionals

www.enfield.gov.uk



The death of a child is always tragic. Talking and thinking about a child's death is a particularly sensitive and painful subject. However, it is vital that all child deaths are carefully reviewed, so as much as possible is learned from them to try and prevent future deaths, and to ensure that families are supported. This leaflet provides information that you may find useful.

What the Law requires

From 1st April 2008, the Government introduced a law which requires all local authorities, via their Safeguarding Children Board, to review the death of every child (up to the age of 18 years) in their area. This is because the Government believes that it may help other children and families in the future. This will be done in two ways:

1. Rapid Response

A rapid response by a group of key professionals, who come together for the purpose of enquiring into a sudden and unexpected death of a child.

This may mean a visit, within the first few days, to where the child died, by a police officer and/or health professional.

Most importantly, the rapid response will seek to ensure that support offered to the family is coordinated.

2. Review of all child deaths (under 18 years)

The Child Death Overview Panel, consisting of doctors, other health specialists and childcare professionals, must review and consider information on the circumstances surrounding each child's death. In Enfield, this usually takes place about six months after the child's death.

What is the purpose of a Review?

The Child Death Overview Panel will consider whether they should make any recommendations regarding services for children and their families. Recommendations may be reported to local health trusts, children's services and police, and, where appropriate, specialist agencies, such as fire services or traffic authorities. These recommendations may assist in the planning of services for children and families in the future.

Panel Meetings

In Enfield, the Chair of the Panel writes to all parents when the circumstances of their child's death are to be reviewed. Parents are invited to share any information that they want the Panel to know.

Unfortunately, it is not possible for parents or family representatives to attend Panel meetings.

All the information gathered is treated with the deepest respect and in strictest confidence. None of the findings, recommendations or reports will name the child or family.

The Coroner

All sudden and unexpected deaths must by law be reported to the Coroner and the police: for example, when the cause of death is unknown, due to an injury or following an operation.

The coroner may arrange for a post mortem examination to take place and hold an inquest.

For more information on the role of the coroner, please see the leaflet 'When Sudden Death Occurs', available online at: www.dca.gov.uk/corbur/sudden_death.pdf

The Coroner will be asked to share any relevant information concerning the death of the child with the Child Death Overview Panel.

For further information about the child death processes, visit London Safeguarding Children Board website: www.londonscb.gov.uk

APPENDIX 3 EPIP LEAFLET



WHO CAN BE REFERRED?

- If a parent is struggling with worries about their relationship with their baby as a result of Ante- or Post-natal Depression or anxiety.
- Parents who may have had PND with a previous baby and are concerned that these difficulties may arise again and are anxious about bonding.
- Parents can be referred ante natally if they are worried about how they might manage emotionally with their baby due to previous trauma or circumstances.
- If a parent has had difficulties in forming a bond with a previous child and is worried this may happen again.
- If a baby appears to be struggling more than expected with feeding, sleeping or other issues and parents are worried.



WHO CAN REFER?

We work closely with other professionals and welcome referrals from Midwives, Health Visitors, GPs, Perinatal and Hospital



based teams, Children's Centres, Voluntary Organisations, Social Care and many others.

The process for referrals will be to have an initial discussion with someone in the team to think about whether a particular family can be helped by EPIP.

If it is agreed that a referral should be made, the referrer will be asked to complete the referral form and return it to EPIP team.

WHERE ARE WE?

We are based in CAMHS premises at 265 Church Street, Edmonton, N9 9JA. We also see families at Children's Centres, Enfield Parents & Children's Centre and sometimes at their home.

FURTHER INFORMATION:

If you would like to find out more about our service or would like to discuss a potential referral please do contact:

Carol Levine (Team Lead)
020 8360 6771 or 07815 492535
carol.levine@enfield.gov.uk

Maggie Harris (Specialist Health Visitor)
maggie.harris@nhs.net

www.e-pip.org.uk



Enfield Parent Infant Partnership

Developing secure relationships between parents and their babies

A GUIDE FOR PROFESSIONALS



EPIP is a new service which has been set up in recognition of just how difficult it can sometimes be for parents and their babies in those first 18 months.

We see the importance of developing a strong and positive bond between parents and their babies and our aim is to support and facilitate those early attachments and relationships.

WHO ARE WE?

EPIP is a service which has been created, supported and funded by partners from Enfield Local Authority and NHS, Enfield Parents & Children, Enfield Children's Centres, and PIPUK.

We are a small team of parent infant psychotherapists, a specialist health visitor and a counselling therapist, who are able to work with families individually or in groups to help:

- address the worries parents may have about their relationship with their babies;
- address the difficult feelings that may arise



on becoming a parent;

- with the concerns parents may have about their baby's development and behaviours;
- work together with parents where they are finding parenthood hard to cope with.



WHAT WE DO:

Consultation:

The team offers consultation to anyone who is working with families in the perinatal period. We aim to help think through with others when there might be a concern or query around a parent's emotional state and/or a baby's behaviours, development or the family's circumstances.

The consultation may lead to a referral to EPIP or may be useful in considering other possibilities for a family.

Our Specialist Health Visitor may also offer to join the allocated Health Visitor for a consultation to meet with the family to help think through in more depth the concerns they may have about their baby.



Therapy:

We work with parents and their babies therapeutically to support the development of a sensitive bond between them. We aim to think together and notice communications between them and work through issues impacting on the relationship.

Sometimes parents may need some time on their own to explore issues that may impact on them being the kind of parent that they want to be. Families will be offered an initial meeting with one of the clinicians in the team, and a range of therapeutic support may be offered.

- Parent Infant Psychotherapy sessions.
- Specialist Health Visitor therapeutic support and guidance.
- Group work with parents and babies around developing positive relationships with each other.
- Individual Therapeutic Counselling Support.





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Public Health
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