




**Maternity Matters Early Adopter Site
Health Equity Audit of Access to Maternity Services
in SE London**

PROJECT REPORT

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PSA Delivery Agreement 19: Ensure better care for all

“ Women who are able to access maternity services for a full health and social care assessment of needs, risks and choices by 12 completed weeks of their pregnancy will have the full benefit of personalised maternity care and improved outcomes and experience for mother and baby. Improving access to maternity care will improve outcomes for mothers and babies by providing opportunities for women to make informed choices and share decisions about their maternity care”

(HM Government.2007.7).

Executive Summary

This report provides a summary of the learning from the process of conducting a Health Equity Audit (HEA) of timely access to maternity services in SE London.

HEA is a key tool, which embeds evidence on inequalities into mainstream NHS activity such as planning, commissioning and service delivery. The purpose of the Health Equity Audit is to support the narrowing of health inequalities by informing the planning and commissioning process on inequalities and to measure the impact of change.

The project was funded by the Department of Health. The work was conducted over 7 months on a part time basis.

The SE Sector

The South East Sector of London comprises Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Primary Care Trusts (PCT's). The provider units are:

- Guy's and St Thomas NHS Foundation Trust (GSTT)
- Kings College Hospital NHS Foundation Trust (KCH)
- The Princess Royal University Hospital (PRU)
- Queen Elizabeth Hospital NHS Trust (QEH)
- Lewisham University NHS Hospital Trust (LUH)
- Queen Mary's Hospital, Sidcup (QMH)

The aims of the project were to provide;

1. A baseline audit of each maternity provider for 2007 of,
 - The percentage of women who completed a needs, risk and choice assessment by the completion of the 12th week of pregnancy.
 - The percentage of women booking after 22 weeks of pregnancy.
2. A Health equity audit with the use of 'proxy fields' to identify those women at greatest risk of poorer outcomes.
3. Stakeholder consultation and mapping of planned and current provision in Children's centres and specific outreach services.
4. Evaluation of the process for conducting the audit.

Findings from the projects were;

Data

The poverty of data information systems within the sector.

The need for regular ongoing training and support for those within the provider units working with the data.

A lack of data sharing standards and agreements

A need for education regarding the safe transfer of data

Low inputs for some data fields making the final analysis less useful

The percentage of women who completed a needs, risk and choice assessment by the completion of the 12th week of pregnancy.

There was a need for clarification of what constitutes a needs, risk and choice assessment.

There are variations in provision for completion of the needs, risk and choice assessment. The influence of historical custom and practice in one unit, currently under review, demonstrates very low numbers of women booking for care before the end of the 12th completed week.

Completion of Needs, Risk and Choice Assessment by 12+6

UHL has the highest percentage (57%) of women accessing this service in a timely way, the PRU 39.3%, GSTT 35.1%, KCH 18.9%, QEH 18.2% and QMH 0.4%.

A number of interventions across the sector are being employed to address the need for women to be booked earlier, including 'catch up' clinics at the weekends and in the evenings and 'speed' booking.

Interventions aimed at advocates and other members of health teams to reduce infant mortality in Southwark, Lambeth and Lewisham are possibly positively affecting earlier booking times.

The demographics of the maternity population for each provider unit demonstrates differences in levels of poverty as measured by Index of multiple deprivation and ethnic background. KCH, GSTT, QEH and UHL have the majority of their users living in the two lowest quintiles.

Percentage of women booking 22 weeks and above.

The PRU had the lowest percentage (8.2%) of women booking after 22 weeks, the highest was QEH at 22.5%. The other units were GSTT 18.8%, KCH 15.1%, LUH 11.4% and QMH 10%. For the central London units, women transferring in after an initial booking elsewhere in the country, for clinical reasons affected these numbers.

A Health equity audit with the use of 'proxy fields' to identify those women at greatest risk of poorer outcomes.

Where there were more services and greater relative percentage of need and the provision of care more 'everyday', there was greater equity than where the numbers of women were smaller and there were correspondingly less specialised services. This was particularly apparent at the PRU and QMH.

Issues of capacity and growing demand had a larger influence on booking times than the particular characteristics of the women.

Women requiring interpreting services booked later.

Women with 5 or more children or undergoing their 6th pregnancy were represented in a higher proportion as booking after 22 weeks than women with fewer children.

Women who had mental health problems were well represented in the units where there was good interdisciplinary planning and service provision.

Women who accessed their care in the community were able to do so in a more timely way than those channelled through the antenatal clinic.

All the units had dedicated midwives for teenagers and for the most part this reflected in the data with a large percentage of young people completing their needs, risk and choice assessment by the end of the 12th week.

Mapping of current and planned provision of midwives in Children's Centres

Many of the Children's Centres are still being built. Whilst there are examples of the system working well for many others, the experience of working out of Children's Centres has optimised the word 'out' with poor clinical and office provision. Understanding of the midwives role has not, in many cases, been met.

Direct Access to midwives

Although there are 'pockets' of direct access to midwives, there are palpable anxieties of increasing resource requirements to meet this policy, once it is rolled out.

Recommendation

The main message is that through effective data recording and interrogation it is possible for local services and commissioners to identify, measure and track changes in demand and capacity and crucially the needs of the maternity population. This should include:

- Ability to record, interrogate data and provide reporting formats which are shared between providers and commissioners of local maternity services.
- Choice of maternity information systems which can capture relevant data items.
- Robust coding needs to be agreed so that interpretation becomes useful.
- A maternity data department to support effective fit for purpose function.
- Maternity data base staff who are skilled, trained and regularly updated.
- A comprehensive information sharing agreement integral to all maternity service specifications.
- Security level for systems is put in place to NHS standards.

There are some excellent examples of good practice in the SE Sector however:

- Whilst Children's Centres are being built, there is still time to plan for durable physical space and identity of midwifery provision.
- Supervision for midwives, especially around mental health, needs to be built into the system, as the expertise needed exceeds that of the midwifery supervisors. This is particularly the case where midwives do not regularly meet other members of a multidisciplinary team. Where midwives work more on their own, in the small, less central units, this is particularly the case.
- Cross sector learning and support should be encouraged and facilitated with the specialist midwives from all different locations meeting each other.
- Facilities to improve the use of interpreters should be instigated across the sector.
- Proportionally women, who have a parity greater than 5, book late usually after 22 weeks; opportunities arranged around childcare and school hours need to be instigated in the community, in venues such as Children's Centres, where women can access more easily.

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Contents

	Executive Summary
	Acknowledgements
1	Contents
2	Charts, Graphs, Tables, Diagrams and Appendix
3	Introduction

Background

7	Background Policy and rationale
11	What is a needs, risk and choice assessment
14	What is a Health Equity Audit
16	Aims of this Health Equity Audit

Enabling Access: The Qualitative data

19	Specialist midwives and assertive outreach
27	Children's Centres

Who, When and Where? The Quantitative data

35	Profile of the sector
45	GSTT
53	KCH
65	UHL
69	PRU
73	QEH
77	QMH

Conclusions, Reflections and Recommendations

83	Data collection
90	Coding
103	Recommendations
104	Conclusion

Appendix

Charts, Graphs, Tables, Diagrams and Appendix

List of Charts

- 29 Access routes to maternity/midwifery care in the 6 provider units in SE London
- 28 Current and planned midwifery provision in Children's Centres.
- 90 Coding of the proxy Fields

List of Graphs

- 40 Gestation at completion of Needs, Risk and Choice Assessment in SE London
- 42 Ethnic Profile of Maternity users in SE London
- 41 Index of Multiple Deprivation (IMD) of Maternity users in SE London

- 45 Bi-variant analysis with gestation and proxy fields for GSTT
- 53 Bi-variant analysis with gestation and proxy fields for KCH
- 65 Bi-variant analysis with gestation and proxy fields for UHL
- 69 Bi-variant analysis with gestation and proxy fields for PRU
- 73 Bi-variant analysis with gestation and proxy fields for QEH
- 77 Bi-variant analysis with gestation and proxy fields for QMS

List of Tables

- 43 Gestation at completion of needs, risk and choice assessment, ethnicity and IMD for the SE Sector
- 49 Table of Bi-variant analysis of GSTT data using excel
- 60 Table of Bi-variant analysis of KCH data using excel
- 67 Table of Bi-variant analysis of UHL data using excel
- 71 Table of Bi-variant analysis of PRU data using excel
- 75 Table of Bi-variant analysis of QEH data using excel
- 79 Table of Bi-variant analysis of QMH data using excel

List of Diagrams

- 15 Health Equity Audit Cycle
- 89 Flow chart for conducting a baseline health equity audit within maternity services

List of Appendix

- i Euroking
- ii Data systems in SE Sector questionnaire
- iii Data of Proxy fields available in SE
- iv Access to midwives questionnaire
- v Current and planned provision of midwives in Children's Centres questionnaire
- vi The Healthcare Commission Review of Maternity services in 2007

Introduction

In January 2008, a climate of opportunity for information, and a willingness to help, encompassed the commencement of this Health Equity Audit (HEA) from the six maternity providers in SE London. The six providers are Guys and St Thomas NHS Foundation Trust (GSTT), Kings College Hospital (KCH), Queen Elizabeth Hospital, (QEH), Queen Marys Hospital (QMH), The Princess Royal University Hospital (PRU) and University Hospital Lewisham (UHL). The data set was large; 29,230 individual entries with a multiple collection of fields. It began in the shadow of the Health Care Commission report (Healthcare Commission, 2007) and before the recommendations of the latest Confidential Enquiry into Maternal and Child Health (Lewis, 2007) could be put into place.

The HEA aimed to ascertain primarily, which women in the SE sector of London were able to access their, 'Needs, risk and choice assessment' by the end of the 12th completed week of pregnancy, and those who accessed maternity services after 22 weeks of pregnancy.

This report is colour coded. Orange is the optimum and signifies most importantly compliance with the PSA 19 (HM.Government, 2007) indicator of completed needs, risk and choice assessment by the end of the completed 12th week. Yellow represents women who book after 22 weeks of pregnancy and Green those who book between these two dates.

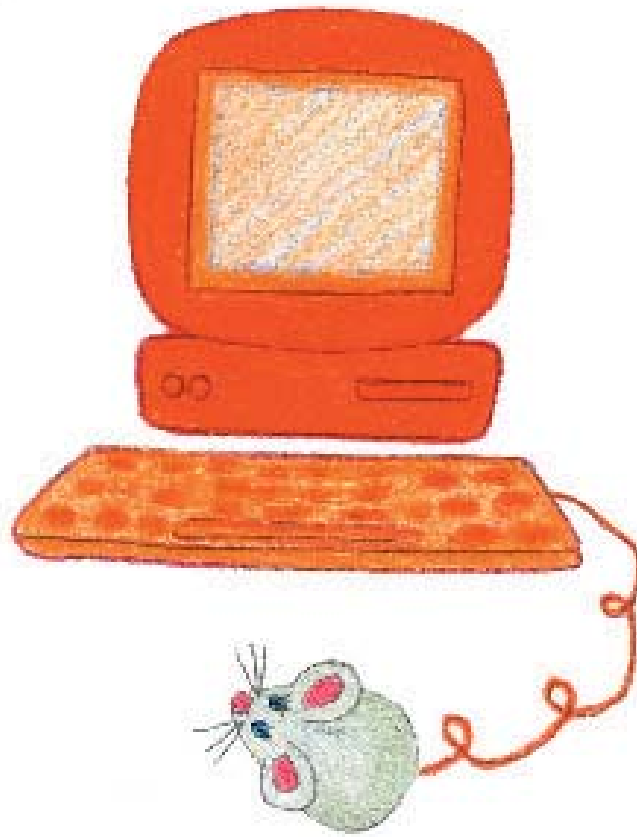
The project data collection was undertaken over five months on a part time basis and the lessons learnt were significant. In sum, the audit in spite of positive 'buy-in' by the six trusts concerned, was more challenging than had been anticipated. What became apparent was the poverty of data systems within a number of units. Indeed it was not until the ultimate moment of the project, that data was produced. Although this has affected the level to which the data has been analysed, this report is concerned with the process and challenges and the learning which can be taken forward. Significantly, issues such as the recording and sharing of data, training around data management, resource implications for providers with the introduction of direct access to midwives and a wealth of wonderful examples of emerging good practice are shared herein.

Owing to the timescale of the project it was not possible to present a rigorous description of all the outreach practices for each unit, only an overview and one or two examples of practice from each.

In interviews, consultations and sharing of the objectives of the project, there has been a level of uncertainty about the meaning of the needs, risk and choice assessment. A number of current policy and guidance documents, namely the NICE Antenatal Guidelines launched in April 2008, the PSA 19 Indicator (DH, 2007) and the NHS Operating Framework (DH/NHS, 2007) clarify the meaning. These will be summarised in the report.

Midwives are currently facing increasing service demands compounded by relative shortages of midwives and places where care can be provided and accessed. Between 2002/3 and 2006/7 there was an increase in the birth rate in London of 17% (Truttero, 2007). It is not the intention of this report to heap all the responsibility onto the midwives for improving data, rather, it lies with the commissioners to ensure that systems, software and training are in place to make data entry easier. Only then, when the data is truly reflective of the population it represents, can audits track improvements and direct service delivery.

The report is aimed at policy makers, commissioners and providers of maternity services. It is hoped that it will be cascaded to midwives inputting the data. It has been presented as far as possible in a visual way, but charts and plenty of numbers parade the report too. They should be looked at in unison. It is a beginning, it makes no claim of polish or answers but hopefully it will be the start of conversations.



Background

Policy Background and Rationale

Early and timely access to maternity care is pivotal in improving outcomes for both mother and baby.

Confidential Enquiry into Maternal and Child Health

In 'Saving Mother's Lives' it states that,

"Around 20% of the women who died from Direct or Indirect causes either first booked for maternity care after 20 weeks gestation, missed over four routine antenatal visits, did not seek care at all or actively concealed their pregnancies" (Lewis, 2007.x).

The report asserts that,

"Maternity service providers should ensure that antenatal services are accessible and welcoming so that all women, including those who currently find it difficult to access maternity care, can reach them easily and earlier in their pregnancy. Women should also have their first full booking visit and had hand held maternity records completed by the 12 completed weeks of pregnancy" (Lewis, 2007.x)

The Women as central; Changing Childbirth to Maternity Matters

Behind the instigation for this Health Equity Audit are a comprehensive list of reports and policy guidance, which span as far back as Changing Childbirth (DH, 1993). This marked the beginning of a culture of care designed around the needs of mother and baby rather than being service driven.

The National Service Framework for Children, Young People and Maternity Service

In 2004 the National Service Framework for Children, Young People and Maternity Service (NSF) set out national standards for ensuring that pregnant women would receive optimal care, improved access and that the needs of different communities would be addressed. There was a priority to tackle inequalities.

Maternity Matters

Maternity Matters (DH, 2007), the implementation document for the NSF (standard 11) clarified the Governments commitment to modernising NHS maternity services. It includes improving access to care. It asserts that by 2009 women and their partners will have choice of how to access maternity care,

"When they first learn that they are pregnant, women and their partners will be able to go straight to a midwife if they wish, or to their General Practitioner. Self Referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services" (DH, 2007.12).

" Women and their partners may choose antenatal care to be provided by midwives in the community or by the midwifery team. However, for some women care from a team of maternity professionals, including midwives, obstetricians and other specialists will be the safest option. For others, who have complex social needs, maternity care can best be produced in partnership with other agencies. These could include children's services, domestic abuse teams, substance misuse services, drug and alcohol teams, youth and teenage pregnancy support services, learning disability services and mental health services" (DH, 2007.14).

Making it better for mother and baby

Shribman, 2007 emphasises the importance of early access,

"Early contact with a midwife is very important since it gives more time for informed choices in planning their care and ensures women can take advantage of all support and tests..." (Shribman, 2007.6)

Ascertaining information about possible risks and need that will inform care planning and multidisciplinary referrals with the woman and her family will form the basis of the needs, risk and choice assessment.

Building on the Best, Choice, Responsiveness and Equity in the NHS

In the white paper entitled 'Building on the Best, Choice, Responsiveness and Equity in the NHS' (DH, 2003) the lived experience of negotiating health services for more vulnerable populations was recognised,

"All of us-not just some among the affluent middle classes-want the opportunity to share in decisions about our health and health care, and to make choices about that care where appropriate; we want the right information, at the right time, as well suited to our personal needs as possible...our health needs are personal, and we would like services to be shaped around our needs, instead of being expected to fit the system" (DH, 2003.7)

A Framework for Action

In a Framework for Action (Darzi, 2007.) choice, preventative care and a focus on health inequalities are recommended as ways of tackling inequalities in health. Pregnancy may represent the first time a woman and her family access health services and the needs, risk and choice assessment is an ideal opportunity to discuss with them their options in maximising the health of their babies, their families and themselves;

" As part of the booking process, a midwife should carry out an early needs assessment on the expectant mother, with the resulting needs profile informing their subsequent antenatal care. Women with high medical needs, for example, would need additional obstetric antenatal care. Women with high social needs (for example women with mental health problems or misusing alcohol or other substances) would need active help to engage them with relevant services and co-ordinate care across multiple agencies" (Darzi, 2007.45).

Towards a better birth, a review of maternity services in England

The recent Healthcare Commission report, 'Towards better birth, 'A review of maternity services in England' (2008) describes it succinctly as giving an opportunity for midwives to provide women with information on a healthy pregnancy, to agree a care plan with the woman including offering information about screening tests, taking risk factors into account and for women to ask questions and express concerns.

Public Service Agreements

More recently two Public Service Agreements (PSA) have added increased weight to improving the time at which women complete their needs, risk and choice assessment. PSA targets or indicators set out what organisations agree to deliver in return for funding, they key improvements that the public can expect from Government expenditure.

The Review of the Health Inequalities Infant Mortality Public Service Agreement (PSA) Target highlighted the link between health and life expectancy with social circumstance and poverty.

“ Infant mortality is a sensitive measure of the overall health of a population. It reflects the apparent association between the causes of infant mortality and other factors that are likely to influence the health status of the whole population, such as their economic development, general living conditions, social well being, rates of illness and the quality of the environment” (DH, 2007.11).

The Government in response has set a national health inequalities PSA target. This is:

“To reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth” (DH, 2007.11).

Actions considered by the Health Inequalities Unit at the Department of Health to contribute to this target included timely and early access to a needs, risk and choice assessment.

Public Service Agreement 19, indicator 4 makes the needs, risk and choice assessment a priority,

“Women who are able to access maternity services for a full health and social care assessment of need, risk and choices by the 12th completed weeks of their pregnancy will have the full benefit of personalised maternity care and improved outcomes and experience for mother and baby” (HM Government, 2007.5).

The NHS in England: The Operating Framework for 2008/09.

Further impetus has been added by the NHS in England: the Operating Framework for 2008/09. This sets out the business and financial arrangements for the NHS. It describes the principles for the year that include a list of indicators by which performance can be measured across a range of commissioning responsibilities. It recognises the importance of access generally for all health care;

“Improving access to services will not only help to improve the patient’s experience but will deliver real improvements in health outcomes” (DH/NHS, 2007.12).

The Operating Framework emphasises that maternity is an area in which commissioners are required to take action and indicates that they should aim to;

“Increase the percentage of women who have seen a midwife or a maternity healthcare

professional for a health and social care assessment of their need, risk and choice by 12 completed weeks of pregnancy” (DH/NHS, 2007.19).

“New and different types of care will be designed to meet the needs of all women and their families who need additional support such as outreach services for those who traditionally do not access maternity care early in their pregnancy” (HM Treasury, 2007.7).

In sum the 12 week indicator, which has been integrated into the NHS Operating Framework outlines the priority to improve health outcomes by ensuring early, timely access to a ‘booking’ assessment and to reduce inequalities in health by targeting excluded or vulnerable women. This audit aims to provide a basic picture of how many women in 2007 were accessing their booking assessment by the end of the 12th completed week in the SE Sector and a mapping of what interventions were currently in place to address inequalities, such as additional midwifery support.

Choice, Needs and Risk

The Governmental agenda has shaped the emergence of a modern maternity services designed around the woman rather than service led. The needs, risk and choice assessment, more commonly known as the 'booking' appointment, is the point at which a full social, physical and psychological history is taken usually by a midwife. This information then provides the baseline for planning and delivering individualised care with providers working in partnership with the woman and her family.

"Each pregnancy is different and each woman has different social, physical and emotional needs as well as specific clinical factors that may affect her pregnancy. Good maternity services place the mother and her baby at the centre of care and plan and provide services to meet their needs" (DH, 2004.7).

All women, Maternity Matters outlines, should, at the beginning of their pregnancy,

"...have a discussion with their maternity professional about their individual needs and preferences. Each woman will undergo a standardised risk and needs assessment to help her in her decision making process" (DH, 2007.13-14).

The all (women) is important here because it recognises that any woman's risk, needs and choices cannot be apparent until she undergoes this assessment. The advantage of making it a standard means that asking sensitive questions around issues such as domestic abuse or weight become de-stigmatised.

Choices

In the preface to the white paper 'Choosing Health' (DH, 2004) the then Health Secretary acknowledged that people want to take responsibility for their own lives and they wanted the appropriate information to help them make these changes and to have informed choice.

The whole antenatal period up to the completion of the needs, risk and choice assessment must be centred around providing the woman with information to enable her to make informed choices about her care and to be an active participant in planning care pathways according to need. Women need to know for example; what screening tests are offered and why, information about lifestyle options such as smoking cessation, diet and exercise, choices about antenatal care, where to birth their baby and antenatal appointment schedules.

What is meant by choice and shared decision-making is clarified in the NICE guideline for antenatal mental health where it clearly stated that,

"Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Carers and relatives should have the chance to be involved in discussions unless the patient thinks it inappropriate" (NICE, 2007.3).

Within mental health the guidelines stipulate that the healthcare professional should discuss with the woman the absolute and relative risks associated with treating or not treating the mental disorder during pregnancy and the postnatal period. Information should be given which is culturally sensitive and include the impact of the disorder and on health of the mother, fetus or child including the side effects of medication (NICE, 2007). This is the underlying principle that needs to be applied across the board to all the issues in the needs, risk and choice assessment.

The Healthcare Commission (2008) emphasises the importance of not just giving women leaflets but recognising the significance of personal discussion about care.

Communication should be presented in a variety of formats according to need and in a timely manner so that women are given time to consider the information before deciding. Provision should be made for interpreting and translation services and family and friends should not be used. Women and their family may need to be referred to specialist medical teams or support organisations to help them make, at times, difficult decisions (NICE, 2008).

Risks and needs

Risks and needs go together, one cannot occur without the other. The Antenatal guidelines released in the spring of this year clearly outline what is meant by assessing risk. Women who are at higher risk, because of physical, psychological or social reasons are known to have poorer outcomes for themselves or their babies (Lewis, 2007). The guidelines advise, therefore, that the reason for the assessment is to identify these women and provide the additional support they need.

Among the clinical conditions identified by NICE (2008) are psychological disorders, epilepsy requiring anti-convulsant drugs, severe asthma, HIV or HBV infections, women who are obese or underweight, women who smoke, haematology disorders, renal disease and cardiac disease including hypertension. For the most part this information can be gained by asking the woman, however the last CEMACH (Lewis, 2007) report recommended that new migrant women should be offered and heart and lung examination early in their pregnancy. This is because they may not be aware of any problems. Women who are vulnerable because of their youth, immigration status or English language skills for example should be identified and accordingly be provided with additional care.

“Women with high social needs (for example women with mental health problems or misusing alcohol or other substances) would need active help to engage them with relevant services and coordinate care across multiple agencies” (Darzi, 2007:45).

The NICE guidelines clarify screening offered to women for gestational diabetes, Down's syndrome, Sickle cell and thalassaemia. Women who present who have had previous problematic pregnancies such as recurrent miscarriages, preterm birth, large or small for gestation babies, haemorrhage in the antenatal or postnatal period, previous uterine surgery including Caesarean Sections, severe pre-eclampsia or blood group antibodies should also be offered enhanced care and appropriate referral.

Clarifying the optimum time period for the Needs, Risk and Choice assessment.

The antenatal guidelines (NICE, 2008) both for professionals and the version aimed at women both say that the booking appointment follows the first contact with a health professional. What the first contact constitutes is not stipulated but is meant to highlight that when the woman and midwife meet the woman has already received information. The PSA 19, indicator 4 stipulates that the assessment should be completed by the end of the 12th completed week, completed is the important word and reminds us that it may be a number of encounters between woman and health care provider.

The antenatal guidelines recommend that the booking appointment is conducted ideally by the 10 week. This is so that women who may need additional care are identified early. Ideally screening for sickle cell disease and thalassaemias should be offered to all women before the 10th week of pregnancy.

Earlier consultation or encounters may be on a continuum between talking to a midwife on the telephone, reading leaflets sent through the post, early pregnancy sessions in the community or hospital or one to one consultations. Information may be through specialist services such as problematic addiction clinics, through community mental health workers, via specialist medical teams or early pregnancy units.

The end of the booking period marks the end of a full baseline assessment but it does not undermine the fact that further information may be shared later in the pregnancy as relationships of trust are established. An example of this may be women disclosing domestic abuse. This may not always be shared or disclosed, for example because a member of the family is present. It is imperative that the maternity provider creatively makes provision to ask and give information at a later date.

What is a Health Equity Audit (HEA)?

Health Equity Audits are a tool, which enable commissioners and providers to ensure that resources in staff and money are directed towards reducing inequalities.

Definition:

There is a difference between health inequality and health inequity:

“Health Inequality describes the difference in health experience and health outcomes between different population groups according to socio-economic status, geographical areas, disability, gender or ethnic group.

Health Inequity describes difference in opportunity for different groups, which result in unequal chances (For example access to services).

Health Equity Audits focus on how fairly resources are distributed in relation to the health needs of different groups” (Hamer et al, 2003.11)

Health Equity is a process by which local parties are:

- Able to review inequalities in access to effective services and their outcomes for a defined population.
- Ensure that actions to address inequity are incorporated into local plans, services and practices.
- Evaluate the impact of the action taken on reducing inequity and modify as necessary.

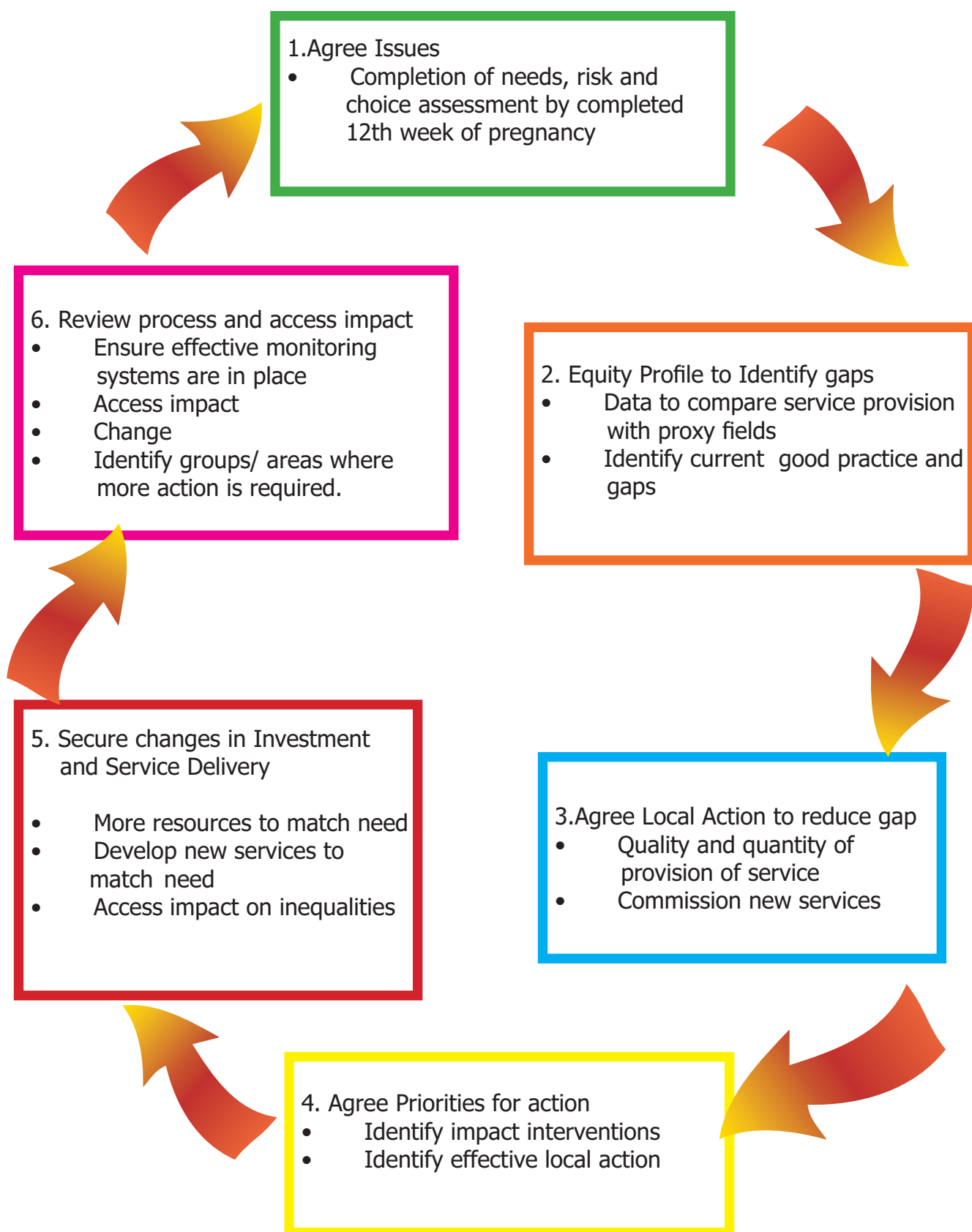
It can;

- Inform the commissioning of services to better meet the needs of groups currently underserved
- Help identify where particular forms of working are effective and to distinguish where new services need to be commissioned for people with the poorest outcomes.
- Contribute to local performance management by providing data according to identified priorities, for example Public Service Level Agreements (PSA).
- Highlight with proxy fields whether the needs of vulnerable people are being met (Hamer et al, 2003).

Health Equity Audit is a cyclical process whereby actions taken are reviewed in relation to regular analysis of data. This can be depicted as a diagram (Diagram I).

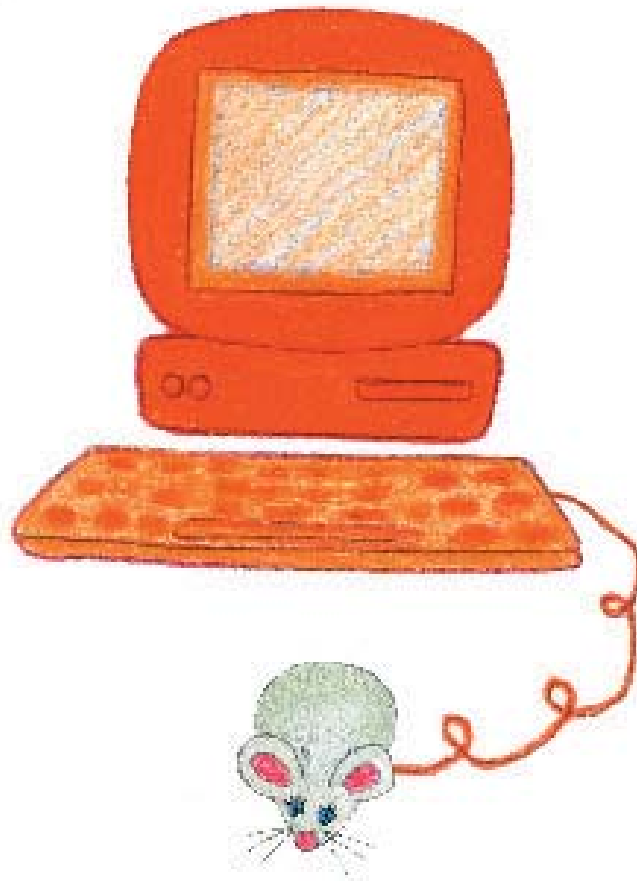
Re-auditing is a central aspect of the audit cycle. If the initial data collection and analysis demonstrates ‘room for improvement’ data collection and analysis should be re-run once changes to the service have had time to make an impact. Depending on the nature of the changes this could take weeks or months. The process of collecting data, analysing it, taking action and reassessing should be conducted until the results of the audit meet the benchmarked standards (NICE, 2008). The overall aim is not to distribute resources equally but in relation to need. Changes in investment and services as a result of health inequity will aim to reduce avoidable health inequalities and promote equal opportunities to the determinants of good health.

Diagram No 1 Health Equity Audit Cycle Adapted from (Flowers,2003)



Aims of this Health Equity Audit

1. Baseline audit of each maternity provider for 2007 of,
 - The percentage of women who completed a needs, risk and choice assessment by the completion of the 12th week of pregnancy.
 - Percentage of women booking 22 weeks and above.
2. Health equity audit with the use of 'proxy fields' to identify those women at greatest risk of poorer outcomes.
3. Stakeholder consultation and mapping of planned and current provision in Children's Centres and specific outreach services.
4. Evaluation of the process of conducting the audit to,
 - Identify organisational gaps and barriers in completing this process to inform business planning processes in each locality.
 - Identify detailed practical steps to achieve completion at the highest level, eg ability of data systems to be able to produce outcomes based on monthly, quarterly and annual reports, to track improvements and how equitable access is to maternity services.
 - Identify the best systems to implement direct access to



Enabling Access: The Qualitative data

Specialist midwives and Assertive outreach services

This section looks at provision in Children's Centres and assertive outreach services for women who are less likely to access and engage with maternity services, for example, women who have problematic drug and/or alcohol use, women with mental health problems, teenagers, asylum seekers and refugees. The information given here is intended as a snapshot of emerging good practice rather than a fully comprehensive mapping.

The specialist midwives, funded frequently from an external source, are in a position to offer more time to individual women in need. They describe it as a different way of working that can enable more vulnerable groups to access and engage with services.

Women with mental health problems

At GSTT and KCH there are dedicated interdisciplinary teams supporting women with serious mental health problems. These teams, named Mappin and Brierley are integrated with perinatal psychiatric services. Women are referred to the midwives from within mental health services, via the GP, following initial needs, risk and choice assessment; where a need is identified or women may access the teams directly. Not all women can be looked after under the umbrella of Brierley because of capacity and demand issues (Demilew, 2007) but the women may still be appropriately referred to the psychiatric team and the midwife given advice and support for their care.

At QMH in Sidcup, women who are risk assessed as vulnerable are discussed at a Pregnancy Support Team meeting. Members include, antenatal clinic counsellor, child protection specialist, a social worker and a midwife. The counsellor links with the MINHS, a mental health service. Although there no perinatal psychiatrist it is felt that the unit had fluid access to services, in particular the Royal Bethlem Hospital. At the PRU the midwife who specialises in mental health works closely with the Maudsley and the Royal Bethlam.

A psychiatrist, a midwife from Best Beginnings Team and an Obstetrician make up the TIME team which provide specialist care for women with mental health problems at QEH.

Teenagers

All the provider units have midwives who specialise in looking after young people. For some provider units this translates as teams, for others individual midwives, for some the teenage pregnancy strategy work is a percentage of a broader work stream. In Lewisham, engaging with teenagers who are pregnant actions out of Connexions. The midwives describe working within a supportive team and an excellent virtual team that includes reintegration officers, young father workers, a sexual health nurse, benefits advice workers and key workers for Sure Start Plus. They meet once a month, support each other and share information.

"Our philosophy of care is that we visit around the woman's needs"
Tania Pearce, Teenage Pregnancy Midwife.

The Bessemer Midwifery Practice is a Team of 5 midwives working together to provide care and support to young people, less than 19 years of age. The teenagers are referred to the team by GP's, Health Visitors, Social Workers, Sure Start/Children's Centers Connexions workers and women self-refer. The team provides care and support antenatally, intrapartum and post-natally. The team provides 24-hour cover and continuity of care. The majority of the women are booked by the team and there is a drop in clinic for follow-ups. All the young women are offered a 36/37 week Home Visit for a birth discussion to enable the midwife to know them better. They are offered homebirths, however this is not always possible because of housing needs. The Team works closely with the young father workers from Lambeth to provide support for the young fathers.

"We aim to support out young people to look after their health both for themselves and the wellbeing of their babies"
Eunice Ximes, Bessemer Team midwife

Asylum Seekers and Refugees

Historically, GSTT did have a dedicated service for asylum seekers and refugees, however with the National Asylum Model (NAM) dispersal scheme, the reduced numbers of asylum seekers locally, meant that any additional support is provided by Children's Centre midwives providing enhanced care.

In Bermondsey, a Children's Centre midwife, Hannah Rodgers works closely with the Refugee Health Team and practices assertive outreach to help asylum seekers and refugees to access care. She produced a booklet which provides useful information for professionals working with this group of women on how to access services, including the GP, Midwife, Sexual Health, Health visitor and Children's Centres. The booklet also contains information about national and local support services, housing and home support and accessing funds. At a refugee health day she 'manned' a stall and talked to everyone about how to access a midwife in the UK. She felt that the experience had taught her that she could sell double-glazing in the summer, but more importantly that the women had been very receptive.

Pregnant and want to talk to a midwife?

MIDWIFE DROP-IN SESSION

Mondays – 1-3 pm (Not Bank Holidays)

Kintore Way Children Centre

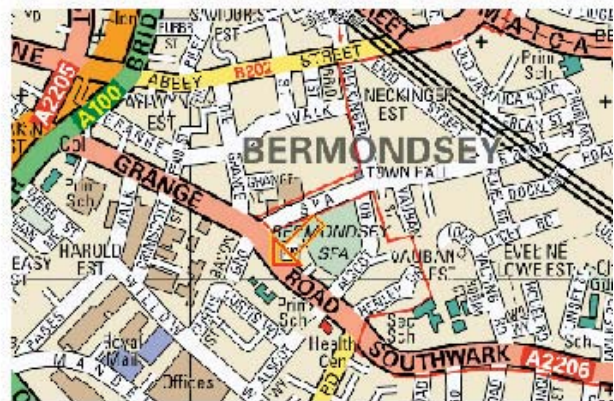
GRANGE ROAD

SE1 3BW

- Come and talk to a midwife
- Antenatal Checks
- Breastfeeding support



Hannah Rogers
Midwife
07950 424 782



Another Children's Centre midwife had been 'in trouble' for providing care and a needs, risk and choice assessment for two women who had been unsuccessful in their asylum claim. They had been refused care at a GP surgery.

The African Well Woman's Clinic



- The clinic provides support, information and advice to women/girls who have undergone Female Genital Mutilation. We also provide a one stop clinic for surgical reversal of FGM.
- For more information and referrals please call **Comfort Momoh (MBE) FGM Specialist on 02071886872 or 07956542576 or page her on 08700555500 (Code:881018)**
comfort.momoh@gstt.sthames.nhs.uk
- Also provide training, conference and seminars for all professionals world-wide

Female Genital Cutting (FGC/FGM)

A Well Women clinic at GSTT offers a service for women who have been affected by circumcision. The women can self refer or are referred by professionals. Comfort Momoh, a midwife, who runs the clinic, has observed that there are an increasing number of women being referred to the clinic after the needs, risk and choice assessment.

Assertive outreach for women with problematic drug and /or alcohol use

At KCH, women with problematic drug or alcohol use can access the Woodvine clinic. Here a 'one stop shop' with an addiction specialist, a midwife, a drug worker and a substance misuse nurse work together. Women access the service in a number of ways. Most women are referred from drug agencies and midwives through the perinatal meetings. Referrals are also received from prisons, probation, voluntary organisations, social services and GP's. In 2007 there were 65 referrals.

*"We practice assertive outreach to engage all clients referred"
Tracey Gage. Specialist midwife for women with problematic addiction*

The River Team at QEH has a dedicated midwife within a multidisciplinary team. Many of the referrals are from a drug agency in Woolwich, the Beresford Project. Sue Watson the midwife has noted that 5-6 years ago the women were booking at 10+ weeks gestation but now they are accessing her earlier at 6-8 weeks. Women can ring directly or drop into one of the clinics. There are posters in toilets etc but the scheme is working well largely due to word of mouth, the midwife being known and visible in the community. In 2007,16 women were helped by the River Team.

*"Women can ring me directly and I provide care up to six months postnatally"
Sue Watson. River Team Midwife*

At UHL there is a multidisciplinary team within the hospital but no outreach team in the community.

A community midwife, Sue Sampson, based in Welling and Belvedere describes her role as a liaison midwife for women with problematic addiction. Women access the specialist midwife in the community, either directly or via another community midwife, or via Signpost, a drug and alcohol service in Bexley. The women are fast tracked into the service. Previously there had been a specialist clinic, the Willow clinic, which was held at the hospital with a GP, drug worker and midwife working together, but a reduction in client numbers meant that it was curtailed. Today, she works as a liaison midwife, advising and supporting other midwives to provide care. If the midwife is not confident in providing care for a particular woman she will take over the care.

*"Ideally I would like a service where women can text you and get hold of you easily...we also need fliers that are attractive and visible"
Sue Sampson Community Midwife*

Best Beginnings Team

The Best Beginnings Team looks after women with additional needs such as domestic violence disclosure, mental health problems, asylum seekers and women, who, because of particular circumstances find themselves socially excluded. The midwives provide enhanced care during pregnancy and early parenthood. The aim of the team is to address inequity and inequality by providing additional support.

*"We work closely with other multi professional agencies to ensure we deliver an enhanced level of care in the Greenwich Borough to all vulnerable women and their families, throughout the child bearing process".
Vlora Hindley, Best Beginnings Midwife.*



Early pregnancy/ Pre-Conceptual Clinics

The sector has a number of early pregnancy sessions, providing a means for women and their partners to make contact with the maternity services and to get information to better enable them to make informed choices. The longest running of this sort is held monthly in the evening in the antenatal clinic at the PRU, but other units have followed suit including KCH. At the PRU, external organisers have stalls where women can find out more information dependent on their interest. Information such as; smoking cessation, water births, breast-feeding, homebirths, car safety and doulas are just some of the topics covered. A smaller, local session is held in Bellingham by a Children's Centre midwife.

Early Pregnancy Session

Find out about:

- Staying Healthy
- Exercise
- Healthy Eating
- Scans, tests etc.
- Birth Choices
- Feeding your baby
- Get your questions answered and more

Planning a pregnancy or just found out you're pregnant?

What happens next?

Come to our friendly and relaxed session, and meet a Midwife.

Partners and friends welcome.

Dates and venues for sessions coming up:

27 February, 12.30-2.30pm	Seminar room, Antenatal Clinic, Lewisham Hospital
19 March, 7-9pm	Bellingham Children's Centre 109A Randlesdown Road
23 April, 6.30-8.30pm	Waldron Health Centre, Stanley Street, New Cross, SE8

For more information visit www.lewisham.nhs.uk/earlypregnancy/ or phone Community Midwives Office on 020 8690 5036

"A Polish women saw our poster in a local supermarket and came to the early pregnancy session; she was asked to come the next day and I booked her...she was approaching 10 weeks ...if she had gone through the normal channels of seeing a GP and then being referred to a midwife it would have taken ages, she wasn't even registered with a GP, she did not know how to"...

"A woman expecting her first baby was quite anxious, partly because she was disabled. She came to the early pregnancy session and was able to ask lots of questions. She left reassured with my phone number and kept in touch throughout her pregnancy and text me when her son was born...she is eager to join the MSLC"

..." A teenage couple wondered in asking for pre-conceptual advice...we talked about diet, smoking, alcohol, responsibility of parenthood, finances etc...they decided to wait a few years to become more healthy and independent."

Sue Rowlands. Children's Centre Midwife

In UHL, the midwife who specialises in providing care for women with diabetes runs a pre-conceptual, early pregnancy clinic. GSTT has just commenced a Diabetes Preconceptual Care in the community project.

Reducing Infant Mortality

In Lambeth and Southwark, external consultants have been working on interventions to reduce infant mortality. This has included working within Children's centres and other venues with a broad spectrum of people who interact with potential parents and pregnant women (Rowe and Benson, 2007).

Work under the same umbrella of need consultations has been conducted in Lewisham. The work looks at early and easy access to midwives, the availability of free pregnancy testing and awareness in the community, for example the 170 Project in New Cross, (Cross, 2006). This project helped to develop the poster for the early pregnancy sessions in Lewisham. Women stated that they wanted a picture where the woman was obviously pregnant even though the message was to attend early. most importantly, was the message about pregnancy and where to go. These leaflets are available on the website for the PCT, in local libraries, GP Clinics, pharmacies and in Children's Centres. Part of the work being conducted by Pauline Cross is to talk to a diverse group of service users about direct access to maternity care.

A picture of Health

Paulette Lewis is currently leading a project-offering women choice regarding where they choose to have their care. The project spans UHL, QEH, PRU and QMS and entails a woman having an early pregnancy meeting with one of the project midwives. At this meeting the women is provided with information about the different provider units.

Children's Centres

The table opposite illustrates that Children's Centres are increasingly becoming part of the landscape of midwifery care in the community. The provision within these facilities varies. In the ones near the PRU the facilities for midwives are excellent whilst others in the sector have nowhere for the midwife to conduct care; no couch, hand washing or waiting facilities. Although there are some examples of excellent work in Children's Centres, a number of midwives talked about being sidelined into education and about colleagues in the team not understanding their role. Although the psychology of the Children's Centres is that they should be 'part of the local community' and 'women and child friendly' the midwives found that they were not midwife friendly, as for some there was no office space or facility for women to drop in and the architecture of the building was not inviting, women having to be buzzed in through the front door.

It became apparent during the course of meeting midwives that there is an undercurrent of uncertainty with regard to the continued funding of specialist roles. One midwife said,

"I am really passionate about this job. I was re-interviewed for it because there is a chance that it may have disappeared. Continuity is important and people building the service up...these initiatives are built on, and sustained on the personal interests and passion of individual practitioners with little back up or recognition".

A relaxed welcoming atmosphere, a cup of tea and a 'mini Battenberg' or 'Fairy cake' were often the ingredients that were the starting point for engaging some vulnerable women. Group sessions/ discussions/ Baby massage groups/ drop in session are made friendlier and for some a real treat. Yet funding is not always available to cover these costs and it becomes custom and practice that midwives pay for these items themselves.

Although some of the midwives interviewed had excellent creative partnerships within the Children's Centres the issue about supervision was a common one. Although all midwives have a named Supervisor of Midwives who they can ask for advice and support, the increasing role of caring for women with specialist needs means that this is often not enough. Although many midwives felt supported especially when they worked in multidisciplinary teams there is a clear need for broader provision of specialised supervision around issues such as mental health, domestic violence and problematic addictions.

**Mapping current and projected provision within Children Centres
Chart of Current and planned midwifery provision in Children Centres**

<p>GSST</p> <p>5 Children Centres and a further 5 planned Midwives working in Traditional care, additional midwifery support and case load models of care</p>	<p>KINGS</p> <p>6 Children Centres with a further 2 planned and 3 in Southwark. In Southwark some mainstream antenatal clinic provision with an antenatal clinic and a drop in plus additional midwifery support</p>
<p>Currently a 3 year contract with Lambeth Early Years for Children Centre midwives jointly between GSST and Kings. Core service provision with flexibility to the needs of the women. Work to include antenatal and postnatal group sessions, baby massage, 1:1 support for vulnerable women and Breast feeding support including a café or group</p>	
<p>UHL</p> <p>There are currently 6 Children Centres with midwives working in/ out of 2 providing additional care, smoking cessation and some parentcraft. Vision is to move more midwives from GP practices to Children Centres and Health Centres. Plan to offer free pregnancy tests from Children Centres</p>	<p>PRU</p> <p>17 designated Children Centres which are gradually becoming operational for midwifery services. Currently operating from 4 with additional midwifery care, parent education, traditional care, teenage pregnancy and postnatal clinic. Plan to set up a base for 5 community teams from Children Centres and in time to move antenatal clinics from GP surgeries to the Children Centre</p>
<p>QEH</p> <p>27 Children Centres are planned with 4 currently facilitating midwives to work in and from them offering antenatal care and drop in sessions. Vision is to have a midwife in every Children Centre</p>	<p>QMS</p> <p>18 Children Centres, the majority of which are still under construction. 2 are currently being used as drop in clinics and additional midwifery support model of care. In the process of reconfiguring the community service and working towards holding antenatal clinics in Children Centres in the near future</p>

Access route to maternity/midwifery care in the 6 provider units in SE London

<p>1.GSTT</p> <p>Via GP Referral letters co-ordinated within antenatal clinic. Via Foetal Medicine Unit Via Day assessment unit Some direct referrals through specialist midwives doing outreach work. Pre-booking/ Early pregnancy sessions in Bermondsey. A and E</p>	<p>2.KCH</p> <p>Via GP Via specialist medical-obstetric team Via family planning Direct access referral form May book directly with midwifery teams, Children Centre Midwives and some community midwives</p> <p>Early Pregnancy session in antenatal clinic and a community location.</p>
<p>3.UHL</p> <p>Currently part of the 'Choice Project' where women are seen at 6-8 weeks and given information so that they can choose where to book. Referral letter from GP to antenatal clinic Some provision for direct access via specialist midwives.</p>	<p>4.PRU</p> <p>Currently part of the 'Choice Project' where women are seen at 6-8 weeks and given information so that they can choose where to book Via GP Via self referral</p>
<p>5.QEH</p> <p>Currently part of the 'Choice Project' where women are seen at 6-8 weeks and given information so that they can choose where to book Via GP's Via specialist midwives.</p>	<p>6.QMS</p> <p>Currently part of the 'Choice Project' where women are seen at 6-8 weeks and given information so that they can choose where to book Referral letter from GP to antenatal clinic Needs risk and choice assessment after the first scan appointment after 12 weeks of pregnancy. Initial assessment earlier when bloods are taken, scans booked and some information given. Currently implementing early access care pathways. Direct access to specialist midwife.</p>

Direct Access to Midwives

The Department of Health's commitment to early access to care for all women is clear. Within this, the aim is to enable and advocate that women are able to access midwives directly,

" Enabling women and their partners to access midwifery services directly should mean that they enter the maternity care system in places and at times that suit them and at a more advantageous stage in their pregnancy."(DH, 2007.13).

In a consultation with women in SE London conducted by Health First (New et al, 2006) women were asked about their preference regarding access. The majority responded that they would have liked to go to a midwife first as the first point of contact as they were likely to have more skills and more time. The fact that midwives were likely to be female and would therefore meet cultural expectations for female carers only was a contributing factor. Some women interviewed said that they would like to see their GP first, this was partly because of an established good relationship but also because the women felt that they were aware of their particular circumstances. A few women accessed via sexual health services. The most cases the option to go directly to the midwife had not been an option. The report also highlighted that one of the barriers to timely access was the general difficulty in accessing GP's especially for those who have insecure immigration status such as asylum seekers.

In some places this is already happening. There are patches of direct access to midwives already in place, for example some of the teenage strategy work. Within the SE sector, some of the midwives who were providing specialist services and enhanced care are already experiencing women accessing them directly. The Midwife for the Rivers Team (QEH) for women with problematic addictions was gently confident that direct access to her care was a gradually rising phenomenon as she became known in the area. A midwife working out a Childrens Centre in Erith had booked vulnerable women who had been denied access to a GP, they were asylum seekers. One respondent to the questionnaire felt that direct access would mean that the midwives would be responsible for 'policing' entitlement to care,

" Spending more time assessing how legitimate women are which is usually done by GP surgery clerks would be a time waster, eg, finding out if they are entitled to NHS care. This is with the assumption that you do not have to register with a GP to directly access a midwife".

Other Children Centre midwives commented that the architecture of the Children Centres created around education rather than health meant that they were not a place that women could 'pop into' and that as practitioners they were invisible thus women did not access them directly.

A small appraisal of midwives perspective on direct access

The project sent out a questionnaire to the six providers to circulate to all midwives. This was not intended as a survey but was a means to enable interested midwives who were not interviewed to contribute to the project. It aimed to ascertain the perspective of midwives on direct access.

There were only a small number of replies, 32 in total, of which 12 were Team Midwives, 6 were from a 'traditional' community set up, 2 Children Centre Midwives, 6 specialist midwives, 5 hospital based midwives and 3 managers. Of this 23 were working in a way that enabled women to access them directly for care. For the majority, 13, this was for less than 10% of the women they cared for, 2 provided 10-25%, 4 provided 50-75% and 3 midwives said that 75-100% of the women they cared for accessed them directly.

Two of questions asked were:

"What challenges do you face (or predict you would face) in managing your caseload when women access you directly?"

and

"Any other comments?".

This brought a plethora of remarks which reflect both an eagerness for this policy to become practice and an underlying fear of increasing workloads exceeding capacity.

Advantages to direct access

The general impression through talking to midwives in the SE sector and the questionnaire was that Direct Access is a positive thing, many were impatient for a system to be implemented

"I can only see advantages if this were the norm, as the delay in referrals from GP to a booking appointment would not occur. The midwife could book at a base or in the woman's home and refer on as necessary"

and

" To be honest, I think it would improve our service if women were more able to access us directly prior to booking as a lot of our difficulties lie in poor communication between GP's and the maternity unit. Referral letters are 'lost' or 'not received' by the antenatal Office on a regular basis , resulting in delays in booking".

and

"Personally I would welcome seeing women early on as now when women see us after 3 months, they have often had very little suitable advice and support during the first few weeks ...as we are trusted, women fleeing domestic violence or abuse such as trafficking may be more likely to seek us out".

another midwife said,

"Women presently just walk into the surgery and ask for an appointment to see the midwife, or they can phone...although most have seen a GP first"

" I see women in the GP surgery and they either self refer or are asked by the GP to see me. The time taken gives women real choice and explains the processes to them"

For some midwives who are already working in this way the question regarding challenges was rebuffed with comments of, 'No problem already doing this" , "none at all, its easier" and

" It has been good recently that we can just fax a referral note to antenatal services to sort a booking appointment, this is for women who find it difficult to access care or are afraid to. Midwives are usually trusted members of the healthcare team and may improve women's decisions to access healthcare if they just know they need to find us rather than approach a GP with whom they may have had a poor experience or who is well known to her family and may have confidentiality worries".

Capacity and management issues

Although there are emerging examples of good practice of 'small' scale direct access to midwives the logistics of a centralised system of direct access has not yet been instigated and a few of the people who replied were concerned about individual midwife or team capacity. Particularly well known and liked teams, it was feared, would attract more work as the women chose where they wanted their antenatal care. This would ultimately lead to capacity issues not just in time but space within Surgeries etc.

"In due course, word of mouth would make women directly particular midwives and not others"

"If the women who access us are out of our area it increases our workload because of the incurred transport costs. It is not just the booking but the commitment to care that could affect the amount of women we can safely look after".

"Very hard to manage the numbers of women we have now, if we were to take referrals directly we would need additional time to complete the paperwork etc. Same old story, too much work, too little time, losing clerical support, more paperwork, more guidelines, colleagues leaving and not being replaced".

Current direct access is through word of mouth, dropping into the clinic/ base to see the midwife, booking an appointment via a GP surgery, texting and phoning the midwife. Although the latter are positive means of engaging hard to reach groups it was asserted that,

"...e-mails are fine and manageable and non disruptive to our own clinical work. Mobiles can ring at the wrong time"

Many of the replies listed capacity issues, time and physical space in which to practice. Certainly the imperative across the responses was the necessity for a coordinator for the referrals once the woman had made contact. This would ensure that referrals were evenly distributed through the midwife providers. This is currently how the system works except the referral is usually a letter or form. It was thought that clerical support would be needed to be flexible to the changing system, to organise notes, create hospital numbers etc.

For a number of people the replies were positive on all fronts,

“ Nothing too challenging; would need to be more organised in arranging the scans and need clerical support for the initial organising the notes etc but otherwise everything would be as it is now”

and

‘Women will benefit from accessing us directly’.

The Role of the GP

Interdisciplinary working and the positive role that GP’s can play in maternity care was recognised by many of the respondents. This was particularly regarding their knowledge of the woman as a means to begin a risk assessment. It was felt that systems would need to be put in place to write to/contact the GP for information about the women and to inform the GP of the pregnancy. The CEMACH report makes clear that GP’s are in a particularly important position to provide information about the woman (Lewis, 2007). Although across the sector the present system of referral by a GP, by letter or form, works well there was a high incidence (anecdotal) of some practitioners not providing the necessary information needed.

Many of the midwives involved in this project reported excellent working relationships with GP’s and perceived no problem in this continuing once direct access to midwives becomes policy however for some, especially the midwives providing enhanced services and or direct access, engagement was difficult. For one midwife filtering information about her outreach work to local GP’s via e-mail, telephone, letters, fliers and in person was unproductive. On several occasions she met with hostility and disregard.

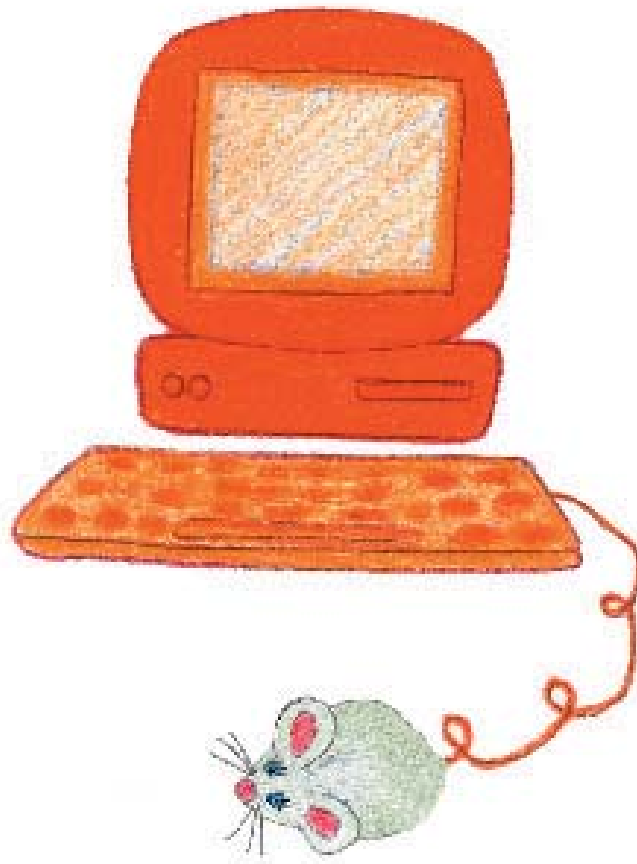
In the most recent CEMACH report, Saving Mother’s Lives it recommends that migrant women,

“... who have not previously had a full medical examination in the United Kingdom , should have a medical history taken and clinical assessment made of their overall health, including a cardio-vascular examination at booking, or as soon as possible after. This should be performed by an appropriately trained doctor, who could be their usual GP” (Lewis, 2007.x1).

This was interpreted by one unit to mean that around ‘booking’ all women should see their GP, and if this examination had not been conducted previously it would be. Guidelines were being discussed as to how to introduce this.

The role of the GP in managing choice and risks around early pregnancy was recognised. Women may approach their GP uncertain about continuing with their pregnancy for medical and social reasons and if they decide to continue be referred to a midwife,

“However if they feel we are the main source of referral they may feel that they are committed to the pregnancy if they see us and therefore not access us to talk about their options...we need to ensure we promote unbiased views on termination”



**Who, when and where?
The Quantitative data**

How many? Who, when and where?

Introduction

Conducting an audit, using comparatively historical quantitative data and interpreting it within a dynamic contemporary service, is limiting. The qualitative data is contemporaneous; no one wanted to consider what had been happening on the 'shop floor' in 2007 because things have improved, there are new contracts within Children's Centres and ever increasing understandings of need. Two of the units had a change of leader during the course of the project. However, there are many things to reflect on and the potential for shared learning is enhanced by the scope of the geography from Inner London, from the Thames, to the garden fronted suburbs of Bromley. Comparison of timely access between units is unavoidable, especially when data is presented as pie graphs side by side, but the other criteria also need to be considered, capacity of the units, ethnicity and mobility of the population and the Index of Multiple Deprivation.

Health equity is concerned with characteristics that potentates imbalances in access for some women in comparison to others. In other words, does being a teenager living in Southwark mean that it is more difficult for you to access care than a woman in her mid to late 20's? Is the percentage of white affluent women, able to access services, higher? If so, what is being done to help those, who are not white or affluent, access services? Within the sector there are remarkable differences in the demographics of the maternity population in terms of Index of Multiple deprivation and ethnic mix. The data has been presented as descriptive charts and graphs with percentages of pregnant women. The information is presented as bi-variant analysis, that is, for example, what are the affects of age on timely access to the needs, risk and choice assessment. The graphs depict the percentages of women in each category but for perspective it is useful to look at the charts. The aim for 'orange' is to be applauded but note should be taken of the not given, not recorded data

Small Numbers are important

Routine protocols for eliminating data where information is not available have been bypassed in this audit because of the questions;

- Why?
- Why is the information missing?
- Is data missing because there are women who, because they access late, have shorter engagement times; because those with inherently socially complex lives disclose less.
- Is it more difficult, more uncomfortable to ask some women some questions in a sensitive manner in a limited time period?
- Is it a lack of understanding of the value of data?
- Are the women who we are not recording data on, the ones we should be concerned about?

The graphs depict % of women in each category, the relative number of women may be very small but access for these small groups is important as a timely and robust needs, risk and choice assessment may affect outcomes. There are also differences in the

provision of outreach services within inner sector units, having multiple teams and the smaller units having only one team or even a midwife who is charged with 'catching all'. Specialism increases expertise, confidence and support through interdisciplinary teams. Where there are fewer professionals the work is no less challenging, the needs of the woman and her family, no less pressing.

Interpretation of the Data

The interpretation of this data is best conducted by those who have a complete picture of the provision of services. This paper can only be the starting point. It is suggested that the data be interpreted with the following questions as a baseline:

1. Who in the population is not accessing in a timely way?
2. Who is accessing late, after 22 weeks?
3. What services/interventions are in place to enable women to access?
4. What systems are in place to understand changes in capacity and demand to deliver services that;
 - better enable women to access in a timely way?
 - address health inequalities?
5. What local knowledge can be employed to interpret the data and promote best practice?

Description of Ethnic profile, Index of Multiple deprivation and timely assessment of needs, risk and choice across the SE Sector

GSTT

- **Access**

35% of women undertook a needs, risk and choice assessment before the completion of the 12th week of pregnancy, for 18.3% this was after the 22nd week of pregnancy. For 1.3% of the demographic, the gestation was unknown. The number for compliance to the PSA 19 target may well be higher because the data system records the date the information was entered. This may not be the date that the woman was seen and unless the practitioner proactively changes the date the default date will be inaccurate.

In the Healthcare Commission Review of Maternity services published in January 2008, GSTT was given 2/5 for access, where 5 represents best practice and 3 a suitable acceptable standard. The unit received 3/5 for data capacity and 5/5 for staffing. The number of women booking for care in 2007 was 6632 and the midwife/women ratio at delivery episode was 1/33. This includes bank and agency midwives (Truttero, 2007).

A small, in house audit in the autumn of 2007 demonstrated that the transfer in of women from other units for clinical reasons affected the overall percentages of women who book later in their pregnancy, women visiting was also stated as a reason. The graphs illustrate the bi-variant analysis of place of booking and gestation illustrates this well with a predominant yellow column.

- **Ethnic Profile and Index of Multiple Deprivation (IMD) of the maternity demographic**

Nearly 50% of the maternity population accessing GSTT are White, 19.2% are Black African, 16.4% Black, 5.4% Other and 6.9% are Asian.

Over 80% of the profile comes from postcodes in the 2 lowest quintiles for IMD. 2.6% are in the most privileged quintile.

KCH

- **Access**

18.9% of women accessed their full needs, risk and choice assessment by the end of the 12th completed week with 15.1% booking after 22 weeks. Again transfers in and a transient population are reflected in these numbers. The data system changed over to the E3 system, and occurred mid year which has affected the overall presentation. Capacity issues within the unit have meant an increasing number of Saturday and evening Catch-up clinics manned mainly by staff working extra on the 'bank'. The long term affects and sustainability of reliance on staff working additional hours is questionable and concerning (Demilew, 2007). Audits within the antenatal clinic demonstrate that in 2007 there was an inexorable increase in the delay between referral for maternity booking and availability of booking appointment slots, reaching at one, point 8-10 weeks from request to appointment. This has now been provisionally rectified but these figures are related to a 25% increase in the numbers of women giving birth within King's maternity service. This has implications for the physical space for provision of antenatal services and staffing provision.

In the Healthcare Commission review (2007) KCH received 2/5 for access, 2/5 for data capacity and 4/5 for staffing. The annual supervision report for 2006/07 recorded a ratio of 1:27 midwife/women (Truttero, 2007). 5800 women booked for care in 2007. However;

"Women with complications need additional consultations according to their need ... about 60% of the women" (Demilew, 2007.15).

- **Ethnic Profile and Index of Multiple Deprivation (IMD) of the maternity demographic**

The White population using maternity services at KCH is only 40.7% with an equal number of people from the Black population, 24.7% Black African. 4% are Other and 6.2% described themselves as Asian. Nearly 83% of the users came from the 2 lowest IMD quintiles, 54% from the lowest. Only 0.5% of the women came from the highest, most affluent quintile.

UHL

- **Access**

57% of women who present for care at UHL receive their needs, risk and choice assessment before the end of the 12th completed week, with 11.4% booking after 22 weeks. There has been considerable work linked to reducing infant mortality/low birth weight babies programme and the Choice Project in the locality (Cross, 2006).

The Ratio of midwife/women in 2006/07 was 1:32 (Truttero, 2007). 4375 women booked

for care. The Healthcare Commission awarded 3 for access, representing a suitable acceptable standard and 2/5 for data capacity and 3/5 for staffing levels.

- **Ethnic Profile and Index of Multiple Deprivation (IMD) of the maternity demographic:**

46% of the maternity users reported their ethnicity as White, 19.7% as Black and 9.9% as black African; 7.1% were Asian and 2.4% Other. Nearly 50% of the population came from postcodes in the 2nd most deprived quintile, 35.7% in the lowest quintile and the lowest % in the sector of people living in the highest quintile, only 0.3%

PRU

- **Access**

39.3% of the women who booked at the PRU in 2007 did so before the end of their 12th week of pregnancy and 8.2% booked after 22weeks. 14.1% of the records have no record of gestation at booking.

The Healthcare Commission Review (2007) awarded only 1 for access demonstrating a poor standard, data capacity was also poor at 1/5 and staffing levels low at 2/5. The staffing ratio recorded by the supervising authority was 1:35, the average for London (Truttero, 2007). A total of 4319 women booked for care.

- **Ethnic Profile and Index of Multiple Deprivation (IMD) of the maternity demographic**

The Ethnicity profile and IMD distribution are remarkably different at the PRU compared to the rest of the sector with a population of 70% White. For 14.7% there is no record of ethnicity. As the unit furthest away from central London it is also within the wealthiest area, with 31.3% of the women living in the highest quintile and only 10.9% in the lowest.

QEH

- **Access**

18.2% of women booked before the end of the 12th week in Woolwich and 22.5% were late bookers after 22 weeks.

The Healthcare Commission review (2007) awarded 2/5 for access, 5 for data capacity and 4 for staffing, however the supervision ratio demonstrated significant difference in ratio to the other units with 1: 40. The number of women recorded booking for care in 2007 was 4713.

- **Ethnic Profile and Index of Multiple Deprivation (IMD) of the maternity demographic**

Nearly 30% of the ethnicity recordings for QEH were not given. A Black African population of 19.9%, higher than at GSTT and a 6.7% Other population which would be the local Chinese Community. Again, in terms of IMD, a poor area with over 88% of the women living in post-coded areas in the lowest 2 quintiles and only 0.9% in the highest quintile.

QMH

- **Access**

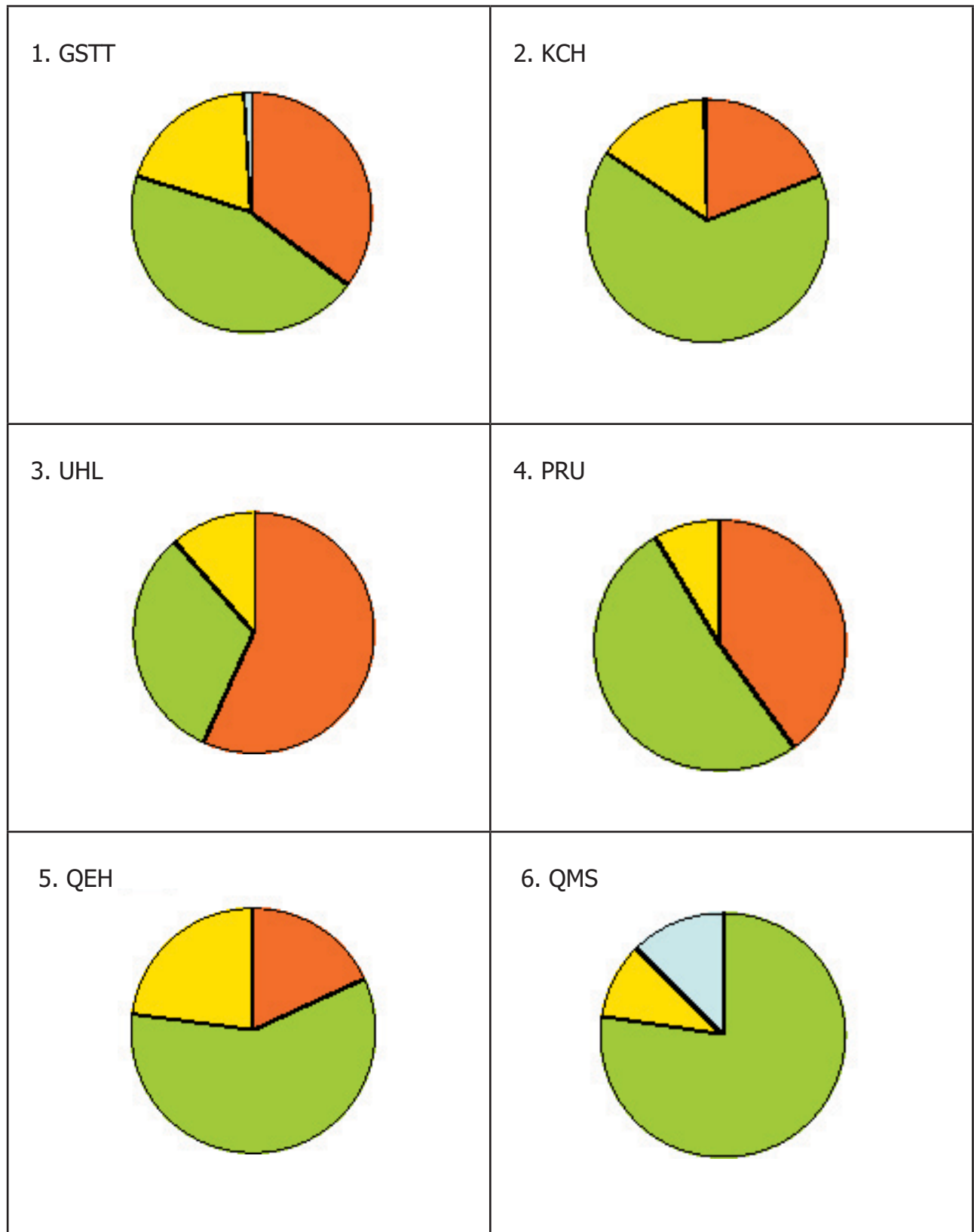
QMH has a booking system that has built up historically around the nuchal scan. Women are seen early in their pregnancy and a skeletal assessment with BP recording, height, weight, estimation of gestational age by dates and bloods taken. They are also given information at this appointment. Although this is a marker of good practice highlighted by the National Service Framework, standard 11, the full needs, risk and choice assessment is not completed until after the scan around 15-16 weeks gestation. This is clearly represented in the data for this audit with only 0.4% of women receiving a full needs, risk and choice assessment by the end of the 12th completed week. 22.5% of women book late and 12.5% have no gestation known at booking. At the beginning of this audit meetings were being conducted to change the system. The unit traditionally books most of the women at home, but again capacity issues meant that increasingly women were being asked to come to the hospital antenatal clinic. Catch-up clinics for bookings are currently being done.

The ratio of midwife/ women was 1:27 in 2006-7 (Truttero, 2007) and the Healthcare Commission Review awarded 4/5 for staffing. In 2007 there were 3382 women registering for antenatal care at the unit.

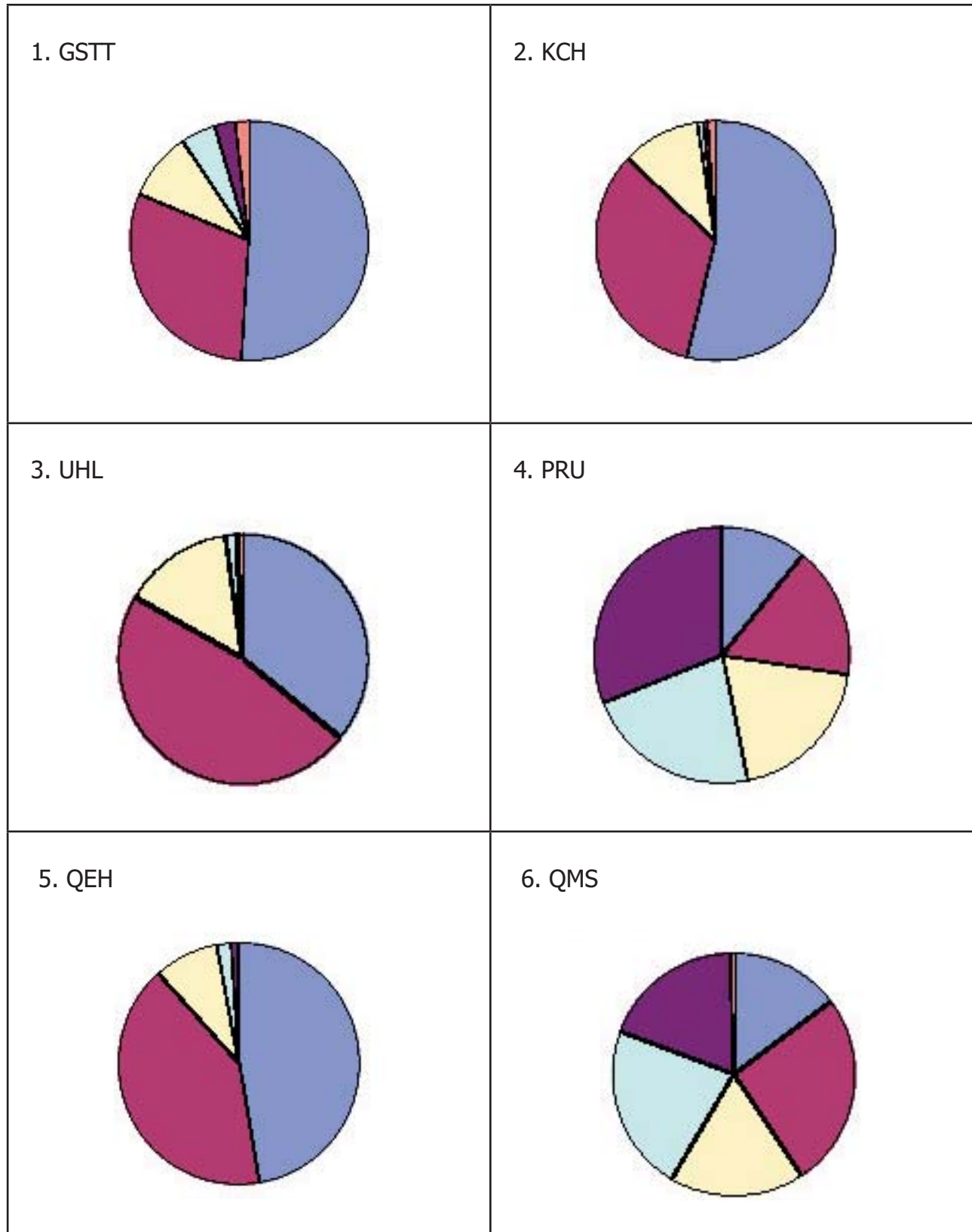
- **Ethnic Profile and Index of Multiple Deprivation (IMD) of the maternity demographic**

Nearly 90% of the maternity demographic for 2007 was White, 9.0% Black African, 4.8% Asian, 3.1% Black and 1.9% Other. The IMD profile for the area is more evenly mixed with 25.8% in the lowest quintile and 18.4% in the highest.

Graphs showing Gestation at completion of needs, risk and choice assessment in SE London, 2007



Graphs showing IMD profile of maternity users in SE London, 2007



Index of Multiple Deprivation where 0-20 is the lowest and 80-100 the most affluent

0-20  20-40  40-60  60-80  80-100  Blanks 

Graphs showing Ethnic profile of maternity users in SE London 2007

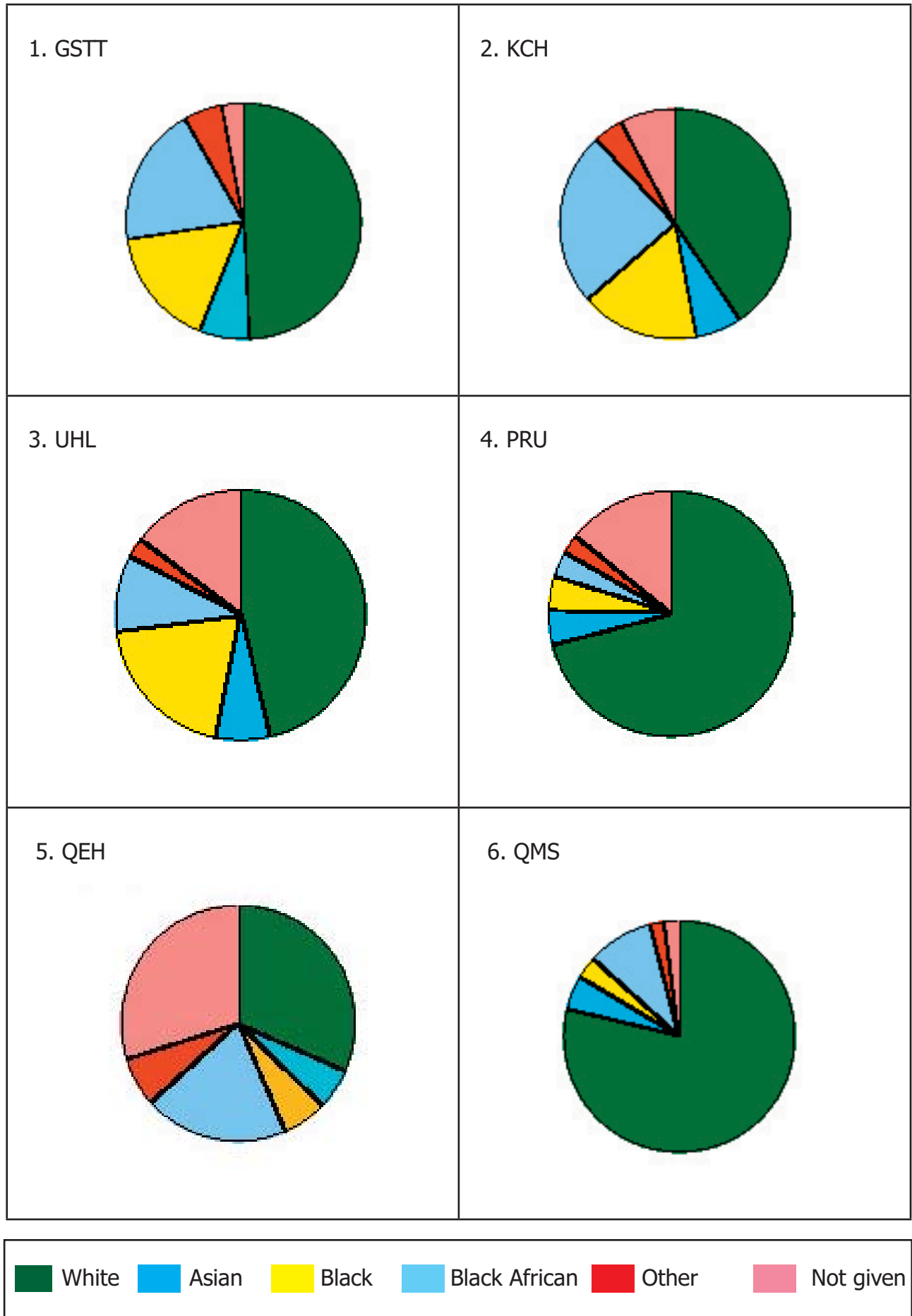


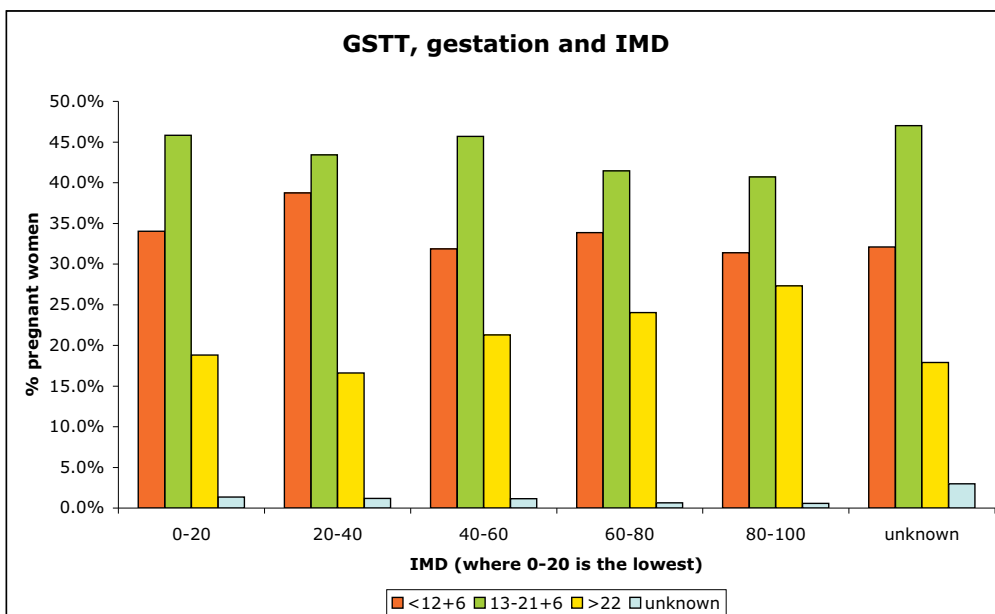
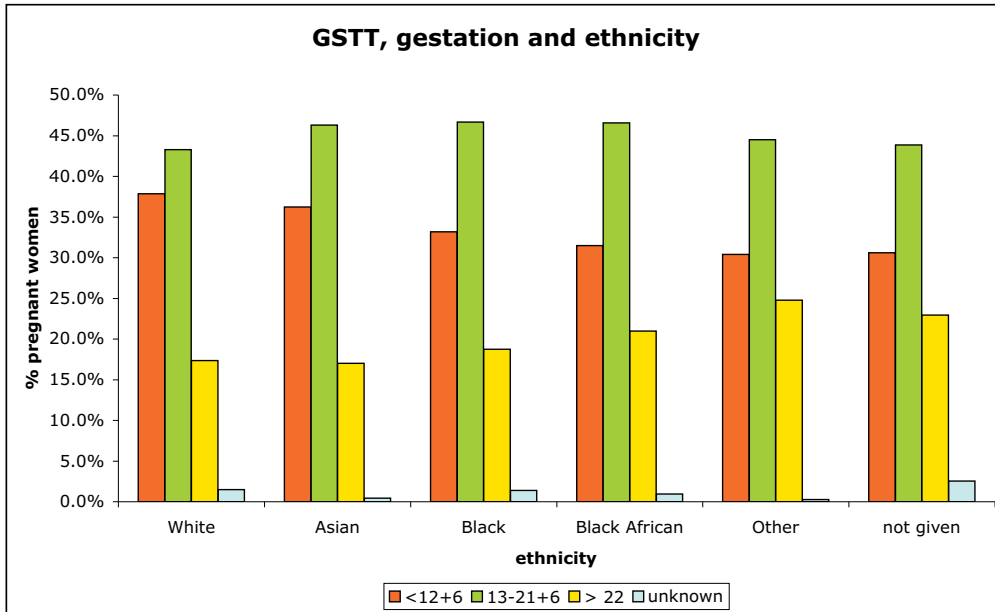
Table illustrating Gestation at completion of needs, risk and choice assessment, ethnicity and IMD for the SE London Sector

Characteristic	GSTT	KCH	LUH	PRU	QEH	QMH
Gestation at Booking						
<12+6	35.1%	18.9%	57%	39.3%	18.2%	0.4%
13-21+6	44.8%	65.5%	31.6%	51.5%	59.1%	77.1%
22+	18.8%	15.1%	11.4%	8.2%	22.5%	10%
Not given	1.3%	0.6%		14.1%	0.2%	12.5%
Ethnicity						
White	49.2%	40.7%	46.1%	70.9%	31.7%	78.9%
Asian	6.9%	6.2%	7.1%	4.6%	5.6%	4.8%
Black	16.4%	16.6%	19.7%	4.3%	6.2%	3.1%
Black African	19.2%	24.7%	9.9%	3.5%	19.9%	9%
Other	5.4%	4%	2.4%	2.5%	6.7%	1.9%
Not given	3%	7.8%	14.7%	14.7%	29.9%	2.3%
IMD						
0-20 is lowest						
0-20	51.2%	54%	35.7%	10.9%	47.1%	14.7%
20-40	30.3%	32.8%	47.7%	16.7%	41.3%	25.8%
40-60	9.1%	10.5%	14.1%	18.9%	8.6%	18.3%
60-80	4.8%	1%	1.4%	22.8%	2%	22.8%
80-100	2.6%%	0.5%	0.3%	31.1%%	0.9%	18.4%
Not known	2%	1.1%	0.8%	0.1%	0.2%	0.6%

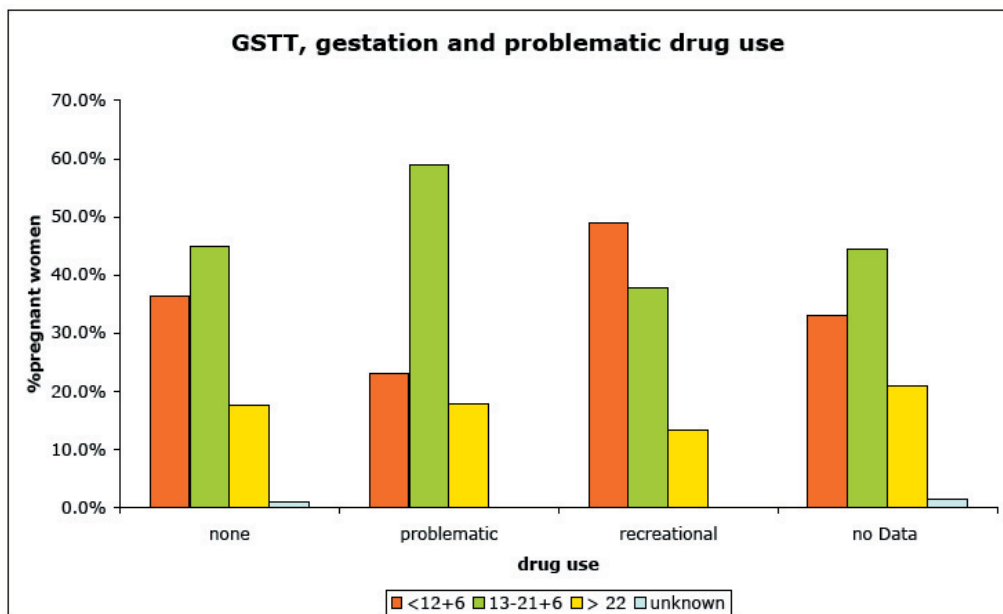
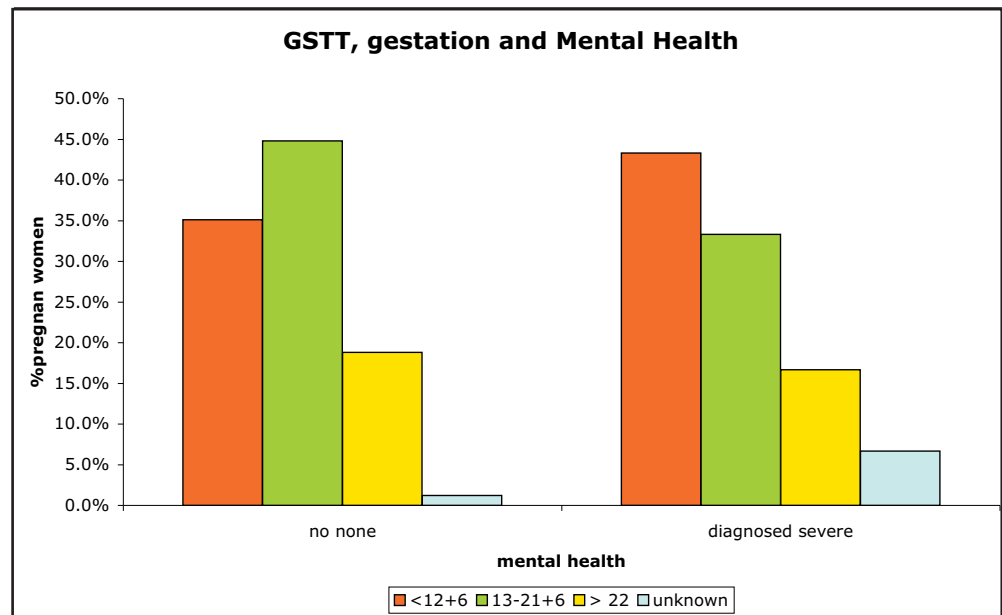


Bi-variant analysis

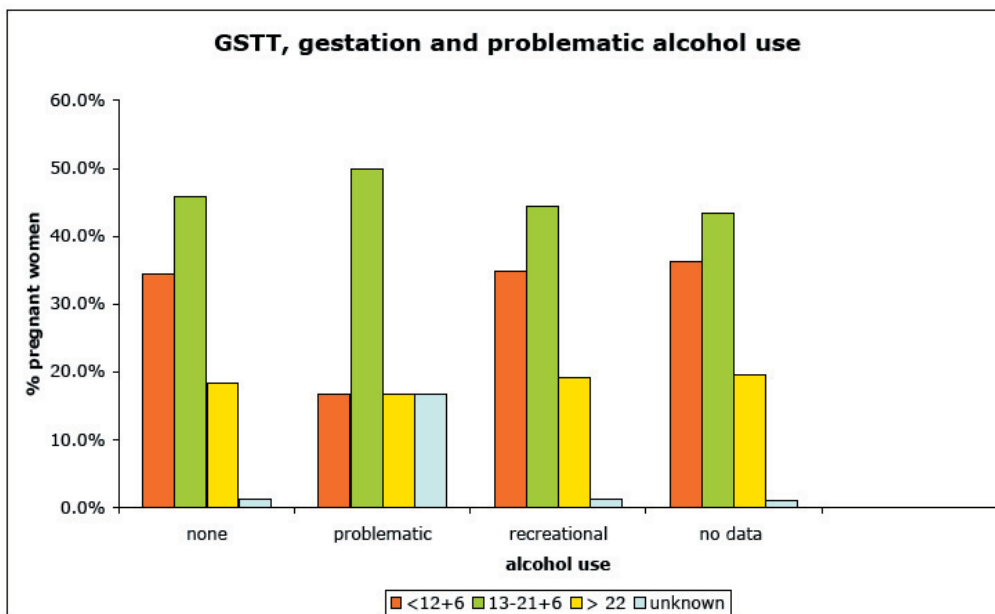
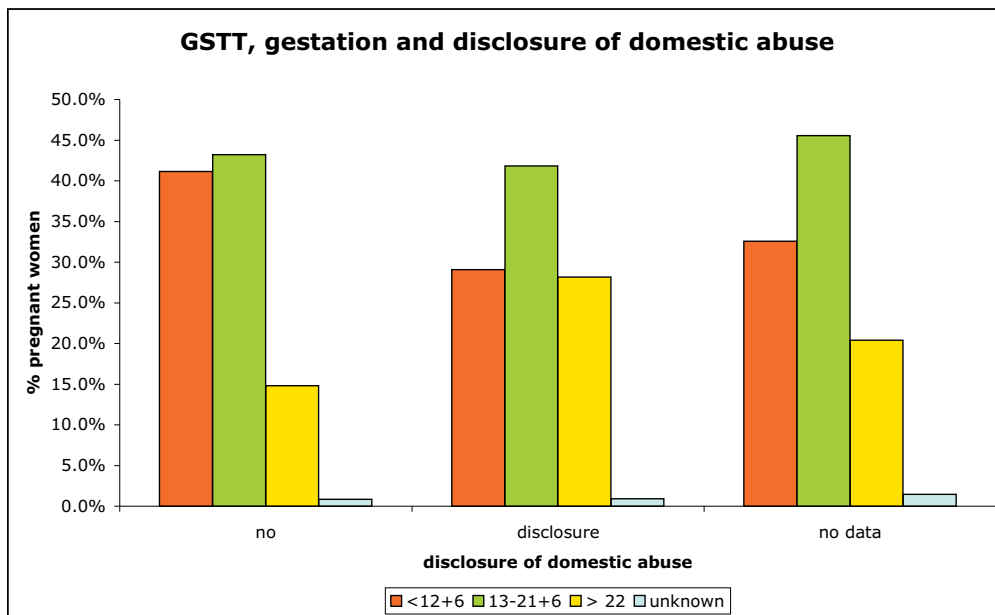
Graphs of Bi-variant analysis with gestation and proxy fields for GSTT



Graphs of Bi-variant analysis with gestation and proxy fields for GSTT



Graphs of Bi-variant analysis with gestation and proxy fields for GSTT



Graphs of Bi-variant analysis with gestation and proxy fields for GSTT

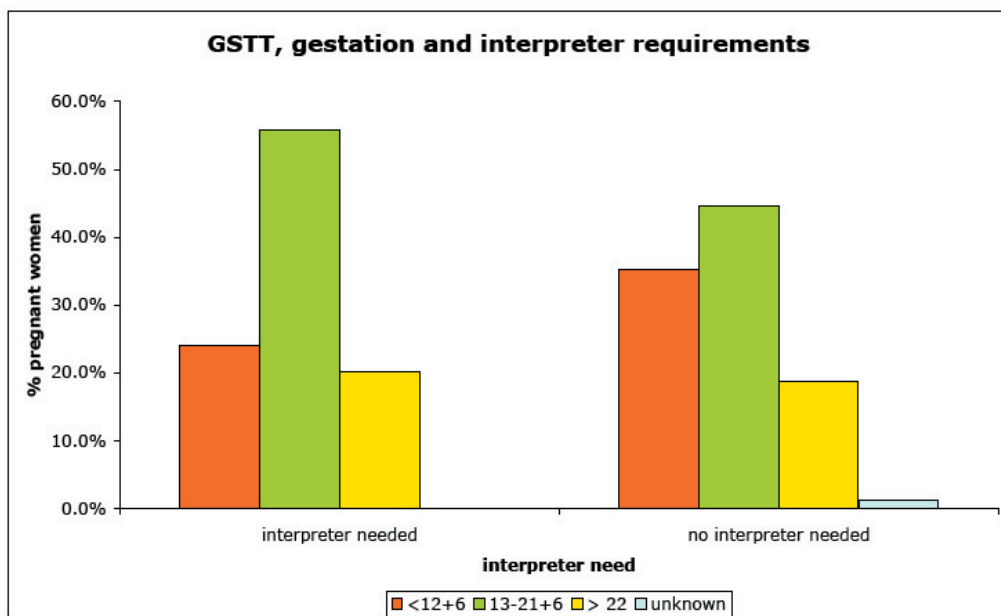
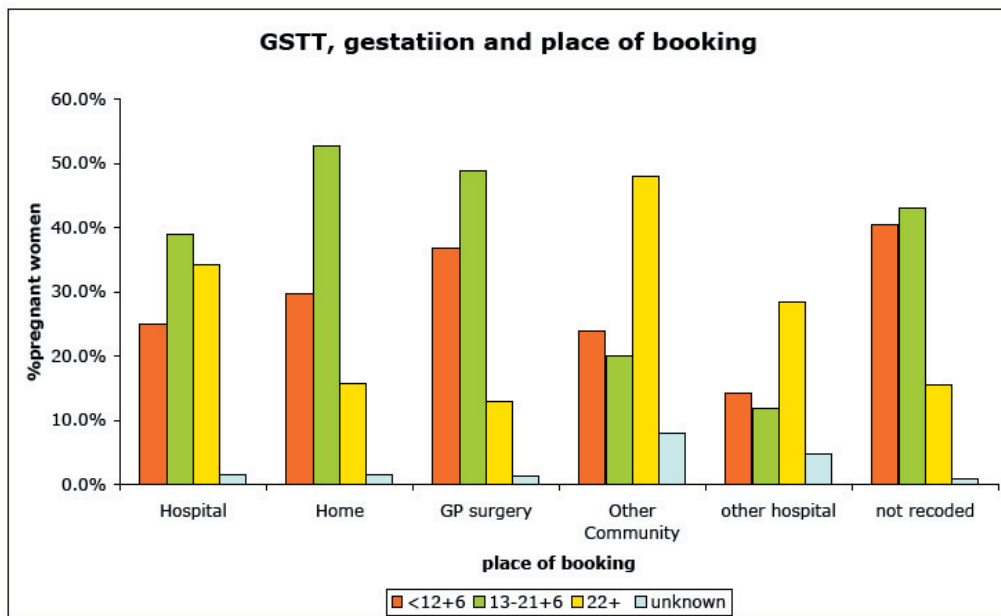


Table of Bi-variant analysis of GSTT data (using excel). Total pregnant women 6632		Gestational age at booking				
		Total	12w+6 (%)	13w-21w+6	22+	unknown
Age	<18y					
	18-24					
	25-34					
	35-44					
	45+					
not provided for audit						
Ethnicity	No record of gestation and/ or age					
	white	3262	37.9%	43.3%	17.4%	1.5%
	Asian/ Asian British	458	36.2%	46.3%	17.0%	0.4%
	Black./ Black British/ mixed	1088	33.2%	46.7%	18.8%	1.4%
	Black African	1273	31.5%	46.6%	21.0%	0.9%
	Other	355	30.4%	44.5%	24.8%	0.4%
	Not Given	196	30.6%	43.9%	0%	2.6%
IMD	Not recorded	84				
	First (Better Off) quintile	172	31.4%	40.7%	27.3%	1.4%
	Second quintile	316	33.9%	41.5%	24.1%	1.2%
	Third quintile (a)	606	31.8%	45.7%	21.3%	1.2%
	Fourth quintile	2010	38.8%	43.4%	16.6%	0.6%
	Fifth (Worst off) quintile	3394	34.0%	45.8%	18.8%	0.6%
Gravidae	No record of gestation and or quintile	84+134	32.1%	47.0%	17.9%	3.0%
	Gravidae 1	2627	34.5%	43.6%	20.4%	1.6%
	Gravidae 2-5	3704	35.8%	45.7%	17.4%	1.1%
Parity	Gravidae >6	301	32.9%	43.9%	22.3%	1.0%
	No record	84				
	Para 0	3907	37.0%	44.5%	17.1%	1.3%
Housing Status	Para 1	1661	29.1%	46.5%	23.4%	1.0%
	Para 2-4	996	36.0%	43.7%	19.1%	1.21%
	Para 5+	68	61.8%	33.8%	0%	4.4%
	No record	84				
Mental Health	Permanent Refugee, Asylum seeker/ refugee					
	May change address					
	homeless					
Benefits Data not collected	visiting					
	No record					
	No mental health problems	6599	35.1%	44.8%	18.8%	1.2%
	Self reported symptoms GP/Therapy treated	30	43.3%	33.3%	16.7%	6.7%
Problematic addiction Drugs / substance	Diagnosis of severe mental health problems	3 and 84				33%
	No record					
Problematic addiction Drugs / substance	Not receiving benefits					
	Receiving benefits					
	None	3975	36.5%	44.9%	17.6%	1.1%
	Problematic use	39	23.1%	59.0%	17.9%	0%
Problematic addiction Drugs / substance	Recreational use	45	48.9%	37.8%	13.3%	0%
	No record	2573	33.1%	44.5%	20.9%	1.5%
	Employed	765				
	Housewife/Carer unemployed					
	Not recorded					

Characteristics		Gestational age at booking				
		Total	12w+6 (%)	13w- 21w+6	22+	unknown
Place of Booking	Hospital	1329	25.08%	39.1%	34.3%	1.6%
	Home	252	29.8%	52.8%	15.9%	1.6%
	GP surgery	2778	36.8%	48.8%	13.0%	1.3%
	Other Community	25	24.0%	20.0%	48.0%	8.0%
	Other hospital (not GSTT)	42	26.2%	14.3%	57.1%	2.4%
Domestic Abuse	Not recorded	2143	40.6%	43.1%	15.5%	0.8%
	No disclosure	2032	41.1%	43.2%	14.8%	0.8%
	Disclosure	110	29.1%	41.8%	28.2%	0.9%
Interpreter Needed	No record of gestation and /or DA	4490	32.6%	45.5%	20.4%	1.5%
	Interpreter Needed	+84				
	Not required	104	24.0%	55.8%	18.8%	0%
	Not required	2306	35.3%	44.6%		1.3%
Female Genital Cutting	No data					
	YES					
Not provided for audit						

Problematic addiction alcohol	NO/Not recorded					
	none	3549	34.5%	45.8%	18.3%	1.3%
	problematic	6	16.7%	50.0%	16.7%	16.7%
	recreational	739	34.9%	44.5%	19.2%	1.4%
	No data	2330	36.3%	43.3%	19.6%	1.1%

Initial description and analysis of the data

GSTT

Ethnicity:

Although the White population has a slightly higher percentage of 37.9% compared to 30.3% for the Other category, ethnicity appears to make little difference in access to care within the GSTT catchment area. 24.8% of the Other category access after 22 weeks compared to 17.4% of the White population. It would be useful to know if it is the White East and Central Europeans who are represented within this group.

IMD:

3394 women live in the lowest quintile and 2010 in the second lowest quintile. There is very little difference in access in relation to quintile, 34% accessing in the lowest quintile before the end of the 12 completed week and 31.4% in the most affluent quintile. 27.3% of people in the highest quintile as opposed to 18.8% in the lowest access after 22 weeks gestation.

Gravidae and Parity:

Although there are slightly higher percentages of women booking late with increased gravidae and parity the numbers are small; 22.3% of women who were pregnant for the 6th time accessed after 22 weeks compared to 20.4% of women in their first pregnancy.

Mental Health:

43% of women with a diagnosis of severe mental health problems were able to access a needs, risk and choice assessment prior to the end of the 12th week compared to 35% of women with no mental health problems. The percentage of women booking late, after 22 weeks was also lower for this group. This may be a reflection on the MAPPIN (mental health) service provided by the unit.

Drug and Substance misuse:

The coding for this field was difficult and it appears that women who have recreational use of drugs and alcohol are able to access earlier. This may be a case of interpreting the basic data for coding affecting the results.

Disclosure of Domestic Abuse:

4490 women had electronic records that did not reflect if they had been routinely asked about domestic violence. Access for those where there was disclosure demonstrates an overall pattern of later access with 28.2% booking after 22 weeks and 29.1% booking before the end of the 12th completed week, compared to 41.1% where there was no disclosure. This may be a technical issue as it may not be possible to ask at the booking appointment, because the partner or other family member is present and then the computer does not ask for the information later in the pregnancy. There is a dedicated Domestic Abuse service at GSTT and all women should be routinely asked. Posters proliferate the ladies toilets.

Interpreter needed:

Where interpreting services are required there are corresponding patterns of later access to care.

Place of Booking:

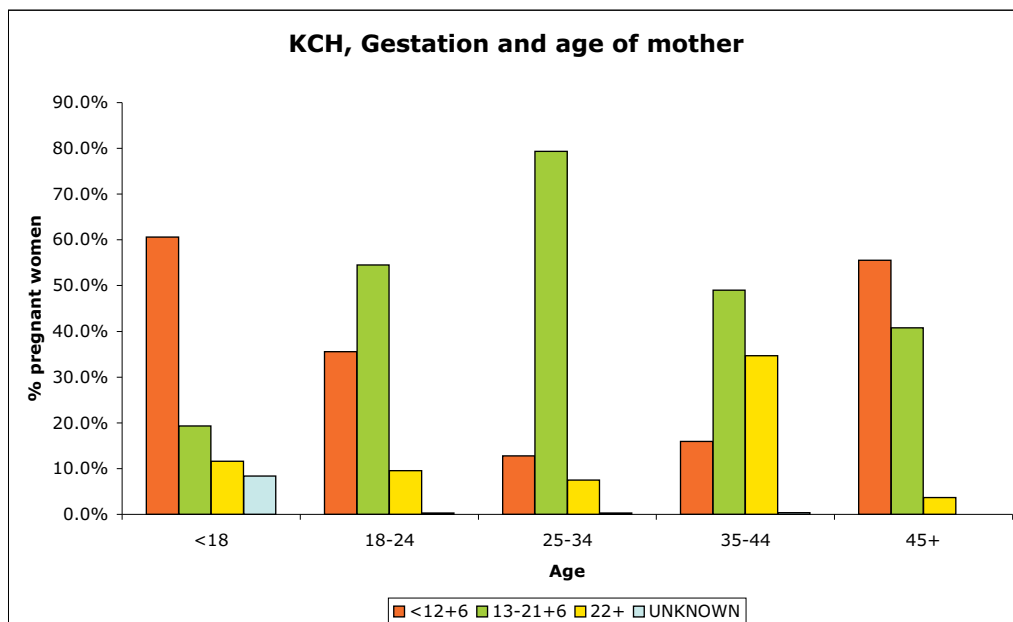
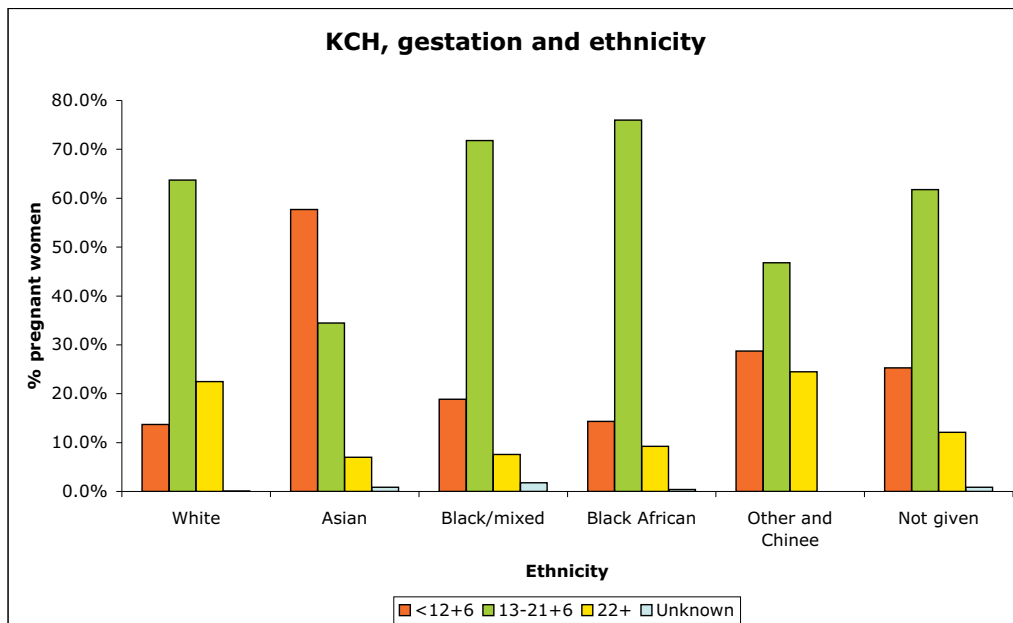
GSTT has a code for booked at another hospital for women who are transferred in from an outside provider because of clinical reasons. 58% of women who are transferred in are more than 22 weeks pregnant. Women who book in their own home or a GP surgery are able to do so earlier than those attending the hospital antenatal clinic, 25% book in the hospital before the end of the 12th week compared to nearly 30% at home and 37% at the GP surgery. Late bookers present predominantly in the hospital antenatal service and 'other' community suggesting that the outreach midwives and Children Centre midwives may be 'picking them up'. For 2143 women there was no indication where they were booked.

Conclusion:

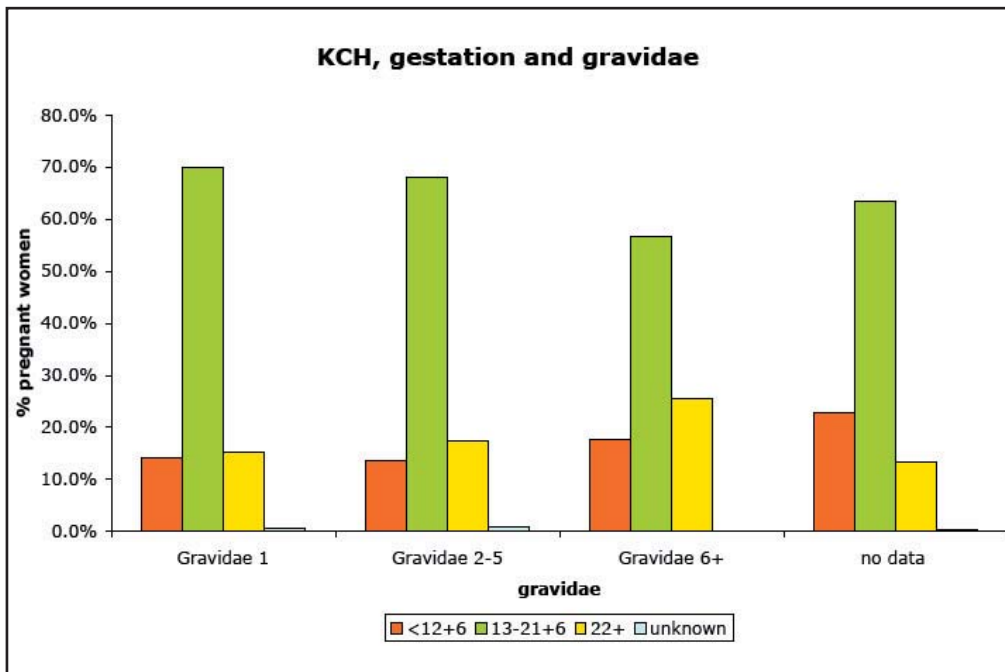
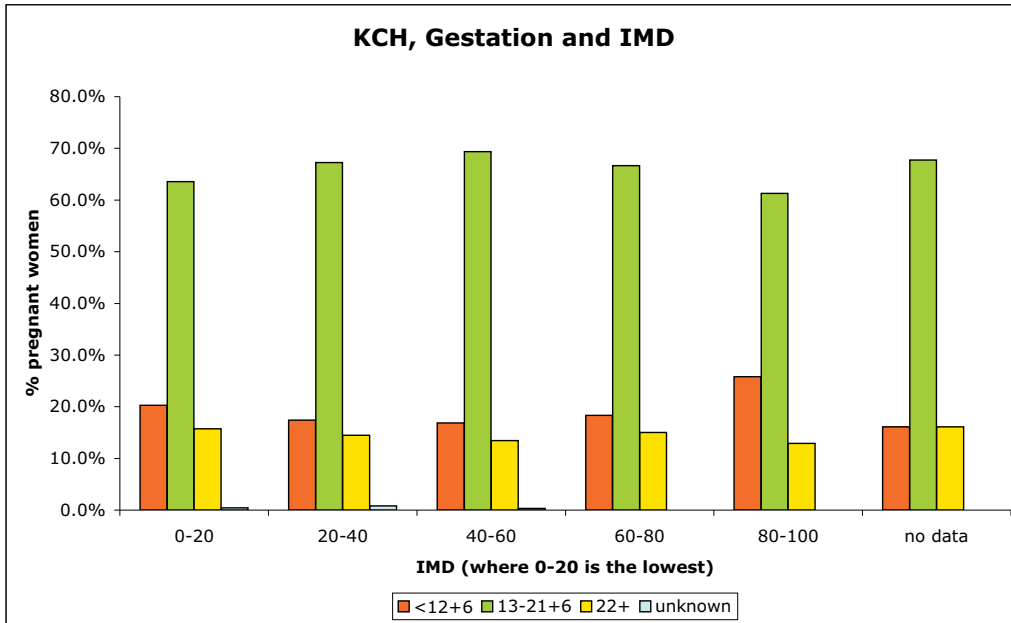
Women who have mental health problems and people who receive their needs, risk and choice assessment in a community setting are more able to access services in a timely way before the end of their 12th completed week of pregnancy.

Women with parity above 5 and those requiring interpreting services are more likely to book late after 22 weeks gestation.

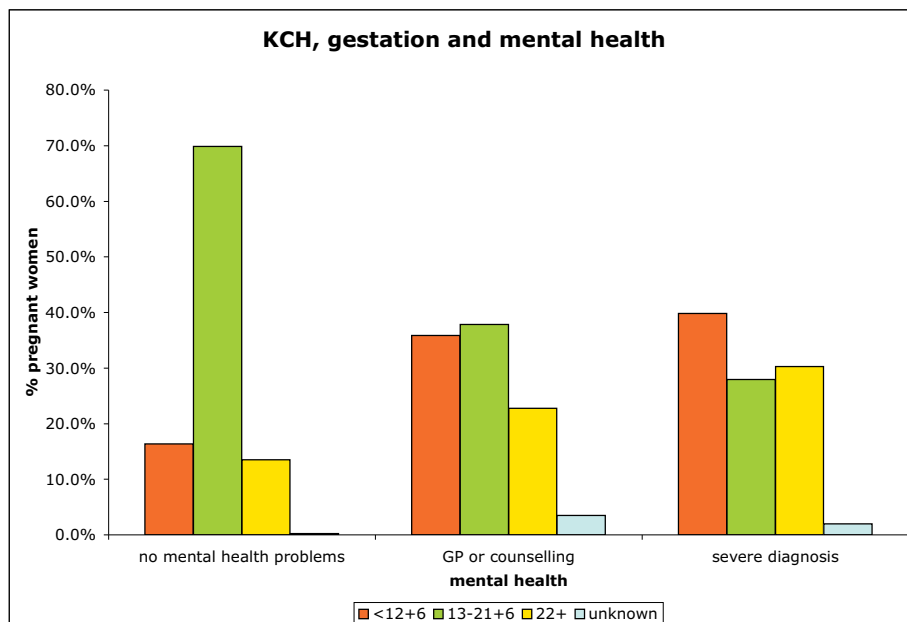
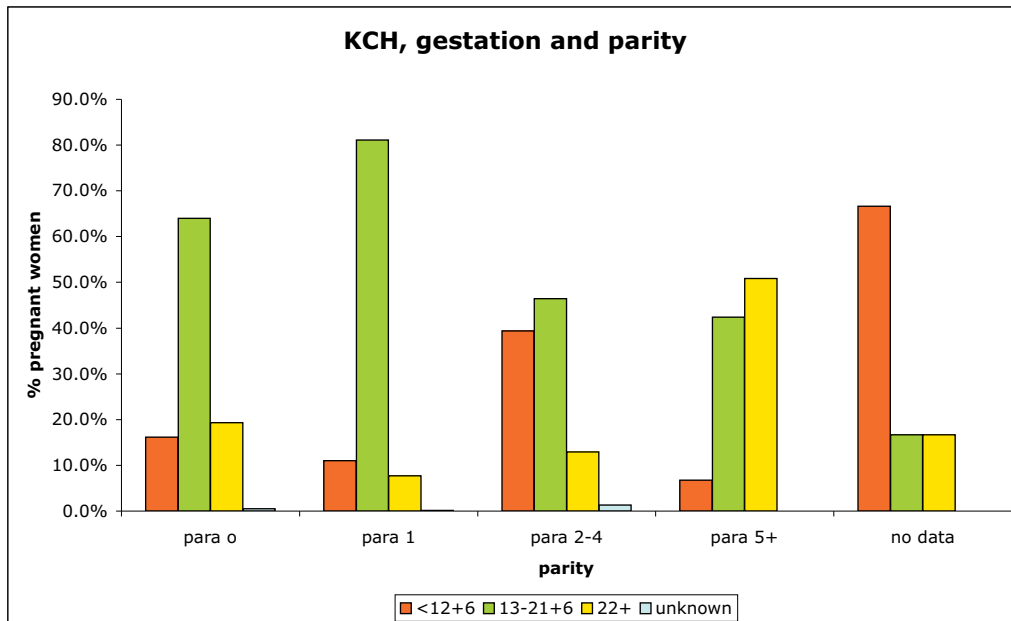
Graphs of Bi-variant analysis with gestation and proxy fields for KCH



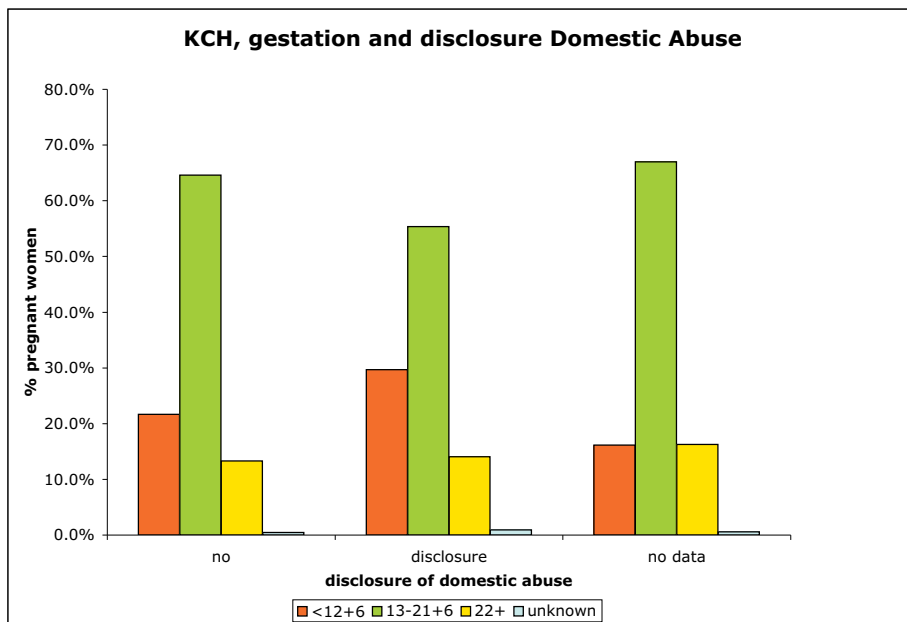
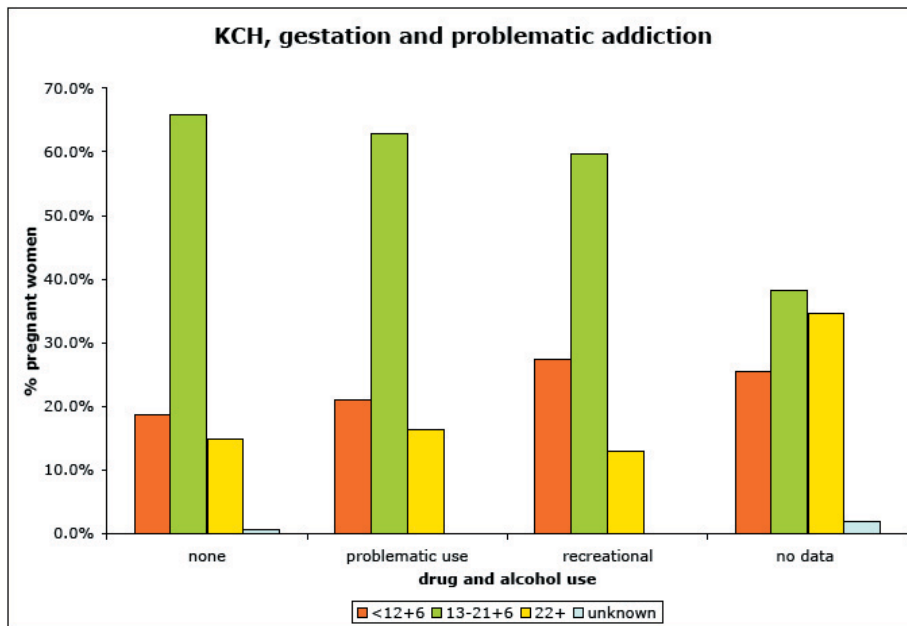
Graphs of Bi-variant analysis with gestation and proxy fields for KCH



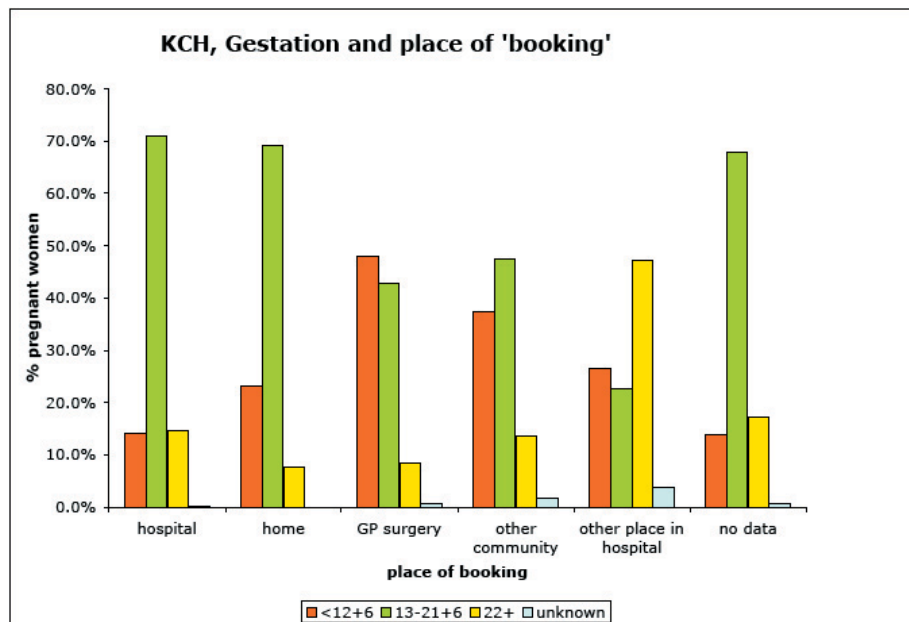
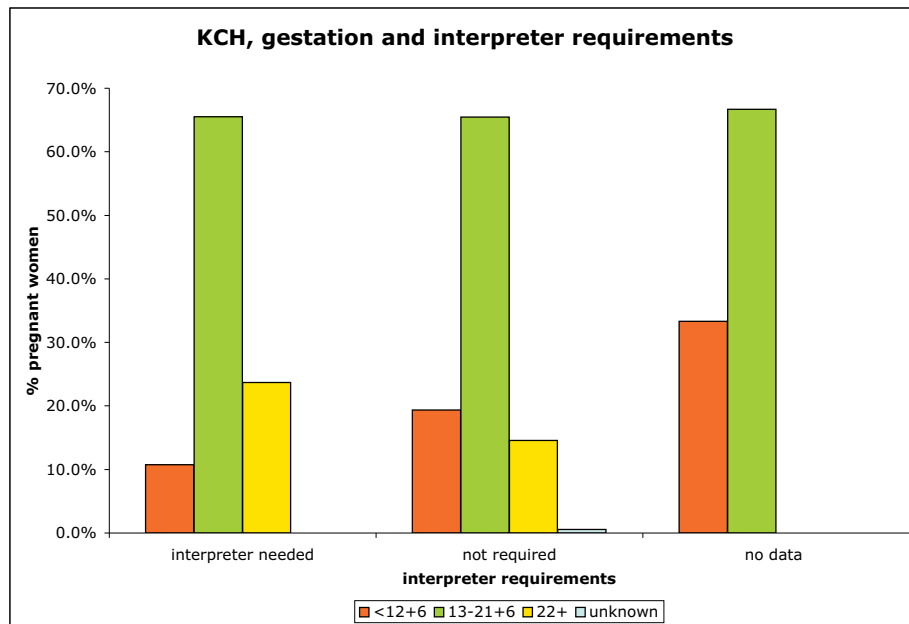
Graphs of Bi-variant analysis with gestation and proxy fields for KCH



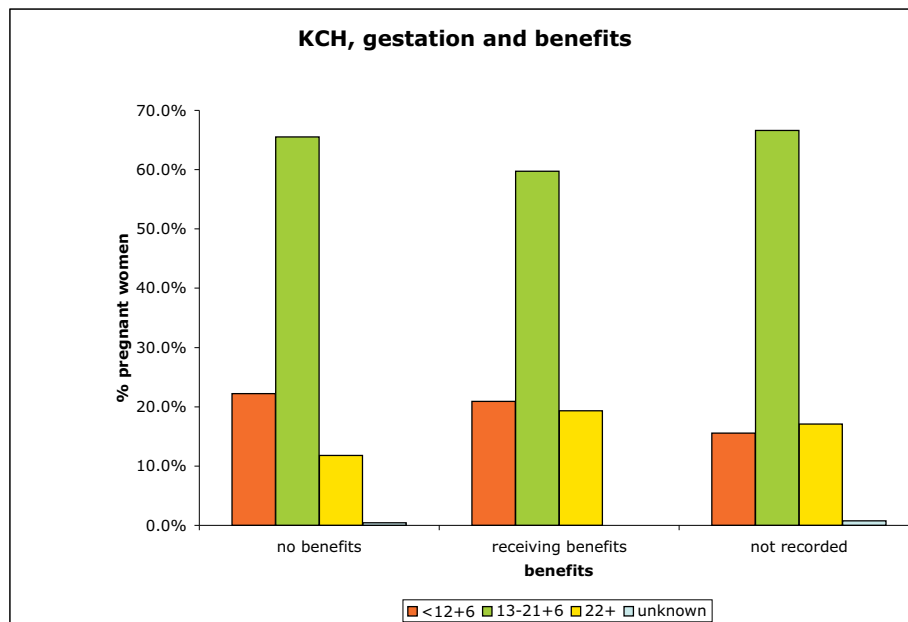
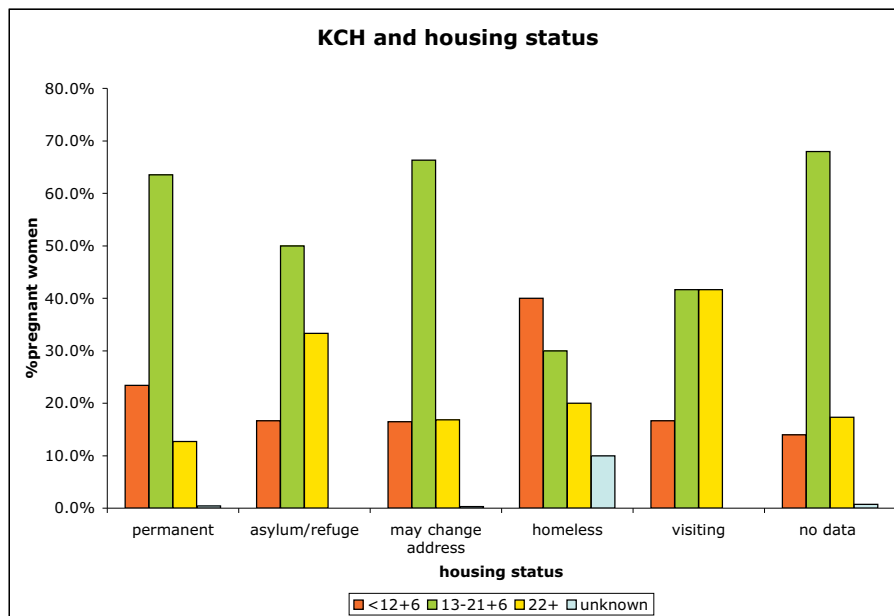
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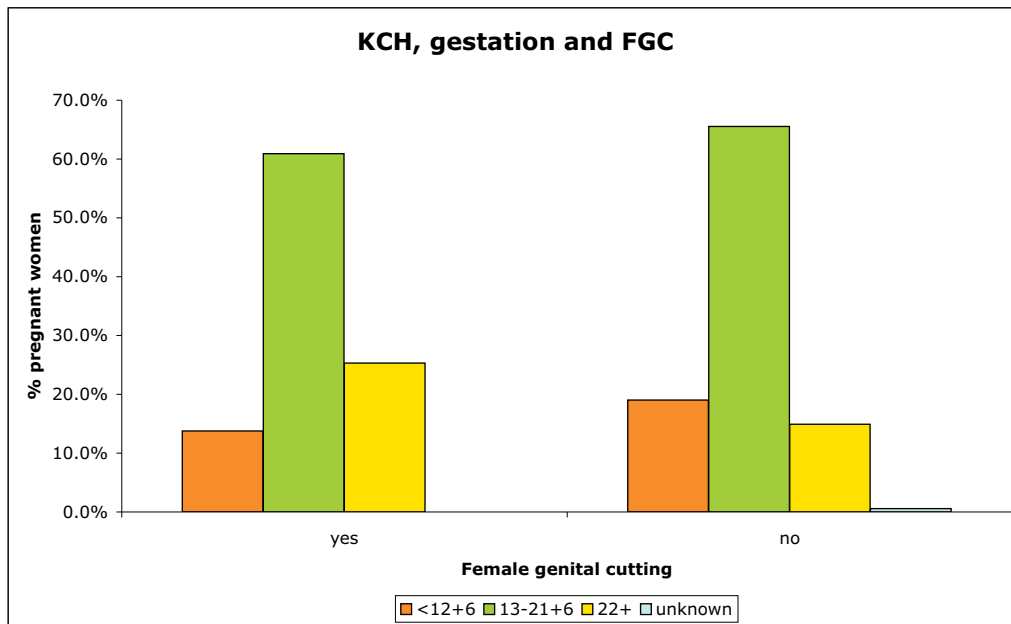


Table of Bi-variant analysis of KCH data (using excel).		Gestational age at booking				
		Total	12w+6 (%)	13w-21w+6	22+	unknown
Total pregnant women 5800						
Age	<18y	155	60.60%	19.40%	11.60%	8.40%
	18-24	981	35.60%	54.50%	9.60%	0.30%
	25-34	3123	12.80%	79.40%	7.50%	0.30%
	35-44	1514	15.90%	49.00%	34.70%	0.50%
	45+	27	55.60%	40.70%	3.70%	0%
Ethnicity	No record of gestation and/or age 32	32				
	white	2360	13.70%	63.70%	22.50%	0.10%
IMD	Asian/ Asian British	357	57.70%	34.50%	7.00%	0.70%
	Black./ Black British/mixed	965	18.90%	71.80%	7.60%	1.80%
	Black African	1430	14.30%	76.00%	9.20%	0.40%
	Other and Chinese	233	28.80%	46.80%	24.50%	0%
	Not given	455	25.30%	61.80%	12.10%	0.90%
	Not recorded					
Gravidae	First (Better Off) quintile	31	25.80%	61.30%	12.90%	0.40%
	Second quintile	60	18.30%	66.70%	15.00%	0.30%
	Third quintile (a)	610	16.90%	69.30%	13.40%	0%
	Fourth quintile	1904	17.40%	67.30%	14.50%	0%
	Fifth (Worst off) quintile	3133	20.30%	63.60%	15.70%	0%
Parity	No record of gestation and or quintile	32+62	18.90%	67.70%	16.10%	0%
	Gravidae 1	713	14.00%	70.00%	15.30%	0.70%
	Gravidae 2-5	1653	13.60%	68.20%	17.40%	0.80%
	Gravidae >6	153	17.60%	56.90%	25.50%	0%
Parity	No record	32+3281	22.70%	63.50%	13.30%	0.40%
	Para 0	2968	16.20%	64.00%	19.30%	0.50%
	Para 1	1692	11.10%	81.10%	7.70%	0.20%
	Para 2-4	1075	39.30%	46.40%	12.90%	1.30%
	Para 5+	59	6.80%	42.40%	50.80%	0%

Housing Status	No record	32+6	80.00%	0%	20.00%	0%
	Permanent	2941	23.40%	63.50%	12.70%	0.40%
	Refuge, Asylum seeker/ refugee	12	16.70%	50.00%	33.30%	0%
	May change address	303	16.50%	66.30%	16.80%	0.30%
	homeless	10	40.00%	30.00%	20.00%	10%
	visiting	12	16.70%	41.70%	41.70%	0%
Mental Health	No record	32+2520				
	No mental health problems	5092	16.30%	69.90%	13.50%	0.20%
	Self reported symptoms	0	0	0	0%	3..5%
	GP/Therapy treated	404	35.90%	37.90%	22.80%	2.00%
	Diagnosis of severe mental health problems	304	39.80%	28.00%	30.30%	1.90%
Benefits	No record	32				
	Not receiving benefits	2468	22.20%	65.50%	11.80%	0.40%
	Receiving benefits	569	20.90%	59.80%	19.30%	0%
Problematic addiction	No record	2763	15.60%	66.60%	17.10%	0.80%
	None	5640	18.80%	65.80%	14.90%	0.50%
	Problematic use	43	20.90%	62.80%	16.30%	0%
	Recreational use	62	27.40%	59.70%	12.90%	0%
	No record	32+55	25.50%	38.20%	34.50%	1.80%
Employment	Employed					
	Education					
	Housewife/ Carer					
	unemployed					
	Not recorded					
Not available for audit						

Characteristics		Gestational age at booking				
		Total	12w+6 (%)	13w-21w+6	22+	unknown
Place of Booking	Hospital	2165	14.00%	71.10%	14.70%	0.20%
	Home	273	23.10%	69.20%	7.70%	0%
	GP surgery	671	48.00%	42.90%	8.30%	0.70%
	Other Community	118	37.30%	47.50%	13.60%	1.70%
Domestic Abuse	Other hospital	53	26.40%	22.60%	47.20%	3.80%
	Not recorded	32+ 2520				
Interpreter Needed	No disclosure	2116	21.60%	64.60%	13.30%	0.50%
	Disclosure	327	29.70%	55.40%	14.10%	0.90%
	No record of gestation and /or DA	32+	16.20%	67.00%	16.30%	0.60%
		3357				
	Interpreter Needed	325	10.80%	65.50%	23.70%	0%
	Not required	5463	19.40%	65.50%	14.60%	0.60%
Female Genital Cutting	No data	32+12	33.30%	66.70%	0%	0%
	YES	87	13.80%	60.90%	25.30%	0.20%
	NO/Not recorded	5713	19.00%	65.50%	14.90%	0.60%

Initial description and analysis of the data

KCH

Age:

60% of young women, less than 18 years of age are able to access maternity services by the end of the 12th completed week of pregnancy. This is likely to be a reflection on the Bessemer group practice, which provides continuity of care for teenagers. Older women, 45 years of age and older also access in a timely way.

Ethnicity:

Asian women appear to be able to access services in a timely way, as do women who define themselves in the ethnic category 'Other'. A higher percentage of Black (18.9%) and Black African (14.3%) women book earlier than White women (13.7%) before 12+6 weeks. White women (22.5%) and Other (24.8%) book after 22 weeks, the percentage of Black and Black African women booking after 22 weeks is comparatively low at 7.6 and 9.2%.

IMD:

As discussed earlier KCH has a poor catchments area, with a large proportion of women living in the 2 lowest IMD quintiles (87%). Women who live in a postcode area that is graded as the most affluent quintile are slightly more likely to access by 12+6 (28.8%) compared to those in the poorest quintile (20.3%).

Gravidae and Parity:

Number of pregnancies and/or children appears to affect gestation at booking little other than by the 6th pregnancy and 5th child more women book late after 22 weeks (Para 5+, 50.8%).

Housing Status:

There were 10 women who were described as homeless who entered KCH maternity services in 2007, 40% of them completed their needs, risk and choice assessment by 12+6 weeks. For other women who could be described broadly as less well integrated access by 12+6 demonstrates a similar pattern; asylum seekers (16.7%), people in temporary accommodation (16.5%), and women who were 'visiting' (16.7%). 23.4% of women with a permanent address were able to complete their needs, risk and choice assessment in a timely fashion.

Mental Health:

KCH has a specialist team, The Brierley, who deliver care within the dynamics of a multi-disciplinary team for women with mental health problems. Women can access the midwives directly. The women are also referred to the midwives through the mental health professional networks. Nearly 40% of women with mental health problems (severe) accessed by 12+6, compared to only 16.3% of women with no mental health problems. 30.3% of women present late who have mental health problems. Although the number of women requiring the service of the Brierley team is higher than capacity (Demilew, 2007), late presentation may also be attributed to aspects of the women's mental health.

Problematic Addiction:

The Woodvine Clinic with a dedicated outreach midwife had 65 referrals in 2007. Referrals

are by the women directly to the midwife, from drug agencies and referrals from other midwives through the weekly peri-natal meetings held at KCH. Referrals are also received from prisons, probation, GP'S, voluntary agencies and social service. 20.9% of the women who were categorized as having problematic use booked before 12+6 compared to those who had no problematic use 18.8%. As with GSTT, the percentage of women described within the coding as having recreational use booked earlier, 27.4%. Although, again this is likely to be a reflection on the coding.

Receiving Benefits:

There appears to be a higher proportion of women who book after 22 weeks who are in receipt of benefits 19.3% compared to 11.8% of women who were not.

Place of Booking:

48% of women who booked at their GP surgery were able to do this by 12+6 weeks compared to 14% who attended the antenatal clinic. Once capacity in GP surgeries is reached the women are diverted to the antenatal clinic (Demilew, 2007). The percentage of women who booked in 'other community' was also higher (37.3%), with 23% of women who are seen in their own home completing their booking by 12+6. This would reflect the number of assertive outreach practices, caseload and specialist midwifery services at KCH, including the Brieley Team for teenagers who work out of Connexions.

Domestic Abuse:

As with GSTT this field presented with a large amount of data unrecorded, however this could partly be attributed to the change over in the system to E3. Of the data available nearly 30% of the women who disclosed abuse booked before 12+6 as opposed to 21.6% women where there was no abuse. This may be attributed to interagency referrals or that Domestic Abuse may best be interpreted in light of other factors using a multi-variant analysis package.

Female Genital Cutting (FGC):

A larger percentage (25.3%) of women with FGM booked after 22 weeks of pregnancy compared to 14.9% of women who answered no or there was no data.

Interpreters:

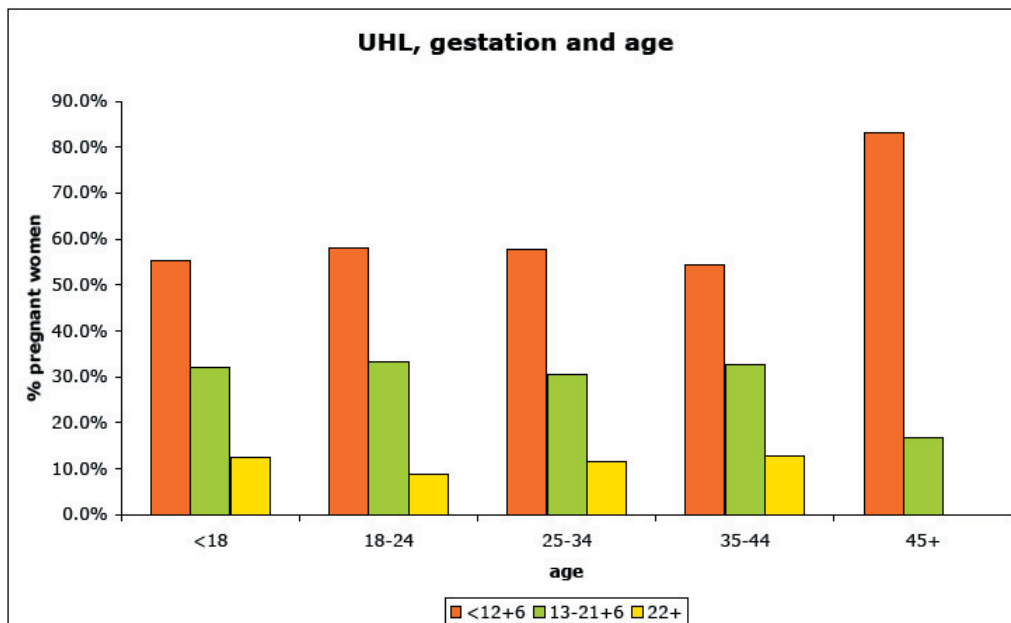
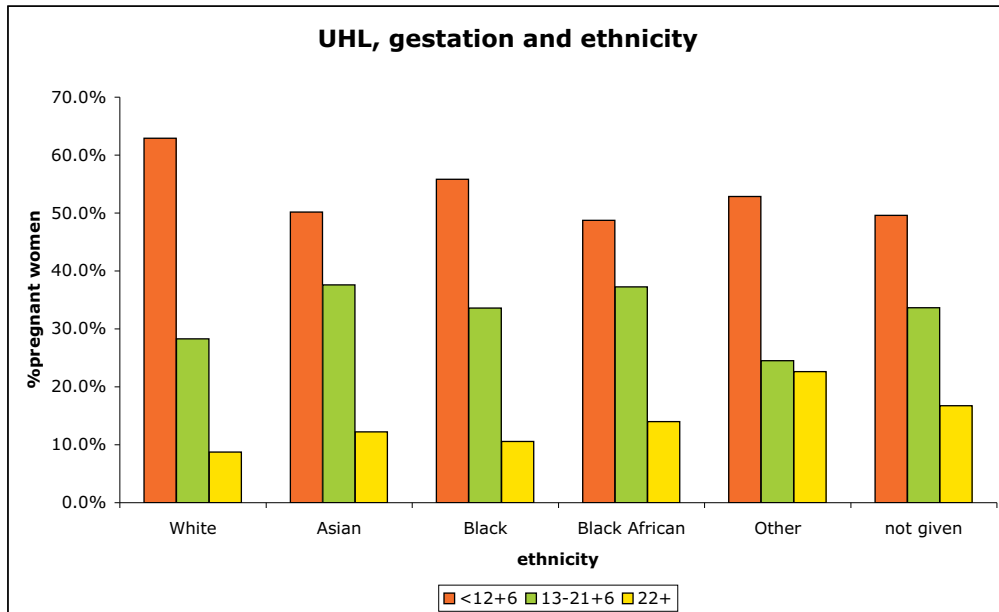
Where interpreters are needed the percentage of women booking by 12+ 6 was lower (10.8 compared to 19.4) and the number of women booking late after 22 weeks higher (23.7 compared to 14.6) than in the group of women who did not need an interpreter. Some of the catch up clinics conducted to reduce the time between referral and completion of needs, risk and choice assessment are conducted on a Saturday when in person interpreting services are not available. This means that women requiring an interpreter wait for an appointment when an interpreter can be available.

Conclusion:

Women who accessed care in the community, Asian women, teenagers, people with mental health problems, women with problematic addiction and homeless women were all more able to complete their needs, risk and choice assessment by the end of the 12th completed week.

Women with 5 or more children, women in receipt of benefits, women requiring interpreting services and women with a history of FGC were more likely to access after 22 weeks of pregnancy.

UHL Graphs illustrating bi-variant analysis



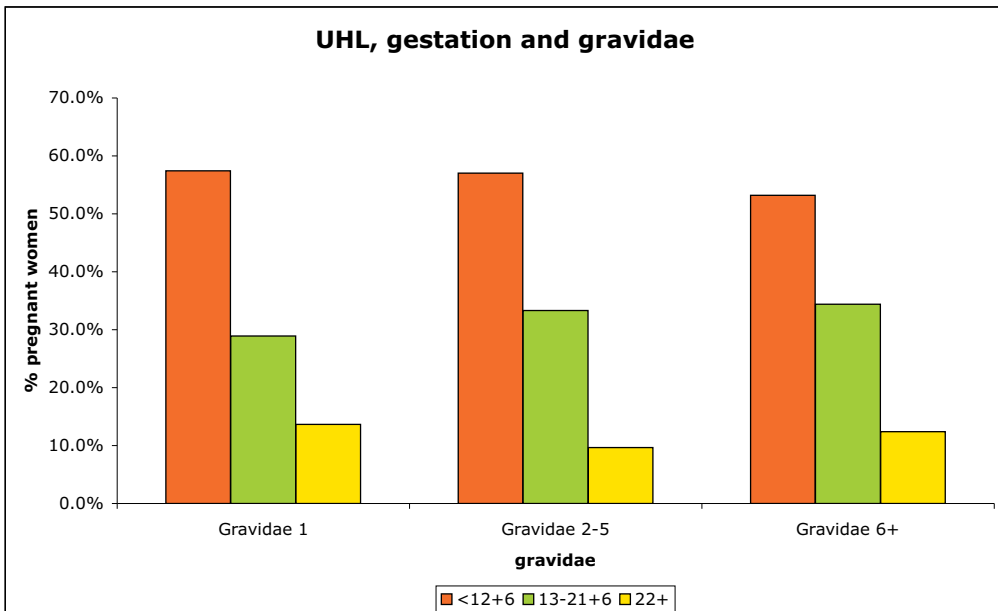
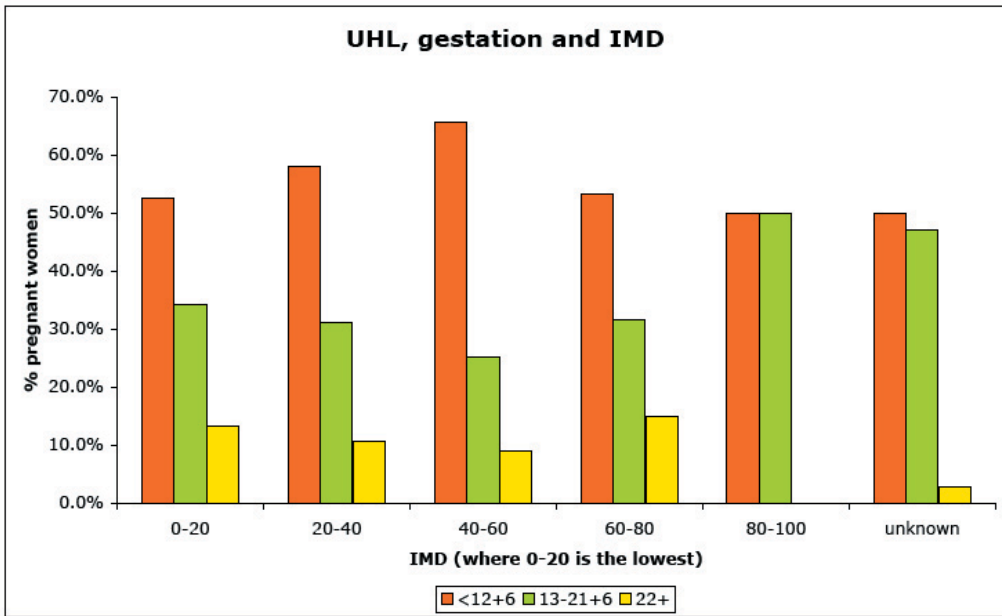


Table of Bi-variant analysis of UHL data (using excel) Total pregnant women :4375		Gestational age at booking				
		Total	12w+6 (%)	13w-21w+6	22 w+	
Age	<18	56				
	18-24	845	55.4%	32.1%	12.5%	
Ethnicity	25-34	2394	58.0%	33.1%	8.9%	
	35-44	1074	57.8%	30.5%	11.7%	
	45+	6	54.5%	32.8%	12.8%	
	White	2018	83.3%	16.7%	0.0%	
	Asian	388	62.9%	28.3%	8.8%	
	Black	860	49.5%	36.1%	14.4%	
	Black African	435	55.8%	33.6%	10.6%	
	Other	29	48.7%	37.2%	14.0%	
	IMD	Not Given	645	69.0%	10.3%	20.7%
	0-20 is the lowest	0-20	1564	49.6%	33.6%	16.7%
	20-40	2087	52.6%	34.1%	13.3%	
	40-60	616	58.1%	31.1%	10.8%	
	60-80	60	65.6%	25.3%	9.1%	
	80-100	12	53.3%	31.7%	15.0%	
Parity	Not known	36	50.0%	50.0%	0.0%	
	Para 0		47.2%		2.8%	
	Para 1					
	Para 2-4					
	Para 5+					
Gravidae	unknown					
	Gravidae 1	1761	57.4%	28.9%	13.7%	
	Gravidae 2-5	2396	57.1%	33.3%	9.6%	
	Gravidae 6+	218	53.2%	34.4%	12.4%	
	Unknown					

Initial description and analysis of the data

UHL

Age:

The graph and chart depicting the age of women and when they were able to access their needs, risk and choice assessment shows that age has little affect on access. Teenagers are able to access the specialist team easily through Connexions, direct access, word of mouth and referrals.

Ethnicity:

White women are marginally better represented in the access and assessment by 12+6 category (62.9%) and are lower in numbers in the category for late bookers (8.8%). There are a slightly higher proportion of women who define themselves as 'Other' (69%) who access before 12+6, but this ethnic group also has a slightly higher no of women accessing after 22 weeks (20.7%).

IMD:

The majority of the women live in postcodes which are in the two lowest IMD quintiles, access to maternity services shows similar patterns across the quintiles, with a slightly higher percentage of women in the 3rd quintile accessing early and a notable lack of women in the most prosperous quintile accessing late. Here the figures are low.

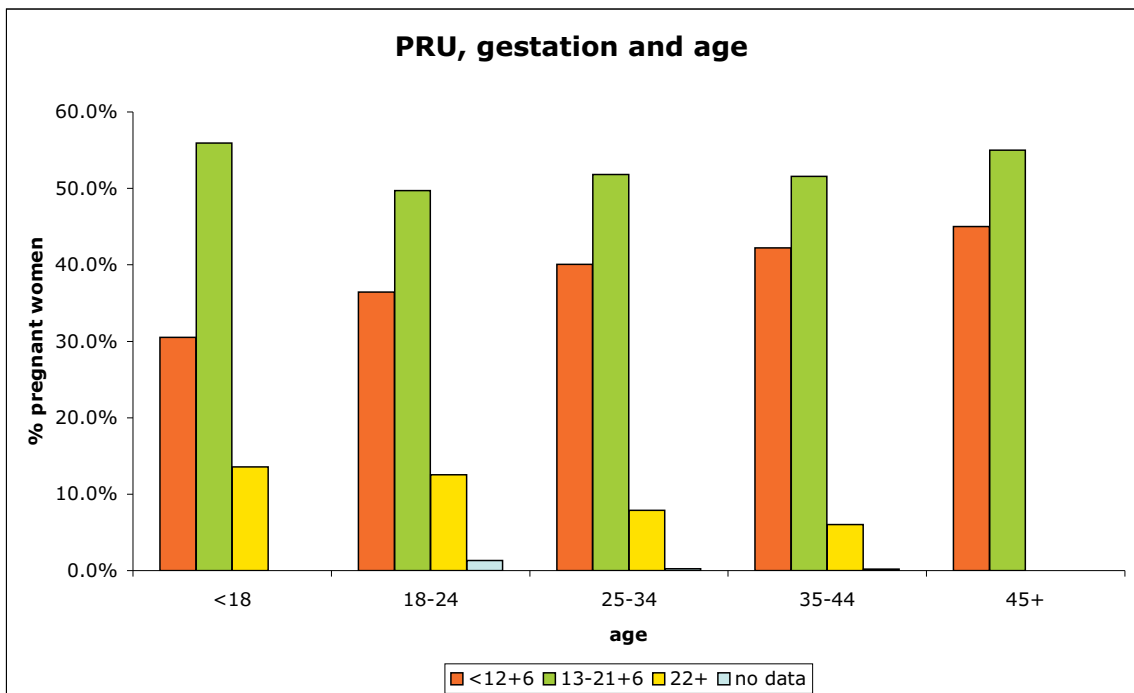
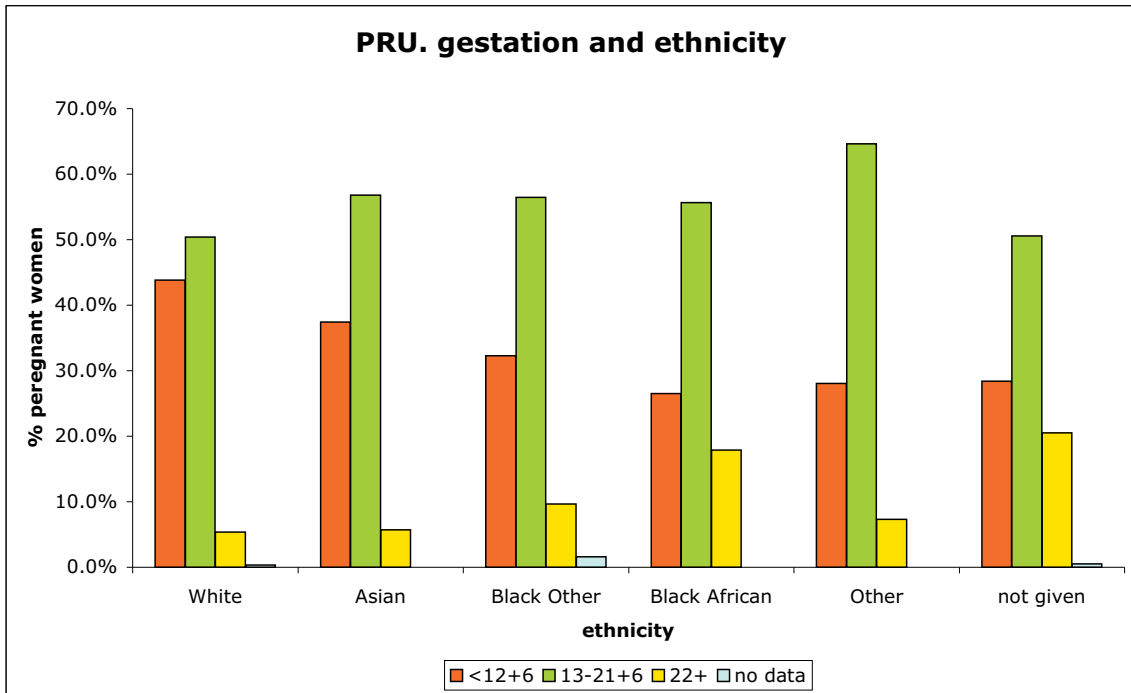
Gravidae and Parity:

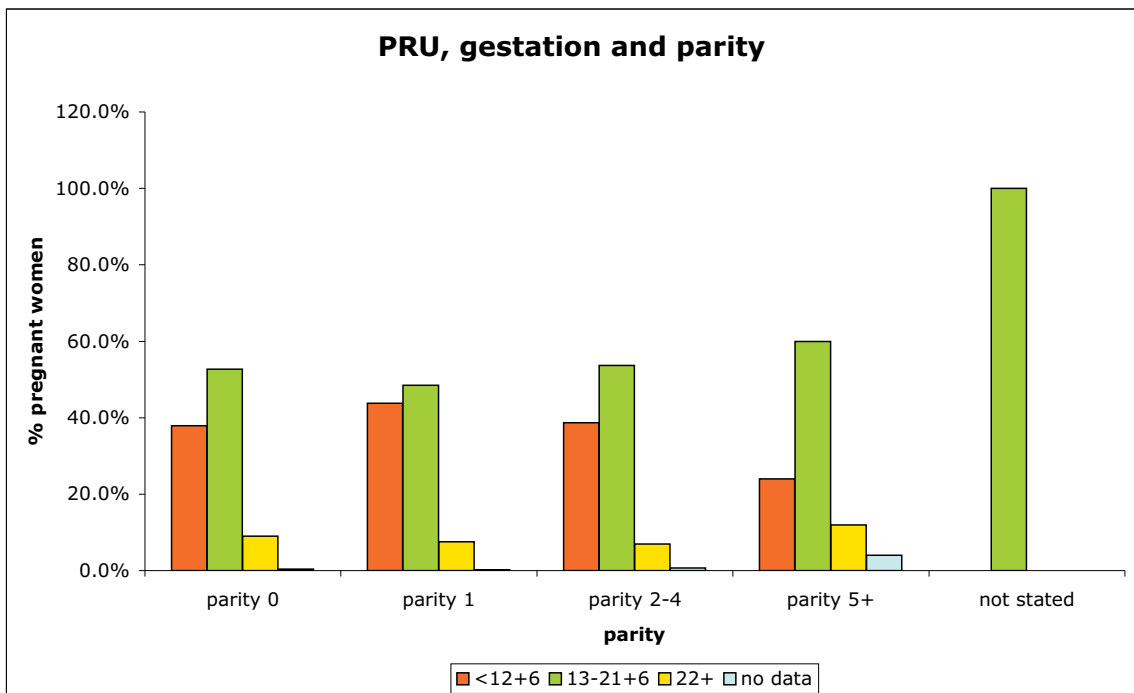
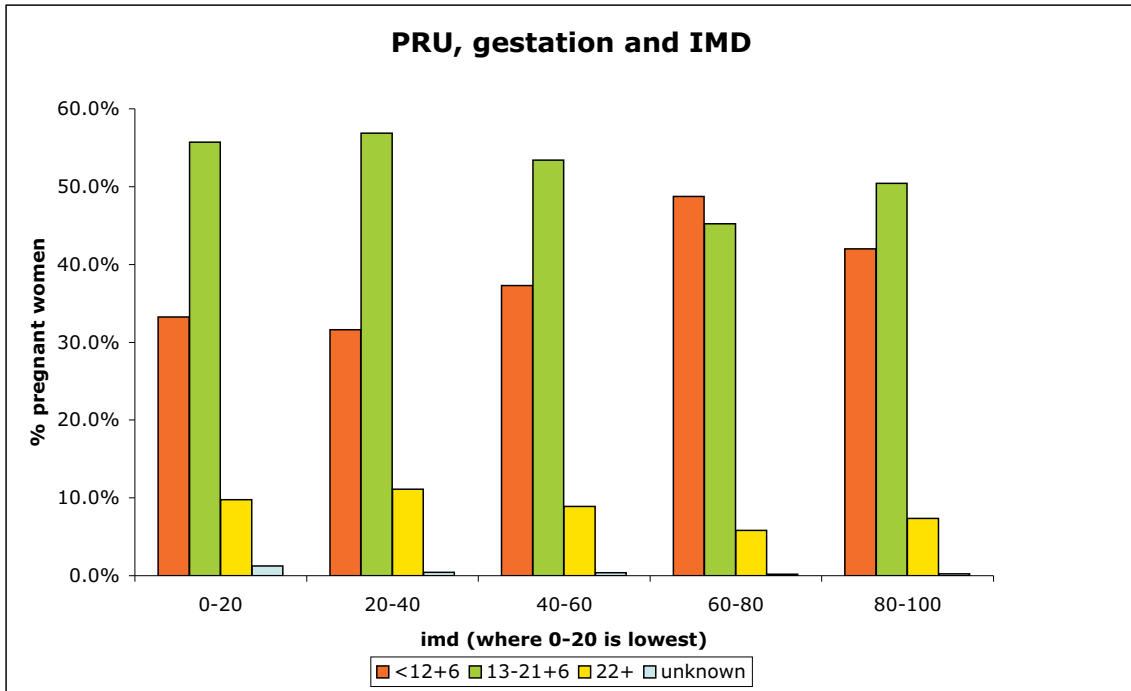
Number of times pregnant and no of previous children has little affect on date of access.

Conclusion:

UHL has an excellent uptake of needs, risk and choice assessment by the end of the 12th completed week which is unaffected by proxy fields of gravidae and parity, IMD, and age. White women are slightly more likely to book earlier.

PRU Graphs illustrating Bi-variant analysis





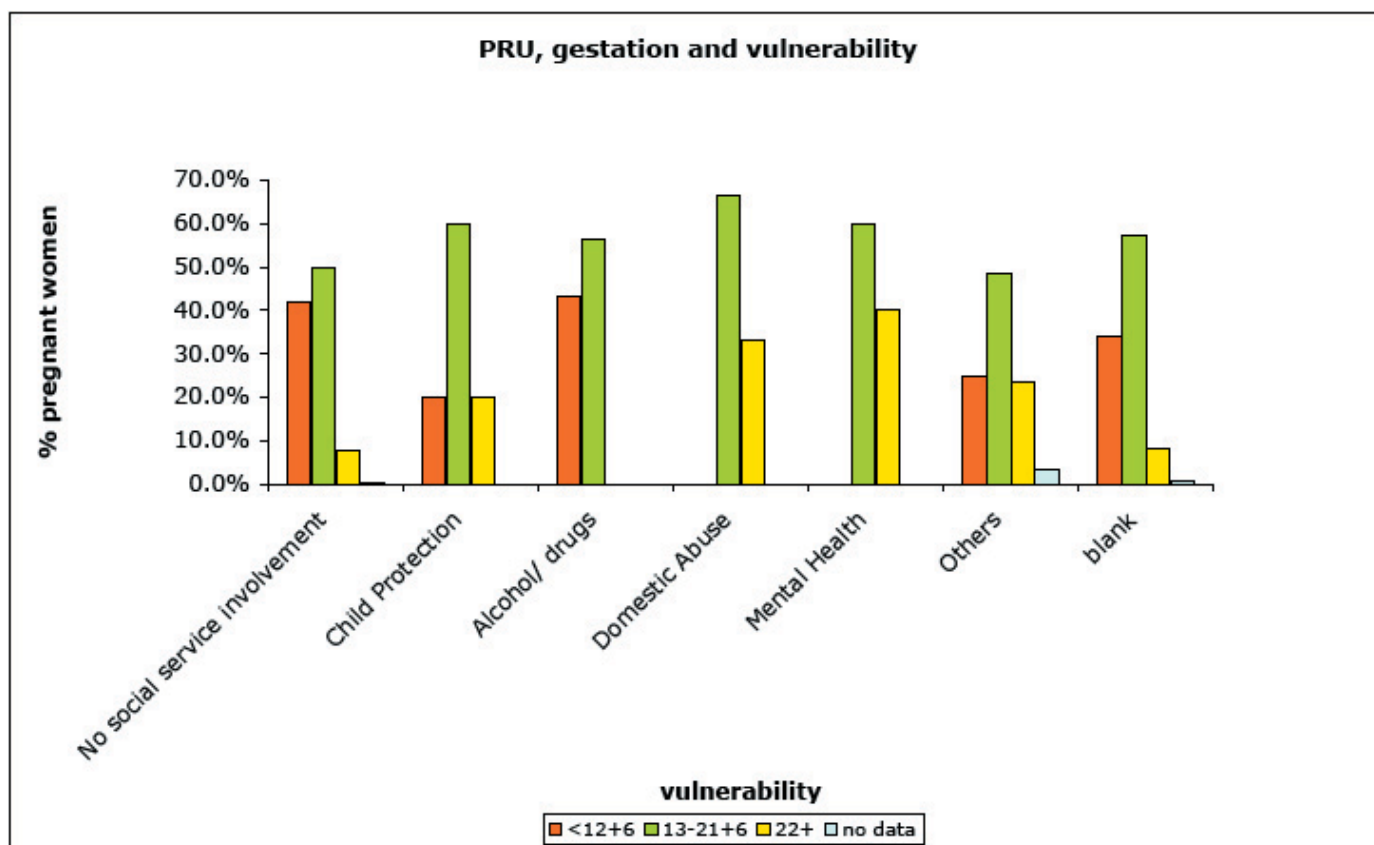


Table of Bi-variant analysis of PRU data (using excel). Total pregnant women :4319		Gestational age at booking				
		Total	12w+6 (%)	13w-21w+6	22+	unknown
Age	<18	59				
	18-24	670	30.5%	55.9%	13.6%	0%
	25-34		36.4%	49.7%	12.5%	1.3%
	35-44	2540	40.1%	51.8%	7.9%	0.2%
	45+	1030	42.2%	51.6%	6.0%	0.2%
Ethnicity	White	20	45.0%	55.0%	0%	0%
	Asian	3064	43.8%	50.4%	5.4%	0.4%
	Black	227	37.4%	56.8%	5.7%	0.0%
	Black African	186	32.3%	56.5%	9.7%	1.6%
	Other	151	26.5%	55.6%	17.9%	0%
IMD	Not Given	82	28.0%	64.6%	7.3%	0%
	0-20 is the lowest	609	28.4%	50.6%	20.5%	0.5%
	0-20	427	33.3%	55.7%	9.7%	0%
	20-40	721	31.6%	56.9%	11.1%	0%
	40-60	818	37.3%	53.4%	8.9%	0%
Parity	60-80	960	48.8%	45.2%	5.8%	0%
	80-100	1348	42.0%	50.4%	7.3%	0%
	Not known					
	Para 0	2133	37.9%	52.7%	9.0%	0.4%
	Para 1	1452	43.8%	48.5%	7.5%	0.2%
Vulnerability Social service involvement	Para 2-4	708	38.7%	53.7%	6.9%	0.7%
	Para 5+	25	24.0%	60.0%	12.0%	4.0%
	unknown	1	100%			
	No social service involvement	3263	42.1%	49.7%	7.9%	0.3%
	Child Protection	5	20.0%	60.0%	20.0%	0%
	Alcohol/ drugs	23	43.5%	56.5%	0.0%	0%
	Disclosed Domestic Abuse	3		66.7%	33.3%	0%
	Mental Health	5		60.0%	40.0%	0%
Other	60	25.0%	48.3%	23.3%	3.3%	
Blank	960	33.9%	57.5%	8.1%	0.5%	

Initial description and analysis of the data

PRU

Ethnicity:

White women (43.8%) who used maternity services in 2007 were able to access services earlier than their Black (32%) and Black African (26%) counterparts. This reflects the picture presented in CEMACH (Lewis, 2007).

IMD:

This was the most prosperous of the catchment areas in the SE Sector of London. The percentage of women who were able to access the needs, risk and choice assessment was higher for the more affluent women with 48% and 42% in the top 2 quintiles and 33% and 31% in the lowest.

Parity:

Women with 5 or more children booked later.

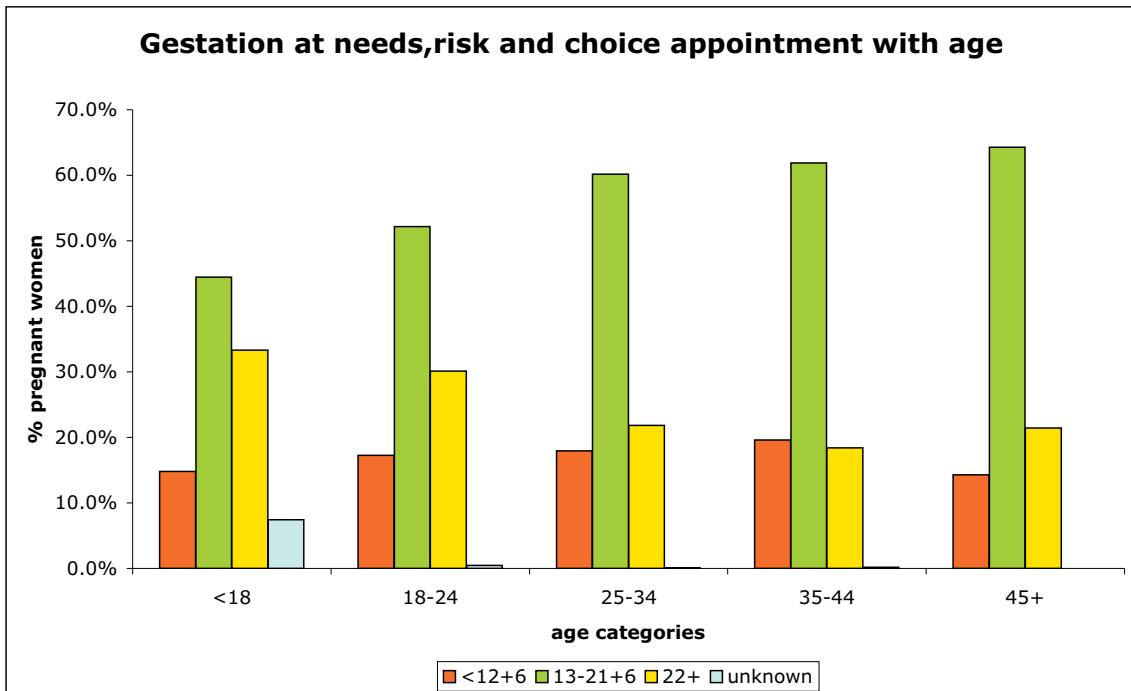
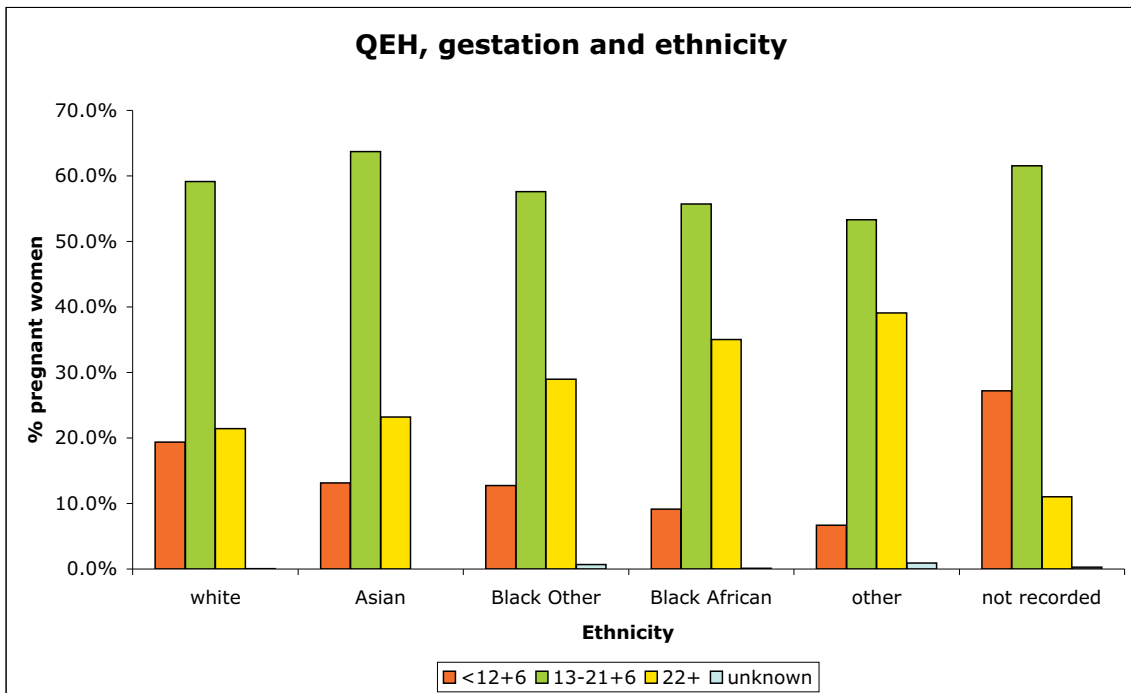
Vulnerabilities:

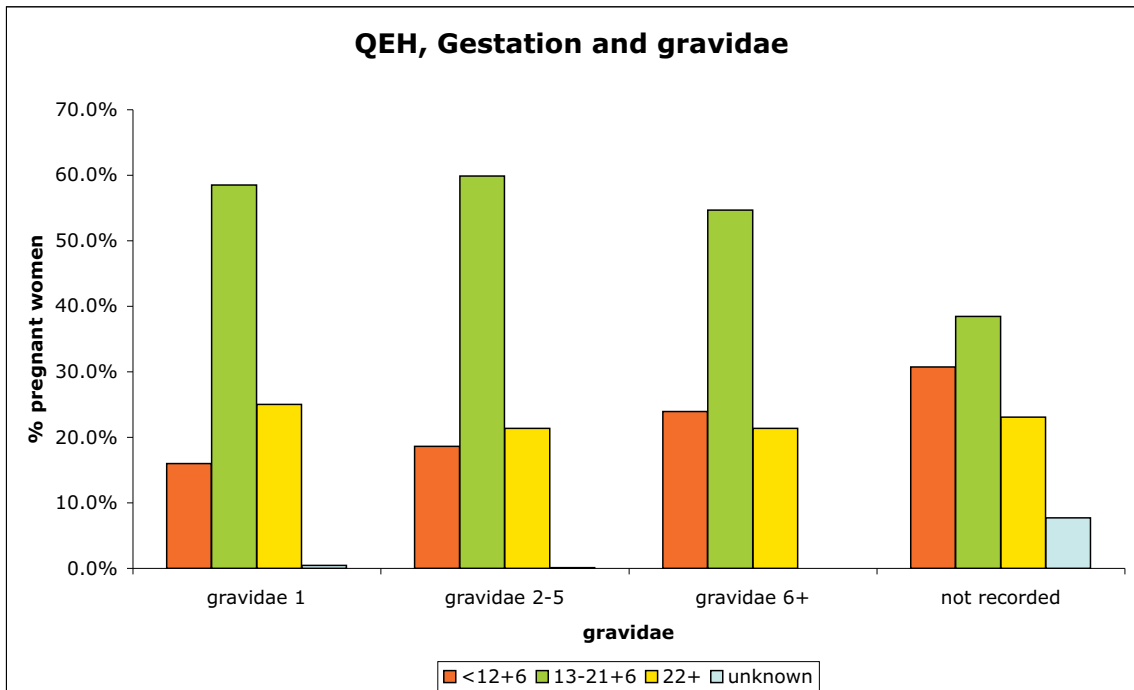
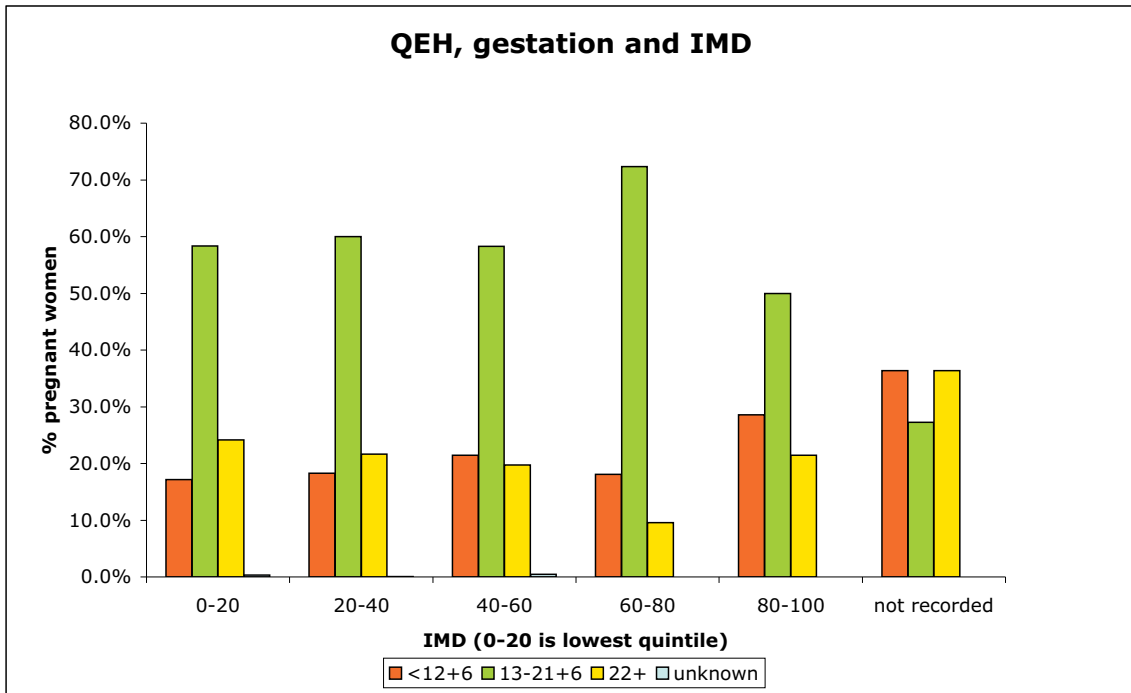
Apart from the 43% of Women with problematic alcohol and drug misuse who accessed before 12+6 the overall pattern was that vulnerable women accessed services later. This was particularly the case for women with mental health problems, women who disclosed domestic abuse and women where there were child protection issues. Teenagers were categorised under the 'other' group and here there is 25% access by 12+6 possibly reflective of the work conducted by midwives through local schools and Connexions.

Conclusion:

There are less specialist services and assertive outreach in Bromley. The numbers of women with known vulnerability are small, 96 in total of which 60 are from the 'other' category. From the numbers interpreted there is a correlation between late booking for vulnerable women in particular those with mental health problems and women who disclose domestic abuse. Women from the higher, more affluent, quintiles were represented in larger proportions in the optimal group who received a needs, risk and choice assessment by 12+6. Women with more than 5 children booked later. White women were more able to access services than Black women.

QEH Graphs illustrating bi-variant analysis





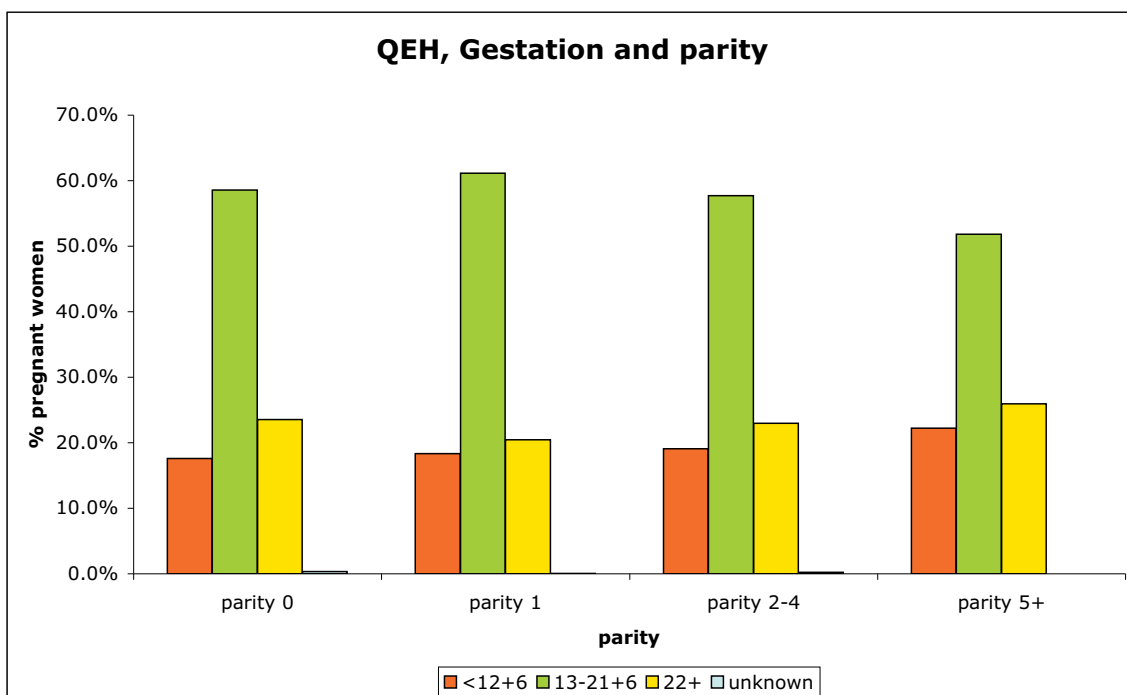


Table of Bi-variant analysis of QEH data (using excel) Total pregnant women : 4713		Gestational age at booking				
		Total	12w+6 (%)	13w-21w+6	22+	unknown
Age	<18	27	14.8%	44.4%	33.3%	7.4%
	18-24	824	17.2%	52.2%	30.1%	0.5%
Ethnicity	25-34	2673	17.9%	60.2%	21.8%	0.1%
	35-44	1175	19.6%	61.9%	18.4%	0.2%
	45+	14	14.3%	64.3%	21.4%	0%
	White	1492	19.4%	59.1%	21.4%	0.1%
	Asian		13.1%	63.7%	23.2%	0%
		358				
	Black	290	12.8%	57.6%	29.0%	0.7%
Black African	939	9.2%	55.7%	35.0%	0.1%	
	225	6.7%	53.3%	39.1%	0.9%	
IMD	Not Given	1409	27.2%	61.5%	11.0%	0.3%
	0-20 is the lowest	2222	17.2%	58.3%	24.2%	0.3%
	20-40	1939	18.3%	60.0%	27.7%	0.1%
	40-60	405	21.5%	58.3%	24.2%	0.5%
	60-80	94	18.1%	72.3%	9.6%	0%
	80-100	42	28.6%	30.0%	21.4%	0%
Parity	Not known	11				
	Para 0	2193	17.6%	58.5%	23.5%	0.3%
	Para 1	1496	18.3%	61.2%	20.5%	0.1%
	Para 2-4	970	19.1%	57.7%	23.0%	0.2%
	Para 5+	54	22.2%	51.9%	25.9%	0%
Gravidae	unknown					
	Gravidae 1	1381	16.0%	58.5%	25.1%	0.4%
	Gravidae 2-5	3052	18.6%	59.9%	21.4%	0.1%
	Gravidae 6+	267	24.0%	54.7%	21.3%	0%
	Unknown	13	30.8%	38.5%	23.1%	7.7%

Initial description and analysis of the data

QEH

Age:

The range of percentages in each age group who accessed the booking appointment by 12+6 ranged from 15-19% in 2007. More significantly late bookers, after 22 weeks increased with age, suggesting the care and access for teenager's works.

Parity:

Slightly higher percentage of women with 5 or more children access after 22 weeks, but overall parity does not appear to affect access.

Ethnicity:

Black African, Black Other and 'Other' ethnic groups were represented in greater percentages (29, 35 and 39%) in the category of women who booked after 22 weeks compared to 21% of White women. 1409 women had not given an ethnicity?

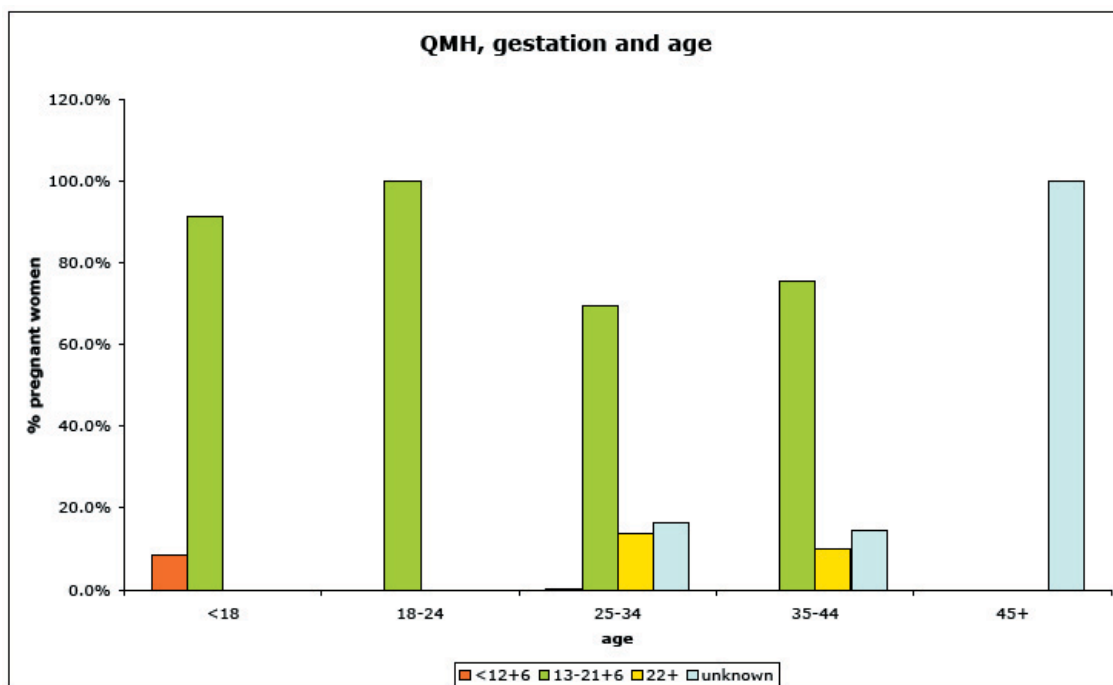
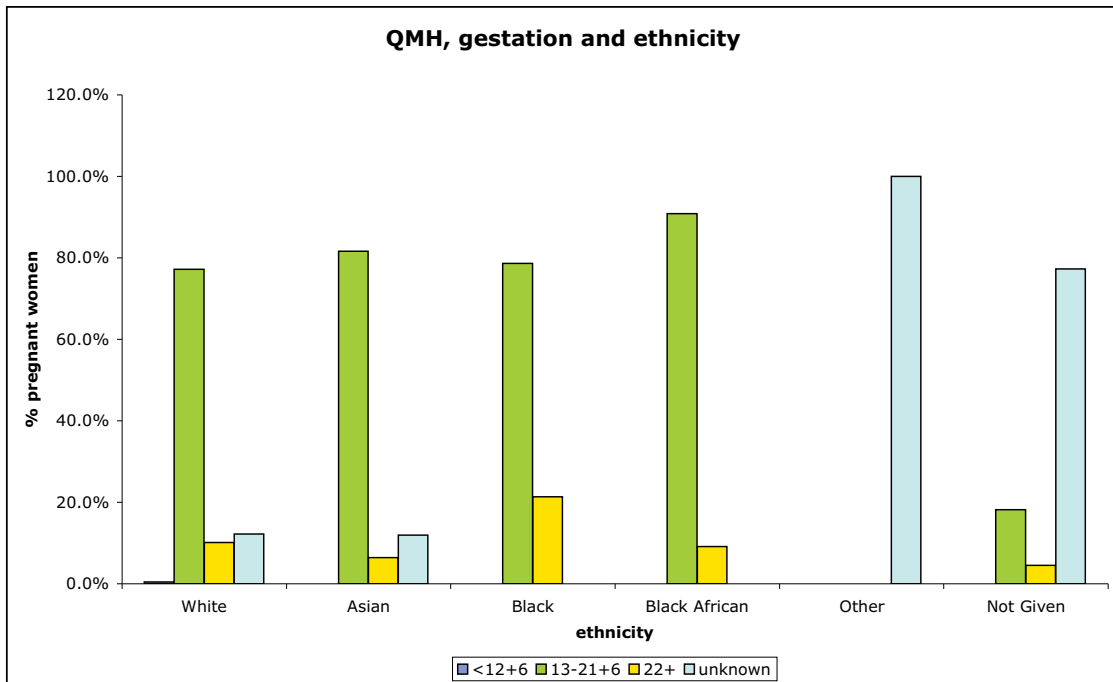
IMD:

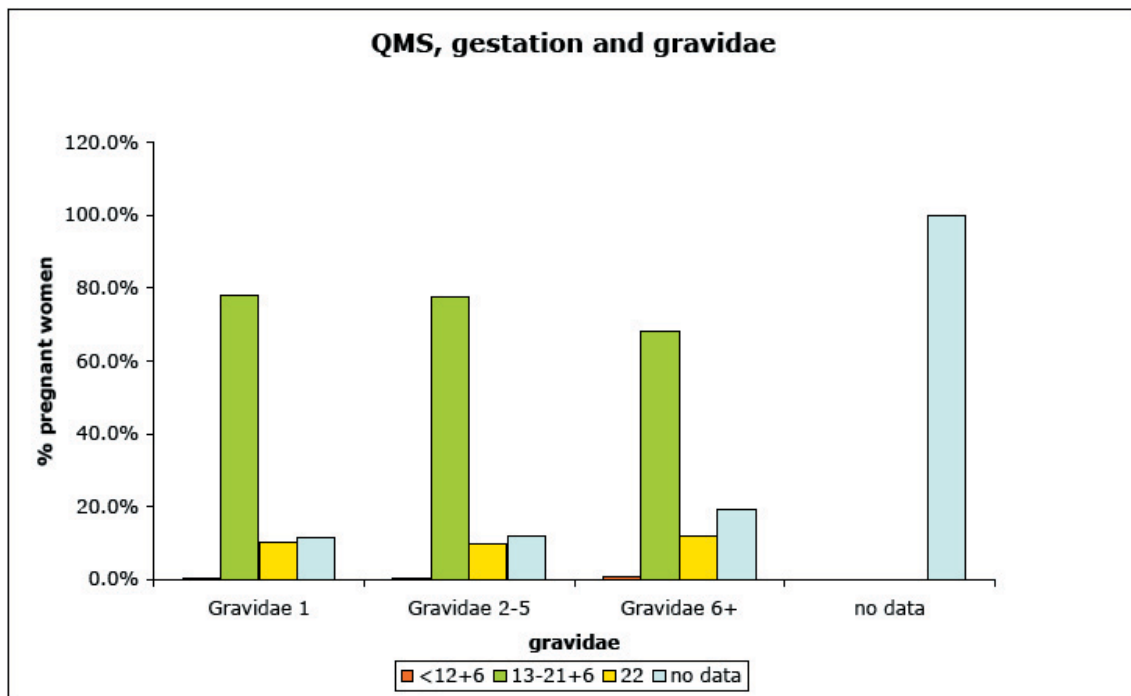
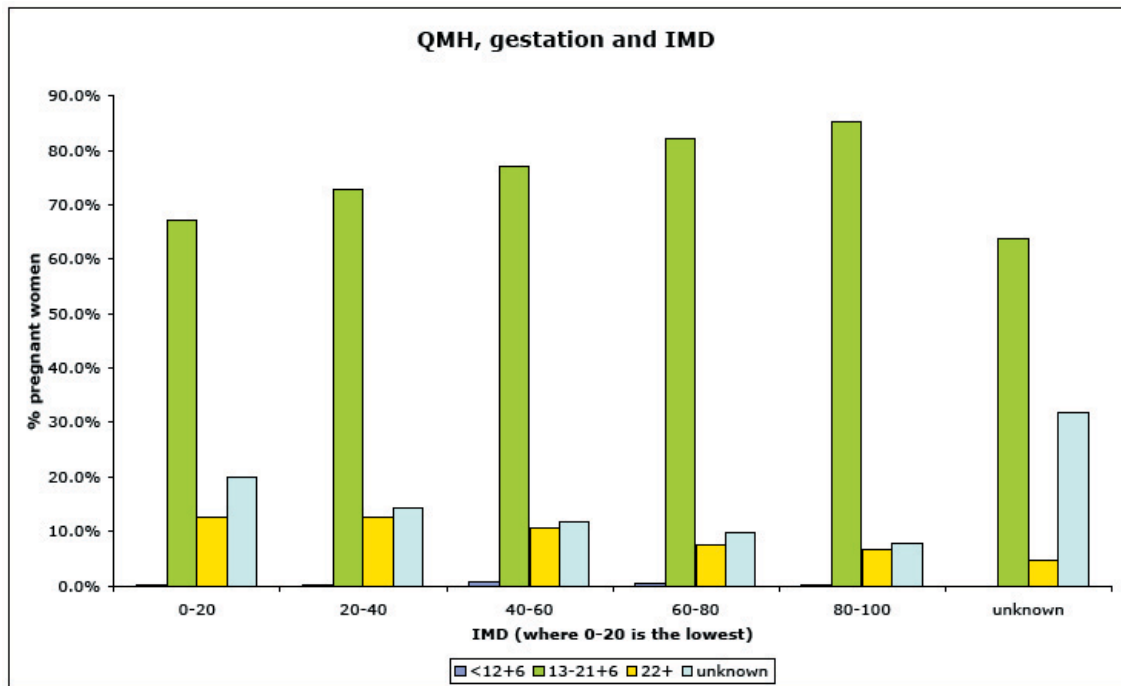
The women in the most prosperous quintile were more able to access services in a timely way, by the end of the 12th completed week of pregnancy otherwise there was little difference in the percentages of women represented in each group.

Conclusion:

Although there is equity of access across the majority of the population a small percentage of women in the most privileged quintile are able to access services earlier. Access for teenagers is good. A large number of records recorded ethnicity as not given, which makes this characteristic difficult to interpret. Women with 5 or more children accessed later.

QMS Graphs illustrating bi-variant analysis





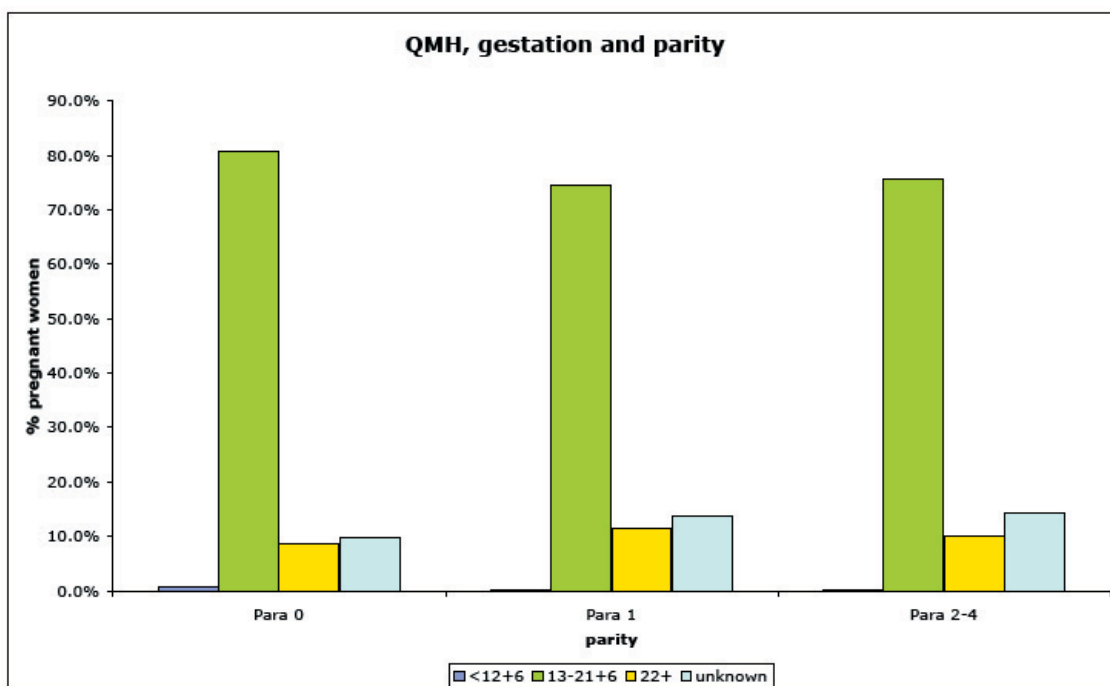


Table of Bi-variant analysis of QMS data (using excel) Total pregnant women :3391		Gestational age at booking				
		Total	12w+6 (%)	13w-21w+6	22 w+	unknown
Age	<18	71				
	18-24	671	8.5%	91.5%	0%	0%
Ethnicity	25-34	1980	0.3%	69.5%	13.7%	16.5%
	35-44	665		75.5%	10.1%	14.4%
	45+	2				
	White	2675	0.4%	72.2%	10.1%	12.2%
	Asian	218		81.7%	6.4%	11.9%
	Black	103		78.6%	21.4%	0%
	Black African	306		90.8%	9.2%	0%
Other	23					
IMD	Not Given	66		18.2%	4.5%	77.3%
0-20 is the lowest	0-20	498	0.2%	67.3%	12.7%	19.9%
	20-40	874	0.2%	73.0%	12.5%	14.3%
	40-60	620	0.6%	76.9%	10.6%	11.8%
	60-80	753	0.5%	82.1%	7.6%	9.8%
	80-100	624	0.2%	85.4%	6.7%	7.7%
Parity	Not known	22	63.6%	4.5%	4.5%	31.8%
	Para 0	1166	0.7%	80.7%	8.7%	9.9%
	Para 1	975	0.2%	74.6%	11.5%	13.7%
	Para 2-4	1250	0.2%	75.8%	9.9%	14.2%
	Para 5+					
Gravidae	unknown					
	Gravidae 1	955	0.2%	78.2%	10.3%	11.3%
	Gravidae 2-5	2277	0.4%	77.8%	9.8%	12.0%
	Gravidae 6+	141	0.7%	68.1%	12.1%	19.1%
	Unknown	72				100%

Initial description and analysis of the data

QMH

Age:

Because the current system for assessing and booking women is coordinated around a nuchal scan, most women book after 12+6. This is currently under review. However 8.5% of the teenage women are able to book in the more optimum time. More women above 25 presented after 22 weeks gestation.

IMD:

Women from the two lowest quintiles were represented as higher percentages (12.7% and 12.5%) than more affluent women dwelling in areas with a higher quintile (4.4%) in the group of women who booked after 22 weeks.

Parity:

This demonstrated negligible variability in the time of access. Women from an ethnic minority were more likely to book after 22 weeks.

Conclusion:

Teenage women were more able to book their care earlier than the majority of users. Women living within the two lowest quintiles were proportionately represented in greater percentages in the late booking group, after 22 weeks. This less equitable pattern was reproduced with ethnicity, with women from ethnic minorities booking later.



Conclusions, Reflections and Recommendations

Data collection

Changing provision of informatics within the NHS

There is currently a mixed economy of paper, hand-held notes and electronic records within the NHS. NHS Connecting for Health is currently changing the climate to ensure that all patient records are kept in an electronic format in the future. This recognises that good data systems are the lynchpin for monitoring current situations and planning for the future. Provision for this to become effective involves staff training in data management to ensure consistent and effective information management that is standards based and fully integrated with other key NHS governance areas. Within maternity provision a minimum data set is currently being produced within the Department of Health.

Ensuring safe and secure data transfer

The NHS Next stage Review (DH, 2008) highlighted the challenge of health in an age of information and connectivity. A central concern raised in the recent Health Informatics Review (DH, 2008) was the confidentiality of personal information, how it is stored, shared and used. Two of the questions raised in the review were;

" What patient information should be available electronically and how could this best be achieved? " ...And..." what information do you need to help you assess and improve services " (DH, 2008.8)

The Health Informatics Review and NHS Connecting for Health recommends increased use of secure N3 network and NHSmail, encryption of data and elimination of the need to exchange information on exchangeable mediums such as CD's and USB's. Connecting for Health advocates that no patient identifiable information should be sent to any e-mail addresses outside the NHSmail service. This builds on the NHS code of Practice for security of information, which provides a framework for NHS information based on legal requirements, standards and professional best practice. (DH, 2007). Importantly confidentiality should not be compromised by unauthorised third party access. The Confidentiality: NHS Code of Practice (DH, 2003) sets out the required standards of practice concerning confidentiality and patients consent to use their records. Best practice is guided by a legal framework, namely the Data Protection Act (1998). Primarily, information should be recorded accurately and consistently and should be physically secure.

Audits carry different guidelines than those governing research, where research is undertaken individuals need to consent to their information being used but for audits this is not a requirement.

" ...clinical governance and clinical audits, which are wholly proper components of healthcare provision, might not be obvious to patients and should be drawn to their attention" (DH, 2003.7)

However the guidelines go on to say that there is no need to seek explicit patient consent for audit when patients understand that some information about them may be shared in order to conduct an audit.

"The evaluation of clinical performance against standards or through comparative analysis, with the aim of informing the management of services, is an essential component of modern healthcare provision. Every effort should be made to ensure that patients are aware that audit takes place and that it is essential if the quality of care they receive is to be monitored and improved" (DH, 2003.44).

Standards in procedure regarding sharing of data are outlined in the Caldicott principles,

1. That the reason for sharing information needs to be justified,
2. Patient identifiable information should not be used unless absolutely necessary,
3. The minimum necessary patient information only should be used and that access to the patient identifiable information is on a need to know basis.

Following the Caldicott report on the Review of Patient-Identifiable information (1999) NHS staff were appointed as Caldicott Guardians with the responsibility to ensure that patient identifiable data is kept secure.

Provision within this audit for the safety of confidential information

For the purposes of this audit personnel providing the data were requested to send it encrypted via NHS mail. The data was then held within a secure file, accessed via password at Lambeth PCT and an encrypted USB.

Caldicott Guardians were assured that the data would be used for this audit only, an audit of the 6 providers of maternity services in SE London, and that the data would be shredded at the conclusion of this report. The data would not be used for any other audit either collectively across the sector or singularly per provider unit.

Apart from one unit, Greenwich that uses NHSmail routinely, personnel needed to access NHSmail in order to comply with the arrangements. Systems within units were not seamless to facilitate this. There was poor understanding of the importance of the instructions and several data sets were sent copied into other e-mails, which were not NHSmail. Connecting for Health makes clear that information that is identifiable should not be sent to e-mail addresses outside NHS,mail but there was poor understanding that: 'professional@hospitalinsector.nhs.uk was not the same as person@nhs.net'. Learning from the process of conducting this audit would recommend staff training and the allocation of NHSmail to anyone sending or receiving data.

Hand Held Notes

Information gleaned and recorded at the needs, risk and choice assessment is guided, especially by less experienced midwives by the midwifery notes. They are seen as a valuable means of empowering women and ensuring that information is shared. There was some hesitancy during the course of the fieldwork from those interviewed that there would be a move to have only computer based records in the future. The midwives felt that the hand held notes were essential especially for women who are more transient. There was some reservation about the confidentiality of both hand held and electronic records but that with hand held notes it was the women's responsibility, although for women with socially complex lives this may be over challenging. Nice Antenatal Guidelines (2008) should reassure that this is not the case, rather that national maternity notes with structure standardised information sharing is the future. Hand held notes in the SE sector

are not standardised, antenatal information pages vary in the depth of 'interrogation'. More experienced midwives gave assurance that for them this was not a problem, however they thought that for some newly qualified midwives there may be loopholes to fall through because of time pressures and inexperience.

Monitoring of Access to Maternity Services in the UK: A basket of markers for local caseload audit

A case note audit in SE London conducted in 2005-2007 to develop a 'basket' of access markers for local monitoring of maternity services found that there was:

- "Lack of consistency in the extent of detail recorded in care givers' accounts. The lack of homogeneity in the recording of information was noticeable...
- Poor recording on some data items...Audit does not allow one to discriminate easily between poor recording and inadequate provision of information or service. Poor records may be expected to reflect a combination of both, and it is important to bear this in mind when interpreting results" (Buller et al, 2007.63).

Information recorded on the Electronic data base

Postcode was requested for reviewing the Index of Multiple Deprivation (IMD) but not the address or hospital or NHS number or name; however the free text area on the data system for a number of entries gave personnel identifiable information such as the name people liked to be called. There was a lack of consistency in what was recorded electronically, one person, for example, may have recorded social worker involvement, problematic drug use etc and another entry would have just 'confidential'.

The skeletal Information collected and recorded across the sector in the handheld notes at completion of the needs, risk and choice assessment showed consistency; however what was recorded onto an electronic database varied (Appendix.3.).

Quantitative awareness of current users of maternity services

Handheld notes are important for the provision of individual care between the woman and midwife, Obstetrician or other provider however if information is not recorded electronically predicting workloads and service provision becomes more difficult. Midwives interviewed in the course of this audit repeatedly commented about an escalating workload, that women with complex social or medical needs required more input in time and resources. If these issues are not quantifiable it is difficult to make provision, an awareness of how many women for example have a BMI above 35 would be useful to know prior to the delivery episode, if there is an increase in the number of women seeking asylum in the area or women who have Female Genital Cutting (FGC). Tracking changes in the population demographics cannot even be done satisfactorily retrospectively if there is reliance of someone going through handheld notes using calamitous dots.

None of the units could provide all the information with proxy fields requested for the audit. Further, where units did record information it was coded differently thus in one unit only severe diagnosed mental health problems are coded, in another a range of mental health problems and or treatments. A lack of 'drop down menus' meant that there was often a broad spectrum of entries recorded differently but meaning the same thing, for example the spelling of ethnic backgrounds.

Ability to respond to requests for information

Prior to commencement of the project the six units in South East London were consulted and wished to take part in the audit. There was a clear commitment to providing the data and no indication that this would prove challenging. At the beginning of the audit all the units were visited and heads of midwifery, senior midwives and staff working on the data were met and the audit explained. Further information was provided by e-mail and in a few cases where people were absent there were telephone conversations. Although all the units were aware that they could not provide all the data for the proxy fields the basic categories such as gestation at completion of the needs, risk and choice assessment were promised. Several 'dead lines' for data became an illusion, as only one unit was able to provide the data. Liaison with the people working on the data highlighted expertise needed to manipulate the data systems to provide the data was significant, where significant people were off sick or on holiday there was simply no one else who could provide the information. Several units had difficulty in giving the gestation, for one unit the accuracy of this data was questionable as the system does not require the 'booking' date to be put in the system, thus if the computer records are not completed contemporaneously with the appointment compliance to the PSA 19, indicator 4 are not going to be accurate. One unit did not have in-house expertise to provide the data as an excel spreadsheet or to manipulate the data to provide gestation, fortunately the PCT was able to provide this expertise.

Across the sector a recurrent comment from those set the task of sending the data was that they worked with systems that needed upgrading, in sum dinosaur systems that are not fit for the changing needs of information sharing. Systems in some cases had the data but this could not be extracted, in others the data was never entered.

On questioning, units were already producing data for other audits, for example, the Local Supervising Authority, The Health Care Commission and the local PCT. Numerous clinical reviews such as decision to delivery time by Caesarean are built into the system so can be retreated easily. Information requested especially around PSA targets for breast-feeding and smoking cessation was routinely collected. Although for most of the units PSA 19 remained problematic for KCH it is monitored monthly which includes a question as a drop down menu to ascertain when a woman presents late why this is. In addition KCH collects data regarding the first contact with a health professional and the information given or discussed.

Staff providing this data included a systems manager, midwives and clerical staff, the paucity of the results are a reflection not on the effort and work they put into providing it but a reflection of a truly Cinderella section of the system. Apart from KCH there was a unanimous call for improvements in IT facilities and systems, training and ongoing support for themselves and their colleagues inputting the data. Empirically there was an impoverished support set up between the IT departments in the individual units and the individuals tasked with providing the data.

The basic quantitative data for the whole SE sector was not received until the last day of May, a total of 5 months from commencing the audit which had an affect on what could be achieved within the confines of the project.

Data systems in SE London

Within the SE sector a number of different data systems and editions are in use to record and store maternity records including Terranova, Healthware, Protos, Euroking and E3 Maternity system (Euroking) and earlier versions of Euroking, Hospital Information Support System. There are plans for one unit to change to CERNA LC1.

The software used by KINGS is E3 Maternity System and this was the only unit able to provide the data within the initial deadline. Kings also routinely collects gestation at completion of needs, risk and choice assessment monthly. Senior personnel in a number of the units requested information about E3 is shared (appendix. 1.).

In addition there are a number of other data systems that records information about women using maternity services including Cerna, PAS, Electronic Patient Records, PMI, Oasis and Viewpoint. There are varying levels of interface between these systems.

Quantitative data analysis, Reflection on the Methodology

Data received from the units was first 'cleaned'; meaning that duplicate records, records where the woman's age was given as 67 etc were eliminated. Normally records with a high amount of unknown data would also be disregarded at this point but for the purposes of this audit were left in. The rationale for this was that it was important to demonstrate the level of unknown, unrecorded data. This was not always of a sensitive nature, for example place of booking. Unrecorded data may represent a data field that practitioners feel uncomfortable asking, such as alcohol consumption or ethnicity, changing systems for recording information, or a lack of awareness of the importance of electronic data bases as records. There is a large amount of data to be collected and recorded by the completion of the needs, risk and choice assessment in addition limited resourced time and facilities to do this, limited availability of computers, limited training in the importance of electronic records and for some people who do not have the computer skills poor inputting skills.

Data was then coded further using excel. The coding was commences with the data from KCH but as other data sets tricked in it became apparent that there was little if any uniformity across the sector in recording the data. The coding was thus modified to try to accommodate the differences and enable any description to be valid. The next section will elaborate on the complexity and technical hitches incurred in the coding process. Certainly it would be a firm recommendation to collect data first, then code all together and that this process should be done as a multi-disciplinary exercise.

Pivot tables were then produced and graphs to pictorially represent the data. This data was bi-variant, thus, for example the percentage of women who 'book' by the end of the completed twelfth week of pregnancy by age category, ethnicity, mental health, parity etc.

It was hoped that a multi-variant of the KCH data would be conducted and ready for this report, however competing priorities meant that this was not possible. This underlines that all levels and systems are busy and that presumptions should not be made that 'something can just be done' by a different team. If, as is necessitated by the PSA 19 indicator regular audits are to be done to track improvements in timely access to care it is imperative that skilled staff are available to analysis and manipulate the data. The coding and description were produced using excel and could, with training, be produced in house

by the provider, however the work around the Index of multiple deprivation (IMD) would need to be PCT level. Owing to the difficulty in units providing the data and the timescale of the project it was not possible to take each units data back to them for interpretation. It is hoped that this report will form the basis for this to be done.

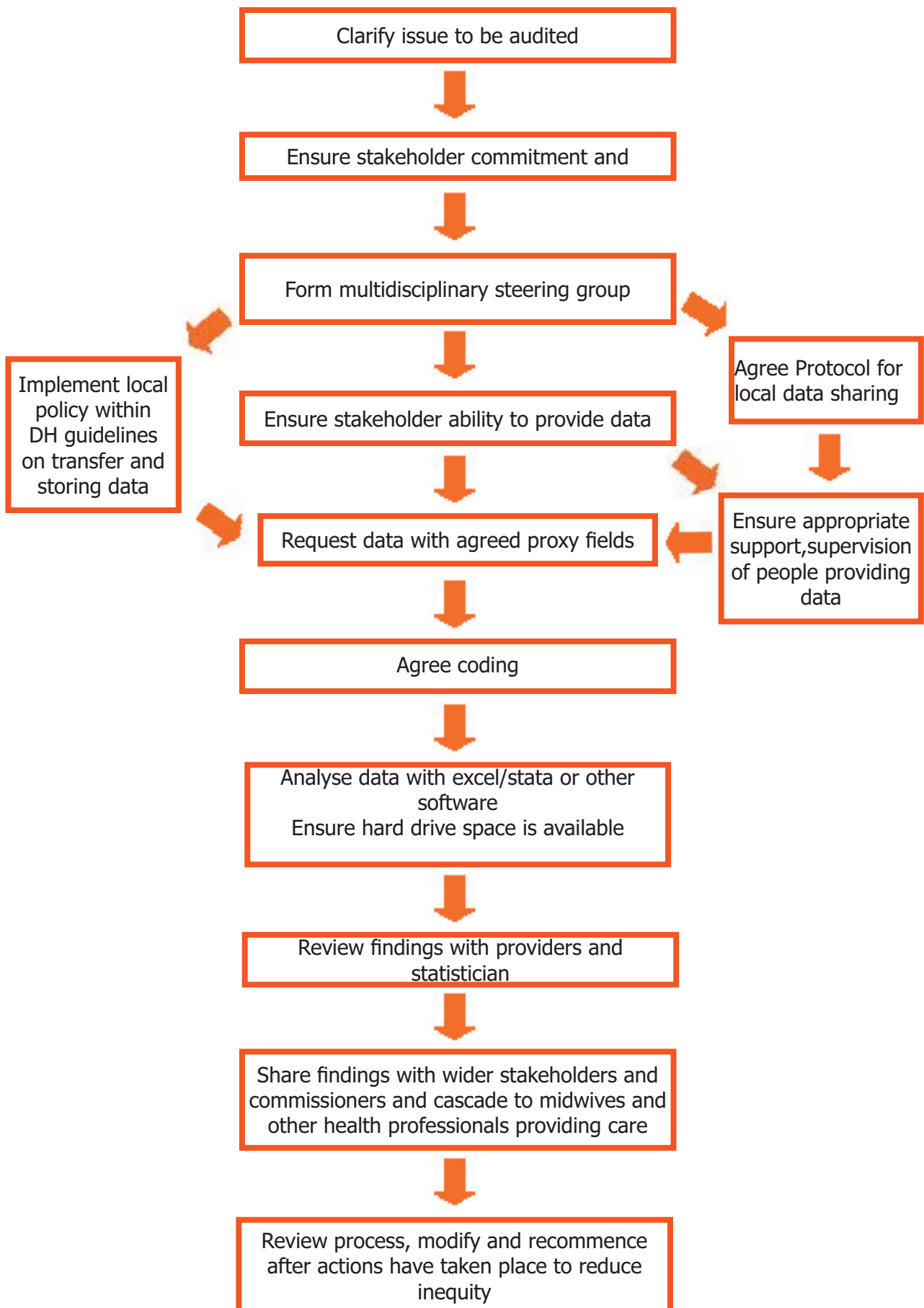
Qualitative Data Collection

All 6 of the maternity provider units were visited on a number of occasions, the Heads of Midwifery and other senior staff were interviewed together with at least two midwives providing assertive outreach work from each of the units. There was a plethora of examples of excellent and emerging good practice.

Three questionnaires were used in the audit to clarify issues and give midwives an opportunity to contribute. The first concerns the data systems used, the second a means to map the provision in Children's Centres and the third a small 'snapshot' of midwives perspectives on direct access (Appendix. 2, 4 & 5.). The responses to the latter was small in number, several units returned the questionnaire as hard copies, many midwives commented that they had not picked up the questionnaire amongst the plethora of messages in their in-box. The dearth of available computers in the units and the need to give up a computer for a colleague who needs to input clinical information as opposed to 'just ' looking at e-mails may have had a contributing to the low numbers received. Several people rang to ask how to complete the form on the computer.

Lastly a literature search was conducted. Personal in the Provider Units were asked by e-mail, in person and at the Stakeholder meeting mid project to contribute any 'grey' literature. Midwives were also asked for fliers and information about outreach services, most could not provide this in an electronic format.

Diagram 2.
Conducting a baseline health equity audit within maternity services



Rationale, Coding and challenges of Proxy fields for Audit

Proxy Field	Rationale	Comments and Challenges
<p>Ethnicity</p> <p>Ethnicity is subjective the DH guidelines (2005) advise that a person assigns his or her own ethnic group, features to help include a shared history, cultural tradition, geographical origin, descent from common ancestors, a common language, a common religion, a distinct group within a larger community.</p>	<p>In the most recent Confidential Enquiry into Maternal and Child Health, 'Saving Mothers' lives' (Lewis, 2007) migrant women were found to have poorer outcomes. Women arriving in the UK may have relatively poor overall health on arrival and are more likely to be a risk of TB and rheumatic heart disease, are less likely to know how to access services. It states that although the coding of ethnicity may be problematic, based on Hospital Maternity Episodic Statistics (HES) the mortality rate for Black African women and to a lesser extent Black Caribbean and Middle Eastern women is higher than for white women. This, the report states, may be due, not just to cultural factors around ethnicity but social circumstances and that some women may have recently migrated. The Race Relations Amendment Act 2000 requires the NHS to demonstrate compliance with the statutory duty to promote race equality, where evidence from monitoring shows unequal outcomes authorities are required to take action to promote greater equity and to overt direct and indirect discrimination.</p> <p>In the Healthcare Commission Report (HC, 2008) there was some association between women who booked late and their ethnicity. 75% of White British women reported they were booked by 8 weeks, only 5% after 12 weeks whereas up to 15% of certain ethnic groups booked later than 12 weeks</p> <p>It is important to know ethnicity in order to interpret some screening tests, for example Haemoglobinopathies.</p>	<p>The categories were originally drawn from the Census classification with 18 fields, which were agreed by the steering group. They were later aggregated into 6 categories. These were then modified to fit the sector, thus Black African has a category to itself and Black other, Black British and mixed became a category. Ethnicity can be de-aggregated a local audit may wish to find out how many Polish or Turkish women, for example, are within their service users population in order to target them.</p> <p>Since April 2005 the DH has directed the NHS to collect information on the ethnicity of individual hospital in-patients, the Hospital Episodic Statistics (HES).</p> <p>The DH guidelines (2005) provide an excellent starting point, which unfortunately was not discovered until after most of the coding had been done. Modifications and adaptations to fit local data would best be done within a team and only once all the data had been collected.</p>

Ethnicity Coding	Initial Coding	Final Coding
	<p>White British (British, English, Welsh, Scottish)=1</p> <p>White Irish=2</p> <p>White other (Albanian, all former USSR, other white, other former Yugoslavia, Gypsy/Romney, Greek, Iranian, Turkish Cypriot, Iraqi, Croatian, Turkish, Cypriot, Kosovan, Kurdish),=3</p> <p>Asian/Pakistani (includes British Pakistani)=4</p> <p>Asian/Bangladeshi (including British Bangladeshi,)=5</p> <p>Asian/Indian=6</p> <p>Asian/Vietnamese=7</p> <p>Asian/other (Sri-Lankan Asian/Chinese, Japanese, white Asian, Tamil, British Asian, Caribbean Asian, mixed Asian, Filipino, Malaysian and white Asian)=8</p> <p>Mixed white and Black Caribbean=9</p> <p>Mixed white and Black Africa=10</p> <p>Mixed white Asian=11</p> <p>Mixed/any other mixed=12</p> <p>Black Caribbean=13</p> <p>Black African (Algerian, Sudanese, Ethiopian, Somali, Ghanaian, Nigerian)=14</p> <p>Black/any other black background (Black British, Black Chinese, Arab. Mixed Black, Other Black African)=15</p> <p>Chinese=16</p> <p>Any other group (Columbian, middle Eastern, Ecuadorian, Other Latin American)=17</p> <p>Not stated=18</p>	<p>White=1</p> <p>Asian=2</p> <p>Black=3</p> <p>Black African=4</p> <p>Other=5</p> <p>Not given=6</p>

Proxy Field	Rationale	Comments and Challenges
<p>Female Genital Cutting (FGC/FGM)</p>	<p>In the most recent Confidential Enquiry into Maternal and Child Health, 'Saving Mothers' lives' (Lewis, 2007) the prevalence of FGC in a population of inward migration was increasing. The report highlighted that FGC can affect a woman's pregnancy and that the deaths of at least four women were connected to the consequence of the procedure. The report recommends that;</p> <p><i>"Women from countries where genital mutilation, or cutting, is prevalent should be sensitively asked about this during their pregnancy and management plans for delivery agreed during the antenatal period"</i> (Lewis, 2007.x1)</p> <p>The CEMACH report highlights that late disclosure may have contributed to a woman's death, for another it was not apparent that she had undergone FGC until she presented in labour. The needs, risk and choice assessment is concerned with sharing information and planning care.</p>	<p>GSTT have the FGM Well Women clinic run by Comfort Momoh. Women self refer to this clinic or may be referred by a professional. An audit is not currently kept on how many access maternity services through this clinic.</p> <p>Challenges: Only KCH was able to provide this data.</p> <p>85 women at KCH had undergone this procedure. The number is likely to be higher because it was only collected and recorded electronically in the second half of 2007.</p> <p>Although KCH codes into types of FGM on the E3 data audit the coding was simplified for the purposes of this yes and no/ not recorded</p> <hr/> <p>Final coding</p> <p>1=Yes 2= No/ not recorded</p>

Proxy Field	Rationale	Comments and Challenges
<p>No recourse to public funds</p> <p>Public Funds includes a range of income related benefits together with housing and homelessness support. No recourse to these funds applies to people who are from a country that is not part of the European Economic Area, people with limited leave to enter for example those on a work permit, student or marriage visa, people at the end of the asylum process who have not been successful in their application, migrant workers without a permit trafficked women. In sum very vulnerable women.</p>	<p>In the most recent Confidential Enquiry into Maternal and Child Death (Lewis, 2007) a new category presents of the Health Tourist. At least five of the women who died in the last triennium had come to the UK specifically with the intention of access to health care; possibly 6 other women came as asylum seekers.</p> <p>Women who have no recourse to public funds are particularly vulnerable, not just in terms of health care but the whole remit of social provision for themselves and their children.</p> <p>" Mrs S, 38 weeks pregnant. Mrs S came to us during her 38th week, having had no prior antenatal care. She had been refused maternity access at her local GP surgery and had been informed that she would not be able to deliver at her local hospital" (Project London, 2008.18).</p> <p>Project London, which operates a free clinic in East London for people who have difficulty in accessing care are registering increasing numbers of pregnant women who have not accessed care from all over London. In 2006 there were 39 women and in 2007 a total of 118 women.</p> <p>..."more than 25% of the women were more than 18 weeks pregnant and had had no antenatal care" "Project London, 2008.18).</p> <p>Confusion over f the 2004 regulations regarding entitlement to NHS care have impacted on access to care for some women (Kelly and Stevenson, 2006). The guidelines for Entitlement to Health Care are under review but the current DH guidelines are that maternity care is termed as immediately necessary care and should always be given. All antenatal, birth and postnatal care should be provided irrespective of ability to pay (DH, 2004).</p>	<p>Discussions with a number of midwives demonstrated that women with no recourse to public funds were sometimes admitted as in patients / and or there was difficulty in transferring them home thus incurring costs to the Trust whilst not particularly helping the mother and baby. Many of the midwives interviewed stated that it was important that women who had no recourse to public funds were supported. Women with no recourse to public funds presented Child Protection Issues, however they remarked that it was imperative that the mother and baby remain together as a Human Rights Issue.</p> <p>A specialist midwife operates in many of the units to coordinate and monitor particular vulnerabilities such as domestic violence and child protection issues, the overseas officer may also have records; however it was evident from discussions through this project that women do not disclose this information voluntarily.</p> <p>Final coding This was not collected by any of the units on the maternity database. NO Data available for coding</p>

Proxy Field	Rationale	Comments
<p>Gravidae and parity Gravidae means the number of times a woman is pregnant Parity is the number of previous babies born after 24 weeks, including stillbirths. Earlier pregnancy losses are documented as + For example G3 P1+1 would indicate a current pregnancy, a baby born after 24 weeks and a loss, either a miscarriage or termination of pregnancy.</p>	<p>To ascertain whether increased parity or pregnancies affected when women completed the needs, risk and choice assessment.</p> <p>If women who already have children 'book' later (Anecdotal data that women with children are too busy and they are more confident in their pregnancy) or whether provision in Children Centres which are providing a midwifery service aids access because they are already engaging with the service.</p>	<p>Final Coding</p> <p>Gravidae:</p> <p>1= Gravidae 1 2=Gravidae 2-5 3= >or = Gravidae 6</p> <p>Parity:</p> <p>1=Para 0 2= Para 1 3= Para 2-4 4= Para 5+ 6= not recorded</p>

Proxy Field	Rationale	Comments and Challenges
<p>Disclosure of Domestic Abuse</p> <p><i>"Any incidence of threatening behaviour, abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality"</i> (Home Office, 2005).</p>	<p>19 women, in the last Confidential Enquiry died as a result of Domestic Abuse, for 70 women it was a contributing factor.</p> <p><i>" lesson to be learnt from them concerning the identification and management of women living with abuse as well as the impact it has on their ability to seek regular health care...81% of the women who died of Direct or Indirect causes and who were in abusive relationships found it difficult to access or maintain contact with maternity services"</i> (Lewis, 2007).</p> <p>Responding to domestic abuse. A handbook for health professionals (DH, 2006).</p> <p>The National Service Framework, Standard 11 (DH, 2004) specified that maternity services should be,</p> <p>"Commissioned within a context of managed care networks and include a range of provision for routine and specialist services for women and their families "(DH, 2004.5).</p> <p>Recommendations made in the CEMACH (Lewis, 2007) report include,</p> <ul style="list-style-type: none"> • Routine enquiry at the needs, risk and choice assessment or at another opportune point in the antenatal period. • Where possible women should be seen at least once to enable disclosure. • Local Trusts should develop guidelines and multi-agency working. 	<p>Challenges: Only recorded in 50% of provider unit database and poor data entry.</p> <p>GSTT has an advocacy service and referral pathways for women who disclose domestic abuse. The maternity providers have mandatory training each year and the results of questioning are coded in the hand held and computer records, however for 2007 there were 3357 electronic entries with no record. An audit conducted by Bacchus in 2007 showed that routine enquiry had risen to 47% with the training. At KCH routine training is also undertaken and the affect of a changing data system affected the result.</p> <p>Final Coding</p> <p>1= no disclosure 2= disclosure 3=no record</p>

Proxy Field	Rationale	Comments and Challenges
<p>Index of Multiple Deprivation</p> <p>English Indices of Multiple Deprivation 2007. Department of Communities and local Government.</p> <p>This is a score based on small local areas called super output areas within electoral wards in England. The postcodes are used to code the addresses that are then grouped into quintiles. It brings together 37 indicators of aspects of deprivation including Income, Employment, Health and Disability, Education, Skills and Training, Crime, Living Environment and Housing services (Noble et al, 2008)</p>	<p><i>"...a clear gradient between the mortality rates for the least and most deprived areas and that mortality rates in the most deprived quintile were around five times higher than in the least deprived quintile. This was true for both Direct and Indirect causes of death independently"</i> (Lewis, 2007.37).</p>	<p>Challenges: Postcode to enable this coding to be done needed to be negotiated through the Caldicott Guardian for one unit. Owing to holiday, sickness and a change of people in positions to give permission this held up the data being released. It was released with the proviso that the data would only be used for this audit and then it would be destroyed</p> <hr/> <p>Final Coding 1= 0-20 (most deprived) 2=20-40 3=40-60 4=60-80 5=80-100 6=no record.</p>

Proxy Field	Rationale	Comments and Challenges
Mental health	<p><i>"All women should be routinely asked in early pregnancy about current and previous mental health problems...maternity staff should sensitively, but explicitly, enquire into the nature and severity of these problems"</i> (Lewis, 2007.152).</p>	<p>50% of the Sector providers collected this information on their electronic database, one unit the PRU, collected it under a broader vulnerable women category. KCH and GSST had different coding. Initially tried to code to reflect NICE guidelines. With categories such as, no mental health problems, counselling/ psychotherapy, including anxiety, eating disorders, domestic abuse and social problems, bereavement and panic attacks, diagnosis of severe mental health problems and not recorded. Bereavement is clearly not a mental health illness and domestic violence is another category although it is recognised that fields and characteristics combine. GSST records only women with severe mental health problems who are referred to the MAPPIN Team. The PRU just yes or no to mental health with no sub categories for a wide spectrum of conditions. QMS refers all women who have mental health problems via a multidisciplinary team. The counsellor in that team records data but this is separate from the data being analysed for this audit.</p> <p>In the coding below there had originally been a category for self reported symptoms but it was not possible always to know who was being treated and who was managing their mental health independently.</p> <p>Being aware of how many people within the maternity antenatal demographic has mental health issues could help to plan services to improve outcomes for mother and baby. None of the coding had personality disorders mentioned</p> <hr/> <p>Final Coding 1=No mental health problems 2= self reported symptoms Counselling/psychotherapy, including anxiety, eating disorders, domestic abuse and social problems, bereavement and panic attacks 3=Diagnosis of severe mental health problems (including depression treated by GP, overdose or self harm, and postnatal depression). 4= not recorded GSTT records only severe mental health.</p>

Proxy Field	Rationale	Comments
Claiming benefits	This was part of estimating the socio-economic situation of the woman and her partner	Only collected by KCH
		Final coding 1=no 2=yes 3= not recoded/disclosed

Proxy Field	Rationale	Comments and Challenges
Housing status	Ascertain security and vulnerability. Enable a picture of the holistic needs of the mother and baby. As a marker of social class classification. This gives an idea about integration within the area and the possibility therefore of those who are more transient experiencing more difficulty in access. It may also reveal information such as immigration status or women who are in a refuge because of domestic violence.	Only provided from KCH
		Final Coding 1=permanent 2=asylum seeker/ refugee 3=may change address 4= homeless 5=visiting 6=not recorded

Proxy Field	Rationale	Comments and Challenges
<p>Problematic addiction. Drugs and alcohol</p>	<p>Women who have problematic addiction have poorer outcomes for both themselves and their babies (DH, 2007, Lewis, 2007). These outcomes are poorer in relation to physical, social and psychological terms. Maternity Matters (DH, 2007), NSF Standard 11(DH, 2004) and CEMACH all advocate early access and multidisciplinary working commencing with the needs, risk and choice platform.</p>	<p>Disclosure may not always be reflective of use especially where there are no specialist joint working services. Women's perception of levels of use may be different from professionals, what is recreational use? Women may have engaged in problematic use around the time of the initial weeks of pregnancy and may have considerable concerns about the affects and yet if the question is not asked or not asked well they may not disclose.</p> <p>The coding for this was difficult because much of the categories were free text and were challenging to categorise or the records said confidential.</p> <p>Final Coding 1=no use 2= Drug use 5 units + a week of alcohol 3= Cannabis only, 1-4 units alcohol a week 4=no record</p>

Proxy Field	Rationale	Comments and Challenges
Employment status	<p>The National Statistics Socio-Economic Classification (NS SEEC) is used to classify social class in all official statistics. Infant mortality is highest in the manual and routine workers category (DH, 2007). In the CEMACH report (Lewis, 2007) the mortality rate for women whose partner was unemployed or whose occupations were unclassified was 7 times higher than for women with partners in employment.</p> <p>Should ideally be recorded and coded as: 1= Higher managerial and professional 2=Lower managerial and professional 3=intermediate occupations 4=Small employers and own account workers 5. Lower supervisory and technical occupations 6= Semi routine occupations 7= Routine occupations 8=never worked and long-term unemployed.</p>	<p>For most of the entries that were recorded this was a free text and it was not aligned with any social class. Ideally this would have been in line with the census collection NS-SEC, however within the time and resource restraints of the system it was not possible to code all the employment into these categories as it would have meant going through each record singularly. Not all the units collected employment status but where they did across the sector it included employment or not, mother/carer, student. Naturally any category needs robust and consist meaning and interrogation. What does unemployed mean to the person asking the question and the person being asked the question? In one trust there was not an unemployment category therefore people who were not working were amalgamated with those whose data was not recorded. The numbers were significant, over 70% of the data and it was therefore not useful to try to interpret it. Does it mean: on maternity leave, not working because a mother/carer /housewife, unemployed, unable to work or student? Unless there is a drop down menu with questions on one woman may say she is a mother and another that she is not employed but they may both be teachers. Some of the fields recorded employment nature and then status, i.e. working or not but then there was data missing in both categories. The PRU had a quite sophisticated coding system that de-aggregated unemployed seeking work and unemployed not seeking work and medically unfit. The PRU coding was used as a baseline for this characteristic for the audit.</p> <hr/> <p>Final Coding 1=Full time employment 2=Student 3=Housewife/ carer/mother 4=Part time employed 5=unemployed 6=no data</p>

Proxy Field	Rationale	Comments
<p>Place of Booking</p>	<p>To ascertain if there is a difference in booking completion in relation to where women are booked.</p>	<p>A number of the units using Saturday Clinics and evening catch up clinics were pooling resources to do this, at QMS where a large proportion of the women are booked at home capacity issues were creating the situation where women were asked instead to come to the hospital. Information is gained by the midwife if she meets the mother in her own home, she is more likely to be aware of support networks, socio economic need etc and the women may be more relaxed and thus better able to engage with the needs, risk and choice assessment. Midwives caring for women with particular vulnerabilities said they booked people at home but that this would take up to 2 hours.</p> <p>Final Coding 1= Hospital 2= Home 3=GP surgery 4= Children's Centre 5=Other Community 6=Other place in hospital 7= not recorded For GSTT other place in hospital was other Hospital to reflect women being referred to unit for specialist care after initial booking and identification of need.</p>

Proxy Field	Rationale	Comments and Challenges
<p>Interpreter needed</p>	<p>In the latest CEMACH report (Lewis, 2007) 48 of the women who died spoke little or no English. Few had access to interpreting services and family members were used. This meant that consultations with the women were ineffectual /and or inappropriate, information was not shared including information about pre-existing medical conditions.</p>	<p>The coding for this proxy field was different with the two units who collected it.</p> <p>QMS asks about literacy levels as well as language, which is quite important because women may be able to read English but not speak it and thus benefit from posters and information in English. Other women may not be able to read and write, not just people migrating into the country but amongst the host population. Illiteracy is quite stigmatised and not disclosed but also creates a barrier to information. Only 50% of the providers recorded interpreter needs on the electronic format. Data may be available through interpreting services used by the providers but was not collected within the confines of this project.</p> <p>A study conducted on case notes in S London found that there were some cases of discrepancies between the information recorded in notes and women's reports in a postnatal survey. (Buller et al, 2007)</p> <p>Placing the column recording requirements for interpreters next to the one coding language provided questions; There were numerous women who were recorded as 'could not speak English' who had interpreter 'NOT required' as did women who had understands a little English, Ethnic recording were interesting here too speaks Amharic and no English but ethnicity recorded as English?</p> <p>Final Coding</p> <p>1=Interpreter needed 2=Not needed 3=No data</p>

Recommendation

The main message is that through effective data recording and interrogation it is possible for local services and commissioners to identify, measure and track changes in demand and capacity and crucially the needs of the maternity population. This should include:

- Ability to record, interrogate data and provide reporting formats which are shared between providers and commissioners of local maternity services.
- Choice of maternity information systems which can capture relevant data items.
- Robust coding needs to be agreed so that interpretation becomes useful.
- A maternity data department to support effective fit for purpose function.
- Maternity data base staff who are skilled, trained and regularly updated.
- An information sharing agreement .
- Security level for systems is put in place to NHS standards.

There are some excellent examples of good practice in the SE Sector however:

- Whilst Children's Centres are being built, there is still time to plan for durable physical space and identity of midwifery provision.
- Supervision for midwives, especially around mental health, needs to be built into the system, as the expertise needed exceeds that of the midwifery supervisors. This is particularly the case where midwives do not regularly meet other members of a multidisciplinary team. Where midwives work more on their own, in the small, less central units, this is particularly the case.
- Cross sector learning and support should be encouraged and facilitated with the specialist midwives from all different locations meeting each other.
- Facilities to improve the use of interpreters should be instigated across the sector.
- Proportionally women, who have a parity greater than 5, book late usually after 22 weeks; opportunities arranged around childcare and school hours need to be instigated in the community, in venues such as Children's Centres, where women can access more easily.

Conclusion

In sum the 12 week indicator, which has been integrated into the NHS Operating Framework outlines the priority to improve health outcomes by ensuring early, timely access to a 'booking' assessment and to reduce inequalities in health by targeting excluded or vulnerable women. This audit aims to provide a basic picture of how many women in 2007 were accessing their booking assessment by the end of the 12th completed week in the SE Sector and a mapping of what interventions are in place to address inequalities, such as additional midwifery support.

Many of the findings of this small audit are not surprising and echo larger studies but they also demonstrate where practices are going well, for example additional midwifery services for pregnant teenagers, provision around domestic abuse, problematic addiction and mental health.

Much of the data is now history, the units are constantly changing and trying to adapt, however a resounding voice from senior members of the midwifery providers is that of capacity. In spite of catch-up clinics in the evenings and Saturdays the picture is changing, the graphs moving away from green and more into the orange this is limited by midwife availability and capacity levels.

In practice this audit has demonstrated more, awakened greater awareness of disparity of information available on a unit level. Additional consciousness has been invoked of the importance and imperative of standard practice for the safe secure transfer of data. Questions have been raised about who has the 'right' to data, and the importance of good accurate data input. Training and supervision needs have also been highlighted.

The findings illustrate that many of the initiatives in the SE Sector to reduce inequity and inequality are working; more teenagers are accessing on time, women with problematic addiction have access to integrated services and an excellent mental health service.

Other areas need improvements; helping women with 5 or more children to access care and provision for women who need an interpreter to enable a meaningful needs, risk and choice assessment to take place.

For, perhaps, the most vulnerable section of our maternity service, women with no recourse to public funds there is little data, their visibility perhaps only highlighted through child protection issues. Their vulnerability and the sensitivity of their situation means that it is difficult to ask the question, to engender trust. Yet their situation can be ascertained in a circumscribe way by asking about housing, benefit and support. Only when we are aware of the needs of the women can we begin to provide care in a holistic manner.

Although there are some excellent examples of innovative practice that exemplifies national priorities and standards articulated in Maternity Matters (DH, 2007) the questionnaire and aspects of the interviews with many of the providers of care emphasise a tortoise rather than hare approach to implementing direct access to midwifery care may be advisable.

Good data systems are the lynchpin for monitoring the current situation and making provision for the future. With a dynamic and changing population within the capital regular

audit are necessary to respond appropriately to new emerging communities. Heads of Midwifery could benefit from projected service requirements informed by good data collection at 'booking', to, for example, have a quantitative information about the number of women with socially complex lives. Women within this broad category have poorer outcomes and require input from a multidisciplinary team, often with the midwife as main provider. Ultimately the data we collect from each individual woman needs to ensure that they have care designed around their needs but also it has the potential for drawing a picture of the local population profile of need around which services can be designed and improved.

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Appendix : No 1

EuroKing E3

E3 is EuroKings most recent electronic data system for maternity services. It is currently being used at Kings College Hospital London.

Key features include:

- Simple and easy to use graphical interface based on windows technology,
- Mandatory fields ensure consistent data entry and supports ad hoc audits
- Complies with Maternity National Datasets
- Built in data validation at field level

Further information can be found at www.euroking.com

Email: info@euroking.com

Tel: 01932 834 800

Appendix : No 2

MATERNITY MATTERS EARLY ADOPTER PROJECT

Health Equity Audit of Access to Maternity Services with a view to the development of direct /early access to midwifery services

Data Systems

What data system do you use for maternity?

What other data systems are women included in?

Do the different systems link up?

Who currently is available to work on the data systems.?

What audits regarding access to services are currently being conducted routinely?

What other audits are routinely collected?

What were the challenges in providing data with specified fields for this audit ?

Would you be able to provide regular data regarding access to services if asked?

If not, what provision needs to be made in order for regular audits to be made?



Appendix: No 3

Data for proxy fields available in the SE Sector

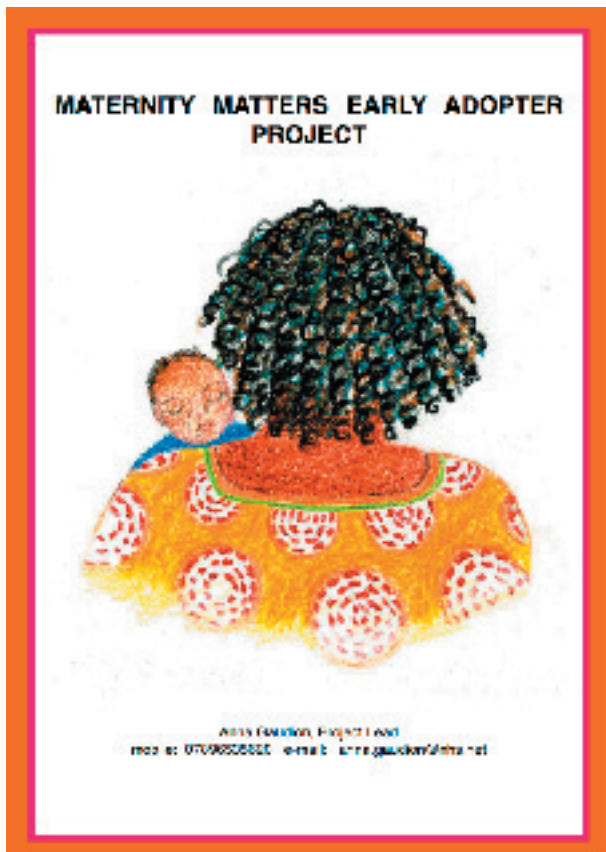
Proxy Field	GSTT	KCH	UHL	PRU	QEH	QMH
ID	X	X	X	X	X	X
Postcode	X	X	X	X	X	X
Age	-	X	X	X	X	X
Gestation at Booking	X	X	X	X	X	X
Gravida	X	X	X	X	X	X
Parity	X	X	-	X	X	X
Mental Health	X	X	-	-	-	-
Ethnicity	X	X	X	X	X	X
Occupation/ Employment	X	X	-	X	-	X
Housing Benefits	-	X	-	-	-	-
Women who have disclosed domestic abuse	X	X	-	-	-	-
Women who disclose problematic addiction with drugs/alcohol	X	X	-	X	-	-
Women with no recourse to public funds	-	-	-	-	-	-
Place of Booking	X	X	-	-	-	-
Interpreter needed	X	X	-	X	-	-
Literacy in English language	-	-	-	-	-	-
Women who have had Female genital cutting	-	X	-	-	-	-
Social service involvement	-	-	-	X	-	-

Appendix: No 4

Access to midwives

Health Equity Audit:
Access to Maternity Services in South East London

Developing Direct / Early Access to Midwifery Services.



This is a request and opportunity for midwives in the South East Sector to contribute their perspective and expertise.

Comments from midwives actually working with women are important on this topic and this brief set of questions will take only a couple of minutes to complete.

Please return it to anna.Gaudion@nhs.net by Friday May 23rd

Thank you

1. Which maternity unit employs/manages you?

- GSTT
- Kings College Hospital
- Lewisham University Hospital
- Queen Mary's Sidcup
- Queen Elizabeth, Woolwich
- Princess Royal

2. As a midwife do you?

- Work in a team
- Traditional Community midwife
- Children Centre Midwife
- Specialist Midwife
- Hospital based midwife
- Other (specify).....

3. Do women ever access you directly for their "needs, risk and choice appointment" (I e "booking")?

- Yes
- No

4. If Yes how many?

- Less than 10%
- 10 - 25%
- 25 - 50%
- 50 -75%
- 75- 100%

5. What challenges do you face (or predict you would face) in managing your caseload if women access you directly?

6. Any other comments

Thankyou for completing this questionnaire. The project closes at the end of July and the report should be available soon after this date.

Appendix :No 5

Current and planned provision in Children's Centres

MATERNITY MATTERS EARLY ADOPTER PROJECT

Health Equity Audit of Access to Maternity Services with a view to the development of direct /early access to midwifery services

Within the objectives agreed for this project is the need to map both current and planned midwifery provision in Children Centres. May I ask you to complete the questionnaire below for clarity across the sector?

1. Midwifery Unit.
 - GSST
 - Kings College Hospital
 - Lewisham University
 - Queen Elizabeth, Woolwich
 - Queen Mary's, Sidcup
 - Princess Royal University, Bromley
2. How many Children Centres are currently within your catchment area?
3. How many Children Centres within your catchment area has midwives 'practicing' within/out of them?
4. What type of care provision are these midwives providing?
 - Case load
 - Additional midwifery support
 - Traditional care
 - Other, please state.
5. What plans are there to increase the number of midwives working from Children Centres?
6. What are the main barriers/ challenges to midwives working within and out of Children Centres?

Thank you for completing this questionnaire
Please return by 27th June to:
Anna.Gaudion@nhs.net



Appendix No: 6

The Healthcare Commission Review of Maternity services in 2007

The Healthcare Commission used 25 indicators to assess the performance nationally of maternity services. The review, conducted in the summer of 2007 accessed 148 trusts providing maternity services and drew on a survey of 26,000 women. The survey was conducted in 2007 and the indicators used reflected services that trusts would be expected to provide. Most relevant for this audit are the findings for access, data collection and staffing levels. The units were scored from 1-5 with 1 demonstrating poor standards and a need for improvement to 5 where best practice was evident. The score of 3 represents a suitable acceptable standard. The review found that in London a larger percentage of women reported not receiving the recommended number of antenatal checks. This may be because it took longer for the completion of the needs, risk and choice assessment (Healthcare Commission, 2008)

Access:

For this indicator the Healthcare Commission's rationale was, ' NICE identifies that booking appointments should occur prior to 12 weeks. It is important that women have made contact with the maternity services as early as possible to ensure the highest quality of care and access to appropriate screening and testing and the early advice for a healthy pregnancy and baby. The first screening test should take place from week 8 (sickle cell and thalassemia) and so any woman making contact prior to 8 weeks should ideally be booked by 8 weeks so appropriate screening can be scheduled" (Healthcare Commission, 2007.16).

Data Capacity

For this indicator (21) "...to manage performance maternity related data should be routinely collected and analysed. In order to benchmark services national datasets must be populated with high quality data. Trusts should have been routinely providing maternity datasets through clarnet" Healthcare Commission, 2007. 29).

Staffing: Staffing levels (indicator 17) were judged in accordance to appropriate number of staff to support delivery episodes.

Provider	Access 1-5	Data capacity1-5	Staffing 1-5
GSTT	2	3	5
KCH	2	2	3
PRU	1	1	2
QEH	2	5	4
QMH	1	1	4

