Metrics for monitoring local inequalities in access to maternity care: developing a basket of markers from routinely available data
S F Murray, A M Buller, S Bewley, J Sandall

ABSTRACT
Background Equal access for all based on need is part of a conceptualisation of quality underpinning recent UK NHS policies.
Objective To develop metrics for access to maternity care from routinely available data in order to inform inequalities monitoring and commissioning.
Design Cross-sectional cohort design using case-note audit and postnatal questionnaire.
Setting London hospital, UK, in an area of relative socio-economic deprivation.
Methods Stage 1: Identification of potential markers. Stage 2: Testing of markers via case note audit and postnatal questionnaire. Stage 3: Selection of final basket of markers of access to maternity services.
Results Of 71 possible markers identified, 32 used information obtainable from maternity case notes. After testing in the case-note audit, 21 were discarded, and 11 included in the final basket covering: timely entry to maternity care; appropriate assessment and identification of needs of individuals; referral and communication with other related health and social care services.
Conclusion It is possible to devise a local basket of markers covering a range of important entry and in-system access metrics. Such a tool offers an unobtrusive means to audit the effectiveness of some of the processes intended to help women move through the maternity and related health and social care systems during pregnancy, and to monitor progress on reducing social inequalities in access over time.

INTRODUCTION
‘Enduring principles of equal access for all based on need’ are held to be a key feature of the National Health Service in England as in the other UK countries, and to be part of a conceptualisation of quality that encompasses clinical effectiveness, patient safety and patient experience. Recent government policies also reflect a renewed interest in strategies for reducing inequalities in health.

The London Health Observatory issued a basket of 70 health inequality indicators to help support local action to achieve government national inequalities targets for life expectancy and infant mortality. Drawing upon this approach and concern about early and easy access to maternity services articulated in recent policy documents, our study considers the development of locally usable metrics for access to maternity care.

At its simplest, ‘access’ to healthcare can be used to refer to whether those who need care ‘get into the system or not’. Where coverage is very high or universal, the focus becomes timely entry into the system, as recommended by various reports and in the Public Service Agreement (PSA) targets. However, ‘healthcare’ is seldom a single event, and it is increasingly accepted that access ‘concerns the appropriate combination and deployment of resources to facilitate the process of entering and moving through the health system’ (p 9, our emphasis). Similarly, Pechansky and Thomas suggest that ‘access’ describes the ‘degree of fit’ between clients and the health system.

During the course of a pregnancy, women in the UK move through a complex system of health and social care. Maternity care cuts across ‘community,’ ‘primary’ and ‘acute’ divides, and encompasses promotion of well-being and physiological processes as well as early detection and treatment of complications. This scenario poses a considerable challenge for the measurement of progress against policy aims for ‘easy access’ using routinely available data. Our study aimed to identify a group of access markers that would cover a wide range of these issues as reliably as possible, to include indicators of different aspects of health system performance and to focus on facets of service provision in which social inequalities may be observed.

Recruitment and participants
Ethical and site research and development approval was sought and given for all stages of the study. The design included an ‘opt-out’ approach with a 24 h answerphone in English, French, Portuguese, Spanish and Somali. Study information posters were displayed at hospital and community clinics, and information packs offered to women at discharge, providing details about the study methods and its implications.

The case note audit cohort comprised all women who received birth care from one NHS Trust irrespective of home or hospital birth during a 10-week period (N=1197, table 1). Postnatal questionnaires were sent to those resident within the geographical catchment area but excluding women who had stillbirths or neonatal death. Twenty-one women could not be traced, resulting in a survey subsample of 859 women.

METHODS
Stage 1
We reviewed government policy documents and guidelines, international maternity system quality measures and existing health equity profiling tools and research studies in order to identify potential utilisation-based markers of access to maternity care (figure 1). Twenty-one
individual and group consultations were conducted. Potential markers were matched against information recorded in the maternity case notes to establish accessibility.

Stage 2
An audit protocol was developed and midwife researchers trained in its use to standardise data collection. Data were extracted on demographics, postcode and components of the markers. A postnatal survey provided additional validation data regarding meaning, relevance and discriminatory ability of markers. The questionnaire was pre-piloted via cognitive interviewing. For comparisons between groups for each marker, \( \chi^2 \) tests at the 95% confidence level were run with SPSS statistical software on a merged database with data from both the audit and the survey (SPSS, Chicago, Illinois).

Stage 3
Markers were evaluated using technical criteria, eliminating those that were unreliable due to poor documentation (cut-off: 45% data bits required), had a low occurrence (cut-off 5%) or were infeasible due to overly complex data retrieval. Finally, for inclusion in this basket with its focus on social inequalities, markers either had to be supported by research literature that indicates social differentials in health (eg, for smoking or breastfeeding) or demonstrate statistically significant differences on socio-demographic or economic variables within our study cohort (\( \chi^2 \) test \( p<0.05 \)).

RESULTS
Stage 1 produced an initial list of 71 markers. Less than half could be constructed using data solely recorded in the local maternity case notes, and 32 provisional markers were identified, for which information ought to be available. Following stages 2 and 3, a final basket of 11 markers was identified. These are

---

**Table 1** Socio-economic and demographic characteristics of audit cohort

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Proportions in cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>16–19 years</td>
<td>4.6%</td>
</tr>
<tr>
<td>20–30 years</td>
<td>45.6%</td>
</tr>
<tr>
<td>31–44 years</td>
<td>49.8%</td>
</tr>
<tr>
<td>Country of birth classification</td>
<td></td>
</tr>
<tr>
<td>Using World Bank economies list</td>
<td></td>
</tr>
<tr>
<td>Low income country</td>
<td>20.4%</td>
</tr>
<tr>
<td>Lower middle income country</td>
<td>10.3%</td>
</tr>
<tr>
<td>Upper middle income country</td>
<td>4.5%</td>
</tr>
<tr>
<td>High income country (including the UK)</td>
<td>57.7%</td>
</tr>
<tr>
<td>Socio economic status</td>
<td></td>
</tr>
<tr>
<td>Using Index of Multiple Deprivation (IMD)</td>
<td>Grouped in quintiles</td>
</tr>
</tbody>
</table>

---

STAGE 1: Identification of potential markers of access to maternity care, via
- Policy and research literature review
- Interviews with stakeholders – key national user groups; local women’s groups representing minority ethnic groups; Maternity Service Liaison Committee; local maternity service practitioners; local maternity service managers; and service commissioners.

STAGE 2: Testing of markers

**Casenote audit**
All women who delivered with the site’s maternity services (hospital or home) during a 10-week period. No one opted out of the study – 1,180 (98.6%) maternity records from 1,192 were located. Data was collected on site and entered into an SPSS database.

**Postnatal questionnaire**
Self-completion questionnaire (in English and other common minority language versions) & pre-paid envelope sent out on day 17 postpartum. Unreturned questionnaires followed up with phone call from researcher offering assistance with completion and / or interpreter assistance. Second reminder sent by post. Final cooperation rate of 70.2% (603/859). Data entered into SPSS database.

Data analysis
SPSS databases merged for analysis using participant unique identifier code. Descriptive statistics conducted. Chi-square analysis run on markers, for age, country of birth and IMD. The ‘least deprived’ IMD quintile within the cohort served as the reference measure to assess socio-economic inequalities in access.

STAGE 3: Selection of the final basket of markers
Markers evaluated by two researchers for accessibility, feasibility, validity, reliability and representativeness; and for their utility in an audit to highlight inequalities to access. After independently rating each marker, researchers discussed and agreed on the final basket of markers.
40% survey respondents reported that they
Women born in high income countries were more likely to
<
Women in the
<
<
Most women (72%) did not write in their maternity notes.
No one was provided with interpreting services for all their
6% had an interpreter at 50% or more of maternity
<
29% (65) had no recorded interpreter provision;
<
Percentage of women who had language needs identi
'percentage of women who delivered with the service and were
1. Timely entry into maternity care
Percentage of women who delivered with the service and were
‘booked’ with it by/before a gestation cut-off date of 12 weeks.17
► 43.3% booked later than 12 weeks’ gestation
Timely entry was more common in:
– women born in high-income countries than women born in low
income countries (59.8%; 45.5%);
– women with good command of English than women
without command of English (61.5%; 47.1%);
– women in the highest IMD quintile within cohort than
those in the lowest (85%; 75.6%).
2. Identification of language needs
Percentage of women who had language needs identified during
the ‘booking’ consultation. This marker indicates coverage but
not quality of activity; therefore use is recommended in
conjunction with Marker 3.
► Most women (98%) had language and communication needs
recorded by a care provider.
► Survey results suggest that assessment quality is not always
good. Eighteen of 41 survey respondents who said they
‘did not feel confident with English’ had been classified by their midwife
as speaking and understanding English with no problems.
3. Interpreter services provided
Proportion of total number of interactions with health staff
during pregnancy; labour and delivery; and discharge for which
formal interpreter services were provided:
Of women documented as needing an interpreter:
► 29% (65) had no recorded interpreter provision;
► 6% had an interpreter at 50% or more of maternity
consultations;
► No one was provided with interpreting services for all their
maternity consultations.
4. Women write in their maternity care plans
Evidence of women’s written input into plans about their care
in the allocated sections of hand-held case notes:
► Most women (72%) did not write in their maternity notes.
► Women in the ‘least deprived’ IMD quintile were more likely to
write in their case notes than those in the, ‘most deprived’
(58%; 22%).
► Women born in high income countries were more likely to
write in their case notes than women from low income
countries 57.9%; 12.9% (no association with command of
English).
► 40% survey respondents reported that they ‘did not feel free
to write’ in their case notes.
5. Minimum required number of antenatal consultations achieved
Proportion of women from whom at least the minimum
required number of antenatal care consultations19 is achieved:
► 86.7% (767) had at least seven consultations. (Those who had
booked after 22 weeks of gestation, delivered before 36 weeks
or were transferred in during the pregnancy excluded from
this analysis).
► Women from the ‘least deprived’ IMD quintile were more
likely to have at least seven consultations than those from
the ‘most deprived’ quintile (93.5%; 83.4%).
6. Dental care needs assessed in pregnancy
Percentage of women attending antenatal care for whom dental
care needs were assessed, and to whom the FW824 (maternity
exemption form) for free NHS dental care and prescriptions
were provided:
► 94% had dental needs assessed by a maternity care provider.
► Women with a command of the English language were more
likely to have their dental health needs discussed than those
without a command of English (96.7%; 88.9%).
► 50% received the FW8 form from their midwife or
obstetrician; 3.7% were recorded as not requiring it.
7. Continuity of carer from antenatal to intrapartum
Percentage of women for whom at least one member of staff
providing labour/delivery care was known from antenatal care:
► 18.5% received care in labour/delivery from a midwife or
doctor they knew from antenatal care.
► Women born in high-income countries (including UK) were
more likely to receive care during labour/delivery from a
known member of staff than women from low-income
countries (20%; 12.9%).
► Women from the ‘least deprived’ IMD quintile of the cohort
were more likely to receive care from a known member of
staff during labour/delivery than those from the ‘most
deprived’ quintile (22.5%; 17.4%).
8. Early initiation of breastfeeding
Percentage of babies breastfed within half an hour of birth:
► Full information for marker recorded only for 46.5% case
notes.
► Of these, 50.7% initiated breastfeeding within half an hour
after birth.
9. Obesity care provided
Percentage of women attending antenatal care for whom the
Body Mass Index (BMI) was calculated at booking; those with
BMI of more than a specified cut-off who were referred to
specialist maternity consultant, dietician and/or anaesthetist:
► 56.7% had their BMI calculated and recorded in case notes.
► Women from the ‘most deprived’ IMD quintile of cohort
were more likely than those from the ‘least deprived’ quintile
to have BMI>30 (19.5%; 4.1%).
► Of 89 women identified as having BMI>30, 57.3% were
referred to a specialist maternity consultant, and only four
(4.5%) to a nutritionist/dietician.
► Of those with BMI of >35, 9.7% were referred to an
anaesthetist.
► Only two women were documented as receiving their
complete care pathway according to local guidelines.
10. Domestic violence routine enquiry and referral
Percentage of women attending antenatal care to whom an
enquiry about domestic violence (DV) was made and recorded;
percentage disclosing DV to healthcare provider; and referred to an advocacy service:

At the time of the audit, a DV service had recently started in the study site:

► 15% (171) were asked about DV, and 11% of this subgroup (18) revealed violence.
► For over half (10) revealing violence, there was no record of discussion of referral to the advocacy service.
► 55% who were asked about DV came from the two ‘most deprived’ IMD quintiles; 6% came from the ‘least deprived’ quintile suggesting targeting of enquiry by social group.
► One year later, a repeat audit showed that routine enquiry rates had reached 47%. Coverage was no longer skewed across IMD quintiles.

11. Smoking assessment and referral to cessation support

Percentage attending antenatal care for whom smoking status is assessed and, if needed, smoking cessation support is offered:

► Women in their teens were more likely to smoke than women over 30 (84.5%; 8.8%).
► Women in the ‘most deprived’ IMD quintiles smoked more than those living in the ‘least deprived’ areas (16.1%; 6.8%).
► Of 143 women documented as cigarette smokers, only 71.2% had a documented offer of help to quit.

DISCUSSION

Approximately two-thirds of the markers of access that we tested were rejected for the basket on one or more of the technical criteria mentioned above. Poor quality of recording of information in case notes was a factor in rejection of five markers. Eleven markers did not differentiate among subgroups of the population and thus did not offer the insight on differential access that we were seeking. Data for several care pathway markers specific to needs of vulnerable subgroups did not occur with sufficient frequency to be testable in a cross-sectional audit of this size.

The final basket contains five access markers that relate to good practice in routine maternity care provision (markers 1, 4, 5, 7, 8); three concerning appropriate assessment and identification of needs of individuals for specialist services within maternity care (markers 2, 3, 9); and three concerning referral and communication with other related health and social care services (markers 6, 10, 11). This offers managers and commissioners a means to assess a range of processes intended to help women move through maternity and related health and social care systems during pregnancy, and to monitor these for improvements over time. It includes markers that highlight some of the different social characteristics that have a bearing on entry and in-system access such as socio-economic deprivation, and command of local language.

Case note audit is popular because it is relatively straightforward and inexpensive, and does not interfere with clinical activity or make demands on service users. It is easily replicable and lends itself to monitoring changes over time. There are limitations. First, high retrieval rates are very important in audits concerned with detecting inequalities in access, and this is labour-intensive. Second, case note audit captures little about access barriers to NHS care encountered by women outside the system such as those classified as ‘not normally resident’. Third, it inevitably confines enquiry to the perspectives of those authorised to write in the records, and is highly dependent on the type and quality of information they record. Audit does not allow easy discrimination between poor recording of activity and inadequate provision of information or services. However, there is likely to be some relation between the two. Poor documentation in an area—such as that of initiation of infant feeding—may serve to flag up a need for further investigation.

Our findings indicate that some, but by no means all, dimensions of access to high-quality care can be measured through case note audit. Other complementary methods of data collection are thus important, such as patient surveys used to quantify different aspect of access, and qualitative studies of the views of patient experiences across the interface between primary and secondary healthcare.

There has been a recent upsurge of interest in tools to monitor maternity service performance at the national level. The Healthcare Commission, for example, recently introduced a 25-indicator scoring assessment for its national maternity reviews. Our basket of markers for use in internal case-note audit complements this activity. It has a far more specific focus—markers that will reflect relative entry-access and in-service access within populations, and it is designed for local use by service managers or commissioners.

As with other baskets of indicators for monitoring health inequalities, local adaption may be necessary, and users may wish to select from the basket or to supplement with additional locally available and relevant indicators. This version of the basket was developed in a site serving a highly mobile multi-ethnic urban population. Future research will be required to test and adapt the tool for use in other settings.

Acknowledgements We thank the women who permitted their case notes to be reviewed and who completed the survey questionnaires; the members of stakeholder groups who contributed to the marker selection process; the interpreters who facilitated the survey; midwifery researchers M Callaghan, C Monoh and C Singh for input on the design of tools and for conducting the data extraction for the case-note audit; P King for administrative support; M Ahmed, intern, for research assistance; R Steinbach for statistical advice; and L Bacchus, who advised on Domestic Abuse routine enquiry.

Funding Funded by a grant from Guy’s and St Thomas’ Charity. Quality of care research programme (reference No R031111p2). The authors’ work was independent of the funders, who had no role in the study design, analysis of data, writing of the manuscript, or decision to submit for publication.

Competing interests None.

Patient consent Obtained.

Ethics approval Ethics approval was provided by the Trust Hospital R&D process and Ethics Committee (St Thomas’ Hospital REC ref. 05/0702/127).

Contributors SFM had the idea for the study and drafted the paper with contributions from all authors. AMB and SFM conducted stakeholder consultation, designed and piloted the tools, and wrote marker statements. AMB led the data-collection team, established and cleaned the database, and conducted statistical analysis with inputs from SFM. SB and JS provided specialist advice during the process of the project.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES


