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MAPPING COMMUNITY MIDWIFERY IN BIRMINGHAM

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INTRODUCTION

Heart of Birmingham Teaching PCT (HoBtPCT) experiences one of the highest perinatal mortality rates¹ in the country. In 2004 this stood at 14.8/1000 live births across the whole PCT area, although in one ward the rate was as high as 24/1000. This contrasts with the national perinatal mortality rate of 8.1/1000 and a West Midlands rate of 9/1000. In real terms this means that including stillbirths, 131 babies died before they were a week old, with a further 33 babies dying before their first birthday.

Reducing perinatal mortality is one of the Strategic Health Authority's (StHA) and the PCT's top priorities. Evidence suggests that one factor in reducing perinatal mortality is the early detection and active management of pregnant women whose babies are not developing appropriately. Furthermore, the ability to detect 'small-for-dates' pregnancies is linked to the quality of antenatal care that women receive and particularly the degree of continuity they receive, with a small number of health professionals (ideally one midwife) getting to know them sufficiently well, to be alerted to any signs of babies failing to thrive.

This project aims to map the current provision of community midwifery care available to women living in the HoBtPCT area and makes recommendations for how services might be improved to enhance antenatal care and particularly continuity of midwifery care.

The report is structured in four sections:

SECTION 1: OVERALL THEMES This section summarises the quantitative and qualitative data available in the Primary Care Trust (PCT) and three provider units, assessed against national benchmarks and best practice. The observations about the distribution and quality of community-based midwifery have been grouped under four headings:

- **CAPACITY** – the number of staff and other resources available to deal with the workload presenting
- **MODELS OF COMMUNITY MIDWIFERY** – the design of services and the way staff and other resources are utilised
- **RELATIONSHIPS** – the connections between community midwifery services and other staff and agencies vital to the wellbeing of pregnant women
- **LOCAL INTELLIGENCE** – the state of knowledge locally about the factors relating to high perinatal mortality

¹ Perinatal deaths is defined as all deaths less than 7 days old, including still births

SECTION 2: THE CURRENT PICTURE This section reports the findings from a survey of all 76 midwifery clinics operating within HoBtPCT together with data collected at visits to around a third of the clinics. Information collected in this mapping exercise is presented under three headings:

- **CLINIC ORGANISATION AND ACTIVITY** – the survey and visits were used to collect additional data relating to capacity, the models of care, relationships and the state of local intelligence
- **MIDWIVES' PERCEPTIONS OF FACTORS IMPACTING ON PERINATAL MORTALITY** – staff working in the clinics were given an opportunity to comment on the challenges they face
- **WOMEN'S FEEDBACK ON SERVICE PROVISION** – whilst this was not a formal user survey, women's opinions have been included, allowing triangulation or findings with data collected and midwives' views

SECTION 3: STAKEHOLDER ANALYSIS This section reports the views of senior midwives in the three provider units and provides an opportunity to verify the independent research findings.

SECTION 4: THE FUTURE This section includes an option appraisal of a series of recommendations for enhancing community midwifery services across HoB. This section will form the key part of any forthcoming action plan and the basis of future collaboration between the three providers and the PCT.

SECTION 1: OVERALL THEMES

CAPACITY

HoBtPCT commission's maternity services from three provider units, all of which deliver community based antenatal and postnatal care, as well as intrapartum care. All three units experience significant staffing shortfalls both in terms of their funded establishment and their ability to fill posts. The factors that lie behind this include:

- Historic and baseline staffing establishments have been inadequate and have not been substantially improved
- Workload, in terms of numbers of women using services is increasing without a corresponding increase in staff
- The complexity of the case mix of women using services has increased, with a higher proportion of vulnerable women and high risk pregnancies
- A national shortage of midwives leads to difficulties recruiting staff and therefore high levels of vacancy and long term vacancy
- High levels of maternity leave and sick leave within the workforce leading to difficulties retaining staff
- Maternity services experience higher than normal (for the NHS) numbers of staff working part-time. This puts considerable strain on a 24 hour, seven days a week service
- Short term financial pressures in the provider have sometimes resulted in vacancy freezes

The extent of staffing shortfalls across the three units is demonstrated in appendix 1. This indicates staffing of community midwives, maternity care assistants and language support workers.

Midwifery staffing levels

Appendix 1 illustrates that the caseload of community midwives in all three units is around 150 women a year. By 'caseload' we mean the number of women to whom each midwife delivers community based antenatal care, most usually provided in GPs surgeries and postnatal care, most usually provided in women's own homes.

All the providers agree that these caseloads are too high to allow them to provide the quality of service they would wish. Professional consensus suggests a caseload of around 110 women a year per wte midwife (not also undertaking intrapartum care) in normal circumstances and where midwives provide all care. However, in areas of high deprivation with women experiencing complex health issues pre and during pregnancy, this figure should to be reduced, to around 100 women a year.

Two of the three provider units have undertaken BirthratePlus, the only robust and credible staffing/skill mix audit tool available, which is endorsed both by the Royal College of Midwives and the Department of Health. According to BirthratePlus, staffing levels across the whole of the maternity service are inadequate for workload by 48 midwives at Birmingham Women's Hospital and 35 at Heartlands. City Hospital has recently agreed to undertake a BirthratePlus analysis, starting in January 2006. Data should therefore be available in June 2006.

The impact of staff shortages across the whole maternity service is generally managed by prioritising the labour ward at the expense of community based antenatal and especially postnatal care. This is certainly the case in the three HoBtPCT provider units. Endeavouring to maintain a safe labour ward environment has inevitably meant that in all three-provider units community midwifery services have suffered. This is evidenced in:

- Time spent with women
- Continuity
- Reduced postnatal support
- Withdrawal of attendance at BBAs

Time spent with women

Professional consensus suggests that the average length of time a midwife should spend with a pregnant woman at her first, or booking visit is one hour. This should allow time for a full history to be taken and for the midwife to explain to the woman what she can expect and what choices she can make during her pregnancy. However, even one hour may well be insufficient in cases where women do not speak English, as delivering care through a translator is inevitably time consuming. In reality midwives working with HoB women are only able to spend around 30 minutes at this first appointment. Indeed many midwives do not complete the booking (particularly if the woman is booked to deliver at another hospital) and it is expected that booking will be completed at the hospital antenatal clinic when the woman attends for her dating scan at around 18-20 weeks. This invariably shifts the workload back to the hospital antenatal clinic. In addition professional consensus would suggest that subsequent antenatal appointments, following NICE guidelines should each take around 20-30 minutes. In reality most community midwives are only able to spend 10-15 minutes with each woman.

Continuity

The staffing levels in the community have largely shaped the models of care provided. The model at all provider units is of team midwifery, with individual midwives assigned to specific GP practices. This is a model, which should ensure a high degree of continuity during antenatal and postnatal care, particularly if the team has a stable, well-supported workforce, which develops a common approach to care. Its effectiveness at all three sites is compromised by the large caseloads discussed above and all three units recognise that continuity of carer could be better. At both Heartlands and City community midwives rotate into hospital for short designated periods as part of their continuous professional development. At the Women's Hospital community midwives also staff the birth centre and therefore regularly take part in intrapartum care, whilst this has a small impact on the ability of the teams to provide continuity antenatally it has a much more significant impact on continuity postnatally. However, this too could be ameliorated if caseloads were smaller.

Reduced postnatal support

All of the provider units have rationalised or withdrawn from elements of postnatal care because of staffing pressures. Even though most units operate six and 12 hour discharge policies after delivery, it is unlikely that women will receive more than three postnatal visits. These are unlikely to be accompanied by any form of language support. Continuity in postnatal care is the most difficult for all units to provide – particularly where women are discharged at the weekend and community midwives are on call.

Unable to attend BBAs

Shortages of community staff mean that women in the early stages of labour are unlikely to receive a home visit from a midwife to assess their condition and help them make a decision about whether it is appropriate or not to go into hospital. This means that many women are arriving on labour wards in the early stages of labour and are either advised to go home or choose to remain waiting in the hospital's public areas. In addition at one unit, community midwives no longer attend women who go into labour at home unexpectedly. Instead calls for assistance are routed through to the ambulance service, which attends women as emergencies and then transfers them into hospital.

Midwifery support staff

All three units report inadequacies in the levels of funding for support staff and the impact this has on increasing the workload of community midwives. Appendix 1 illustrates the extent of the shortage:

- At Birmingham Women's each community team has a dedicated Maternity Care Assistant (MCA) support worker, employed at Grade B
- City employs two support workers, employed at Grade A, although one is permanently assigned to a team that serves the neighbouring PCT area
- Heartlands has no support staff but has recently developed a business case to employ 26 midwifery assistants at NVQ Level 3 in order to bridge the gap in its midwifery staffing establishment

Midwifery support staff are variously named and have a wide variety of job descriptions, roles and grades across the country. In essence, there are three support functions, which if effectively deployed could ensure midwifery time is used more efficiently. This includes:

- Administrative and clerical staff – most HoB community midwives still undertake their own administration including booking appointments, referring women to other staff/specialisms, chasing diagnostic tests, following up DNAs, entering data onto hospital information systems. In other units these have been roles assigned to Health Care Assistants (HCAs) who can make a major impact on the smooth running of clinics. However, in recent years it has been recognised that restricting HCAs role to merely A&C duties is less rewarding for staff and makes recruitment and retention problematic. Some units are therefore now developing and extending the HCA role to provide career development opportunities
- Health (Maternity) Care Assistants – with appropriate training and supervision MCAs are able to provide a wide range of midwifery back up tasks such as taking blood pressures, phlebotomy and urine testing, demonstrating formulae preparation and baby bathing
- Midwifery assistants – a number of units around the country are now seeking to develop the role of Midwifery Assistants to truly support midwifery practice and provide a career development opportunity for support staff. With appropriate training and supervision midwifery assistants can provide health education and advice, breastfeeding support, parenting education and undertake routine clinical observations such as postnatal cord and baby checks

In none of the provider units is there yet a systematic and strategic approach to the development and deployment of appropriate midwifery support.

Language support staff

The HoBtPCT area has a diverse ethnic mix and a large proportion of the population do not have English as their first language. Endeavouring to meet the needs of women attending antenatal care, who do not speak English, all of the provider units use a variety of mechanisms, including dedicated link workers who work exclusively within the maternity service, translators employed in city based organisations and a telephone based interpreting service.

Appendix 1 illustrates the number of dedicated link workers each service can call upon. This demonstrates that current funded provision is insufficient to provide each team of midwives with access to language support, much less each community clinic. Arrangements for organising language support are similar across the three provider units; where a midwife is aware that a woman attending one of her clinics has a specific language requirement, she will endeavour to book one of the link workers. Equally where a midwifery clinic takes place in an area where a common language can be predicted, midwives will endeavour to book a link worker. If this cannot be done, midwives will try and book an interpreter and as a last resort will use the telephone based language line.

However, all provider units report that this provision is inadequate for the populations they serve. Link workers are unavailable at weekends and in the evenings, but also work across the hospital site and thus even when requested in advance cannot be guaranteed. Unless midwives are very familiar with the families covered by their clinics or have good relations with GPs they are unlikely to know in advance of a woman's first visit whether she has language needs. This invariably means that the first meeting between midwife and woman is conducted without language support. Securing language support at postnatal visits is accorded less priority than at antenatal appointments. Midwives report operational and cultural difficulties using the city based interpreting service (sending male interpreters) and the impersonal telephone language line.

In addition, the range of languages covered by the link workers is not able to keep pace with newer waves of immigration into the city – most notably Somali and eastern European languages.

Example from mapping exercise

The importance of language support is highlighted through the GP practices where in a significant number of practices a midwife may go through a clinic with the majority of patients in need of some language support. When language support is not available a relative may often interpret on behalf of the pregnant woman. This does not ensure effective communication of vital and sometimes complex, medical information.

MODELS OF COMMUNITY MIDWIFERY

The models of care deployed in all three-provider units are in large part constructed and constrained by the staffing issues described above. The three elements of service design that are pertinent to this project are:

- Location and physical environment
- Organisation of work and priorities
- Current and planned innovations

Location and the physical environment

In all three units midwives are organised into geographical based teams that reflect the distribution of GPs, with each team covering a number of GP practices. In most cases midwives work from GP premises. As a model, this is one that should facilitate continuity of care(r) for women antenatally and postnatally.

However, the low number of community midwives means that individual midwives within each team will cover a number of GP practices and the larger practices may have two or three midwives attached, with pregnant women seeing whichever midwife is available on any given day. Across and within the three provider units the teams are by no means uniform in their workload or working style. The teams are to a large degree self organising, allowing midwives to determine working patterns that best suit their needs. In most, midwives work in pairs within the teams to try and cover leave, sickness, etc, but the degree to which this works effectively is dependent on the personalities and relationships within each team. Therefore the degree of continuity women receive will depend on her GP and therefore the team to which she is assigned. In all three-provider units, it is acknowledged that some teams make more effort to ensure continuity than others.

To date the model of community midwifery care reflects traditional ways of working, with women attending scheduled appointments at a midwifery clinic for their antenatal care, receiving a number of home visits postnatally, and in a few limited cases drop-in antenatal and postnatal clinics offered in addition. The extent to which midwives can provide innovative woman centred care is in part constrained on the environment and facilities in which they work. All providers acknowledge that whilst many GPs provide suitable accommodation for community midwives, a number do not. It is not unusual for midwifery antenatal clinics to be held in small cramped rooms, without access to a computer or even a telephone line. Midwives have to bring in their own equipment, because they are not able to use scales etc belonging to the practice. Few midwives are able to organise group antenatal or postnatal drop in sessions, parentcraft or other health education sessions, evening or weekend clinics using the GP facilities available to them.

Example from mapping exercise

GP practice C1: *There were two midwives present for the midwifery clinics. The practice also had the capacity for a third midwife which would reduce the caseload per midwife and improve the level of patient care. This was restricted however because a potential midwifery treatment room was being used to stockpile disused computers. Despite calls from the midwives for the computers to be removed and promises by the Practice Manager that they would be, this was not carried out and the room remained as it was.*

GP practice C1: *This did not provide IT or telephone access to midwives within treatment rooms. Midwives had to leave the consultation rooms and request the use of receptionist phones when in need of telephone access. This greatly disrupted the flow of care given to the patient and consumed valuable session time.*

Whilst GP practices may not always provide the most suitable environment for providing woman centred care, the provider units are reluctant to encourage more care in women's own homes for reasons of security and cost. For all three providers, midwives' security when working in the community is a real issue. Many midwives are reluctant to undertake home visits and to attend women at home in the evening. At City midwives on-call undertake home visits in pairs at night, placing a further strain on already stretched resources. All three-provider units find it difficult to recruit and retain community staff to work in the most disadvantaged and unattractive areas.

All three-provider units report that discussions and dialogue with local authority representatives on the potential for including midwifery services within developing Children's Centres in the HoB area have been rudimentary and unspecific, although they have been more detailed in other PCT areas. All three units have engaged with local Sure Start projects and midwives have been either seconded or employed within local schemes. However, this again has been on an ad hoc and opportunistic rather a strategic basis. Equally the role and remit of midwives working in Sure Start has not always been clear. In some cases the Sure Start midwives have been additional to the established community team leading to both fragmentation and duplication of care. There is a real question now amongst all three provider units about whether attaching a single midwife to a Sure Start project is indeed the best use of resources.

All the provider units aspire to provide more routine antenatal care in the community, in line with best practice and the requirements of the NSF. However, all three feel constrained by lack of resources and appropriate facilities. The Women's Hospital currently has one midwife trained to undertake dating scans in the community (who is nearing retirement) and is planning to train at least two midwives a year to provide this service. This will reduce the number of women attending hospital antenatal clinics for routine appointments. None of the units provides consultant out-reach clinics in the community. All of the units are currently providing antenatal education and parentcraft classes solely in hospital. This is in part due to a lack of affordable community based facilities and in part a response to staff shortages. All identify that encouraging women, particularly from minority communities, to attend antenatal and other classes is difficult, even if these are held in community health venues. Organising community based

sessions, in locations and times that are convenient and then stimulating their use requires a strategic approach to service development and engaging in a meaningful way with local communities.

Organisation of work and priorities

According to NICE guidelines and best practice we should expect that community midwives would take a full history of each pregnant woman at the booking visit. This should be undertaken as early as possible in pregnancy to ensure that all health professionals have access to the most complete and comprehensive information about each woman and any likely risk factors that may affect her pregnancy. This, together with the use of standardised woman held midwifery notes, is the underpinning of continuity of care – even where continuity of carer cannot be achieved. It is therefore very disturbing to learn that at one-provider unit midwives appear to be working to an informal policy not to complete this booking for women who are unlikely to be delivered in their own unit. Furthermore, even where women are delivering at their unit, the booking is often left incomplete, due to a lack of time, until the woman attends the hospital clinic for her dating scan. This fragments care and delays the collection of important information about a woman's health and lifestyle, which may have a bearing on her pregnancy.

Example from mapping exercise

Clinic C2: The community midwife will not fully book or administer pregnancy notes to women who will be delivered at a certain hospital. This is due to a dispute between both hospitals as to who should pay for the pregnancy notes at booking. Women not of the community midwives unit are sent to their delivery hospital for booking. This disrupts the continuity of care to the women and can restrict early detection and treatment of antenatal problems.

None of the provider units have yet taken active steps to implement the Government's manifesto commitment to provide women with direct referral to a midwife.

Attempts to improve continuity antenatally and to deliver a woman centred community service have been undertaken in the past. The Bellevue project provided a dedicated midwife for antenatal and postnatal care into a large GP health centre with a caseload of 70-80 women a year. Whilst this evaluated exceedingly well in terms of outcomes, professional and women's satisfaction, it was considered uneconomic and discontinued. Similarly, a case loading model of care with a small team of midwives taking total responsibility for the antenatal, intrapartum and postnatal care of specified women was piloted at the Women's Hospital. This proved unsustainable because of burn out amongst midwives and high costs.

Current and planned innovation

Community midwives at Birmingham Women's Hospital also work 0.56 of the time in the birthing centre, providing intrapartum care for low risk women. Whilst generally, the development of birth centres is viewed as 'a good thing' in maternity services, there are some unintended consequences which may impact on the resourcing and quality of community midwifery services.

Positive consequences of birth centre	Negative consequences of birth centre
Provides a focus on normality in childbirth and a counter to traditional medical obstetric model	May attract the more committed midwives, who are thus delivering the highest quality of care to low risk women – therefore exacerbating the inverse care law
Provides women with a choice in how and where they deliver	Using community midwives as part of rostered staffing impacts on their ability to provide postnatal continuity
Provides woman centred care	
Allows midwives to use full range of skills and has positive impact on recruitment and retention	Attracts midwives from other units making their own recruitment and retention harder

The most serious of these concerns lies in the potential for a birth centre to exaggerate the inverse care by attracting the most highly skilled and committed midwives who will be delivering the highest standard of care to low risk women, particularly if women from neighbouring areas choose to deliver at the unit. However, this could be overcome if the PCT and unit worked together to promote the birth centre amongst local women and particularly those in the most vulnerable areas.

Heartlands Hospital has recently introduced midwifery led antenatal care, in which midwives make a judgement during booking, using agreed protocol, about a woman's likely risk during pregnancy. Those judged low risk and filling agreed criteria are allocated to midwifery led care and are not referred to the hospital consultant antenatal clinic. This reaffirms the 'normality' model of pregnancy for low risk women, prevents unnecessary travel to hospital clinics and gives midwives the opportunity to use the full range of their skills as lead professionals. Moving to such a system is a large culture change for many midwives and early audits indicate there is still more work to be done to ensure their confidence in deciding on a woman's suitability for midwifery led care.

Innovation in midwifery care is reliant on both adequate resources but also on excellent leadership and management within the profession. These two units are demonstrating a strong vision and commitment to improving services. The impact of the current modernisation agenda and structural reform in the NHS pose some very particular challenges for the way that maternity services are delivered in the future. It is therefore imperative that each of the provider units has both strong and dynamic management of operational services as well as coherent strategic leadership.

RELATIONSHIPS

Delivering antenatal care that meets the needs and preferences of individual women, builds on their personal strengths and resources, is flexible and woman centred and which is able to identify and act on presenting health and social risks, requires community midwives to act in collaboration with a wide range of stakeholders. Their personal and institutional relationships with these will play a significant role in the quality of community based care women experience, this includes relationships with:

- Midwifery colleagues and others in same Trust
- Midwifery colleagues and others in neighbouring Trusts
- The primary health care team
- Social services departments at an operational and strategic level
- Other advice agencies and support organisations
- Relations with women

Midwifery colleagues and others in same Trust

Within each of the provider units, community midwives have good collaborative relations with their midwifery colleagues. In all three units the community midwifery staffing includes a number of highly experienced, confident and competent midwives and in general the teams work well.

All three-provider units report intermittent but regular problems in managing the transition from community to acute based services. At its most simple and frustrating this relates to difficulties transporting blood and urine samples taken at community clinics to the hospital labs and then the prompt return of results. The consequence is community midwives waste valuable clinic time chasing results or repeating tests. Equally all units report frustrations in trying to help woman navigate their way through hospital clinic appointments, particularly where midwife, sonographer, phlebotomist and consultant appointments will be involved

Example from mapping exercise

This is a recurring issue in community midwifery practise. All midwives interviewed recorded problems with receiving blood results from other provider units but their own. In many instances midwives would have to interrupt precious consultation time to locate blood results.

Clinic H1: During the clinic session the midwife and link worker made two or three attempts to recover blood results for a woman but were still unsuccessful in receiving them from the hospital in question.

Midwifery colleagues and others in neighbouring Trusts

Across the patch there are significant issues of cross boundary flows, with large numbers of women receiving antenatal care from one provider and intrapartum care in another. However neither at a strategic nor operational level does there appear to be any formal mechanisms for collaboration and cooperation to smooth women's journeys.

At a strategic level there is no forum at which the three provider units, together with the PCT, meet to discuss service design or delivery. Thus there is no dialogue or possibility of resolving issues such as the failure to complete bookings in the community where a woman may deliver elsewhere.

The lack of collaboration at a strategic level models behaviour by individual midwives. Whilst some individual midwives have made efforts to make connections with neighbouring units in order to support women, on the whole most are unaware of services or protocols in neighbouring Trusts. This is particularly important where women with identified risk factors are referred into hospital during their pregnancy.

The primary health care team

Midwives relationships with the primary health care teams (PHCT) are patchy and dependent on individual personalities. Community midwives are not employed by GPs, many do not feel formally part of the PHCT. Few attend practice meetings or have opportunities to discuss issues arising from their caseload, unless they have particular health concerns about an individual woman. This means midwives are rarely involved in strategic discussions within the PHCT and tend not to engage in wider primary health care forums.

Social services departments at an operational and strategic level

At a strategic level the provider units are not engaged with the citywide discussion and development of Children's Centres. There has been little in the way of formal discussion between social services and each of the units about how midwifery services might be incorporated within new developments. The discussions that have taken place have been ad hoc, based around a single team or a single site. There is no evidence of a citywide analysis of how the emerging Children's Centres as a whole could be a resource for community midwifery.

At operational level, the increasing child protection workload means that midwives are working more closely with social services departments. There appears to be some frustration that feedback about referred cases is poor.

Other advice agencies and support organisations

Given the high degree of social and economic deprivation across the patch, it is surprising that midwifery services have not formed stronger alliances with other agencies working broadly from a public health perspective. It is of course unrealistic to expect midwives to be able to support women's multiple social or emotional needs, however, they should be able to signpost women to appropriate support and advice.

Example from mapping exercise

Clinic C3: The midwife present increasingly faces social issues surrounding patients including domestic violence and drug abuse. It is vital that her and other midwives in similar environments are thoroughly informed and trained in responding to these social issues.

Relations with women

Each of the provider units participates in a forum to involve local women in commenting on service delivery. However, there is no HoBtPCT wide Maternity Services Liaison Committee functioning as recommended in the NSF guidelines – bringing all professional stakeholders together with users to look both at strategic and operational issues. Whilst the PCT has funded a one off snap shot survey of women's views in one part of the patch, it has no formal mechanism for involving women's views in its deliberations on maternity care. Neither does it use qualitative data such as complaints or other feedback received in the provider units to assess user satisfaction with the service.

LOCAL INTELLIGENCE

None of the provider units, or indeed the PCT has a detailed picture of the complexity of need presenting amongst pregnant women in this community. Anecdotally provider units report an increasing incidence of high-risk characteristics such as; alcohol and drug abuse, domestic violence, child protection, female genital mutilation, and asylum seekers. Whilst this information is recorded on individual women's notes, it is not collected at a unit level and none are able to quantify the extent of these problems. Equally whilst all maintain that there is insufficient support for women whose first language is not English, none are able to quantify the gap between existing provision and real need (i.e. how many women who would benefit from language support or a link worker do not receive this). Reports from midwives at all sites confirm that it is not unusual for midwives to struggle through antenatal and postnatal care without language support – particularly at the initial booking visit.

Teenage pregnancy has been a national target; both the PCT and provider units have collected data on incidence, location, ethnicity etc in respect of teenagers. Equally the newly agreed data set for perinatal mortality will require all provider units across the StHA to collect and record information about smoking and breastfeeding rates. This will add significantly to the understanding of local health profiles. However it has also been decided that for this initiative information on drug and alcohol use will not be recorded.

Outcome data is also only available across a broad range of indicators and does not really allow for a detailed analysis of who the most vulnerable women are and who is experiencing the worst morbidity. For example, Appendix 2 shows some examples of PCT and provider unit data. In terms of obstetric outcomes it should be noted that despite the extremely vulnerable population being served, outcomes at all three units are good and compare well with West Midlands averages. This should be a point of celebration. None of the provider units yet have accurate or detailed data on breastfeeding (for example by ward or by ethnic group) and none collect data on the incidence of postnatal depression. None of the units know how many women do and do not access parent education and support and none collect data on how many professionals women routinely see during pregnancy.

There would appear to be a lack of clarity in the definition, recording and reporting of activity data. In the past this may have been of little consequence. However, under Payment by Results (PbR) it will be crucial for both the PCT and provider units to have confidence in the information available.

Under PbR, hospitals will move away from locally negotiated block contracts to being paid ONLY for the care they actually provide. If their actual costs are lower than the national tariff they will in effect make money, which they can use as they see fit. If, however, their actual costs are higher than the national tariff they will have to look at ways to bring their costs down, or increase activity in other areas to generate income.

Like many maternity unit contracts between HoBtPCT and the three provider units they are based on historic data and the past negotiating skills of individual managers; rather than a true reflection of either reference costs or recent changes in the volume of activity undertaken. From now on PCTs will only pay for the actual maternity care provided in terms of both volume and case mix. This system should ensure a fair and consistent basis for maternity funding.

Whilst under the current system developments in service are the subject of additional bids for funding from the PCT, the presumption is that the tariff will increasingly be the only source of providers' income. The success of PbR therefore rests on accurate data. Under the new system hospitals will not get paid for unrecorded or badly recorded (uncoded) activity.

Appendix 3 details the breakdown of HOBtPCTs current planned maternity expenditure across the three sites, including elements of care within and so far excluded from PbR. At first sight there appears to be some anomalies in this data for example:

? According to HRG Code N12, all of the provider units are admitting more women into hospital as in-patients during their pregnancy for antenatal complications than they actually deliver. Given that in fact the majority of women experience no serious health problems during pregnancy this is unlikely. The more likely reason is this code is being used to record other activity.

? According to Code 501, Heartlands is only booking 437 women for antenatal care, yet data it supplies at Appendix 1 indicates this number is more like 650. Similarly it appears that women receive on average only 1.9 antenatal appointments. This suggests an under-reporting of activity, certainly a different definition than being used at the Women's.

? According to the line community midwifery, the PCT is paying around three times as much for community midwifery at City as it does at the other two units. However, when taken overall, the overall cost of maternity care per woman at each unit is not significantly different. The PCT does not have activity data for community midwifery and it is unclear to what this cost relates to.

Whilst it is not surprising that in the early years of PbR there should be confusion, it is important that if the PCT is to receive value for money and if the provider units are to be adequately resourced to fund community midwifery, more work will need to be done by the organisations to clarify definitions, recording and reporting of activity.

The reasons behind poor local knowledge include:

- Little engagement between provider units and the PCT on the public health agenda. Until the work around perinatal mortality commenced there was very little dialogue between the PCT and provider units about the impact and contribution maternity makes to the wider health agenda
- Culturally there is a difficulty in engaging midwives in data collection. Traditionally maternity information sets across the UK have not been high quality because they rely on midwives collecting and entering the data. Midwives tend to view such effort as time away from clinical or 'real' midwifery and therefore do not give it priority. Equally midwifery managers have not in the past ensured their staff are sufficiently IT literate or that midwives personally benefit from the collection and analysis of data

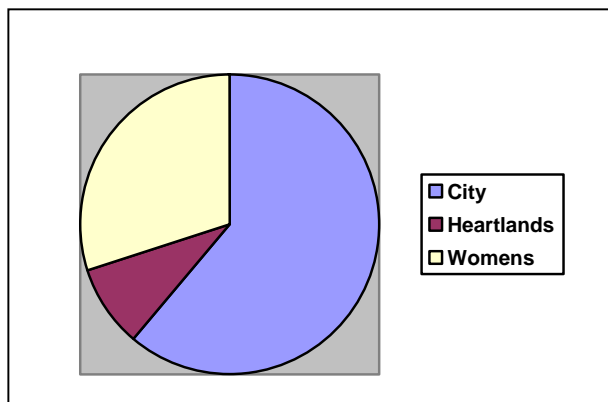
- Data collection is hampered by community midwives lack of access to appropriate technology. Midwives do not always have IT access in GPs surgeries, nor do they have mobile IT. For those without access at clinics any data they need to enter onto the hospital computer system has to be done from the hospital. This inevitable leads to an inputting backlog
- The heavy workloads of community midwives and lack of administrative support mean that recording data is a low priority

SECTION 2: THE CURRENT PICTURE

INTRODUCTION

HoBtPCT) currently commissions community midwifery services from three provider units, delivering care through approximately 76 maternity clinics based in 70 GP practices (some practices hold more than one clinic a week). These practices cover the following wards: Aston; Bordsley Green; Handsworth; Ladywood; Lozells; East Handsworth; Nechells; Soho; Sparkbrook and Springfield. The distribution of clinics between the three providers is indicated in Diagram 1.

Diagram 1: The split of GP practices under the three provider units



- **City Hospital covers approx 60% (48 Clinics)**
- **The Women's Hospital covers approx 30% (22 Clinics)**
- **Heartlands covers approx 9% (6 Clinics)**

This element of the project aims to produce a detailed picture of the level and quality of midwifery services provided through HoBtPCT's GP practices. It also comments on key issues and barriers to the delivery of an effective service. The mapping process involved the following elements:

- 1) A survey of all 76 clinics to systematically collect data on resources and activity – [please see appendix 4 for raw data results]
- 2) Observational visits to around 30% of clinics which included:
 - a. Interviews with community midwives, and
 - b. Tracking and interviewing women
- 3) Focus groups and interviews with Community Midwife Managers

Data collected from this exercise is presented under three headings:

- Clinic organisation and activity
- Midwives' perceptions of factors impacting on perinatal mortality
- Women's feedback on service provision
- Conclusions

CLINIC ORGANISATION AND ACTIVITY

Number of midwives on site at the clinic

The number of midwives varied across the clinics, according to caseload. 60% of maternity clinics across the Heart of Birmingham are staffed with only one midwife. Clinics also display some worrying discrepancies in the caseloads of midwives.

Example from mapping exercise

For example Clinic C4: two midwives were covering a large caseload of approximately 25 – 28 women in one clinic session. At clinic H2, one midwife alone covered approximately the same caseload.

Duration of clinic and each individual woman's appointment

Clinic sessions were generally over two hours long, but could last up to four or five hours, depending on the caseload. Midwives tended to continue running clinics until all women had been seen. On average each woman is allocated between 10–15 minutes for an antenatal session. New bookings are allocated between 20–30 minutes.

The majority of midwives did not believe that the session times they had available to them were sufficient. Midwives were regularly witnessed having to extend session times in order to deliver necessary care. This often led to backlogs of women due to caseload numbers.

A focus group consisting of community midwifery team managers described the level of care they can offer due to time restrictions as 'basic'.

This is a vital issue, which needs to be addressed as it frequently causes disruptions and delays to the level of care given to women.

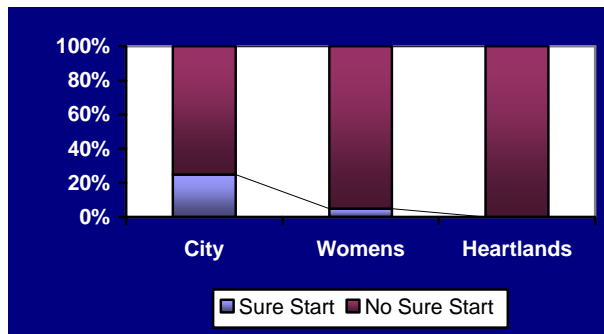
Example from mapping exercise

Clinic W3: A midwife spotted a potential problem with a woman, which required urgent attention. The midwife at the GP surgery could have performed the necessary tests but due to time restrictions the woman was sent to a hospital, which further delayed her care.

Availability of a Sure Start worker on site at maternity clinics

Only approximately 13% of maternity clinics regularly had a Sure Start worker on site, see Diagram 2. Visits to clinics indicated that where Sure Start services operate within maternity clinics they can be of great benefit to women. Interviews with women suggest they value the services that Sure Start workers provide, such as health advice, hand massaging etc.

Diagram 2: Sure Start availability across GP practices



Interviews with midwives also revealed that they would like more Sure Start services within the antenatal clinics.

However, for Sure Start services to be most effective they must be utilised to their full potential. This did not always appear to be the case with some indication of both duplication of care from the Sure Start and community midwife and some fragmentation of care.

Midwifery support staff

A wide range of different kinds of support staff were found within community clinics, including link workers, health care assistants with and without language skills and maternity assistants. However, only 42% of clinics had regular support of any kind for midwives and it was not clear if there was any rationale behind this distribution.

Hospital provider	Approx % of maternity clinics with any regular support staff
City	35%
Women's	50%
Heartlands	66%

Antenatal breastfeeding support

This study shows that primarily midwives within clinics provide the majority of breastfeeding information and support. Julia Brown (Breastfeeding Coordinator HoBtPCT) is currently engaged in developing and delivering a major breastfeeding project across HoBtPCT. In a significant number of clinics, due to time restrictions and caseload levels, midwives struggle to give breastfeeding advice to women.

IT access available to midwives at GP practices

The level of IT support given to midwives varies widely between the practices and is dependent not just on what IT the GP practice has available, but also on the relationship and degree of co-operation that exists between GPs themselves and midwives.

Approximately 60% of GP practices provide some form of IT provision for midwives. The majority of this is for booking appointments only. In a small number of cases midwives can record women's information on computer, which greatly enhances the level of data that is recorded and streamlines the process of attaining relevant information.

Where appropriate IT is not available or accessible midwives continue to use paper based records for recording information at booking.

Example from mapping exercise

Clinic C4: Receptionist staff would frequently over book clinics and in some instances book three or more women for the same appointment causing obvious problems for the midwives and distress for the women. Clinics where appointments are booked on computer eradicate this problem.

In addition, information gathered during routine antenatal care is not always recorded electronically. Midwives with access to IT reported that it assisted in the following ways:

- More detailed information from the antenatal session could be recorded
- Information on the computer highlighted potential problems and patterns which paper based files could not
- Midwives unfamiliar with an individual woman can more efficiently access relevant information for the woman in question

Midwives without this facility record session information on paper based files. These are less detailed than IT based recording and can be time consuming when sifting for relevant information.

Administration support at the GP practice

Midwives and midwifery support staff provide administrative support for maternity clinics. However nearly all GP practices will write referral letters as required for women.

Blood testing

The majority of clinics experienced bottlenecks in processing blood and urine tests. Midwives frequently have to actively chase hospital providers for blood results for women during clinic sessions, therefore taking up time that should be spent talking and listening to women.

The process of sending blood for testing and receiving results varies across provider units and midwifery clinics. Some midwifery clinics will take blood from women attached to any delivery hospital whilst others only take blood tests from those attending their own hospital (in these instances women would be sent to their own delivery hospitals for blood tests). There does not appear to be a standardised procedure across the maternity clinics and hospitals for sending for blood tests and receiving results.

MIDWIVES' PERCEPTIONS OF FACTORS IMPACTING ON PERINATAL MORTALITY

As well as quantifying the provision of community midwifery across the GP practices, the visits offered the opportunity to explore with midwives their views about the factors responsible for high perinatal mortality locally and their suggestions for improving services and outcomes. In discussion midwives raised a number of recurring themes and issues.

Consanguinity (unions between second cousins or closer)

When midwives were asked the reasons for perinatal deaths within HoBtPCT, nearly all suggested consanguinity as a primary cause. Midwives often feel powerless to address this issue within the community.

Example from mapping exercise

A focus group of community midwifery team managers also believed consanguineous unions to be the main cause of perinatal deaths within their ward population and yet do not feel in a position to tackle it.

Medical evidence shows a link between consanguinity and congenital abnormalities leading to perinatal death. Currently, there is insufficient data to quantify the number of consanguineous marriages within HoBtPCT and the numbers that are linked to perinatal death. However, qualitative evidence would suggest that a significant percentage of pregnant women within HoBtPCT are involved in consanguineous marriages. Further investigation into this matter is required within HoBtPCT.

Cultural influences

In relation to the community that midwives are serving they perceive the following as barriers to providing good quality care. Firstly, those family members give advice to expectant mothers, particularly about diet and wellbeing during pregnancy that is contrary to the advice given by midwives. Secondly, a disregard for the importance of antenatal appointments, particularly with women who have had previous pregnancies or are new into the country. Midwives believe that many women they care for view antenatal check ups as 'low' priority compared to other commitments and duties they have. Finally, midwives believe they themselves struggle to overcome cultural barriers and administer the care they want to give to women.

Language barriers

Midwives perceive a deficit in knowledge of key medical issues involved in pregnancies among many of the women attending their maternity clinics, e.g. diet and the importance of antenatal check ups.

Language barriers are also closely linked to the difficulties midwives experience in providing women with appropriate care. The need for effective communication between midwives and women is clearly evident. Where there is not adequate language support there is a risk that vital information is not effectively passed on to mothers.

Example from mapping exercise

Midwife x expressed a fear that some women were not aware of key indicators of perinatal problems largely due to language barriers and illiteracy which prevented them from accessing and understanding key information.

Social deprivation

Midwives pointed to the fact that Heart of Birmingham covers some of the most socially deprived areas in the UK and that social deprivation also has a strong link to perinatal mortality. They see this as a significant factor in limiting the effectiveness of the care they provided and cited many examples including homes where poor living conditions result in health problems for pregnant women.

WOMEN'S FEEDBACK ON SERVICE PROVISION

This project did not aim to systematically collect and record women's views about the services they received. Nevertheless as part of the visits to clinics opportunities were taken to informally seek women's opinions. Interviews with women conducted as part of this project did not always provide the depth of information required to make a valued judgment of women's satisfaction. Women were often reluctant to talk in an in-depth way about their experience and language barriers often affected their effective communication of thoughts. However, from conversations in clinics the following themes emerged:

- A general satisfaction with the personal care offered by most midwives. This was recorded most frequently in situations where women had continuity with the same midwife throughout their antenatal sessions
- The need to improve waiting environments was often suggested. Not all practices have the capacity to provide separate waiting areas for women, nor are all clinics sufficiently able to carry the caseload of women at the clinics.

Example from mapping exercise

Clinic C5: Some pregnant ladies were forced to stand whilst waiting for appointments due to lack of seating. The midwife present also advised women to avoid using some of the seating due to its unsatisfactory condition.

- Requests for more maternity services within waiting areas was also highlighted e.g. for Sure Start health advice, hand massaging etc
- Improved facilities for expectant mothers with children was another request

Example from mapping exercise

One of the issues, which midwives cited for non-attendance at antenatal appointments was related to family commitments such as caring for other children. This obstacle can be reduced when childcare facilities are available at clinics.

- Complaints were also made about duplication of appointments and people 'jumping appointment lists'.

CONCLUSIONS

Community midwives within clinics are on the whole attempting to give the best care they can but are largely restricted by the systems, processes and environments that they are required to work in. A more uniformed methodology of working between maternity services from all three hospitals would address many of the key problems within maternity clinics.

This GP mapping exercise has also highlighted the significant impact of socio-cultural issues on maternity services and perinatal deaths within HoBtPCT.

SECTION 3: STAKEHOLDER ANALYSIS

In addition to the researchers' analysis and conclusions about the strengths and weaknesses of community midwifery across the HoB area, key midwife stakeholders at the three provider units were asked to add their own assessment of the state of the service provided. These personal comments reinforce the data already presented.

In your opinion has the quality of community midwifery services offered to local women (specifically HoB residents) got better, stayed the same, or got worse in the last 3-5 years? Why?

Improved

"Staff are better informed and up to date with current practices."

Got Worse

"Current agreed staffing levels are inadequate which is further complicated by the national shortage of midwives and the unattractive area in which staff are expected to work, i.e. increasing violence, drug abuse, child protection issues, domestic violence and language difficulties. The difficulty in recruitment has a negative impact on midwifery caseloads, as they are too large to offer quality time to women."

"Increase in workload and complexity (including child protection, domestic violence, female genital mutilation, HIV infection, etc). An influx of residents from different ethnic/language groups has added to the difficulty in both communication and recognition of need. Midwives also struggle with the need to access information from the hospital without the benefits of electronic communication networks."

"Higher demands on the midwife through increased responsibilities, poor moral and insufficient resources. The resulting sickness and poor retention has further impacted on the lack of midwives in this area."

From your perspective what is the best or most encouraging aspect of the community midwifery currently provided to HoB residents? Why?

"Some degree of continuity of carer, for some women, during the antenatal and postnatal period."

"A pretty stable and loyal workforce in the teams covering the HoB areas. Many of the midwives on those teams have worked in the areas for 10 plus years. This continuity provides a valuable understanding of the local support networks and an awareness of the teams."

"Dating scans in the community, this service is valued by women who do not have to make the trip to the hospital."

"The link workers."

"Midwifery led antenatal care was introduced last year which provides most of the care to low risk women in the community by a known midwife."

From your perspective what is the worst or most disappointing aspect of the community midwifery currently provided to HoB residents? Why?

“Large caseloads, therefore not enough time allocated to women to fully address their needs.”

“The workload continues to increase but there is no mechanism to link this to adjusting midwifery establishment. Neither is there a tool to measure additional factors that need additional support mechanisms such as interpreters, link workers, social care, etc.”

“Every national initiative aimed at improving public health recognises the value of midwives in the promotion of healthy lifestyle issues, but no one acknowledges the amount of time it takes to deliver these programmes in addition to the core midwifery role. As a consequence of this everyone wants midwives to contribute, but no one is willing to fund these things or even think through whether it really needs a midwife or whether someone else would do as well.”

“Midwives simply do not have the time to provide the aspects of care required to meet mothers’ education and emotional needs or recommended in the NSF.”

What would be your priority for providing a better community midwifery service to local women in the future, in terms of service reorganisation, resourcing or staffing?

“Independent flexible venues. Non-dependence on GPs. More flexible times to meet the needs of women, for example evening and weekend clinics. Women allowed to state their availability – may reduce DNA rates.”

“Smaller caseloads.”

“More support staff and easier access to interpreting services. The current BILKS system requires 24 hour advance booking and use of agencies is very expensive.”

“Service establishment needs to be increased with midwives or para-professional and support grades based round identified priorities.”

“Review skill mix, invest in human resources.”

“More holistic care for women in the community such as dating scans for low risk women. Full booking in the community.”

“Map the requirements of the area, using acknowledged tools to calculate the need and cost of service improvement. The funding bodies can then prioritise where the greatest need lies.”

“Develop strong links with primary care and Children’s Centres.”

SECTION 4: THE FUTURE

IMPROVING COMMUNITY MIDWIFERY SERVICES – OPTIONS FOR THE FUTURE

This review of community provision across the HoBtPCT area demonstrates that there is significant scope for improving the quality of antenatal and postnatal care provided to local women. It has also demonstrated that in the main, the three provider units are aware of their shortcomings and that in the main, although not wholly, these are due to a lack of resources. It is also clear that to date developments at each unit have been piecemeal and that there has been little strategic direction or leadership from the PCT.

Therefore we make five key recommendations for moving this service forward:

- Fund and recruit more community midwives
- Fund and recruit more support staff
- Develop new models of community based provision
- Establish a maternity forum of the PCT and three provider units with a firm and explicit commitment to collaborating on service improvement
- Refine data collection, particularly around activity and costings

Fund and recruit more community midwives

It is clear that the funded establishment in the three provider units is inadequate for the workload and case mix they are dealing with. Using the data provided, it is estimated that to ensure all community midwives have a caseload of 110 women would require nine additional midwives across the patch. This translates as: 1.9 wte at Heartlands, 5.2 wte at Birmingham Women's and 2 wte at City.

+ve implications of increasing midwifery staffing	-ve implications of increasing midwifery staffing
More midwives will lead to smaller caseloads, with midwives able to give more time to individual women	National shortage of midwives means that even with funding it may be difficult to recruit staff
	More staff will not address and maybe used to avoid discussion about appropriate midwifery models
	Provider units may resist staffing increases ring fenced to HoB residents

Fund and recruit more support staff

It is clear that the funded establishment for all support staff; administrative/clerical; midwifery care assistants and link workers is inadequate for the workload and case mix.

Whilst each of the provider units is working to slightly different models of midwifery assistant and link worker, using the data provided, it is estimated that to ensure each HoB community team had two dedicated support staff (one with and one without community language skills) would require nine additional staff of mixed grades, depending on role. This translates into 2 wte at Heartlands, 3 wte at Birmingham Women's and 4 wte at City.

Any increase in support staff should be accompanied by an agreement to systematically define the midwifery tasks to be delegated to support workers.

+ve implications of increasing midwifery staffing	-ve implications of increasing midwifery staffing
Increasing support staff will reduce workload on community midwives	It is difficult to recruit and retain support staff to work in some areas of HoB
Additional support staff could take on new roles such as health care trainers	Much of the valuable work support staff could do is work that is currently not being done at all. Thus whilst their employment might improve the quality of service, it may not affect the workload of midwives
	More staff will not address and may be used to avoid discussion about appropriate midwifery models

Develop new models of community based provision

The three provider units are currently providing antenatal services from over 70 GP venues, many of which are inappropriate and have poor facilities. The provider units continue to try and staff each GP practice, regardless of how many pregnant women use the service each year, so one midwife may work from a number of practices. This is an inefficient use of midwives' time, fragments resources and does not give them a settled community base. Across HoB the plans to establish 29 Children's Centres offers an opportunity to have a strategic discussion about rationalising the number of places community midwifery is provided from and to co-locate midwifery with other relevant services in more suitable venues. This should be used as an opportunity for a joint discussion by the three provider units and the PCT together, of the suitability and acceptability of GP based services. New venues should be chosen to provide the capacity and environment for:

- Group antenatal and postnatal sessions
- Language support
- Parentcraft education (perhaps contracted out to lay providers)
- Nutrition and other lifestyle advice
- Drop in antenatal and postnatal advice
- Evening and weekend sessions
- Baby massage
- Appropriate networked IT to allow midwives to book and refer women
- Dating scans
- Appropriate equipment in situ to stop midwives having to transport it from venue to venue
- Building relationships with local communities to raise awareness of health issues and to help midwives better understand cultural norms and practices
- Midwifery development opportunities to support confident practice in relation to the socio-economic and cultural environment in which they work.

+ve implications of co-locating community midwifery in Children's Centres	-ve implications of co-locating community midwifery in Children's Centres
Provides midwives with suitable premises and facilities	Significant financial investment in appropriate venues and facilities
More efficient use of midwifery resources by rationalisation	GP resistance
Establishes community presence and will facilitate direct referral to midwife	Midwives across three provider units will need to co-operate
Easier access to appropriate health and social support for vulnerable women	

Establish a maternity forum of the PCT and three provider units with a firm and explicit commitment to collaborating on service improvement

In relation to the planning and commissioning of maternity services, the NSF calls for:

“All NHS Trusts, together with neighbouring NHS Trusts, Social Services Departments and if necessary Strategic Health Authorities should plan and commission maternity services as part of a **locally agreed managed network** of maternity and neonatal care appropriate and accessible to all women.” (our emphasis)

The key to improving community midwifery provision to HoB residents lies in a commitment from the three provider units and the PCT to work together to make best use of their combined resources, to agree common priorities for investment and development and to collaborate over service redesign. The first step should be the agreement to form a maternity service forum, perhaps using the MSLC model, but with senior staff commitment to work with the information provided in this report and other policy drivers such as ‘2010, Payment By Results’ and ‘Healthcare out of Hospitals’. The PCT should provide support to this forum, perhaps with external facilitation, to produce an action plan of agreed priorities, assimilate existing initiatives and improvement programmes, begin joint discussions with the local authority about the potential of moving midwifery bases into Children's Centres and agree common policies and procedures across units to facilitate continuity of care and care pathways. Such a forum would seek to develop community midwifery within the context of improving maternity services as a whole, in line with the NSF and could perhaps agree as a starting point a number of underlying principles such as:

- Working to 1:1 care in labour
- Maximising continuity antenatally
- Targeting the most disadvantaged and vulnerable women

+ve implications of provider unit and PCT collaboration	-ve implications of provider unit and PCT collaboration
A strategy for equity of provision for all HoB women	
A strategy that makes the best use of resources to improve capacity	
Strengthens the negotiation of individual units within their own Trusts and with GPs	
PCT can support and facilitate innovation	

Refine data collection, particularly around activity and costings

It is clear that neither the PCT nor the provider units yet have detailed reliable data about activity, cost, demographic and socio-economic indicators or outcomes. Without robust information it is difficult to redesign services or to make a strong case for additional resources. The PCT could act as a resource for the three units to reach a common agreement on definitions and data recording and reporting. The production of meaningful data would enhance strategic decision making about midwifery services and support individual professional practice.

+ve implications of refining data collection	-ve implications of refining data collection
Better information on case mix supporting better targeting of resources	Cost in IT provision
Better identification of activity matched by appropriate resources	Cost in staff time to record, enter and analyse data
Better understanding of risk areas	
Better feedback to individual midwives as part of their professional development	

STAFFING LEVELS MEASURED AGAINST DEMAND

	HEARTLANDS	BIRMINGHAM WOMEN'S	CITY
Number of HoB deliveries	1095	1832	2502
Annual caseload of HoB community midwives	650	2119	(2660)
Number of community midwives total	32.9 estab (27.7 in post)	47.3 estab	26.69 estab (22.09 in post)
Number of community midwives in HoB	4.4 in post	14.08 estab	18 in post
Spend on community midwives	£252,000	£437,000	£1,999,000
Ratio community midwives to women in HoB	147:1	150:1	140:1
Ratio midwives to births (total)	37	32.8	34.7
Number of link workers total	4	4	6
Number of MCAs total	0	10	2
Number of MCAs available in HoB	0	3	1
Specialist midwife ² : Teenage pregnancy	4	4	4
Specialist midwife: Domestic violence	4	4	4
Specialist midwife: Mental health	4	4	4
Specialist midwife: High risk antenatal care	4	4	4
Specialist midwife: Substance abuse	4	4	4
Specialist midwife: Child protection	4		4

² Specialist midwife posts may not be a whole time equivalent. In most cases the same person performs several specialist roles.

HEART OF BIRMINGHAM
SUMMARY OUTCOME DATA

	Deaths under 1 Per 1000 (2002)	Low birth weight % (2002)	Teenage pregnancy Per 1000 (2000)
Aston	10.1	11.85	65.82
Handsworth	19.9	13.25	46.69
Ladywood	12.9	7.33	65.93
Nechells	16.9	12	58.98
Sandwell	2.4	12.59	n/a
Smallheath	10.1	10.48	31.34
Soho	13.4	10.45	67.11
Sparkbrook	14.2	11.63	57.29
Sparkhill	19	11.45	35.19
W Mids Average	9.1		46.8 (2003)
Nat Average	8		42.3 (2003)

	Heartlands	City	Women's	West Mids average
% Normal deliveries	66.77	69.98	64.76	65.81
% Caesarean section	23.53	22.48	23.27	23.15
% Epidural/spinal	7.79	30.46	22	30.06