

King's termination of the Albany Midwifery Practice Contract

Albany Action Group Briefing Document

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Background

The Albany Midwifery Practice in Peckham, in the borough of Southwark, South London, UK provided a caseload midwifery model of care for around 200 women per year for the past 12 years, operating in the community as a self-employed, self managed partnership under contract to King's College Hospital NHS Foundation Trust. In line with national maternity policy, the Albany gave genuine choice to the women whom it served about place of birth and provided continuity of carer throughout pregnancy, birth and the postnatal period.

Peckham is the 14th most deprived district out of 354 districts in England, yet Albany statistics have been consistently outstanding. The Jarman Index of deprivation for the postcodes served by Albany is 64.31, one of the highest scores in the Trust. The Albany Midwives cared for a caseload of local women regardless of their perceived medical or social risk. Their perinatal mortality rate however (4.9/1000 from 1997-2007) is lower than the national average (7.9/1000 for England and Wales 2006, CEMACH 2008) and far lower than the average for Southwark borough as a whole (11.4/1000 from 2003-5, Southwark PCT 2007).

Figures for Albany over the past 10 years:

Spontaneous vaginal birth 80.1% (47%*)

Caesarean Section rate 16.4% (24.6%*)

Homebirth rate 45% (2.68%*)

Exclusive breastfeeding 76% at 28 days (45% at 7days**)

Instrumental delivery rate 3.2% (12.2%*)

*National Average taken from NHS Information Centre (2009)

**National Average taken from The Infant Feeding Survey (2005)

A model in line with National Maternity Policy

The Albany is recognised as a birth model that works (Davis-Floyd et al 2009) and has long been regarded internationally as the gold standard for midwifery caseloading. It has been carefully evaluated (Sandall et al 2001) and is precisely the kind of individualised maternity care advocated in government strategy documents since 1993. Continuity of care, first endorsed as a way of improving outcomes for mothers and babies in **Changing Childbirth** (DH 1993) is associated with increased choice, less need for analgesia, less conflicting advice, an increase in normal birth, fewer interventions, higher rates of homebirth and higher rates of breastfeeding compared with standard care (Warren 2003).

Maternity Matters states 'every woman will be supported by a midwife she knows and trusts throughout her pregnancy and afterwards so as to provide continuity of care' (DH 2007, p9) with the aim of achieving this by 2009. **The Darzi Report** in 2008 confirmed that 'women want high quality, personal care with greater choice over place of birth, and care provided by a named midwife' (DH 2008, p18). However, despite national policy, choice and continuity of care are rare in the UK, with most maternity services in England providing an institutionalised, hospital/obstetric-based model of care with high levels of medical intervention and operative deliveries.

Only 58% of women nationally
saw the same midwife for antenatal care

On average only 21% knew the midwife who
cared for them during labour and birth
(Healthcare Commission 2008).

The national caesarean rate has risen from
15% in 1993, to **22%** in 2003,
to **24.6%** in 2008
(NHS Information Centre 2009).

Albany midwives care for a multi-ethnic, deprived population, known to be at a far higher risk of childbirth-related mortality and morbidity compared with a white, middle class sample (Lewis 2007). Albany has had consistently excellent outcomes, and the families for whom they care think very highly of the service (Sandall et al 2001, Rosser 2003). For over a decade, King's College Hospital NHS Foundation Trust has renewed the Albany's 2-yearly contract, suggesting that the model has worked well for the Trust, as well as for families and for the self-employed Albany midwives (NCT 2009).

Why has King's management terminated Albany's contract?

The reasons for the termination are given as patient safety and governance issues. However we are concerned that there may be different reasons. For example, the NCT, who has met with the Head of Midwifery at King's, believes poor management led to a breakdown in relationships (NCT 2009).

In January 2009, King's management commissioned an external review of a number of babies from the Albany practice admitted to Special Care during a 31 month period (March 2006 - October 2008). A number of cases with an initial diagnosis of HIE were selected and then the Centre for Maternal and Child Enquiries (CMACE) was asked to investigate.

One of the cases sent to CMACE, which seems to have triggered the investigation was that of a baby who died one week after he was born at King's attended by Albany midwives. His mother had had a caesarean for the birth of her first baby but wanted a natural birth for her second and was keen to use a pool in labour. The lawyers for the family claimed that proper procedures were not followed, because the baby's heartbeat was monitored intermittently rather than continuously. NICE guidelines recommend offering continuous electronic fetal monitoring in this situation; however intermittent monitoring may be chosen by women opting for a vaginal birth after caesarean section (see, for example, Sellar 2008), as this reduces the chances of a repeat caesarean.

The consultant obstetrician stated at the baby's inquest that continuous monitoring would have saved the baby's life. This statement is impossible to prove; irrespective of 'risk' status, the use of continuous cardiotocography is not associated with a reduction in infant mortality (Alfirevic et al 2006). The baby's mother referred the midwives to the Nursing and Midwifery Council (the regulatory body). The NMC declared there was 'no case to answer' and the case was closed without any suggestion of malpractice.

At the end of September 2009, following an unexpected poor outcome at a homebirth, King's suspended the Albany homebirth service. One of the midwives involved was also suspended from duty pending the outcomes of the investigation into this case and the CMACE report.

King's then terminated the Albany contract and posted a statement on their website as follows:

King's College Hospital puts patient safety before all other considerations. For this reason we have terminated our contract with the Albany Midwives practice. We have become concerned about the safety record of the practice in comparison with the Trust's overall maternity safety record. Our records show that whilst Albany delivered babies for 4% of all King's births, those births accounted for 42% of our full term babies born with Hypoxic Ischaemic Encephalopathy, a condition whereby brain damage may be caused by a lack of oxygen to the brain, at or around the time of delivery. The Trust formed the view based on this evidence that babies delivered by an Albany midwife were at higher risk of contracting serious Hypoxic Ischaemic Encephalopathy (HIE).

We consider King's statement to be defamatory. We challenge their statement and demand that King's provide full evidence. We refute the conclusion that Albany babies 'were at higher risk

of contracting (sic) serious HIE'. We find it somewhat odd that, although King's purports to be concerned about the safety of 'babies delivered by an Albany midwife', in the same statement it expresses 'hope that individual Albany midwives will join the Trust as employees'.

The term HIE has been the subject of much scientific debate and in fact the National Perinatal Epidemiology Unit has now strongly recommended that the term be discontinued, and the term 'neonatal encephalopathy' (NE) adopted instead (Kurinczuk et al 2005). Several studies have challenged the view that all NE results from adverse intrapartum (during birth) events and therefore necessarily reflects poor obstetric or midwifery care. As Marcio Sotero de Menezes, Associate Professor, Children's Hospital of Seattle, writes: 'use of the term NE removes from obstetric practitioners the unfair blame they receive for poor neonatal outcome (de Menezes 2006).

It seems likely that most NE cases are due to antepartum factors; for example one study found that only 5% of infants with moderate-to-severe NE had only intrapartum risk factors (Badawi et al 1998a, 1998b). De Menezes comments: 'Neonatologists ... and other health professionals should refrain from using the statement 'HIE due to intrapartum asphyxia or intrapartum ischemia' unless unmistakable, documented proof is present. Such proof is rarely present. The mere presence of the clinical syndrome in the neonate does not prove anything because it may have multiple etiologies ... In the past, the terms 'HIE of the newborn' and 'perinatal asphyxia' have been used, rather loosely, as synonyms. Clinical signs of HIE are often wrongfully considered to result from intrapartum asphyxia (lack of oxygen during birth). This misconception has led to HIE being considered a marker of perinatal obstetric mismanagement' (de Menezes 2006).

Further, having in essence accused Albany midwives of unsafe practice, and terminated their contract as a result, King's is surely obliged, at the very least, to publish the CMACE report and all the evidence upon which it has based its decision to terminate the Albany contract. King's has consistently refused our requests to see the CMACE report and insists that it is confidential.

We know that the report stated: 'the study methodology employed does not lend itself to meaningful statistical analysis'.

Mavis Kirkham, Emeritus Professor of Midwifery at Sheffield Hallam University, has said King's methods are 'bad science and fundamentally flawed' (Mahony and Lister 2009).

The Royal College of Midwives has stated: 'In the interest of transparency and improving care for all women, the RCM believes that the report must be made public' (RCM 2009).

Professor Alison Macfarlane, Statistician and Professor of Perinatal Health at City University, London, and former advisor to the organisation which became CMACE, has also challenged King's methods. She has commented: 'In the absence of information about sources of the case series, the definitions and inclusion criteria used, the longer term outcomes of the babies who survived, the extent to which the babies included ... had factors which were associated with neonatal encephalopathy, and the lack of denominators and statistical power, it is impossible to draw any inferences' (cited in Reed 2009).

In the Albany cases King's selected, the level of HIE was not defined or graded in a consistent manner- it is normally graded from I (mild) to III (severe). This is important, as a recent review of 12 studies found that the proportion of infants with NE and went on to develop adverse outcomes

was nil in stage 1 (mild), 32% in stage 2 (moderate) and almost 100% in stage 3 (severe) encephalopathy (Pin et al 2009). We do not know whether King's has examined the long term outcome of the Albany babies diagnosed with HIE; however we do know that at least one of the Albany babies included in King's statistics is now a healthy toddler.

Given the above considerations, King's methods and allegations must be questioned. We consider its statement to be an unsubstantiated slur on the good name and practice of the Albany Midwives. Further, King's has not consulted the families who are affected by the termination of the contract; several women have already been forced to give birth with different caregivers in an already overstretched service. The Albany midwives are supported by a community group 'Albany Mums' and a petition in support of the Albany, set up by the group, had over 3000 signatures by mid-January 2010.

Poor management

We understand that the CMACE report has criticised King's for failing to engage positively with some staff groups. The National Childbirth Trust (NCT) has stated: 'the NCT is concerned that the contract has been terminated suddenly – a situation which we understand to be due to a breakdown in communication and good contract management. This poor management has led to difficult relationships between the Trust and the Practice, and questions being raised about the care provided'. (NCT 2009). It is widely accepted that there is sometimes tension and conflict between the medical and the social models of care; thus there are likely to be complex issues relating to culture and power underlying King's actions, rather than immediate concerns about the safety of mothers and babies cared for by the Albany midwifery practice.

Statements of support:

Obstetrician

'The suspension (from duty) of one of the Albany Midwives and cessation of their practice reminds me of my own suspension in 1985. The same intolerance to alternative ways of providing maternity care, despite comparable outcomes for the babies and lower Caesarean section rates, the same technique of selecting cases with adverse outcomes without looking at the overall care, and the same refusal to look at what the women themselves want. I hope that King's will listen to those who consider this suspension an outrage and reinstate the midwife and the service immediately.'

Wendy Savage MBBCh MSc HonDSc FRCOG

National Childbirth Trust

'... It is imperative that these issues are dealt with at the most senior level, and we call on the Department of Health to lead on this. The NCT wants families in all areas, especially vulnerable and marginalised women, to have care that is tailored to their particular social and clinical needs, and to have support in achieving a positive start to family life. This can be achieved by protecting and expanding this model.'

(NCT 2009)

Royal College of Midwives

'The RCM has over many years promoted and supported the Albany Practice in making woman-centred, midwife-led care a reality. The Albany Practice has been highly evaluated by women receiving their care and in previous external evaluations. We express our great disappointment that their contract has been terminated by King's College Hospital ...

The RCM believes that if maternity services are to deliver on the policy commitments of governments throughout the UK, innovative midwifery care models, such as the Albany midwifery practice, must be supported both locally and nationally'
(RCM 2009)

Mother cared for by Albany Midwives

'I feel blessed and truly privileged to have had the Albany midwives care for me during my pregnancy. They are an amazing group who go out of their way to treat their women (and our families) with the care and consideration we deserve during our pregnancies. I know for a fact that I wouldn't have had the confidence to resist an instrumental delivery if I had not been so well informed and supported during my pregnancy and labour. I also know that I wouldn't be the confident mother I am today if I had not met the Albany midwives. They have made a profound impact on my life and if I am blessed with a further pregnancy I wouldn't hesitate in trusting them again with my care.'

Serra Jadama Barry

What we are asking for:

the removal of the defamatory statement on King's website
the immediate publication of the CMACE Report
the re-instatement of the Albany Midwifery Practice
a public enquiry into all the maternity care provided by King's

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References

- Alfirevic Z, Devane D, Gyte GML (2006)
Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour.
Cochrane Database of Systematic Reviews Issue 3. Art. No.: CD006066. DOI: 10.1002/14651858.CD006066.
- Badawi N, Kurinczuck JJ, Keogh JM, Alessandri L, O'Sullivan F, Burton PR, Pemberton PJ, Stanley FJ (1998a)
Antepartum risk factors for newborn encephalopathy: the Western Australian case-control study.
British Medical Journal 317: 1549-53.
- Badawi N, Kurinczuck JJ, Keogh JM, Alessandri L, O'Sullivan F, Burton PR, Pemberton PJ, Stanley FJ (1998b)
Intrapartum risk factors for newborn encephalopathy: the Western Australian case-control study.
British Medical Journal 317: 1554-8.
- Confidential Enquiry into Maternal and Child Health (2008) Perinatal Mortality 2006.**
<http://www.cmace.org.uk/getattachment/4cc984be-9460-4cc7-91f1-532c9424f76e/Perinatal-Mortality-2006.aspx>
Accessed 8th January 2009
- Davis-Floyd R, Barclay, L., Daviss, BA., Tritten, J., (Eds) (2009)
Birth Models that Work.
University of California Press Ltd. London.
- De Menezes MS (2006)
Hypoxic-Ischemic Brain Injury in the Newborn.
<http://emedicine.medscape.com/article/1183351-overview>
Accessed 9th January 2009
- Department of Health (1993)
Changing Childbirth.
HMSO, London.
- Department of Health (2007)
Maternity Matters. Choice, access and continuity of care in a safe service.
DH, London.
- Department of Health (2008)
High Quality Care For All – The Darzi Report.
DH, London.
- Hatem M, Sandall J, Devane D, Soltani H, Gates S. (2009)
Midwife-led versus other models of care for childbearing women.
Cochrane Database of Systematic Reviews 4: CD004667
- Healthcare Commission (2008)
Towards better births: a review of maternity services in England.
Commission for Healthcare Audit and Inspection, London
- Kurinczuk JJ, Barralet JH, Redshaw M, Brocklehurst P (2005)
Monitoring the incidence of neonatal encephalopathy – what next?
Report to the Patient Safety Research Programme. Oxford: NPEU http://www.haps.bham.ac.uk/publichealth/psrp/documents/PS023_Final_Report_Brocklehurst.pdf
accessed 9 Jan 2009
- Lewis G (2007)
Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2003–2005.
The 7th Report on Confidential Enquiries into Maternal Deaths (CEMACH). London: RCOG Press.
- Mahony E and Lister S (2009)
Secret report damns safety of model homebirth service.
The Times, December 23rd.
http://www.timesonline.co.uk/tol/life_and_style/health/article6965597.ece
Accessed 9th January 2009
- National Childbirth Trust (2009)
Albany practice terminated.
<http://www.nctpregnancyandbabycare.com/press-office/press-releases/view/190>
Accessed 9th January 2009
- Pin TW, Eldridge B, Galea MP (2008)
A review of developmental outcomes of term infants with post-asphyxia neonatal encephalopathy.
Eur J Paediatr Neurol. May;13(3):224-34. Epub Jun 27.
Review. PubMed PMID: 18585940.
Accessed 9th January 2009
- Reed B (2009)
Choices are not choices if you are not allowed to make them for yourself.
The Practising Midwife 13 (1) 4-5
- Rosser, J., (2003)
How do the Albany midwives do it? Evaluation of the Albany Midwifery Practice.
MIDIRS Midwifery Digest. Volume 13. (2). Pg 251–257.
- Royal College of Midwives (2009)
RCM comment on Albany Midwifery Practice.
<http://www.rcm.org.uk/college/media-centre/press-releases/copy-of-rcm-comment-on-albany-midwifery-practice/>
Accessed 9th January 2009

Sellar M (2008)

The VBAC Waterbirth experience in Fife.

Midwives, August/September.

<http://www.rcm.org.uk/midwives/features/the-vbac-waterbirth-experience-in-fife/Southwark> PCT (2007) Annual Report of Director of Public Health

The NHS Information Centre (2009)

Available online at <http://www.ic.nhs.uk/news-and-events/press-office/press-releases/archived-press-releases/april-2007--march-2008/latest-maternity-statistics-show-how-the-pattern-of-giving-birth-in-england-is-changing>
Accessed 9th January 2009

The NHS Information Centre.

Infant Feeding Survey (2005)

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/infant-feeding-survey/infant-feeding-survey-2005>
Accessed 9th January 2009

Warren C (2003)

Exploring the value of midwifery continuity of carer.

British Journal of Midwifery 11(10): S34-S37.

Further reading

The Albany Midwifery Practice

Reed, B., Walton, C (2009)

Birth Models that Work.

Davis-Floyd., Barclay, L., Daviss, BA., Tritten, J., (Eds) (2009)

University of California Press Ltd. London.