AIMS For a better birth...

CMACE

AIMS Journal, 2010, Vol 22 No 3

Nadine Edwards and Sarah Davies present a summary of their critique of the CMACE Report on the Albany Midwifery Practice

As we know, birth in most high income countries became increasingly medicalised and centralised during the nineteenth and twentieth centuries, particularly from the 1970s onwards. As we also know, a Conservative Government, concerned about these developments, published Changing Childbirth in 1993. This document emphasised the importance of midwifery care, keeping birth normal, and providing choice, continuity and control for women, preferably in a community setting. Further Government documents have reiterated this policy.

In response to Changing Childbirth a pilot midwifery project was set up in Deptford in South East London to put its aims into practice. This midwifery practice flourished for three years with excellent outcomes for mothers and babies, and was very popular with women and their families. When its contract with Lambeth and Southwark came to an end in 1997, a new contract was set up between the midwifery practice and King's College Hospital Trust, London. The newly named Albany Midwifery Practice moved to a community centre in Peckham in south London, where it was based until 2009. This contract was the first of its kind in the UK and was seen by many as paving the way for the maternity services of the future, in which midwives would be able to provide choice, continuity and control in a community setting. The Practice's outcomes continued to be excellent and the model of care provided by the Albany midwives was extremely popular with its local community. The Practice's contract was abruptly terminated by King's in December 2009 (See AIMS Journal Vol:21 No:3 2009 and AIMS Journal Vol:22 No:1 2010).

The contract was terminated without consultation with the Albany Practice midwives, or the local GPs who referred women to the midwives, or crucially with the women and families it served. To close a service without consultation is only permissible when carried out on safety grounds. Thus, on its website, King's states: King's College Hospital puts patient safety before all other considerations. For this reason we have terminated our contract with the Albany Midwives Practice. The Albany Action Group remains extremely concerned and puzzled by this statement and are calling on King's to withdraw it. The service has been evaluated on numerous occasions and outcomes have been shown to be exemplary[1,] [2,] [3] For example, the Albany Midwifery Practice's perinatal mortality rate from 1997 to 2007 was 4.9 per 1000. This is lower than the national average and far lower than that of the local area as a whole, which was 11.8 per 1000 from 2004 to 2007.[4] Compared with other women in the area, women cared for by the Albany Practice midwives had a higher vaginal birth rate, higher intact perineum rates, lower episiotomy rates, a lower elective caesarean rate, lower induction rates, less use of pethidine and epidurals and a

higher use of birthing pools. In addition the breastfeeding rates were exceptionally high, at around 80%[1, 3, 5, 6, 7] These outcomes were achieved in a population where many families are among the most disadvantaged fifth of the population of England. Women and babies in these groups are known to have the highest mortality and morbidity rates, as shown by the Confidential Enquiries into Maternal and Child Health (CEMACH).

The start of investigations

In 2008, King's claimed that proportionally more babies cared for by the Albany Midwifery Practice were suffering serious ill health at birth than other babies born within the King's service. A list of babies looked after by the Albany Midwifery Practice with poor outcomes at birth was put together, covering a 31-month period from March 2006 to October 2008. This list was revised on three occasions because of King's mistakes in the data collection, but nevertheless King's claimed that this list showed that the Albany Midwifery Practice's morbidity rate was ten times that of the Trust's overall.

Alison Macfarlane, Statistician and Professor of Perinatal Health at City University London and former advisor to CEMACH, has done a review of the list of cases compiled by King's. She concluded that it would be 'impossible to draw any inferences' from this data because of the incomplete nature of the data set.

The CMACE Report

Despite the concerns of the Albany Midwifery Practice that the data that King's was using was incomplete and misleading, King's commissioned an enquiry into the list of cases it had identified, in early 2009. The enquiry was started by CEMACH in early 2009, but the organisation became the Centre for Maternal and Child Enquiries (CMACE) in July 2009 and it is CMACE that produced a Report on the cases, called The London Report, in November 2009. The National Childbirth Trust, and others, produced critiques of the CMACE Report. AIMS produced its own critique because it was so concerned about how the enquiry had been carried out, the lack of details in the Report on which to judge the findings, and how it had arrived at its findings, especially when these contradicted the findings of all the other analyses of the Albany Midwifery Practice mentioned above. For example:

- King's selected the cases referred to CMACE, and the selection criteria are not provided in the Report. We would have expected CMACE to recommend what data it needed in order to conduct an enquiry.
- The babies included in the enquir y were all born over a 31-month period. We thought that this time frame was very unusual, especially when it so happened that this 31-month period included two babies cared for by the Albany Midwifery Practice who had poor outcomes, one at the very beginning of the period and one at the very end of the period. Alison Macfarlane commented that, 'This time frame is not long enough to allow the possibility for time trends to be investigated. If the compilation of the lists was prompted by concerns that morbidity might be rising, then a longer series of data should have been compiled.' Given the length of time that the Albany

Midwifery Practice had been operating, it would have been possible to extend this period to a more appropriate length.

- The Repor t considered the care of a number of babies looked after by the Albany Midwifery Practice who had 'serious unexpected problems' at birth, but did not provide any context for these outcomes. In particular, the Report failed to mention that babies cared for by the Albany Practice (despite their all-risk caseload) had a much lower perinatal mortality rate than babies born under King's hospital care. Nor did it mention the overall excellent results of the Albany Midwifery Practice.
- The Report considered the care of 11 babies cared for by Albany Practice midwives, 10 babies cared for by other community midwives attached to King's, and no babies cared for by King's hospital staff. As well as a longer time frame for the enquiry, we would have expected similar groups of babies born at King's to have been included in the enquiry.
- The Confidential Enquiry's methodology which was used to assess the data was not appropriate for such a small number of cases. The National Patient Safety Agency recommends that for small numbers of cases, root cause analysis is a more appropriate methodology.
- King's diagnosed the babies who had been cared for by the Albany Midwifery Practice with hypoxic ischaemic encephalopathy (HIE): a diagnosis which suggests that babies have suffered lack of oxygen and subsequent brain damage during labour and/or birth. However, the National Perinatal Epidemiology Unit in England has strongly recommended that this term be replaced by the term neonatal encephalopathy (NE), as this describes the condition without assuming the cause.8 This is because several studies and a review have suggested that NE is rare, occurring in only 2.5 per 1000 births, and that in approximately 86% of these, NE is due to antenatal factors rather than mismanagement in labour. The Report also failed to look at the longer term outcomes of the babies involved, although the National Neonatal Audit now requires a two-year follow-up for any baby diagnosed with NE. This is because while some babies with NE suffer long-term problems (some of which are very serious), some babies do not show any signs of any problems as they develop.

Interestingly, King's had already investigated the cases referred to CMACE through its own risk-management procedures and had found no problems associated with the midwifery care provided by the Albany Midwifery Practice. There is no evidence either that the midwives involved had been referred for supervision or had received any support as a result of any of the unexpected outcomes.

As we read through the Report it became clear that the data was viewed from a medicalised perspective and that holistic midwifery knowledge and care were not well understood, nor their benefits recognised.

We were also very concerned about the lack of understanding in the Report about women's abilities and rights to make decisions about their care, and a midwife's duty to support these. Although the right to make our own decisions about our own bodies is enshrined in law, and at the heart of Government policy, the CMACE Report appeared to suggest that this is not possible or desirable in practice and that women's decisions should be guided by practitioners following local policies and practices. Indeed one of

the criticisms of the Albany Practice midwives was that the women they cared for did not always comply with King's guidelines. However, if women receive good information, they will each make their own decisions, which may on occasion fall outside local guidelines.10 Midwives supporting these women should be applauded not punished.

Most of the Report's recommendations were about how to improve management failures. The Report did not recommend closing the Albany Midwifery Practice, but King's almost immediately terminated the contract with the Practice. We believe that, to date, King's has failed to address the management issues raised by the Report.

Developments since the CMACE Report

After the closure of the Practice, which King's claims was for safety reasons, all the Albany midwives were offered jobs within the Trust, and King's management stated at a public meeting that it had no concerns about the midwives' practice.9 In a subsequent letter to AIMS, in response to its critique of the CMACE Report, it became clearer that the main reason for closure was to do with King's inability to manage what it mistakenly considered to be an 'arm's length' body.

The impact of the closure continues to be felt very acutely by the local community the Albany Practice served. It is unusual for women to mount campaigns, yet within days, the Albany Mums was formed, and attracted in the region of 700 parents from the Peckham area and beyond. The Albany Mums Group has sustained a remarkably vigorous campaign, including organising numerous demonstrations, writing to and meeting with members of their Primary Care Trust who commission maternity services, contacting MPs, journalists and others, attending public meetings and consistently attempting to meet with senior staff at King's. The loss, both immediate and long-term, to the community cannot be over stated.

The closure also has national and international consequences way beyond the Peckham boundaries. The Albany Midwifery Model is a crucial benchmark for midwifery services and what can be achieved by excellent midwifery care. Not only does this model provide excellent physical and emotional outcomes for mothers, babies and families, it contributes to strengthening the community and improving health and well-being, is well liked by women and midwives, and is sustainable. The closure of this service is striking at the heart of good midwifery and what can be achieved through continuity, choice and control, even when women are suffering the impacts of poverty.

The Albany Action Campaign is supported by the Albany Mums, AIMS, the National Childbirth Trust, the Association of Radical Midwives, Independent Midwives UK, as well as many senior academics, statisticians, midwives, obstetricians and GPs.

We would appreciate your support, and would ask you to write to the Minister of Health to ask what steps he is taking to enable the Albany Midwifery Model to be established elsewhere in the area and also established in every Health Trust in the country.
www.info.doh.gov.uk/contactus.nsf/memo?openform

To read a copy of the full AIMS critique, go to www.aims.org.uk/Publications/CMACECritiqueAIMS.pdf

References

1. Sandall J, Davies J, Warwick C, (2001) Evaluation of the Albany Midwifery Practice. Kings College, London www.kcl.ac.uk/teares/nmvc/research/project/docs/72-albany.pdf (last accessed 23/2/2006)
2. Reed B (2002) The Albany Midwifery Practice. MIDIRS Midwifery Digest, 12,(1):18-21.
3. Demilew J (2007) King's Midwifery Services & Public Health Report - Supporting wellbeing and tackling health inequality, King's College Hospital, London.
4. NHS Southwark (2009) Southwark's Children & Young People's Health: The annual report of the Director of Public Health. www.southwarkpct.nhs.uk/documents/ 6015.pdf (accessed 9/7/2010)
5. Huber U and Sandall J (2005) Continuity and trust in the context of maternity care and breastfeeding www.albanymidwives.org.uk/ReportsAndArticles/ContinuityAndTrust.pdf
6. Kemp J and Sandall J (2010) Normal birth, magical birth: the role of the 36-week birth talk in caseload midwifery practice. Midwifery 26 (2):211-221
7. Leap N, Sandall J, Buckland D, Huber U (2010) Journey to Confidence: Women's Experiences of Pain in Labour and Relational Continuity of Care. Journal of Midwifery & Women's Health 55(3): 234-242
8. 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 www.haps.bham.ac.uk/publichealth/psrp/documents/PS023_Final_Report_Brocklehurst.pdf (accessed 9/7/2010)
9. Health and Adult Services Scrutiny Sub-committee (2010) Minutes 23rd Feb 2010 www.lambeth.gov.uk/moderngov/ieListDocuments.aspx?CId=109&MId=6742&Ver=4=4
10. Rosser J (2003) How do the Albany midwives do it? Evaluation of the Albany Midwifery Practice MIDIRS Midwifery Digest 13 (2): 251-257.