AIMS For a better birth...

Keeping women and babies safe

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Becky Reed reflects on outcomes from the Albany Practice

Following the recently published Kirkup investigation into poor outcomes at Morecambe Bay NHS Foundation Trust,[1] and the widely reported findings that in many cases it was the midwifery care that was to blame, it feels like the right time to re-examine the safety record of the Albany Midwifery Practice (AMP), which was set up in April 1997 and closed down by King's Healthcare Trust in December 2009.

The AMP had held a sub-contract with King's for over 12 years, enabling the midwives to offer a gold standard model of care to local women within the NHS. Following concerns expressed by the Trust about perinatal morbidity statistics (based on a highly questionable 'case series' produced at the end of 2008), and a subsequent report by CMACE (which did not recommend closure of the Practice, as AIMS[2] and others highlight), the contract with the AMP was abruptly terminated, and King's published a statement on its website, declaring: 'We have become concerned about the safety record of the Practice in comparison with the Trust's overall maternity safety record.'

As Albany midwives we had admittedly pursued the goal of normal birth where possible, and had been proud of our lowerthan expected caesarean section (CS) rate. So to see that a group of midwives at Morecambe Bay has been charged with pursuing 'natural childbirth at any cost' prompts a desire to examine what this might mean, and its possible repercussions in the wider midwifery world.

The history of the AMP has been written about in previous issues of this journal, and there is a website where information about the Practice is available (thealbanymodel.com). The Practice (originally The South East London Midwifery Group Practice) was started by a group of dedicated midwives following the publication of Changing Childbirth in 1993.[3] The aim was to deliver excellent NHS midwifery care to an all-risk group of women; to be based in the community, and to provide choice and continuity of midwifery carer. We were acutely aware that this was an innovative model, and wanted to show that as well as being woman and midwife-friendly, it was a safe and effective way to provide care. Clinical outcomes were kept from the start in orderto monitor this. An early evaluation of the AMP in 2001 reported that 'there is a clear pattern of woman centred care being offered and of partnership with women, which may contribute to the positive evaluations... and good clinical outcomes.[4]

An analysis of the total outcomes of the AMP (1997- 2009) is under way and is expected to be published later this year. However, an interim study was done examining the outcomes of 2000 women cared for by the Practice between 1999 and 2007, and was presented at the ICM in Glasgow in June 2008. One of the

stated aims of the study was to 'investigate the quality and safety of caseload midwifery in this setting'.

The 2000 women study showed that women cared for by the AMP had a homebirth rate of 44%, a spontaneous vaginal birth rate of 80%, a CS rate of 16%, and an instrumental delivery rate of 3%. In comparison, the CS rate for England in 2007 was 23.5%, the instrumental delivery rate was 11.1%, and the national homebirth rate for England during the period of the study never rose above 3%[5]

So here lies the fundamental question: were these impressive birth outcomes somehow compromising the safety of women and babies being cared for by the AMP? Looking at the outcomes in the study quoted above, it is clear that this was not the case. During this period the perinatal mortality rate (PNMR) for the AMP was 4.9/1000, compared with a PNMR for England and Wales in 2006 of 7.9/1000 (CEMACH 2008) and 11.4/1000 for Southwark, the London borough where the AMP was based. Based on these statistics, the AMP - at least for the period of the 2000 women study, and based on mortality rates - could clearly not be described as a dangerous model of care. Obviously it is important to review the outcomes for the total period (adding in data from 1997/98 and 2008/9), but there is no reason to believe that either the caseload or the midwifery care was substantially different during those years. This begs the question of why and how King's came to the shocking conclusion that the safety record of the AMP was concerning, and indeed why the Trust took the dramatic and devastating action that it did.

Safety in midwifery care is clearly paramount. An expectation of care that is as safe as possible should be a given for all women, and their families. As Cathy Warwick, General Secretary of the Royal College of Midwives (RCM) says in her comment for the RCM on the Kirkup report: '...safety is the priority both for women and babies... The basis of competent midwifery practice is high quality decision making based on assessment throughout the care pathway and with appropriate consultation...'. The lack of consultation with obstetricians is a strong criticism in the report. Embedded in the AMP's philosophy of care was the need to work alongside other like-minded professionals, and for many years this was achieved. A mutually-agreed named obstetrician was available for consultation at all times, with the obvious consideration that the AMP was caring for an all-risk caseload. Relationships were good, and we met socially as well as professionally. At the AMP's 10 year celebration party 'our' obstetrician gave a speech saying how much she had learned from the midwives about 'cooperation between midwives and doctors, and particularly being the advocate for the woman...', also stating: 'I think they're remarkable... because they never stop thinking about at any point in a woman's pregnancy or labour, what is the best thing for her. So it's never about what's easy for them, it's always about what's best for the woman.' These comments appear particularly extraordinary now, given that less than two years later, this same obstetrician was joining in with calls for the closure of the Practice. We can only speculate on the reasons for this. One theory is that it was the loss of a strong and supportive head of midwifery, combined with the involvement of other professionals with an entirely different agenda, which led to the undermining of relationships and the subsequent vulnerability of the AMP contract.

Becky with Alex, Justin and baby Freya

Safety is defined as 'not likely to lead to harm or injury', which implies that morbidity as well as mortality should be included in the concept of keeping women and their babies safe. Deaths are a stark and obvious measure; in the AMP there were no maternal deaths and the PNMR (at least for the period of the study outlined above) was less than half that of the local borough. Morbidity is much harder to define, and yet it was morbidity rates (most specifically admissions to the neonatal unit of babies with alleged Hypoxic Ischaemic Encephalopathy) that were the catalyst for the allegations against the AMP in the lead-up to its demise. The poor quality 'case series' that was put together in an attempt to show that the AMP was practising dangerously was carefully examined by Professor Alison Macfarlane, perinatal epidemiologist and statistician, who concluded that 'it is impossible to draw any inferences' from the evidence put forward. Even if the AMP did for a short period have a slightly higher than expected rate of babies admitted to SCBU, it has been pointed out by Professor of Midwifery Mavis Kirkham that with a decrease in mortality rates this could be an expected outcome, since babies 'saved' from death may well suffer from a certain morbidity.

Keeping women and babies safe also covers many aspects of disease prevention. Breastfed babies are less likely to become ill in their first year ; the AMP midwives actively promoted an expectation of breastfeeding, and worked hard to maintain high rates of exclusive breastfeeding. 92% of AMP babies were exclusively breastfed at birth, 81% at ten days and 74% at 28 days. In comparison, at the time of the study, only 35% of UK babies were being exclusively breastfed at one week and 21% at six weeks.

Morbidity for mothers includes scarring (from a caesarean wound) or perineal damage, and possible associated postnatal infections. When CS rates are kept low, and when midwives work hard to minimise perineal trauma, women are healthier as they start out as mothers. These things are of enormous importance to women, and yet are often overlooked in the morbidity statistics. Mental health is harder to quantify, but overwhelmingly important. Suicide is the second leading cause of maternal death in the UK, therefore anything that can be done to help prevent postnatal depression should be examined and embedded into models of care. The AMP midwives believed passionately that continuity of carer,

building a relationship with women and their families, and providing individualised midwifery care all contributed to a safer, healthier and happier outcome for mothers and babies. Postnatal support was given a high priority, with AMP women not discharged from midwifery care until 28 days after the birth, and then encouraged to attend the postnatal group for as long as they wished.

With all of the above evidence about safety in mind, a campaign is ongoing to vindicate the Albany model of care, which has been so besmirched since the closure of the Practice just over five years ago. After continued requests to remove the damaging (and libellous) statement about the safety of the Practice from King's website, this has finally been done. And when the complete statistics are available we are planning a publicity campaign to ensure that all those charged with organising maternity services in the future are aware of the enormous benefits to mothers, babies, families and midwives of an Albany-style model of midwifery care.

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References

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