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The Albany analysis

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Sarah Davies summarises the long-awaited analysis of the Albany Midwifery Practice data

Midwifery continuity of carer in an area of high socio-economic disadvantage in London:*A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009). Midwifery 48 (2017) p1-10 by Caroline Homer, Nicky Leap, Nadine Edwards, Jane Sandall.*

Background

This paper is an important read for anyone who wishes to learn more about the huge benefits of continuity of midwifery carer. Understanding a little of the background to the paper will also give an insight into the politics of autonomous midwifery in the NHS.

The Albany Midwifery Practice (AMP) (1997-2009) was a unique and ground-breaking practice; it was the first midwifery practice in the UK to negotiate a contract between an NHS trust and self-employed midwives. The AMP model provided midwifery continuity so that each woman was able to get to know and trust one or two named midwives who then looked after her during pregnancy, labour, birth and postnatally. During its first few years, the model was rigorously evaluated and found to have excellent outcomes.[1] The AMP explicitly aimed to reduce inequalities and promote long term health gain through the provision of NHS community based midwifery care to women in an area with high levels of social deprivation, with the aim of replication elsewhere.[2] It became an exemplar for midwifery continuity models nationally and internationally.

As well as evaluations showing excellent outcomes,[1] qualitative studies described less measurable but equally important benefits, such as women growing in confidence as a result of their care.[3],[4] Nadine Edwards, who interviewed women cared for by the AMP wrote: 'together the midwives and women developed a positive birth culture that increased confidence, self esteem, knowledge and skills in both women and midwives'.[5]

However, in 2009 the AMP was closed by the host Trust, King's College Hospital Foundation Trust, (KCHFT) with no prior consultation with women and without proper provision in place to replace the service. Justifying its decision to close the Practice, King's cited safety grounds.[6] A statement on its website claimed that the Albany rate of referrals to the neonatal unit for serious Hypoxic Ischaemic Encephalopathy (which they described as brain damage caused by a lack of oxygen to the brain around or at the time of birth) was much higher than for women cared for by other King's midwifery practices, or by

hospital midwives. It stated that *'although Albany looked after 4% of our mothers, 42% of all the poor outcomes associated with serious HIE involved infants in their care'.*

The statistics upon which King's were basing this extremely serious allegation were questioned by various authors.[5],[7],[8] They were based upon a specially selected time period of 31 months and one day; and according to one author[9] were 'riddled with methodological flaws and (...) scientifically invalid through gross selection bias'. Meanwhile, the decision by King's left mothers without their midwives, the midwives bereft and a cloud over the name of the Albany. As Denis Walsh, Associate Professor of Midwifery at Nottingham University wrote: *'The repercussions of the Albany Midwifery Practice Group losing their contract with King's (were) felt not just across the UK but internationally'.*[7]

The paper

The outcomes of the 2568 women cared for by the AMP from April 1997 to September 2009 have been retrospectively analysed by a team of researchers, led by Professor Caroline Homer from the University of Technology Sydney, Australia. Their findings totally vindicate the Albany Midwifery Practice and provide further evidence of the superiority of continuity models of midwifery carer over other models. The AMP outcomes are striking, especially given that 57% of the women looked after by the Practice were from Black, Asian and Minority Ethnic Communities and a third of the women were single. These women and their babies have been frequently shown to have poorer outcomes when cared for within usual maternity services models. The following is a discussion of some of the key findings of the paper, but it should be read in its entirety: www.sciencedirect.com/science/ar ticle/pii/S02666138173 01511

Findings and discussion

Continuity

The researchers found that over the 121⁄2 years, 95.5% of AMP women were cared for in labour by either their primary or secondary midwife. 87.1% of women had their primary midwife at their birth.

Home birth

Home birth rates were the highest ever described in any UK setting. 28% of women booked for home at the initial visit; this increased to 38% at the 36 week visit with 43.5% of women ultimately giving birth at home. These statistics demonstrate the recognition by the midwives that decision about place of birth is not a one-off choice, but a process.[10] The AMP home birth rate may be contrasted with the UK's current home birth rate of 2.35%.[11] It now seems clear that continuity of midwifery carer is the model that must be implemented if women are to have meaningful choice regarding place of birth as recommended by numerous UK policy documents.

Induction

6.5% women had an induction – this compares with a current national induction rate of 27.1% in 2015–16.

Use of analgesia

Although there are no national records for comparison, use of analgesia was low – 9.9% of women used epidural analgesia, 1.2% pethidine and 15.4% Entonox.

Transfer to hospital for women planning a home birth

Overall, 15.1% of AMP women transferred to hospital during labour with rates of 12.4% for primiparous, and 5.5% for multiparous women. As the authors note, this contrasts strongly with data from the Birthplace In England study[12] which described transfer rates of 45% for primigravidae and 12% for multigravidae.

Mode of birth

79.8% of women had a spontaneous vaginal birth. The current rate in England is 60%. The overall caesarean section rate for women cared for by the AMP was 16% as compared with a current rate in England of 27.1%. There was a low incidence (4.2%) of instrumental birth (forceps/ventouse) which is a third of the current rate in England of 12.9%. The authors suggest this may be linked to the low use (9.9%) of epidural.[13] All AMP women were supported by known midwives, which increases the likelihood of spontaneous vaginal birth.[14] As noted by the authors, this finding underlines the value of midwifery continuity of carer to help women cope with labour pain.

Third stage

Of the women who had a vaginal birth, 78% had a physiological third stage. UK national rates are not available for comparison but this means that a large percentage of babies benefited from delayed cord clamping.[15]

Neonatal outcomes

There were 2585 babies, 21 sets of twins and one set of triplets.

The preterm birth rate was 5.1%, with 4.5% babies low birth weight (below 2500g). This was lower than the national average – 5.1% compared with the UK rate of 7- 7.5% from 2006-2010. This finding is in keeping with high quality evidence that midwifery continuity of care reduces the rate of preterm birth.[1]

6.2% of babies were admitted to neonatal unit for more than two days; the most frequent reasons for admission were preterm or low birth weight.

Breastfeeding

91.5% commenced breastfeeding at birth, while 74.3% were exclusively breastfeeding at 28 days. These figures compare very favourably with UK rates from the Millennium Cohort study which found that 70% of mothers initiated breastfeeding and 49.3% were breastfeeding at one month.[16] As the authors note, this difference is hugely important in terms of the well documented public health benefits of breastfeeding.

Perinatal mortality

The perinatal mortality rate (PMR) rate for babies born with the AMP was lower than the rates for the UK over a similar period. AMP rates varied over the time period from 1.8 – 7.7 per 1000 total births

compared with the UK rate during the same period of 7.5-8.5.17 These figures are especially important given that the AMP was situated in an area of high ethnic diversity and social deprivation where outcomes would be expected to be poorer.

Overall this study vindicates the Albany Midwifery Practice and demonstrates outstanding outcomes for the 121⁄2 years of its existence. It has now been unequivocally demonstrated that the AMP provided important health and psycho-social benefits for mothers and babies. The study lends even more weight to arguments for providing this model of care for all women.

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