Midwifery 48 (2017) 1–10

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Midwifery continuity of care in an area of high socio-economic disadvantage in London: A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009)

Caroline SE Homer, RM, MMed(ClinEpi), PhD Professor[a,*],
Nicky Leap, DMid Adjunct Professor of Midwifery[a],
Nadine Edwards, PhD Independent Researcher[b],
Jane Sandall, PhD, CBE Professor and NIHR Senior Investigator[c,d]

[a] *Centre for Midwifery, Child and Family Health, Faculty of Health, University of Technology Sydney, PO Box 123, Broadway, Sydney, New South Wales 2007, Australia*
[b] *Independent Researcher*
[c] *Division of Women's Health, Faculty of Life Sciences & Medicine, King's College London, United Kingdom.*
[d] *Women's Health Academic Centre, St. Thomas' Hospital, London SE1 7EH, United Kingdom*

ARTICLE INFO

Keywords:
Albany Midwifery Practice
BAME outcomes
Home birth
Midwifery continuity of carer
Caseload midwifery
Midwives
Midwifery practice
Normal birth
Social disadvantage

ABSTRACT

Objective: in 1997, The Albany Midwifery Practice was established within King's College Hospital NHS Trust in a South East London area of high social disadvantage. The Albany midwives provided continuity of care to around 216 women per year, including those with obstetric, medical or social risk factors. In 2009, the Albany Midwifery Practice was closed in response to concerns about safety, amidst much publicity and controversy. The aim of this evaluation was to examine trends and outcomes for all mothers and babies who received care from the practice from 1997–2009.

Design: a retrospective, descriptive analysis of data routinely collected over the 12.5 year period was undertaken including changes over time and outcomes by demographic features.

Setting and participants: all women booked with the Albany Midwifery Practice were included.

Findings: of the 2568 women included over the 12.5 year period, more than half (57%) were from Black, Asian and Minority Ethnic (BAME) communities; one third were single and 11.4% reported being single and unsupported. Almost all women (95.5%) were cared for in labour by either their primary or secondary midwife. There were high rates of spontaneous onset of labour (80.5%), spontaneous vaginal birth (79.8%), homebirth (43.5%), initiation of breastfeeding (91.5%) and breastfeeding at 28 days (74.3% exclusively and 14.8% mixed feeding). Of the 79% of women who had a physiological third stage, 5.9% had a postpartum haemorrhage. The overall rate of caesarean section was 16%. The preterm birth rate was low (5%). Ninety-five per cent of babies had an Apgar score of 8 or greater at 5 minutes and 6% were admitted to a neonatal unit for more than two days. There were 15 perinatal deaths (perinatal mortality rate of 5.78 per 1000 births); two were associated with significant congenital abnormalities. There were no intrapartum intrauterine deaths.

Key conclusions: this analysis has shown that the Albany Midwifery Practice demonstrated positive outcomes for women and babies in socially disadvantaged and BAME groups, including those with complex pregnancies and perceived risk factors.

Implications for practice: consideration should be given to making similar models of care available to all women.

Background

In 2016, *Better Births,* the five-year forward view for maternity care in England, proposed major changes to how maternity care is delivered. Key recommendations included '... continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community

* Corresponding author.
E-mail addresses: caroline.homer@uts.edu.au (C.S. Homer), nickyleap@me.com (N. Leap), nadine@nadineedwards.org.uk (N. Edwards), jane.sandall@kcl.ac.uk (J. Sandall).

http://dx.doi.org/10.1016/j.midw.2017.02.009
Received 19 October 2016; Received in revised form 11 January 2017; Accepted 24 February 2017

who knows the woman and family, and can provide continuity throughout the pregnancy, birth and postnatally"(p. 9) (NHS England, 2016).

This policy directive was a response to reports of fragmented care, seen increasingly in high income countries where relationships have been replaced by technology (Davis-Floyd 2001; Mander and Murphy-Lawless 2013). The report cited robust evidence identifying the benefits of midwifery continuity of carer for mothers and babies in terms of improving safety, clinical outcomes, and positive experiences for women (Sandall et al., 2016).

There is now considerable evidence – from randomised controlled trials as described above (Sandall et al., 2016), descriptive and comparative analyses (Page et al. 1999; McIntyre, 2012; Tracy et al., 2014) and qualitative studies (Leap et al., 2010; de Jonge et al., 2014) as to the benefits of midwifery continuity of care for women, midwives and the health system (Homer, 2016). In light of the evidence supporting midwifery continuity of care, the World Health Organization's guidelines on antenatal care (WHO, 2016) recently recommended that: '*Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well-functioning midwifery programmes*' (p.89).

Despite the benefits, implementation and scale-up, so that every woman benefits from a continuity of carer model of care, has been challenging in many countries. However, learning from previous models operating in the United Kingdom (UK) may assist this process. In the early 1990s, in response to government documents encouraging more choice, control and continuity of care for childbearing women in England (House of Commons, 1992; Department of Health, 1993), a group of six midwives, based in a community centre in Deptford, established the South East London Midwifery Group Practice and negotiated the first National Health Service (NHS) contract between a local health authority and self-employed midwives. They successfully applied for NHS funding to address inequalities in health and promote long term health gain through the provision of community based, continuity of midwifery carer throughout the childbearing period (caseload practice model) to groups of women known to have poor health outcomes due to various forms of disadvantage (Reed and Walton, 2009).

The Albany Midwifery Practice

In 1997, the South East London Midwifery Group Practice negotiated a new contract with the King's College Hospital NHS Foundation Trust, who agreed to indemnify the midwives in accordance with clinical protocols and Trust policies (Reed and Walton, 2009). The Practice changed its name to the Albany Midwifery Practice and became one of eight NHS midwifery group practices providing midwifery continuity of care within the King's maternity service (Demilew, 2007).

The contract with King's College Hospital (King's) specified that the Albany Midwifery Practice was to provide midwifery care to 216 women per year (36 women per whole time equivalent midwife). The practice was based in the community in Peckham, an area within the South East London borough of Southwark, which was ranked at that time as the 14th most deprived district of 354 districts in England (Sandall et al., 2001). Compared to all other London Boroughs, Southwark had the highest proportion of: babies born with low or very low birth weights; babies of mothers born in East and West Africa and the Caribbean; and, babies of mothers who identified as sole parents during the Birth Registration process (Bowles et al., 2007).

Access to the Albany Midwifery Practice was primarily for women registered with three General Practitioner (GP) practices (family medicine practices) based in a council (public) housing estate in Peckham. The midwives provided care for women, regardless of any perceived obstetric, medical or social risk, the understanding being that they would collaborate with obstetricians, other practitioners and both hospital and community based services as needed. The Albany midwives were an integrated part of the King's NHS maternity service and were thus able to directly access medical and social services and refer women to these at the point of need and at no cost.

Each woman who booked with the Albany Midwifery Practice was assigned two named midwives: a primary midwife responsible for providing and coordinating her individualised care and a second midwife. These two midwives provided antenatal, intrapartum and postnatal care up to 28 days following birth (Fig. 1).

An independent evaluation of the Albany Midwifery Practice, commissioned by King's College Hospital, was conducted in 2001 (Sandall et al., 2001). This evaluation analysed clinical outcomes for only the first three years (1997–1999) and included 636 women. This showed that, when compared to other midwifery group practices at King's, the Albany Midwifery Practice had: a higher homebirth rate; a lower induction rate; a higher vaginal birth rate; a lower elective caesarean section rate; and a very high level of continuity (89% of women were attended during labour by their primary midwife and Albany midwives were in attendance at 98% of the births).

In 2007, an internal report by King's identified the important contribution that its eight midwifery group practices were making to the maternity unit's efforts to tackle health inequalities and promote wellbeing (Demilew, 2007). The report drew on maternity service data for all women who booked and gave birth with King's in 2006 and cited the Albany Midwifery Practice's exceptionally high rates for: initiation of breastfeeding (99%), spontaneous vaginal birth (81.4%), and home birth (44.8%) and also its low caesarean section rate (15.2%).

Various qualitative studies have also commented on the positive experiences for women associated with the relational continuity of care provided by the Albany midwives (Huber and Sandall, 2006, 2009; Leap et al., 2009; Kemp and Sandall, 2010; Leap et al., 2010) and other models of caseload care (Beake et al., 2013; McCourt et al., 1998). In 2009, however, the Albany Midwifery Practice was closed in response to concerns from the Trust about safety, amidst much publicity and controversy (AIMS, 2010; Edwards and Davies, 2010; Yiannouzis, 2010).

In light of the unique nature of the Albany Midwifery Practice, its influence on policy (NHS, 2007; UK Parliament, 2000), practice and research, its high profile in t,he international midwifery arena, and the unresolved controversy around the closing of the practice (Edwards, 2011; Walsh, 2010), an independent examination of the maternal and neonatal outcomes over a period of 12 and a half years was seen critical, hence this evaluation was undertaken.

The objectives of this evaluation were to examine trends and outcomes for all mothers and babies who received care from the Albany Midwifery Practice from 1997–2009, specifically:

- Describe the birth outcomes for these women
- Analyse changes over time in the profile of women booking and in the outcomes for women and babies in three-four year increments over the 12 and a half year period
- Compare outcomes for women from Black, Asian and Minority Ethnic (BAME) groups with outcomes for White women (the BAME group included women from Black Caribbean, Black African, Black British, Asian (Indian), South East Asian and other minority ethnic groups.)

Method

Design and setting

The study design was a retrospective analysis of routinely collected data. As such, we ensured that it complied with the RECORD reporting guidelines identified for such analysis (Benchimol et al., 2015). The study was set in Peckham in South East London, which was an area of high social disadvantage.