



# The Albany Midwifery Practice

This is the first of two articles on the Albany Midwifery Practice. Here, midwife Becky Reid describes the development of the practice. In her second article, to be published in June, she will discuss the day to day reality of practising within this model of midwifery care.

This article documents the evolution of the Albany Midwifery Practice from its beginnings as the South East London Midwifery Group Practice (SELMGP) organised by a group of independent midwives. It charts the development of the SELMGP to what it is today — an exceptional model of midwifery care well established in the NHS (National Health Service) mainstream.

The SELMGP was chosen as a pilot project following the *Changing Childbirth* report in 1994<sup>1</sup>. Its goals were to provide a maternity service which ensured continuity of care and carer to women living in a deprived inner-city area. Despite its success over a two-year period, the Lambeth, Southwark and Lewisham Health Authority was unable to continue funding the group and after lengthy and complicated negotiations a sub-contract with King's Healthcare Trust was signed in April 1997.

The Albany Midwifery Practice is now one of nine midwifery group practices at King's. The group, which comprises seven midwives and a practice manager, is based in the community and operates as a self-employed, self-managed partnership. The practice offers continuity of midwifery care with two known midwives for each woman, providing antenatal, intrapartum and postnatal care. The practice has now provided care for over 950 women in almost five years and has excellent outcomes, in particular, high home birth and breastfeeding rates.

*'Change is never easy. There will, naturally, be some who oppose it. We sincerely hope, however, that their reluctance and their fears will be overcome by proof that the new methods not only work but provide increased satisfaction, not only for the women and their families using the service, but also for those working within it'.<sup>1</sup>*

The Albany Midwifery Practice, based in Peckham, South East London, is an example of one of the 'new methods'

referred to in the government report quoted above. This is the story of the practice, from its conception in the early 1990s, its 'birth' as the SELMGP in 1994, to the present — renamed — Albany Midwifery Practice, a self-employed and self-managed group contracted into the NHS, practising individual caseload midwifery in a socially deprived inner-city area.

In the early 1990s, a group of half a dozen midwives working independently in South East London began dreaming a dream. Although all the midwives enjoyed the autonomy that came from being independent practitioners, they felt passionately that the associated degree of continuity of carer could and should be available to women free of charge within the NHS. The midwives came together in order to find a way to provide a model of midwifery care that would offer women 'choice, control and continuity of care'.<sup>2</sup>

The midwifery group practice (SELMGP) evolved over a two-year period. Three pairs of independently practising midwives, working in the same geographical area of South East London, were drawn together by a common philosophy and the practical need to provide support and cover for each other. They were all providing a service that offered continuity of carer and choice of place of birth. They believed fundamentally in the principles of the NHS and felt that all women should have access to this type of care, free at the point of service, regardless of whether or not they could afford to pay. In order to accommodate these beliefs, they made their services available to local women on a sliding scale basis, with wealthier clients subsidising those who were on benefits. This was seen as an interim measure while they worked towards secure funding to become an NHS project.

One of their intentions was to see if the excellent statistics associated with independent midwifery could be

maintained when the caseload addressed the issues of inner city deprivation and inequalities in health. The midwives' statistics for the years in which they had been working independently were encouraging, showing a high rate of normal births, a very high rate of breastfeeding and low rates of medical intervention.<sup>3</sup>

In 1992, South East Thames Regional Health Authority (SETRHA) held a Consensus Conference to look at the future of maternity services. Nicky Leap (one of the founder members of the SELMGP) gave evidence to the conference and proposed the idea of 'midwifery group practices' composed of midwives with individual caseloads. The panel of this consensus conference recommended that 'as a first step, autonomous midwifery group practices should be set up' and that SETRHA should support the development of at least two pilot schemes of this nature.<sup>4</sup> In the autumn of 1992 Baroness Cumberlege, Parliamentary Under Secretary of State for Health and chair of the Expert Maternity Group, visited the practice with other members of the Expert Group to discuss proposals for the possible future direction of maternity service provision. The SELMGP model of midwifery care was recommended in the ensuing government report *Changing Childbirth*.<sup>1</sup>

*'The [Expert Maternity] Group also heard and discussed evidence about midwifery group practices which aim to provide a high degree of support and continuity... These appear to demonstrate high quality practice and the most complete continuity of carer... The Group would like to see some experimental schemes being introduced within the NHS in the next five years'*.<sup>1</sup>

Following the publication of *Changing Childbirth*,<sup>1</sup> the SELMGP was successful in a bid to become one of three midwifery group practice pilot sites chosen by SETRHA in their 'Maternity Services of the Future' project.<sup>5</sup> These pilot projects were launched by Baroness Cumberlege in January 1994; the (initially) two year SELMGP project began in April of that year, based in Deptford in South East London.

So far, so good. However, the SELMGP was the only pilot site that was not already funded by an NHS Hospital Trust. The only money available to it at that time was the £30,000 'set-up' money that had been awarded by SETRHA. The midwives embarked on a lengthy and complicated negotiation process with the local health commissions, aiming to become the first midwifery practice to secure a contract with direct funding from the NHS. Progress was painfully slow; initial funding for the care of 70 women only was secured, eventually increasing to provision for 150 women in the first year. A decision was made to become a partnership, employing a practice manager. The midwives would be self-employed, with a direct contract to the local health authority. The practice held a firm commitment to providing a midwifery service which was within the NHS and which would serve as a replicable model for implementation nationwide.

I think it is worth outlining here the basic principles of the SELMGP, since they form the underlying philosophy of the present Albany Midwifery Practice.

The SELMGP:

- was a community-based project offering a self-managed midwifery service ensuring continuity of care and carer to women living in a deprived inner-city area;
- performed a national and international function as a resource for all those interested in this type of innovative midwifery practice;
- operated from shop-front premises in a busy community centre, offering free pregnancy testing, antenatal and postnatal groups, walk-in advice and information, and midwifery care that was free at the point of service;
- eventually undertook the total midwifery care of 200 women per year: each woman was allocated two midwives who looked after her throughout her pregnancy, labour and the first month of her baby's life;
- targeted women who were most vulnerable in terms of socioeconomic need; worked with women choosing either hospital or home birth, including those with known medical or obstetric complications.

The midwives met regularly for support, peer review, skill-sharing and to discuss organisational matters with each other and the practice manager. Data were collected in order to perform an on-going audit of the midwives' practice; the project was also audited by researchers from the Policy Studies Institute.<sup>5</sup> An advisory group was set up composed of 50% users of the service and 50% professionals with relevant expertise, including heads of midwifery and consultant obstetricians from the local hospitals. During the following three years, funding proved to be an ongoing headache, with continuing negotiations with a succession of different representatives from the LSL Health Authority. The model of care, however, quickly proved to be very popular with the women, and the group's work soon became both nationally and internationally acclaimed as groundbreaking. SELMGP is still valued as an important resource for all those interested in this type of innovative midwifery practice.

Towards the end of 1996, despite its success, SELMGP was under serious threat. The health authority, although clear in its desire to see the project continue, was suffering from a massive budgetary overspend, and it became apparent that funds would no longer be available to support SELMGP after the end of the financial year. The midwives began to explore ideas for moving forward with the project; with satisfied customers and excellent clinical outcomes it was unthinkable to give up at this point. Ideally, both the midwives and local women would have liked SELMGP to continue in Deptford, but with no support forthcoming from the local Healthcare Trust it became necessary to look elsewhere. Having always had very positive connections with King's College Hospital (KCH) in a neighbouring health authority, and strong support on its advisory group from Cathy Warwick, Director of Midwifery at KCH, SELMGP

proposed a sub-contract with King's Healthcare Trust. Although a sub-contract would mean losing some of their autonomy, the group felt that this would be a price worth paying in view of the potential of such a collaboration. The health authority was supportive of such a solution and agreed to contribute to the funding required for this approach. In the light of SELMGP's excellent outcomes, predicted cost-effectiveness and health gain within the local population, both parties were hopeful about the effects of making the SELMGP model of care more mainstream.

The midwives and the practice manager entered into negotiations with Cathy Warwick concerning the caseload for this new group practice (to be renamed the Albany Midwifery Practice), and the fact that the group wanted to remain self-employed and self-managed. The group was very keen to continue auditing practice outcomes and felt strongly that the caseload should be either geographically based or generated by local general practitioners (GPs), thereby ensuring equity of access to the service. It was agreed that the group, now consisting of six whole caseload equivalent midwives, would take on the care of 216 women per year (36 women per whole caseload midwife, 18 per half caseload). Local GPs were approached by the KCH community midwifery manager and, following discussion, it was agreed that three GP practices based at the Lister Health Centre on the North Peckham Estate plus another GP practice in Peckham, would generate the caseload as far as possible. Most importantly, it was agreed that the Albany Midwifery Practice would remain self-employed, and that King's Healthcare Trust would indemnify the midwives in accordance with clinical protocols and Trust policies. The group would also continue to be self-managed, with the contract managed by Cathy Warwick. The groundbreaking first contract was signed on 1<sup>st</sup> April 1997, accompanied by champagne! The budget agreed was £180,000 for the total midwifery care of 216 women, to be paid directly to the practice in quarterly instalments.

Nearly five years later, the Albany Practice is a well-established and accepted group practice within King's Healthcare Trust, one of nine midwifery group practices at King's. The group currently comprises seven midwives (two of whom have a half-caseload) and a practice manager, and has remained self-employed and self-managed. The practice manager and four of the midwives were members of SELMGP. Having spent the first year based in a health centre condemned for demolition, we now work from a newly-built health and leisure centre, the Peckham Pulse, with an 'office' and access to other rooms for antenatal visits and ante- and postnatal groups. We feel very positive about being based in the community in a non-medical



This woman was able to have her family around her when giving birth

environment; the centre has swimming pools, a gym, a children's play area, meeting rooms and a café, as well as a health suite for alternative practitioners, and is increasingly well-used by local women and their families.

The Albany Practice provides woman-centred care as recommended by the *Changing Childbirth* report.<sup>1</sup> We offer continuity of midwifery care with two known midwives for each woman, providing antenatal, intrapartum and postnatal care up to 28 days. The caseload continues to be generated by four local GPs, with occasional self-referrals and some referrals from consultant obstetricians at King's. Each full caseload midwife looks after 36 women per year as a primary midwife and a further 36 women as a

second midwife; 18 'primaries' and 18 'seconds' for the two half caseloads. We are on-call for our own caseload at all times unless we are on holiday; we have 12 weeks holiday a year, organised well in advance in order to facilitate the allocation of bookings. The women booked with us know that they can contact their midwives at any time if they need to, but are asked not to contact us with non-urgent messages after 8pm or at weekends. We arrange time off between ourselves and liaise with each other for cover for special, unmissable social or family events.

The practice manager, who coordinates the bookings according to the midwives' holidays as the referrals arrive, allocates each woman booked with the practice a primary and a second midwife. The primary midwife is responsible for the woman's midwifery care and aims to keep an overview of her individual situation. She books the woman at home and discusses with her the type of care she would like, arranging appropriate referrals and any screening tests. Further antenatal visits are usually at the Peckham Pulse at a time that is convenient for both the woman and her midwife; antenatal care is seen as a partnership where the woman and her family are involved with the planning of care. The second midwife shares the antenatal care and aims also to build up a relationship with the woman. A crucial element of the antenatal care and preparation for each woman is the 'birth talk', which takes place at the woman's home at around 36 weeks, and is attended by both midwives and the woman and her chosen birth partner/s. This is an opportunity to discuss such important issues as the onset of labour (with particular emphasis on pre-labour), how and especially when to call the midwife, how labour may progress and the role of the birth supporters. Birth photographs are used to illustrate positions in labour and birth, perineal stretching and physiological third stage. Ideally, both midwives attend the birth, the primary midwife calling the second when she feels she would like support. Postnatal care is given mainly by the primary

midwife, to ensure as much continuity as possible with any postnatal issues, particularly breastfeeding.

The midwives do not work in fixed pairs; we all have the opportunity to work with each other. We are able to organise our working weeks individually depending on births and domestic commitments, and we do not (and cannot!) count our hours. Generally a midwife with a full caseload will attend eight births a month; some births obviously will be more difficult and thus more time-consuming than others, but the total workload evens out over the months. It is worth emphasising that each midwife is only on call for the women in her own caseload. This means that the women know their midwives and the midwives know the women who will be calling them — very different from a ‘team’ model. Because of the good relationship we have built with the women we find it is rare to receive unnecessary calls at night, making it much easier to be on-call all the time.

At the start of each week the midwives and the practice manager meet to discuss any practice business and to share what has been happening. The midwives also meet over lunch later in the week to discuss any clinical issues that are currently of interest. During the last 18 months we have also had an arrangement with a clinical psychologist to facilitate a group meeting on a regular basis, in recognition that midwifery is an occupation that at times involves great stress. Supporting each other is a major priority for the group.

An evaluation of the Albany Midwifery Practice was completed early in 2001. It was commissioned as ‘an independent review of the operation and outcomes of the Albany Practice’<sup>6</sup> and its objectives were to:

- investigate processes of inter-professional working since integrating into King’s NHS Trust in 1997;
- examine the implications of self-employment for the midwives and the Trust.
- describe the process of care;
- examine the outcomes of care.

The Albany Practice outcome data for the year 1/1/99 – 31/12/99 were compared with outcomes from the other midwifery practices at King’s. It was noted that the Jarman Index of deprivation<sup>7</sup> for the postcodes served by Albany is 64.31, one of the highest scores in the Trust. In 1999, the caseload reflected the local population at King’s: 42% were Caucasian and 45% were African or Caribbean. 89% of women were attended in labour by their primary midwife; 98% by their primary or another Albany midwife. In 1999 43% of women had a home birth. Overall, the practice had a lower induction rate, a higher vaginal delivery rate, a lower elective caesarean rate, a higher intact perineum rate, a lower episiotomy rate, more use of the birthing pool, less use of analgesia and higher breastfeeding rates at birth. As well as looking at birth outcomes, the study also evaluated women’s feelings about their care during pregnancy, birth and afterwards, inter-professional working, and the impact on service provision and philosophy in the Trust. As stated in the conclusion to the evaluation, ‘*the overall aims of the Albany Practice were to support ‘normality’ (sic) in childbirth, improve women’s*

*experiences of pregnancy and birth, facilitate a good start to parenting, provide accessible care, demonstrate the viability of a self-employed practice and influence the philosophy of care in the Trust as a whole. Processes of care that were chosen to achieve these aims were high levels of continuity and the provision of informed choice’.* It was concluded that ‘*...the Albany Practice have been successful in achieving the objectives they set for themselves in agreement with the Trust’.*<sup>6</sup>

As the authors of the evaluation comment, there have been very few published studies of caseload midwifery, and the Albany Practice’s contractual model is unique in the United Kingdom. ‘*Thus it is hoped that the findings... will inform the ongoing debate in addition to contributing to future policy and practice...’.*<sup>6</sup>

For those of us fortunate enough to be able to work in this way, we can only hope that midwives of the future will have the choice and the possibility to practise midwifery in the way that they choose. Our practice is one model of care that we feel certain deserves to be replicated.

*‘... as any service provider knows, practice must move on and take account of social trends. What still holds true is that giving your child a good birth equips them with a head start in life. Childbirth should be both safe, which it is, and sound, which is where we often fail. While we care more about the quality of our food and water, taking care not to consume impurities, childbirth appears to be moving away from the ‘natural’ and becoming increasingly medicalised. The criteria set out in the report [Changing Childbirth] were threefold. Women should have choice in pregnancy and birth for all services; they should remain in control throughout; they should have continuity of carer; a professional friend and adviser, through pregnancy, delivery and afterwards. Too few mothers will recognise this vision...’.*<sup>8</sup>

Some of the material in this article is taken from original unpublished writings by Nicky Leap, Alison Coyle and other midwives in the Albany Practice.

## References:

1. Department of Health. *Changing Childbirth. Part 1: report of the Expert Maternity Group.* London: HMSO, 1993.
2. House of Commons. *Second report of the Health Committee of the House of Commons on Maternity Services. (29-1) (1991-92).* (Chair N. Winterton). London: HMSO, 1992.
3. Weig M. *Audit of independent midwifery 1980-1991. Data collection, analysis and original report.* London: Royal College of Midwives, 1993.
4. SETRHA consensus statement — *maternity services of the future.* London: Nursing and Quality Directorate, 1992.
5. Allen I, Dowling SB, William S. *A leading role for midwives? Evaluation of midwifery group practice development projects.* London: Policy Studies Institute, 1997.
6. Sandall J, Davies J, Warwick C. *Evaluation of the Albany Midwifery Practice: final report March 2001.* London: Florence Nightingale School of Nursing and Midwifery, Kings College London, 2001.
7. Jarman B. Underprivileged areas: validation and distribution of scores. *BMJ* 1989;289:1587-92.
8. Cumberledge J. In: *The good birth guide.* Sunday Times Magazine, 15 July 2001, p11.

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