



## How do the Albany midwives do it? Evaluation of the Albany Midwifery Practice

### Background

It is surprising how little real innovation there is in midwifery practice across the United Kingdom (UK). Plenty of tweaking, countless projects, many reorganisations – but in terms of a profound and sustained departure from the norm in the whole approach to care, the Albany Midwifery Practice (AMP) is almost alone.

This uniqueness seems to have two roots. The first is that the AMP evolved over a period of years. Its origins are in a group of independent midwives who worked together in the 1980s and then in 1994 formed the South East London Midwifery Group Practice. This practice was the first group of community based self-employed midwives in the country to obtain a contract with a local health authority with National Health Service (NHS) funding. In 1997 this practice developed into the AMP, which works under contract with King's College NHS Trust.

The second root is the commitment of the midwives in the practice to a model of care which delivers a very high level of continuity of carer, is committed to protecting and promoting normality, and which emphasises informed decision making by the women.

### The evaluation

A systematic evaluation of the practice was undertaken between 1999 and 2000.<sup>1</sup> The evaluation describes: the history of AMP, the model of care provided, the clinical outcomes for the women and the views of the practice midwives, other trust midwives, hospital doctors, general practitioners (GPs) and of the women themselves.



*A happy Albany mother and baby*

The full report of the evaluation is detailed and totals 85 pages. What follows is a summary of the key points, with some discussion of the implications for midwifery in the UK. Figure 1 sets out the aims and objectives of the evaluation.

### How the practice runs

Midwifery management at King's College Hospital NHS Trust decided to set up an agreement with the practice in 1997 because they foresaw several potential advantages of such a relationship. These included:

- the opportunity to target disadvantaged groups of women and thus improve outcomes in this group
- the provision of a popular model of continuity of carer
- the integration of a woman-centred approach, so further developing this philosophy at King's.

In the first year, AMP was contracted to take a caseload of care for 216 women per year – which equated to 36 women per whole time equivalent (WTE) midwife. These women were to come from the lists of a Peckham GP practice. The AMP midwives remained self-employed with their contract managed by the Director of Midwifery (Cathy Warwick). The practice was paid £180,000 (ie £833 per woman) by the Trust. The practice consisted of six WTE midwives plus a part-time practice manager. The service provided by AMP included:

- antenatal booking
- antenatal care
- antenatal and postnatal groups
- arrangement of laboratory tests and scans and appointments with specialists as required
- care in labour at home or in King's College Hospital
- postnatal care for 28 days post-delivery.

The practice provides midwifery cover 24 hours a day, seven days a week, 52 weeks per year. The midwives are available to women at all times via their pager. Each midwife has an individual caseload for which she is the primary midwife. The practice has access to the Trust's maternity computer system, laboratory and screening facilities, obstetric consultation and advice, in-patient services, emergency and intensive care facilities and disposable equipment for home birth. The midwives have access to a midwifery supervisor 24 hours a day. The Trust indemnifies the members of the practice. The midwives are expected to work within the protocols and guidelines for the Trust,

**Fig. 1. Overall aims and objectives for the Albany Practice Evaluation**

Aims	Process	Evidence of outcome
Supporting 'normality' To improve clinical and childbirth outcomes To improve women's experience of pregnancy and birth	Continuity of midwifery carer Woman-centred care Informed choice over place, content and provider of care	Home birth rate Intervention rates Breastfeeding rates Other clinical outcomes % primary caregiver at birth Women's views on informed choice Perceptions of control in childbirth
To facilitate a good start to parenting for women and their families	Continuity of midwifery carer Group work	Health visitor and GP views
Provide accessible and appropriate care for women and their families	Community-based practice in an area of deprivation	Comparative outcomes
Demonstrate the viability of a self-employed group practice	Increased autonomy and flexibility over organisation of practice	Staff views
Influence philosophy of midwifery at King's to support 'normality'	Professional activity within the Trust	Staff views

and they have links with a named obstetrician within the Trust.

The practice is self-managing and is responsible for paying the salaries of all members and for covering staff absence including sick leave, annual leave, study leave and maternity leave. The Albany midwives plan their working lives so that they have 12 weeks holiday per year.

When the Albany midwives were asked to reflect on the essential organisational characteristics for their model to work successfully, they cited the following criteria:

- a non-medicalised, community-based office
- a practice manager
- self-employment
- choosing who joins the practice
- 24 hour, seven days a week on-call
- long holidays.

**The midwives**

All seven Albany midwives were interviewed as part of this evaluation. Their clinical experience ranged from 4–15 years, they were aged between mid-twenties to forties. Four had children, aged from 5 to 23. They all saw pregnancy and birth as a social and life event that provided an

opportunity to work with women to build confidence and self-esteem. The philosophy was that a key role of the midwife was to help build social support networks – hence the emphasis on running antenatal and postnatal groups to achieve this. These groups enabled women to draw on their own community resources both during pregnancy and into the early years of parenthood. There was a view that high quality midwifery care contributed to positive long term health outcomes for women, their babies and their families. High quality care included an emphasis on supporting 'normality', especially home birth. However, the midwives also emphasised that it was more important to support women whatever their preferences and experience, prioritising a good relationship and continuity of care with women and their families over a 'natural' childbirth outcome.

**Continuity of carer**

Providing continuity of carer is at the heart of the philosophy of AMP. This is defined by the midwives as 'A pattern of care in which a woman is attended during her pregnancy, labour and postnatal period by a midwife with whom a relationship of trust has been established'. The AMP achieved a very high level of continuity of carer, and ascribes many of its positive outcomes

to this element of its care. In 1999, 89% of women were attended during birth by their primary midwife and all but 2% of women were attended by their primary midwife or another Albany midwife.

The 'on-call' arrangements needed to achieve continuity of carer suited some midwives, but not others. In 1999 three midwives left the Practice, the main reason for leaving given by two of them was the 24-hour on-call. The evaluation summarises this aspect of the model thus:

*'integrating a flexible working pattern and a personal life is an issue all professionals who work flexible hours face. The working pattern in the Albany Practice works for some midwives but not for others and it may suit midwives better at different periods in their working lives. It may only suit midwives who have supportive partners who can be flexible to accommodate this way of working, and who live and work locally. It is harder to successfully balance flexible working and a personal life when commuting times are long. The key to success is devolving autonomy and accountability to the group practice to organise their own working pattern.'*<sup>1 p27</sup>

**Targeting care to those most in need**

The GP practice from which the AMP draws their clients is situated in Peckham in South-East London – one of the two most deprived localities served by the Trust. The area has a high proportion of poor quality housing and inner city deprivation. Of the women cared for by the Albany midwives or a GP at the time of the report, 42% were Caucasian, 45% were African or of other black ethnicity, and 9% were Asian.

**Self-employment**

The Albany midwives insisted upon self-employment when they negotiated their contract with the Trust in 1997. They argued that self-employment gave them autonomy and flexibility in maintaining a level of independence. They were better able to maintain control over working arrangements and to act as an advocate for women, which allowed them to be woman-centred and not hospital/Trust centred. They could not be allocated other tasks by the hospital or have hours and holiday arrangements imposed on them. However, there were concerns expressed about not having a pension or sick/maternity pay provision. This was particularly important for those midwives who left AMP in 2000.

**Views of health professionals**

Hospital midwives felt the Albany midwives were good for the Trust because they did not need to allocate more staff to deal with breastfeeding problems and less medical input was needed for Albany women. On the other hand, some midwives perceived the AMP as being more expensive, due to the practice of two midwives attending a birth. There was also an anxiety that staffing the midwifery practices depleted the number of core staff.

Senior medical staff generally thought the Trust benefited from a group of enthusiastic midwives who were competent and confident. However, junior medical staff tended to be negative. They found the Albany women challenging and difficult to manage (sic) when in labour. They were more anxious going to an Albany birth because the midwives *'didn't like doctors interfering'* and *'didn't treat the junior doctors with respect'*. The evaluation recommends more multidisciplinary training and action by senior midwifery and medical staff to improve joint understanding and working.

GPs were sceptical of the AMP at first, but these views changed and they found that the women on their lists were very positive about their care, and their own workload was reduced.

One health visitor is quoted as saying: *'you could tell who had had an Albany midwife as soon as you entered her home because she was more relaxed, competent and happier'*.

**Comparative outcomes**

In 1999–2000 there were nine midwifery group practices at King's College Hospital Trust, employing 35% of the midwifery workforce (39 WTE midwives) and providing care for 37% of women in the Trust. Eight of the practices covered areas of high social deprivation and all served an ethnically diverse population. Most of the practices were GP linked and all provided care to women with complicated and uncomplicated pregnancies.

For the purposes of the evaluation, comparisons were made between three categories of women: those receiving care from the Albany Practice, those receiving care from another group practice in the same Trust, and those who received care from ordinary community and hospital doctors and midwives.

Figure 2 shows comparative statistics for the three groups and clinical outcomes are shown in Figure 3.

The evaluation had to contend with some shortcomings in the data collected by the Trust – the most serious of which is that the outcomes

**Fig 2. Comparative pregnancy and childbirth statistics 1999**

Pregnancy and birth data	Albany Practice n=206 women, 208 babies	King's midwifery practices n=1258 women, 1290 babies	King's College Hospital NHS Trust n=4044 women
Parity			
Multips	57%	Data not available	Data not available
Primips	43%		
Ethnicity			
Caucasian	42%	43%	46%
Black	45%	40%	42%
Asian and Chinese	9%	4%	5%
Other/missing	4%	13%	8%
Place of birth			
Home (incl BBA)	43%	11%	7%
Hospital	57%	89%	93%
Attendance at birth			
Primary midwife	89%	}	
Other Albany midwife	9%	}64%	
Born before arrival	2%	9%	

maternity services

**Fig 3. Clinical outcomes 1999**

Childbirth outcomes	Albany Practice n=206 women, 208 babies	King's midwifery practices n=1258 women, 1290 babies	King's College Hospital NHS Trust n=4044 women
SVD...	77%	67%	63%
...of which – water births	10%		
Ventouse/forceps	5%	8%	10%
Elective caesarean	2%	9%	9%
Emergency caesarean	16%	16%	18%
Induction	5%	10%	11%
Augmentation	–	2	20%
No pain relief	69%	18%	16% (of women in hospital, n=3292)
Pool at all	13%	0.2%	
Entonox at all	10%	52%	61% (of women in hospital, n=3292)
Pethidine	1%	21%	24% (of women in hospital, n=3292)
Epidural	17%	25%	35% (of women in hospital, n=3292)
Intact perineum (per vaginal deliveries)	47%	29%	31%
1st degree tear	25%	22%	12%
2nd degree tear	21%	14%	20%
3rd degree tear	0%	0.15%	0.5%
Episiotomy (per vaginal deliveries)	3%	9%	15%
Feeding at birth			
Fully breastfeeding	93%	75%	
Mixed feeding	1%	9%	
Bottle feeding	4%	15%	
Feeding at 28 days			
Fully breastfeeding	70%		
Mixed feeding	20%		
Bottle feeding	10%		

for neonates were not available. While it is highly likely that they would be consistent with similar research in this field and mirror the favourable outcomes experienced by the mothers, this cannot be assumed and needs to be demonstrated. A further shortcoming is that the other midwifery practices' data included statistics from a practice specialising in care to 'high risk' women – among whom the caesarean section rate was 50%.

Notwithstanding, there are clearly important differences in many of the outcomes; the Albany Practice have a higher vaginal delivery rate, higher intact perineum rate, more use of the birthing pool, lower episiotomy rates,

higher breastfeeding rates at birth, a lower elective caesarean rate, lower induction rate, and less use of pethidine and epidural. There was less difference in instrumental delivery rates, emergency caesarean rates and first degree tears.

### Women's evaluation of care provision

A questionnaire was sent to 447 women who gave birth under the care of the King's Health Care Trust in 1999. These were:

- a random sample of 299 women who had hospital births between mid October to 1st December 1999

(about 50% of women who delivered during this period)

- all 42 women who had home births over the same period (excluding Albany women)
- 106 women cared for by the Albany Practice between 1st July–31st December 1999 (98% of women who delivered during this period). One woman was excluded, nine women moved out of the area.

Excluded were women who lived outside the Health Authority, and women who had stillbirths and neonatal deaths.

Responses were received from 231 women (52%). Women who had had a

**Fig 4. First pregnancy contact**

When you first thought you were pregnant, whom did you first see about the pregnancy? (n=231)	Albany	Midwifery practices	King's total
A midwife	16%	2%	5%
A GP	79%	94%	89%
Family Planning Clinic	5%	4%	6%

**Fig 5. Venue of first antenatal visit**

Where did your first antenatal check take place? (n=231)	Albany	Midwifery practices	King's total
At a community clinic or GP surgery	53%	65%	62%
At the hospital	13%	28%	27%
At home	34%	4%	10%
Family Planning Clinic	–	2%	1%

**Fig 6. Access to maternity service providers**

During your pregnancy, which professional did you contact first if you were worried about anything or wanted to ask a question? (n=209)	Albany	Midwifery practices	King's total
A particular midwife	82%	37%	47%
Any midwife	6%	45%	27%
GP	8%	15%	22%
A hospital doctor	2%	3%	3%
Other	–	2%	2%

**Fig 7. Choice of caregiver at birth**

Do you feel you were given a choice as to who would deliver your baby? (n=214)	Albany	Midwifery practices	King's total
Yes	76%	38%	40%
No	22%	62%	56%
Can't remember	2%	2%	4%

**Fig 8. Midwifery care in labour**

Did it matter to you whether you knew or had met any of the midwives before? (n=218)	Albany	Midwifery practices	King's total
Yes, it mattered a lot	73%	58%	47%
Yes, it mattered a little	15%	18%	22%
No it didn't matter	12%	24%	32%

The responses to this question are consistent with previous research in that knowing their midwife prior to childbirth becomes more important to women once they have experienced it.<sup>2,3</sup>

home birth and women from the Albany Practice were over-sampled in the survey, and so are over-represented in the responses. The distribution of ethnicity in respondents is an accurate reflection of the whole population of women who received care in 1999.

In most respects, the Albany women were similar to the other women who responded to the questionnaire, eg age, parity, education. The main difference was that there were significantly more

African and Vietnamese women among the Albany respondents.

Figures 4–10, showing data taken from the original report,<sup>1</sup> demonstrate a selection of the findings.

Why more Albany women would have liked more postnatal visits, when they were already receiving a greater number than the other groups, is unclear. Maybe they had higher expectations.

The evaluation notes that 'almost all Albany women breastfed at birth

(93%) compared to 75% of women in the midwifery practices, and this remained high at 28 days (70%). The processes of care that facilitate this warrant further investigation'.<sup>1p78</sup>

The mass of data on the women's evaluation of care, which were presented in over 80 tables such as those reproduced here, does little to capture the enthusiasm and gratitude of the Albany women. This comes across in many direct quotes, such as the following:

**Fig 9. Pain relief in labour**

Do you feel you were offered adequate pain relief in labour? (n=209)	Albany	Midwifery practices	King's total
No pain relief required	49%	15%	24%
Yes	47%	79%	70%
No	4%	7%	6%

*It is interesting that slightly more Albany women felt they were offered adequate pain relief, despite 69% not using any pharmacological pain relief at all in labour.*

**Fig 10. Postnatal care at home**

How often were you visited by a midwife in the first 10 days? (n=222)	Albany	Midwifery practices	King's total
Everyday	28%	13%	17%
Every other day	51%	43%	49%
Every 2-3 days	21%	43%	24%
Would you like to have seen a midwife: (n=228)			
More often	18%	6%	10%
Less often	2%	-	1%
I was happy with the number of visits	81%	94%	89%

*Why more Albany women would have liked more postnatal visits, when they were already receiving a higher number than the other groups, is unclear.*

*'My first antenatal appointment was in the clinic at King's Hospital. I was so appalled by the service that I contacted Albany midwives, who took on my care. I have nothing but praise for the excellent care Albany midwives provided. The continuity of care was brilliant and the midwives were committed, highly professional and very supportive, which gave me and my partner great confidence.'*<sup>p53</sup>

*'Both my children were delivered by the same midwives two years apart and I cannot over-emphasise the positive warm memories I have of both occasions.'*<sup>p59</sup>

The tables also failed to capture the sense transmitted by direct quotes of just how unhappy some women were with hospital care;

*'[Gas and air] was thrust upon me by the anaesthetist – I didn't want it but he shoved it over my mouth to stop me screaming.'*<sup>p63</sup>

*'[the staff were] rushed, unhelpful, offhand, bossy and unsupportive.'*<sup>p72</sup>

**Conclusion of evaluation**

The evaluation concludes that the aims and objectives of the Albany Practice (Figure 1) were met. Specific areas identified included:

1) The Albany Practice was very successful at *facilitating normality in pregnancy and birth*. The home birth rate was very high and fewer Albany women had childbirth interventions.

In addition, one of the objectives of the Trust – to *improve childbirth outcomes in very deprived groups of women* – was also achieved.

2) The extent to which *continuity of carer* was achieved was very high. Almost all Albany women were attended by their primary midwife.

3) The Albany Practice aimed to *provide informed choice*. In most respects, the Albany women reported similar views on the information they received and their ability to exercise choice. This is an extremely difficult objective to measure, as it is inextricably linked with expectations, knowledge and so on. The evaluation was not sufficiently sophisticated to be able to investigate this fully.

4) The Practice aimed to *provide accessible and appropriate care*. This was felt to have been achieved, both in terms of the ethnicity and level of deprivation of the Albany women, and also in the pattern of care they received (eg more antenatal care at home).

5) The Practice *demonstrated the viability of a self-employed group practice*:

*'It was impossible to disentangle the distinctive difference that self-employment made to the organisation and management of the practice as compared to a self-managing practice. Albany midwives reported increased levels of organisational autonomy, but there were also disadvantages for some midwives with regard to loss of benefits of employment such as pension, sick and maternity pay and rights. The contracting process also took up a disproportionate amount of managerial time. There were considerable doubts among many midwives in the Trust as to the desirability for them of working in such a model of care (although these were often based on*

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*misconceptions about how the practice was organised). Without additional analysis of the cost-effectiveness, there is insufficient evidence to suggest that such a model is viable.*<sup>1(p81)</sup>

- 6) The Practice influenced the philosophy of the Trust towards a more woman-centred approach. The achievement of this objective is hard to measure, particularly in the short term. There was some evidence of the other Trust staff recognising the Albany midwives' achievements in maintaining and promoting normality. There was also some evidence of other midwifery practices modelling their care on the Albany Practice.<sup>1(p81)</sup>

### Implications for midwifery in the UK

The findings of this evaluation are spectacular. The reduction in interventions, the increase in normality and the success of breastfeeding are extraordinary. The benefits the Albany model of care confers to the health of women and to 'public health' more generally are massive. It could be suggested that if this model of care was compared to therapy it would be considered negligent not to prescribe it routinely to pregnant women. But it is not a drug, and so nobody is actively promoting it to the NHS and, of course, its adoption is not so easy as writing a prescription. Rather, it requires a deep and pervasive change in the way care is provided; how, where and by whom. It requires a shift in power, away from doctors and midwives and towards women, and a dramatic change in attitude and understanding by caregivers. Midwives would need to be confident and assertive with an unshakeable faith in the superiority of normality and the skill and knowledge to maintain and support normality through all the stages of the childbearing year.

The other great difficulty to this model being adopted more widely is that of the working conditions of the midwife. Three of the seven midwives who had been founding members of the practice in 1997 left in the summer of 2000. While all three had slightly differing reasons for leaving, they all cited 24-hour on-call as

being a key factor. And this is, of course, among a group of midwives who had actively chosen to work this way. It does not bode well for this model being replicated in the rest of the country. The hospital midwives who were interviewed for the evaluation raised concerns about pensions, maternity benefits, career progression, amongst other things, as further reasons why they would not choose to work in a practice such as the Albany. It is likely that these concerns are shared by midwives nationwide. There is already an inspiring example of midwives setting up in a practice that side-steps this latter difficulty. The midwives in the Weston Shore Midwifery Group Practice in Southampton<sup>4</sup> are not self-employed but have normal NHS contracts with their Trust. Notwithstanding, they have managed, with the support of management, to replicate the Albany model very closely and have achieved similarly excellent clinical outcomes.

This is perhaps the crux; thinking of midwifery practices as being self-managed rather than self-employed. No model of care will be adopted widely unless a reasonable proportion of midwives are willing to accept the employment conditions that are attached to the model. It is likely that very few would accept conditions which do not include full insurance cover, sickness benefit, pension rights etc.

This still leaves the issue of working 24-hour on call. For some, the carrot of 12 weeks leave per year may be sufficient, but for most it will not. That has to be accepted. It is not necessary to prescribe in detail how midwives should organise their working lives—much better to create the conditions in which the practice midwives can organise it for themselves in a way that suits their circumstances.

What is to stop midwifery managers throughout the country facilitating the setting up of self-managing midwifery group practices within their Trusts? Rather than concentrating on the minutiae of work patterns and on-calls it would make more sense to concentrate on what matters most to women and babies and to our society. And for this, we need look no further than the first three aims of the Albany Practice:

- 1) Supporting normality to improve clinical and childbirth outcomes and to improve women's experience of pregnancy and birth.
- 2) To facilitate a good start to parenting for women and their families.
- 3) Provide accessible and appropriate care for women and their families.

This is an outcomes-focused approach. Midwives are all too ready to get caught up in the endless permutations of how to organise their working lives, and all too slow to reconsider the content of their work—just what they do and how they do it. Women and babies benefit from improved outcomes. It cannot be beyond the wit of the UK's midwives to organise ourselves to achieve improved outcomes while establishing a working pattern which is sustainable and practical.

Midwives all over the country are eager to work in a way similar to that of the Albany Practice without some of the perceived drawbacks. In fact, midwives are haemorrhaging out of the maternity services because hardly any such opportunities exist. What are we waiting for?

*Copies of the full report are available from Ann Pryor, Florence Nightingale School of Nursing and Midwifery, King's College London, James Clerk Maxwell Building, 57 Waterloo Road, London SE1 8WA. Tel 020 7848 3512. Email: ann.pryor@kcl.ac.uk. Price £10 including postage and packing. Cheques payable to King's College London.*

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**Rosser J. MIDIRS Midwifery Digest, vol 13, no 2, Jun 2003, pp 251–257.**

*Original article written for MIDIRS by Jilly Rosser, Sure Start midwife, Bristol.*  
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