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Evaluation of the Albany Midwifery Practice

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1.0 Introduction

The way in which maternity care is provided in the UK has been influenced over the last decade by official reports recommending fundamental changes (House of Commons 1992, DH 1993). These reports have advocated a shift to a more humanised, woman centred service which has required the provision of a midwife led community based service. It has been hoped that within such a service woman would have greater informed choice, and influence over their experiences of pregnancy and birth, and experience less fragmented care.

It has been eight years since these policy documents have been published and many different models of midwife led care have evolved hoping to achieve the above aims. In addition, since 1993 other policy initiatives have been developed that directly and indirectly influence maternity care. For example, efforts to reduce inequalities in health outcomes (DH 1999) have redirected the efforts of the maternity services to target care to women traditionally excluded from routine service provision. Many midwives are now working in multi-agency Sure Start programmes (DfEE 2000) and teenage pregnancy programmes (The Social Exclusion Unit 1999).

Professional guidelines and standards have focused on improving the delivery of care and childbirth outcomes. Two key recommendations from 'Safer Childbirth' (RCOG/RCM 1999) will affect how current maternity care is organised; that there is enough qualified consultant cover on labour ward and that women receive continuous one to one midwife support during childbirth. Changing the way a service is delivered may not necessarily alter or improve the process of care, so what do we know so far?

Following Changing Childbirth, several models of care developed which either: aimed to improve continuity of care ie provide women with fewer care providers who all follow a similar philosophy, usually in midwifery teams; or improve continuity of caregiver ie provide women with known caregivers with whom a relationship of trust has been established, usually in a caseload model (Green et al 2000). Both models of care have more recently been provided in midwifery group practices.

The research evidence about effectiveness and safety shows that 'new' forms of care are as safe and effective as 'traditional' forms of care (Green et al 1998a). Overall, new schemes have generally resulted in better childbirth outcomes, but there is difficulty in defining precisely what midwifery interventions have been compared in different studies. Some studies compare midwife led care with consultant care, some compare team midwifery with traditional patterns of care, but there has been a lack of accurate description of how 'new' and 'traditional' models of care are organised and delivered (Kaufman 2000). In addition, outcome measures have varied between studies, and few studies have examined the patterns of care in pregnancy and birth on long-term outcomes for women and their families.

Research evidence surrounding women's views on maternity care shows that, in general, 'new' schemes result in higher satisfaction, particularly in regard to relationships with carers and women feel that they are listened to, and treated as individuals. Definitions of 'continuity' and what it means 'to know a midwife' have not been sufficiently precise for research to make comparisons. There is evidence that women from minority ethnic groups (McCourt and Pearce (2000) and from lower socio-economic groups share similar fundamental values and hopes of

the service as women in other groups, but experience greater a greater dissonance between expectation and experience (Jacoby 1988). Equally, the measures of maternal satisfaction used to date have been inappropriate, poorly validated, are not comprehensive, and do not reflect what women want from their care. It is known that women's views depend on how, and when they are elicited, and are shaped by their expectations, experiences and circumstances (Green et al 1998b). Additionally women can only comment on the care they have received and it is difficult to answer hypothetical questions on a service not received (Porter and Macintyre 1984). For example, there is a pattern in research findings for women who receive care from one or two midwives throughout pregnancy and birth to be very positive about this, and feel it to be important, whereas those who do not receive this pattern of care don't rate it as important (Morgan et al 1988). In general, the relationship between continuity of caregiver and satisfaction with birth are unproven. This highlights the complexity of comparing women's views about their experiences of maternity care (Green et al 2000).

Overall, research findings show that women feel badly informed about pregnancy and birth, especially in relation to choices on aspects of care. They report receiving little choice about the type of care they receive, and in general the package of care is decided by the caregiver. Additionally, it is not helpful to women if the choice is between poor quality services, and the primary aim of any service should be to provide high quality care. Therefore the aim of any evaluation is to examine the quality of care rather than assume that continuity of caregiver will automatically lead to high quality care. In general, it is more informative to elicit women's views on specific aspects of service provision.

Health professionals have also been variable in their willingness to accept change. One study in South London found that midwives, and to a lesser extent obstetricians were most keen and GPs least keen to see change (Sikorski et al 1995). In general, evaluations of new models of care have found that GPs have felt excluded from antenatal care, been anxious about home birth and are more likely to see midwife led care as a threat. However, GPs did see the group practice model as a viable way to organise midwifery care (Allen et al 1997). GPs have expressed concerns that the quality of care offered to women by teams is inferior to the traditional 'GP attached' community midwife model of care. GP's were also concerned that that team midwifery reduced overall continuity of caregiver throughout the childbearing process for women and had a deleterious effect on GP/midwife communication (Pankhurst et al 1999, Farquar et al 2000). A Key factor for GPs was whether a GP had their own midwife attached to their practice (Fleissig et al 1997).

Initially, many hospital based midwives were also antagonistic to community based midwife led care due to anxieties about depleted hospital resources and unclear role boundaries (Garcia et al 1997). A study of the views of hospital based medical staff regarding a midwifery development unit (MDU) found that they were also ambivalent. Following the introduction of the MDU, the majority of obstetricians felt that one benefit was that they had more time for high risk women, however, most felt all women should still see a consultant once, and only 55% trusted midwives judgement. The majority also felt that the presence of the MDU undermined the role of the GP and the SHO (Cheyne et al 1995). It is not known how long the new system of care had been running when views were sought, but generally organisational change should be given time to become 'routinised' before attempting evaluation.

There has been an ongoing concern throughout the organisational changes of the delivery of maternity care that midwifery working practices and patterns may not be sustainable for

midwives. Overall, midwives working in 'new schemes' have found that they have a wider scope of clinical practice, but this depends on how their work is organised, and whether they have varying degrees of authority and control over their work (Hundley et al 1995, Sandall 1997). A low perception of control and long working hours were the major predictors of 'burnout' in midwives and these working patterns were more likely to be found in 'new ways of working' ie. hospital and community midwifery teams compared to 'traditional' patterns of care (Sandall 1998).

Overall, midwives working in teams have been more likely to be younger and a lower grade, less likely to have children, and have less experience than staff working in traditional patterns of care, BUT they possessed more qualifications. Team midwives have reported a wider scope of practice and also reported a greater impact on personal life. Some report disillusionment due to trying to provide continuity of carer in a system designed to provide team care (Todd et al 1997).

There have been few published studies of caseload midwifery. Initial outcomes suggest that clinical interventions are reduced (Page et al 1998), and that caseload working has facilitated organisational and occupational autonomy and meaningful relationships with women, but that it is not suitable for all staff (McCourt 1998, Sandall 1997). The summary from a recent symposium reviewing the evidence on the organisation of maternity care (NPEU 2000) recently suggested that: the aim of any service provision is to maximise the health and well-being of women, babies and families, use the best evidence for the organisation and practice of midwifery, conduct research and evaluation that takes a multi-dimensional view of maternity services, best use the skills and experience of all the health professionals, and to deliver a service that is sustainable for midwives.

Although autonomous contractual group practices have been cited as the way forward in the RCM Vision 2000 document, (RCM 1999), there has been very little evaluation of caseload midwifery, and the existing contractual model within the Trust is unique in the UK. Thus it is hoped that the findings of this evaluation will inform the ongoing debate in addition to contributing to future policy and practice in the Trust.

2.0 Evaluation Design

2.1 Aims and objectives of the evaluation

In 1999, the research team was commissioned by the Department of Midwifery in the Women and Children's Care Group of King's College Hospital NHS Trust, to carry out an independent evaluation of the Albany Practice. The agreed 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

2.2 Evaluation Design and Methods

The evaluation was designed as an independent review of the operation and outcomes of the Albany Practice. The evaluation design drew on models of realistic evaluation (Pawson and Tilley 1997). Following consultation with the midwives and the maternity services manager, a model of the relationships between context-process-outcome was developed which provided a focus for the evaluation. Data collection methods included: focus groups, questionnaires, interviews, analysis of routine audit data and document analysis. Participants in the evaluation included managers and health professionals in the Trust and the community, women who had used the service and the midwives of the Albany Practice.

Qualitative methods were used to understand the process of care by gathering the experiences and views of health professionals using a case study approach. One of the advantages of a case study is that it highlights the process of care from differing perspectives (Strong and Robinson 1990). Yin (1989:23) describes the case study as an empirical enquiry that: 'investigates a contemporary phenomenon within its real life context...in which multiple sources of evidence converging on the same set of issues are used'.

2.2.1 Fieldwork

Fieldwork lasted from October 1999 to August 2000. Data collection included a total of 50 hours of interviews with key informants and a range of health professionals including; GPs, health visitors, medical staff, hospital and community midwives. In addition, a focus group with Vietnamese women, collection of policy documents, statistical returns and data from the routine satisfaction survey of women were collected.

2.2.2 Interview data

The report draws on the following data.

- Individual and group interviews with the 7 original Albany midwives plus one new Albany midwife, the Albany practice manager and a student placed with the Albany for several weeks in the early stages of the evaluation.
- Interviews with eleven other midwives: four working in the community/midwifery practices, and seven hospital midwives.
- Interviews with seven medical staff at varying grades.
- Interviews with five hospital managers.
- Interviews with two GPs who refer women to the Albany practice.

- Interviews with two health visitors connected to these GPs.
- Interpreter accompanied group interview with Vietnamese women who received care from the Albany Practice.

2.2.3 Qualitative data analysis

Data was recorded as field notes (Lofland 1984). The early interviews in each staff category were fully transcribed, others were only transcribed at a later date if they added new categories to the analysis. The transcripts and tapes were then listened to, read through and checked. Two transcripts were requested back by respondents. Thematic content analysis was then carried out (Mason 1996). The aim of the analysis was to produce a detailed and systematic recording of the themes and issues addressed in the interviews following Burnard (1991).

2.3 Questionnaire data

The report will draw on responses from women who completed the routine King's Maternity Services' Satisfaction Questionnaire.

2.3.1 Questionnaire Sample

4044 women delivered in Kings Health Care NHS Trust in 1999. The King's Maternity Services Questionnaire was sent to 447 women who gave birth in 1999. The following groups were excluded from the sampling process.

- women who lived outside the LSL HA (n ≈285)
- women who had stillbirths and neonatal deaths (n ≈72).

The questionnaire was sent to the following women:

- 299 women who had hospital births between mid Oct - 1st Dec 1999 (just under 50% of women who delivered during this period)
- All 42 women who had home births mid Oct - 1st Dec 1999 (excluding Albany women)
- 106 women who were cared for by the Albany practice between 1/7/99-31/12/99 (98% of women who delivered during this period). One woman was excluded from Albany sample and nine women who had moved out of the area.

The first mailing of the questionnaire was sent in January and February 2000 with 1 reminder sent on the 14th March and telephone reminders to Albany women in May and June. With 1 woman excluded and 9 women who had moved out of the area, the total number of women who received the questionnaire was 447.

2.3.2 Questionnaire Response rates

A total of 231 responses were received making an overall response rate of 52%. The overall response rate for women delivering with the Albany Practice was 58%. In both groups, the response rate for women who had home births was around 30% higher than women who had a baby in hospital.

2.3.3 Analysis of questionnaire

The data was entered onto SPSS and analysed using descriptive statistics, univariate and bivariate analysis.

3.0 Context And Current Organisation of Albany Practice

3.1 The population

King's College Hospital NHS Trust is based in Camberwell, South East London. It serves the Metropolitan boroughs of Lambeth, Southwark and Lewisham, which are among the most materially and socially deprived areas of England and Wales (LSLHA 1999). For example, the number of dependent children living in non-earning, overcrowded, lone-parent households and with no access to a car, is twice the national average. The area has a rich ethnic mix and a large proportion of residents are from ethnic minorities, 26% of residents are non-caucasian compared to 6% in England and Wales, with the largest ethnic minority group being Black Caribbean. It has a 'young' resident population compared with England and Wales.

The Jarman Index of Deprivation (Jarman 1984) for these areas ranges from 16.55-64.31 ranging from pockets of excellence to social deprivation. Of the three boroughs, Southwark, in which Albany is based, is the most deprived. The Albany Practice is based in Peckham in SE15 where the Jarman Index is 64.31, an area of high deprivation. This locality has a much higher than average deprivation score than England and Wales, with the unemployment rate being more than 50% above the national average, and double the average proportion of residents living in overcrowded accommodation.

The most recent Annual Report for Public Health for Lambeth, Southwark and Lewisham Health Authority states that the whole area exhibits a complex mix of health and socio-economic problems. In 1996, there were twice as many local births (12,246) as deaths, and given the relatively stable population total, this is suggestive of high mobility. Fertility rates are very high, and the maternal age profile is unusual in its high proportion of births to older women (aged 35 and older). Conception rates among teenage females are exceptionally high, with all six PCGs showing rates at least 70% above that of England and Wales. The abortion rate is the highest in England & Wales and perinatal mortality, stillbirth and low birthweight rates are high and showing signs of an increasing trend (LSLHA 1999). For example, perinatal mortality rates have risen since 1996 and in 1998 were 12.7 / 1000 resident live and stillbirths compared to 8.2 for England and Wales. Although LSLHA hosts 4 neonatal intensive care units who accept transfers, this does not account for higher *resident mortality* rates. Low birthweight rates (<2.5kg/100 resident live and stillbirths with stated birthweight) for LSLHA were 9.3 % in 1998 compared to 7.8% in England and Wales. In addition, infant mortality rates are high with an excess death rate among black African babies (South East Thames Perinatal Monitoring Unit 1999).

3.2 Maternity services provision at King's

In 1999, King's College Hospital NHS Trust provided maternity care to 4044 women. A total of 3759 women from LSL and 285 women from outside LSL. Caucasian women accounted for 46% of births at King's, African women 24% and Caribbean women 16%. There were a small number of Asian women from the Indian sub-continent (4%) and Chinese and Vietnamese women (1%) and 9% from other backgrounds.

King's maternity service provides a variety of service provision to meet the differing needs of its population. The service has one of the highest home birth rates in the country, 7% of women gave at home, compared to the national average of 2%, and also houses a regional neonatal

unit, fetal medicine unit and provides care to women with complex medical and obstetric problems. Around 33% of women who booked at Kings College Hospital in 1998 smoked at booking, the highest percentage in South East Thames Region. The percentage of low birth weight babies (<2500g) was the highest in the region at 9.9% and to an extent this reflects the fact that the Trust accepts the most seriously compromised babies.

In 1999 - 2000, there were 9 midwifery group practices employing 35% of the midwifery workforce (39 wte staff). The practices provided care for pregnant women within the geographical area of King's College Hospital. This includes Camberwell, Peckham, Brixton, Herne Hill, Tulse Hill, Nunhead, Upper Norwood, West Norwood, and Dulwich. The practices ranged from 4 to 6 wte staff per practice, all were self-managing and linked to a consultant obstetrician. Each wte midwife was expected to book a caseload of 40 women /year.

The midwifery group practices provided care to 37% of women in the Trust. A total of 15% of women receiving care from a group practice gave birth at home, although the number of home births p/a varied between the midwifery group practices (Yearwood and Wallace 2000). Eight of the practices covered areas of high social deprivation and all served an ethnically diverse population. All the practices provided care to women with complicated and uncomplicated pregnancies and most were linked to GP caseloads. Two practices each cared for women with medical complications and women with mental health problems. A core of medical staff, midwives and health care assistants worked in the hospital.

3.3 History of the Albany Midwifery Practice

The midwives in the Albany Midwifery Practice have been offering care to women since 1997 in South East London. The Albany Midwifery Group Practice developed from the South East London Midwifery Practice (SLMGP), set up in 1994 as a self-employed, self-managed group of midwives and a practice manager. The founding aim of the group was to provide continuity of midwifery care (antenatally, during the intrapartum period and postnatally) with known midwives to local women with a policy of targeting certain groups, and promoting equity of access thereby meeting the objectives of *Changing Childbirth.* The practice was the first group of community based self employed midwives in the country to obtain a contract with a local Health Authority with NHS funding. Being chosen as a pilot midwifery group practice site by the regional NHS Executive facilitated this arrangement (Allen et al 1997).

The establishment of the SLMGP involved submitting a business proposal to the purchasing authorities and setting up a practice agreement covering terms and conditions of employment. SLMGP secured direct funding from the Health Authority to provide midwifery care for 130 women per year plus a further 20 women from Greenwich. Health Authority funding came from non-mainstream funding on the proviso that the practice would target women who were not currently receiving an adequate maternity service from their GP. Thus 80% of women booked with the practice were expected to be in one of the target groups, eg. on benefits, or with mental health problems.

The midwives began practising in partnership with a practice manager from an office in the Albany Community Centre near Deptford Market. Also in the community centre were a café, arts centre and other health and community projects. The practice offered an information, counselling and pregnancy testing service as a walk-in health resource. On average in 1996, this generated between 40 and 100 enquiries a month. The practice ran free antenatal and postnatal groups for women not booked with the practice, and produced three videos in partnership with

the women in the groups. Latterly, a women's health worker co-ordinated outreach work with particular client groups, for example Vietnamese women.

In 1994, there were 7 midwives, but by 1996, three had left and one had joined resulting in 5 midwives, some of whom worked part-time, equalling 4.5 whole time equivalent staff in 1996. Each wte midwife had a caseload of 36 women for whom she was primary midwife, and she was second midwife/working partner to another 36 women, for whom she shared some of the antenatal and postnatal care.

The practice was self managed and recruitment, organisation and future strategy was decided in weekly business meetings. The practice also had an advisory group composed of 50% users and 50% professionals with relevant expertise. Statutory midwifery supervision was provided by supervisors at local hospitals where women gave birth. The midwives were on-call continuously for agreed months of the year combined with a total of 3 months holiday a year.

3.3.1 SLMGP Antenatal care

Local GPs referred approximately 20% of women to the SLMGP practice and the rest of the women referred themselves. Women were booked with the practice if they lived in the designated geographical area or came into the target group. Almost half (45%), of women booked late (after 24 weeks gestation), but the reason for this was unclear. The caseload also included some women with obstetric and medical complications whom the midwives referred to local specialists.

Following referral, all women were booked in their own home. After the booking visit, their primary midwife saw them either at home or at the practice. Most of the antenatal care took place in women's homes and was provided mainly by the primary midwife and her working partner. Virtually all women (97%) had midwife-only care during pregnancy and 3% had shared care with an obstetrician.

3.3.2 SLMGP Intrapartum care

All the midwives were on-call 24 hours a day for women going into labour who contacted the midwife using her pager. Midwives always assessed women at home in early labour and always came to the home with equipment for a home birth. Although the place of birth had been planned and discussed previously, there was flexibility for women to decide in labour whether to stay at home or go to hospital.

3.3.3 SLMGP Postnatal care

The midwives provided postnatal care in hospital and the home. Women were visited according to need until 28 days postpartum. In 12% of births, some midwives also conducted the neonatal examination normally done by the GP. One of the aims of the project was to see if the good childbirth outcomes associated with independent midwifery care (Weig 1993) could be maintained when the caseload addressed the issues of inner city deprivation and inequalities in health. Along with two other pilot sites, the Regional Health Authority commissioned an evaluation. A case note review from 1/4/94 –31/1/97 found that 380 women had babies with the practice. Most women (80%) were in the specified HA target groups, and 73% were Caucasian, reflecting the ethnic mix of the area. Almost all (95%) Albany women had their primary midwife present at the birth and all women had either a primary or secondary midwife. The majority (60%) of women were attended by their midwife at home (43% having their first

babies). A further 20% were attended by their midwife in hospital, and 20% by an obstetrician in hospital (Allen et al 1997).

The model of care offered proved to be very popular with the women and the group's work soon became both nationally, and internationally acclaimed as ground breaking. However, the funding of the project had a history of uncertainty, with short term funding from the Health Authority that required continued negotiation and three midwives left in 1995. The funding problem was exacerbated by the withdrawal of practice indemnity insurance by the Royal College of Midwives for self-employed midwives in 1995/96, although the Health Authority covered the extra cost (£18,000). Towards the end of 1996, despite its success, SELMGP was under serious threat. It became apparent that the Health Authority could not readily make funds available for SELMGP to continue. Having always had very positive connections with King's College Hospital (KCH) and strong support from Cathy Warwick, Director of Midwifery, SELMGP proposed a sub-contract with KCH. The Health Authority were supportive of such a solution and agreed to contribute to the funding required for this approach. In the light of SELMGP'S good childbirth outcomes, predicted cost effectiveness and health gain within the local population, both parties were hopeful about the effects of making the SELMGP model of midwifery care mainstream. The proposal would also relieve some of the pressure imposed by long-term midwifery vacancies at KCH NHS Trust.

3.4 Incorporation into King's College Hospital NHS Trust 1997

Discussions began in Autumn 1996 about the sub-contract moving to King's College Hospital NHS Trust after the group were told that although they had exceeded LSL's expectations of performance outcomes they would receive no further funding from the Health Authority. This was due to the non-recurrence of LIZ (London Implementation Zone) funding and a £19 million deficit within the Health Authority.

From Trust records, potential advantages of incorporation for maternity care provision were identified:

- The provision of a popular model of continuity of care, and a walk in model of care for women booking at King's.
- The opportunity to target disadvantaged groups of women and thus improve outcomes in this group.
- The integration of a woman centred approach and thus further developing this philosophy at King's.
- The continuation of a positive consumer profile at King's.
- The operation of the practice at the King's catchment area boundary would bring new business to King's.

It was agreed that the Albany Practice would take on a caseload of 216 women per year (36 women per whole time equivalent midwife). This caseload was directly related to the lists of local GPs based at the Lister Health Centre in Peckham and the GPs were involved in the planning of this. It was agreed that the Albany Practice would remain self-employed. The group would continue to be self-managed, with the contract managed by Cathy Warwick, the Director of Midwifery. The contract was signed on the 1st April 1997 with an agreed budget of £180,000 for the midwifery care of 216 women cared for between 1/4/97 and 1/4/98, to be paid in quarterly instalments (see Appendix for contract). The practice consisted of 6 whole time

equivalent (wte) midwives plus part a part-time practice manager who worked 3 days a week. The configuration of services provided in 1997 continues today and includes:

- Antenatal booking
- Antenatal care
- Antenatal and post-natal groups
- Arrangement of labouratory 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 Albany Practice provides midwifery cover 24 hours a day, 7 days a week for 52 weeks a year. The practice midwives are available to women at all times via pager. Each midwife has an individual caseload for whom she is primary midwife. Service provision adheres to LSLHA service specification for maternity services and Trust guidelines. The practice has access to the 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 Albany practice has access to a midwifery Supervisor 24 hours a day and follows the Trust induction and Continuing Professional Development Programme (CPD). The clinical records are Trust property.

The practice is self-managing and is responsible for paying wages and salaries of all members and for covering staff absence including sick leave, annual leave, study leave and maternity leave. The Albany midwives plan their work so that they have 12 weeks holiday at some point during the year. The practice is expected to take students from King's College and may take other students providing the delivery of the contract is not jeopardized.

The Trust indemnifies the members of the practice, and the midwives are expected to work within the protocols and guidelines for the Trust as well as other standards eg UKCC rules and Code of Practice. Senior management of the Trust manage the contract which has contract standards and service specifications. Statutory supervision is provided by midwives in the Trust and the Practice is linked with a consultant obstetrician (Michael Marsh) at Kings' College Hospital. Complaints are processed through the Trust complaints system.

The Albany Practice started on 1/4/97, and was based at the Lister Health Centre in Peckham and served the caseloads of 2 GP practices based at the Lister Health Centre (Drs Huynh and Drs Aru/Seeraj & Ullah). There were 7 midwives (6 wte) and 1 part-time practice manager. In addition, women who had previously had babies with the practice, women with special needs, (eg. traumatic previous childbearing experience) and women referred from other healthcare professionals were accepted. Each woman was assigned 1 midwifes who cared for her throughout pregnancy, birth and postpartum up to 28 days with back up from a second midwife at the birth. Women were able to contact their midwives any time, 24 hours a day 7 days a week. The 6 week postnatal check for mother and baby was carried out by the GP.

Over the first year, the practice faced a potentially large shortfall in caseload numbers, as 1 GP had pulled out of the agreement and it proved difficult for the practice to access women on the lists of the other participating GPs. However, it was agreed that the Trust would 'select an adequate group of women' for midwifery care by the Albany Practice. Great care was taken by Trust managers to select local women and avoid other women booking from outside. The

group also offered to look after women who were particularly interested in a waterbirth and met these women via the monthly waterbirth workshop held at KCH. The practice reported that the successful antenatal and postnatal groups that had run at the Albany Community Centre were difficult to run in the Lister Health Centre due to poor premises and low expectations of care provision by the women booking with the practice. In addition, the practice reported spending considerable time in the first year explaining their model to other health professionals in the Trust and in primary care settings.

1998/99

The new contract specified 216 deliveries and paid £179,866 with a 5% tolerance of dropping the number of deliveries without penalty again with 7 midwives (6 wte) and a 0.5 practice manager. The Practice continued to take referrals from the two GP practices at Lister Health Centre and from Dr. Sekweyama in SE15. Additional referrals came by word of mouth and from the waterbirth workshop held at KCH. Some women who transferred late in pregnancy to the practice had caused problems with some of the other community midwives who felt that this reflected badly on their own service.

In May 1998 the Practice moved to Peckham Pulse, a newly opened leisure centre with improved accessibility for local women based off Peckham High Street. Facilities within the centre included rooms for ante-natal and post-natal groups, complementary therapies, physiotherapy, family planning and counselling, swimming pool, fitness suite, crèche, soft-play area and café. The attendance at the groups has since improved. The practice also continued to run breastfeeding and waterbirth workshops for professionals and accepted midwifery students.

1999/00

The contract was renegotiated for another year for fewer women (209), reflecting a rise in Practice running costs since 1997 in real terms. The group comprised 7 midwives and the practice manager. During the first part of 1999, the practice manager was on long term sick leave and temporary cover was recruited. The practice continue to take referrals from 4 GPs and consultant obstetricians at King's, and have a waiting list of women hoping for continuity of care, a home birth or waterbirth. More women are returning for subsequent pregnancies. Donald Gibb, the named consultant left KCH was replaced by Michael Marsh. During this year 3 midwives were replaced by new midwives joining the Practice.

4.0 Aims and objectives of the Albany Practice Evaluation

The aims of the evaluation were specified and agreed at the planning stage in December 1999. They are as specified in Figure 1 and became the focus of the evaluation design. Key questions identified at these planning meetings with the Albany Practice and Cathy Warwick were as follows:

Context

1. What are the aims and objectives of the Albany Practice?
2. What are the key activities and pattern of care provided by the practice and are they implemented as planned?
3. Have social, political and financial circumstances affected the intended activities?

Process

4. Do Albany women receive continuity of carer?
5. Has Albany had any impact on service philosophy in the Trust?
6. What are the implications of self-employment for the Trust and the Albany midwives themselves?

Outcomes

7. What are the benefits for women?
8. Is the service equally effective for different women?
9. Are there any unintended consequences?
10. How generalisable is this model of care?

Figure 1 Overall aims and objectives for the Albany Practice Evaluation

Aims	Process	Evidence of Outcomes
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 Maternal satisfaction rates 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	HV 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 organization of practice	Staff views
Influence philosophy of midwifery at King's to support 'normality'	Professional activity within the Trust	Staff views

In addition the expectations of the Albany Practice should be contextualised within the broader organizational aims and objectives for the maternity directorate as set out in Figure 2.

Figure 2 Broader aims of the maternity directorate

Meet NHS policy objectives Improve childbirth outcomes in most deprived groups of women Effective targeting of midwifery care to those most in need Facilitate a wide variety of care provision Provide cost effective care provision	Capitalise on high quality midwifery care Improve recruitment and retention of midwives Offer a range of student learning experiences in a variety of service delivery models Disseminate good practice locally and nationally

4.1. What are the aims and objectives of the Albany Practice?

The following sections will describe the philosophy and self-defined aims and objectives of the Albany Practice, explore key processes of care and inter-professional working. Throughout the report objectives are assessed drawing on a variety of data sources as described above.

4.1.1 Demographic characteristics of the Albany Practice midwives

All seven Albany midwives were interviewed for this study. There was a broad range of clinical experience in the group, ranging from 4 - 15 years. Two midwives had over 10 years experience, 3 midwives between 5 and 10 years, and 2 midwives 4 years. Three midwives had worked in the South London Midwifery Group Practice in Deptford, and 3 had joined the Albany when it integrated into King's College Hospital NHS Trust in 1997. The age of the midwives ranged from mid twenties to forties and four of the midwives had children, with ages ranging from 5 to 23.

4.1.2 Philosophy of Albany Midwives

There was a shared enthusiasm for providing midwifery care that empowered women, saw pregnancy and birth as a social and life event that provided an opportunity to work with women to build confidence and self-esteem. Continuity of carer and the resulting ongoing relationship between a woman, her family and the midwife was seen as crucial in facilitating individualised women-led care and informed choice. In addition, there was a philosophy that a key role of the midwife was to facilitate social support networks so women could draw on their own community resources that would continue into the early years of parenthood. This was thus there was an emphasis on running antenatal and postnatal groups to achieve this.

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 midwifery care included an emphasis on supporting 'normality', including home birth and physiological birth where appropriate. However, the group 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. One of the established Albany midwives defined her practice philosophy in the following way.

Albany Midwife — *It's about recognising that childbirth is a normal part of women's lives and a normal part of their family, whatever their set up, and also a very special time in their lives. My aim is achieved through continuity, and an approach that empowers women through birth to their future mothering. Making them feel good about the experience and how that helps them become a mother through their culture. Continuity is a way to deliver that philosophy more easily. For woman to have a relationship with a midwife who knows more about her. We don't have exact carbon copies of each other's approach but it is a shared philosophy. The (other midwives) must bring things of themselves.*

Another Albany midwife reflected on what they hoped to achieve and how they hoped to influence women's choices. This midwife was proud that she influences women to have home births and sees it as a balance to the medicalisation of birth in hospital.

Albany Midwife — *I hope ... they do truly benefit from knowing their midwife and getting [the] continuity we work hard to achieve. I hope this audit will give us some answer on that. Continuity [is something we] need to work hard at. Worth it for us but we*

would like to know if the women find it worthwhile. Because of continuity of carer we achieve a sense of them having made the right choices and [they are] happy [they] made right choices throughout. I hope [we] achieve what is important to us: reduced intervention rates, reduced caesareans, and increased home births. It matters to me, and I think to a lot of women.

Albany Midwife *I suspect we don't know how much influence we have on what women choose. I'm aware about informed choice, and that we are going to influence people. People who didn't realise they had choices. I'm happy to give positive input into birth at home because I know how much input [there is] into hospital births.*

We have more demanding and less demanding women, and it usually balances out. There is usually a reason for demands. Because we know a woman and we're interested in why. Occasionally a woman will want more than we are practically able to provide, timewise, but it's unusual.

Two Albany midwives talked about 'trials of scar' and how they encouraged women who have had caesareans to try for normal deliveries, including home births and how this had been supported by their link consultant.

Albany Midwife *I'm passionate about Caesareans and VBACs. [Some of us are] getting involved in audit at King's of elective caesareans. Hopefully we will publish from that.*

One of the other midwives was also positive about VBACs, but also emphasised the level of support given to women who did have C-sections by the group.

Albany Midwife *She had a huge baby before, and she had had a caesarean and the baby just hadn't come down and [she] wanted a water birth at home with the next one and we just went with her to see the consultant and she just laid her cards on the table and she said "this is what I want, this is what I am going for" and the consultant said "well that is fine, give it a try. She ended up having a caesarean and going into hospital but you know the philosophy is: if it has been OK'd by the consultant, and is not thought to be a dangerous option, then we do let women have a try. I personally have not had anybody requesting anything that I wouldn't have felt happy with.*

One of the Albany midwives replied when asked what was the difference between the Albany practice and others:

Albany Midwife *I Looked at Jan/Dec statistics this morning. We have a much higher home birth rate, less use of analgesia, fewer caesareans and instrumental births, higher breastfeeding rates. Something is working. We are pro-informed choice to 'normalise' birth to make it a social event not a medical crisis. Continuity of carer has an impact on getting stats like that.*

4.2 What are the key activities and pattern of care provided by the Albany Practice?

The next section discusses the process of care provided by the Albany Practice. These were providing continuity of caregiver, targeting care to women most in need and providing informed choice.

4.2.1 Providing continuity of caregiver

Providing continuity of carer is at the heart of the philosophy of Albany Practice and is a key distinctive feature from other midwifery group practices. Continuity of carer in the Albany is defined 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. Specifically, by a primary midwife who provides the majority of care throughout pregnancy, birth and the postnatal period backed up by a second midwife where appropriate. The distinction between *continuity of carer* which facilitates the opportunity for a woman to develop a relationship of trust with one or two midwives and *continuity of care*, where a woman may see one of six midwives throughout her childbearing experience has not been made clear in the literature (Green et al 2000). As a result, the relationship between continuity of carer and short and long term childbirth outcomes have yet to be fully explored in research.

The Albany achieve a very high level of continuity of carer and ascribe many of their positive childbirth outcomes to the provision of continuity of carer. The high proportion of women who were delivered by their primary midwife indicates that the Albany was successful in achieving one of its aims. For example, in 1999, 89% of women were attended during childbirth by their primary midwife and 98% were delivered by their primary midwife or another Albany midwife. This is a very high level of continuity, compared to other models of care. There is very little other comparable published data, but in the one-to-one Practice at Queen Charlotte's Hospital 77% of women were delivered by their primary midwife and 88% attended by their primary midwife or another midwife in the practice (Green et al 1998). Within the other group practices, this ranged from 41% of women having a practice midwife present to 90%. The importance of providing continuity of carer for women who have childbirth complications was shown after the following incident.

Albany midwife	*I did [care for] a woman with an elective section, which was a disaster because the baby died after about 30 hours so that was awful.*
Interviewer	***Do you feel in a good position to support people through that?*** *Yes, that has made so much difference. The family and you know [each other] being involved antenatally and because she had this hovering over her pregnancy really, the possibility of a caesarean and you know supporting her afterwards yes, I think it has really helped.*
Interviewer	***I don't want to dwell on stories of things going wrong.... when it does go wrong can there can be benefits and possibly problems [with your model of care]***
Albany midwife	*No, it wasn't a problem for me. No, and I think we really supported her and I was very clear about her setting her boundaries about whether she wanted me to go to the funeral and things like that; there were no assumptions on my part to be involved in anything. But she wanted me to, which was really nice, and postnatally apart from the normal obstetric kind of checking and all that sort of stuff it has very much up to her, how much contact she wanted really.*

Another Albany midwife felt that they were able to provide more realistic levels of woman centred care because of the level of continuity achieved. The midwives visit women when the women want, where the women want and how often the women want. However, the comparative survey data shows that the Albany women have about the same number of visits as other women in the Trust. Overall, this works well for women and midwives.

Albany midwife	*The midwife, who they are building up the relationship with, will feel that whatever they choose is important. For example, if a woman is forty-one weeks and wants to be induced, if she was going through the hospital system, she would be booked for an*

induction and be told come in on this day and have your baby. If she has a midwife who is going to be with her through that induction the midwife will say to her 'this is what an induction is, and this is what your choices are. This is the way that an induction could happen and these are also your choices' and she will not be treated like the proverbial sausage that goes through the factory. I think it is a real benefit that she has someone who will know what will happen to her if X happens.

4.2.2 Targeting midwifery care to those most in need.

Some of the doctors and midwives were critical of the Albany Practice because they perceived it as providing a service for caucasian, middle class women. Interviews with hospital managers, the Albany midwives and Lister Health Centre health professionals suggests that this view was mistaken. Furthermore, the data from EuroKing, shows that the Albany did not have a wholly caucasian, middle class caseload and indeed were working in one of the two most deprived localities served by the Trust.

The Albany was set up to care for women registered with a group of GPs in Peckham in SE London. The area has a high proportion of poor quality housing, and inner city deprivation. The Jarman Index of deprivation for postcodes (SE1,SE15) covered by Albany is 64.31. This is the highest score for a practice in the Trust apart from Commercial Way Practice. (The higher the score, the higher the level of deprivation). The range within the Trust is from 16.55 (SE19, SE21, SE27) - 64.31 (SE1, SE5, SE15, SE17). Most Albany women came from the Lister Health Centre's catchment areas of Peckham, Camberwell and New Cross. Only 12% of Albany women came from outer (suburban) Southwark compared with 34% in other practices and 28% across King's.

Fewer Albany women were caucasian (42%) than throughout King's (46%) or in other midwifery practices (43%). Albany had a higher proportion of African women and other black women (45%) than throughout King's (42%) or in other midwifery practices (40%) and there was a significant minority of Asian women with the Albany which were not found elsewhere (9%). Although some caucasian middle class women did seek out the Albany Practice, the majority of Albany women live in the area or are registered with the doctors for language and cultural reasons (eg one GP is Vietnamese). Initially some women either registered briefly with the GPs or applied directly to the midwives for any vacancies in their caseload. However, over time opportunities for women choosing to join the Albany caseload have become fewer, especially with the inclusion of other local GPs.

Although Albany transferred a minority of women to one of the three special midwifery group practices caring for women with mental health needs, who were HIV positive or young unsupported mothers, they worked with the caseload of their GPs in Peckham. The maternity services manager also confirmed that Albany were specifically given a caseload attached to a deprived area of Peckham and attached to a group of GPs who did not have a midwife working with them at the time'.

Manager *Now that all the practices look after a defined caseload of women. Three groups have caseload defined by social or medical need. Others [including the Albany] link in with a GP caseload. We've gone for GP link simply to help define boundaries. Not a particularly good way, but it is a way. It avoids women choosing it. We tried for high deprivation areas, but in reality [the practices are] peppered around.*

The Albany midwives confirmed that they wanted to work in a way that improved local community access to good maternity care.

Albany midwife — *There has been a gradual increase in home birth rates. Not as high as in Deptford. It has increased since we have been in Peckham. It is a very mixed population, reflective of King's as a whole. Multicultural, and a huge variety of accommodation. There is a growing awareness in the community that it might be a possibility (to have a home birth). An unusually high level of women are not using pharmacological pain relief in labour. We haven't asked women how they feel about this. Our perception is that this reflects how they are prepared for, and supported in labour.*

4.2.3 Providing informed choice

The benefits of continuity are better communication, growing knowledge and understanding of a woman and her needs and empowerment of women (Freeman et al 2001). But not all women wanted to be empowered and the Albany midwives had a variety of views on this issue.

The model encourages midwifery care at home and natural childbirth including low use of pain relief drugs and breastfeeding. These aspects were wanted by some of the women who actively sought out the Albany Practice. However, other women's views varied about these issues. Women in some ethnic groups (eg Vietnamese) preferred hospital births and a longer stay in hospital, due to poor support at home. The Vietnamese women did suggest in a focus group that they felt they had been sent home from hospital before they wished, and before help was available. There were women who also wanted an epidural, elective caesarean etc.

One Albany midwife told a story of helping a woman to get an elective caesarean section, and reflecting on the issue of how far does one go to facilitate choice. Yet, medical staff were still concerned that Albany midwives were expressing their own choices and not the women's, particularly when women were less articulate. One midwife talked about 'choice' possibly going too far and what it meant to the women in their caseload.

Albany midwife — *Sometimes we all want to be told what to do. For some women it's the first time they meet with choice. We have to balance between professional, 'we know best', but encouraging people to make their own choice. For example, choosing a caesarean. Does that come from informed choice?. Or has choice gone too far? We had a woman who needed loads of control. She couldn't cope with the idea of being out of control. She was in such a state, we went to the consultant and she had elective caesarean. So, we give choices we don't really agree with. Choice is difficult. Is it right to choose what's not good for you? Now we have got lost in this maze of choice. Loads of women don't have choice. For those who do, it is difficult to balance. Something I'm thinking about the moment. Choice isn't the be all and end all. Fantastic to have choice for women who have thought about what they want. It's a big thing to be empowered. For others it can be an eye opener and really positive. Lots of other women only slowly realise they have choice.*

Some junior hospital staff found that Albany women were more difficult and challenging to medical staff. This perception may be the effect of informed choice being offered and exercised by women in childbirth. The Albany midwives explained that their aim is to give the same care to all their clients. One midwife said that Albany were still thought to be providing care for middle class clientele because they had a history of working independently and had a high home birth rate. All the midwives agreed that there were significant benefits for women in the way they work. Albany midwives felt that continuity and informed choice were important for women, important to the development of the woman herself and important that a 'good' birth

experience helps people on the road to good parenting. The Albany approach required women to take responsibility for decision making. Some women didn't embrace this opportunity and it was sometimes hard work for the women, and not easy for the midwives. The Albany midwives described how they developed a strategy for women who 'don't mind' and provided a service to women similar to what is 'common' within King's.

All the Albany midwives commented that some women were not used to being offered choice and treated as equals. Some women did not treat the service well and, to a degree, abused the midwives' good will and did not understand the '*give and take'* of a relationship which had evolved for independent midwives who were looking after women who chose not use standard care. Some Albany midwives particularly emphasised that some of the women did not appear to take into account the needs of the midwife. There were stories of appointments not being kept bby women, including on a Sunday evening and some members of the Practice may have been able to negotiate this issue, but others had more difficulty.

4.3 Organising the work in a self-employed Group Practice

Some of the midwives had had experience of working independently and working in a self managed practice, whilst others had not. When the Albany midwives were asked to reflect on the essential organisational characteristics for their model to work successfully, they cited the following criteria. Several of these issues will be discussed in the following sections.

- A non-medicalised community based office
- A practice manager
- Self –employment
- Choosing who joins the practice
- 24 hour, 7 days a week on-call
- Long holidays

4.3.1 Self-employment

Self-employment was insisted upon by the Albany midwives when they negotiated their contract with the Trust in 1997. But, being self-employed was seen as more important to some Albany midwives than others. The Albany midwives 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. For example, 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 a particularly important aspect for the midwives who left the group in 2000. Since 1997, the contract that the Albany Practice received remained the same amount as annual pay rises were being received by midwives working in the Trust. The midwives who have since left, have said they were both financially better off on a monthly basis since leaving, even without taking into account sick pay and pension contributions, which they are now entitled to as employed midwives. However, most of those who are still within Albany feel that taking all issues into account, they are better off as self-employed.

Many staff within the Trust held misconceptions about the Practice that may have contributed to difficulties in inter-professional relationships and joint working. They were known to have a different contract and this caused resentment with some of the health visitors, although it was unclear why this should be. The Albany Practice were known as *'the independent midwives'* by

some respondents interviewed. This was partly because due to a misconception about their self-employed status. The Albany midwives were perceived as midwives who had worked independently in the past, however, only two midwives had worked independently. None of the Albany midwives would prefer to work independently, largely because they welcomed the opportunity to offer care to a wide cross section of the population.

From the Trust side, organising the contract has been time consuming, and with some theoretical risk for Kings. Statutory supervision is provided by the Trust, which, according to all managers, the group uses well, and the group may consult on clinical issues from the consultant to whom they are attached. However, some Trust midwives and managers found difficulty understanding what systems were in place in the Practice to ensure high quality care, and expressed concerns that the Trust would be legally accountable for a group of Self-employed midwives. However, this has been balanced by some management costs for Albany being reduced. This has been problematic for Albany, as costs have risen over the last 3 years, yet the contract has remained static. In addition, pay rises received by midwives working for the Trust , made parity of pay less equitable. In 2000, the contract has been re-negotiated for 3 years at a new rate (see Appendix).

4.3.2 Providing continuity of carer

Continuity of carer is seen as the key process necessary to achieve the aims of the Practice, but the provision of continuity of care involves being on-call 24 hours a day, seven days a week. Albany midwives argue that flexible woman centred care and supporting normality cannot be provided without knowing a woman and establishing a relationship of trust. This requires a commitment to continuity of carer and to be present for the birth, and necessitates 24-hour-on-call. The midwives argue that this way of working works because midwives are autonomous and flexible, and they are able to control their caseload size and working pattern. This is also the working pattern for some midwives working in a similar model of care in Ontario (Bourgeault 2000) and New Zealand (Guilliland and Pairman 1995) and ongoing evaluations of working patterns in both countries will be welcomed (Guilliland 1999).

Caseload midwifery, 24-hour-on-call, and self-employment were not new to four of the seven midwives, and three had worked together in the South London Midwifery Group Practice out of the Albany Centre in Deptford. In their interviews, Albany midwives described their working day. The allocation of women to a named first and second midwife was arranged around the midwives holidays. The practice manager matched the holiday rota and allocation of women, and the midwives negotiated between themselves when to take their holidays. The Albany midwives have three months holiday a year that they can take in any size block. Although they sometimes take several weeks leave at a time this is not obligatory. Since 1997, there has been a trend to hand over pagers for weekends to shorter working periods with more frequent holidays. However, these arrangements vary and have been very flexible. The only ‘given’ is that there are always enough midwives at work to cover the caseload. The Albany midwives carry pagers at all times so that they can respond to the women. They have one fixed clinic session a week and appointments with women for antenatal and postnatal checks, can be individually cancelled if the midwife is attending a birth. For example, one midwife described how she organized her work.

Albany Midwife	*I tend to try to be very busy on a Monday, and I will try and make myself some busy days. Usually Monday, Wednesday and bit of Friday I will aim on doing some work. Tuesday is usually quite quiet and I try to do birth talks and bookings on that day and Thursday I try and have off so I usually work 2.5 and 3.5 days a week, out doing visits.*

Birth talks are where we go to a woman's house when she is four weeks before having the baby and talk to her, and her partner and whoever else is going to be with her, and talk about her expectations for the birth and how to cope, and when to cope and that takes about an hour at least. That is on average one per week and I will try to fit in social things around that really.

She described how most of her planned activities are within Monday to Friday, 9 to 5. Other midwives organised their week differently. Four of the midwives had children, aged between 5 and 23 and had used a variety of childcare support. All members of the practice lived locally which enabled easier integration of on-call into their private lives.

However, many midwives nationally have questioned the sustainability of team and caseload midwifery, and some of the problems that have been identified are that (see Green et al 1998 and Green at al 2000 for a review).

- This way of working is over demanding on the midwife and may lead to burn-out
- There is no advantage in working this way, as continuity of care can be achieved with a shift system
- New systems of care have been poorly managed and exploitative
- The working pattern is not suitable for midwives with family and caring commitments

The midwives had been working in this way since 1997, with no turnover until 1999, the ability to recruit replacement midwives indicates that this way of working is appropriate for some midwives. However, in 1999, during the period of the evaluation, 3 midwives left the practice, and the main reason for leaving Albany given by two of the three midwives who were with the group from April 1997 was the 24-hour-on-call commitment.

The following Albany midwife saw on-call working as essential to the philosophy of continuity of carer and reflected that on-call was not always easy and without costs, but considered that shift work or working fixed hours was less fulfilling and carried different stresses.

Albany Midwife — *On call all the time is a cost. [The] impact of on call is fascinating. I've worked with it for a long time. My views change. I feel different now than a long time ago. A long process of coming to terms with it. When I first went independent, there were times when it was stressful for me and my partner. [There] were more tensions. My partner is used to it. The children are older. By and large it is not a source of stress anymore. Now and then, I wish I wasn't on call. [But] what kind of job would I be doing if I wasn't working this kind of way? No contest really.*

Another Albany midwife found 24-hour on-call more midwife/family friendly than working shifts on a labour ward. She said she saw more of her children and family working in this way; not less. But, she agreed that having good childcare support had helped.

Albany midwife — *I like going to work. It works for me. But doesn't work for everyone. When I trained it was dreadful. When I trained, one of my children was changing from nursery. Hardly ever saw them. You would have to be on labour ward at 7.30 even if no one was there. There is so much more flexibility with the way we work. Because we only look after a controlled amount of women. Only 8 births a month. For me it works.*

Another midwife saw continuity as the most important aspect of the service and accepted that this is achieved through 24 hour-on-call working. For example:

Interviewer	***How is continuity achieved?***
Albany midwife	*As much as possible being available for the woman when she needs you. I carry [my] pager all the time, 7 days, 24 hours.*
Interviewer	***Is living with the pager as you expected?***
Albany midwife	*It's actually- I don't notice the pager. On Community, I used to be on call twice a week. And I used to be really manic and try and do everything. And you don't know who you might be called out to, and where you are going to go. On call all time, I thought I might be stressed. I thought it might curtail my freedom. But I don't- I do what I want to do and my bleep comes with me and I get a bleep and it's a treat, and I say 'hurray'. I thought it would be stressful with a pager every night but it isn't.*
Interviewer	***What a lot of midwives don't want is the being on call all the time. What is it that makes it being OK? Different from other on call?***
Albany midwife	*Yeah, on call for your own women who you know. You know who is likely to come up, you know them, you know where they live, you know what's going on and that's not stressful.*
Interviewer	***Do you feel there is only so far you can travel away from Peckham?***
Albany midwife	*I do feel that now, but as time goes by I will get more confidence to go further. I just feel that nothing is going on at the moment, or something is happening so I want to be in the area. I wouldn't drive out of London for a couple of hours. I might not be able to get back quickly. On call, what I like, I don't like the distinction between life and job. This is a way of life. I like the unpredictability. Keeps you fresh and on your toes.*

It appears that for some midwives, this way of working suits their lifestyles, and for others it cannot be sustained. There is very little published research linking continuity of carer to positive childbirth outcomes, partly because of the problems in defining continuity of care, and what it means to 'know' a midwife (Green et al 2000). The Albany midwives felt that the high levels of continuity of carer they provided were strongly related to positive childbirth outcomes, although other confounding factors were acknowledged to be important such as skill, attitude and the experience of the midwives.

4.4 Have social, political and financial circumstances affected the intended activities of the Albany Practice?

One requirement for a self-managing group practice to be sustainable is that it covers staff sickness and staff turnover. Three midwives who were founding members of the Albany Practice in 1997 but had not been part of SLMGP all left in the summer of 2000 for differing reasons. They had joined the Albany Practice with high expectations, and were disillusioned that *'the perfect job was not perfect'*. In spite of increasing the occasions when they handed their pagers over at weekends and trying to negotiate less 24 hr call, they felt that after 3 years, 24 hour-on-call was a great burden, and that they could not work in this way, long term. For example, one midwife found that being called out during her child's birthday a real low point.

Interviewer	***Can you tell me why you are leaving?***
Albany midwife	*Yes I don't want to be on call 24 hours a day 7 days a week if I am not on holiday. I find it very very restricting on my life.*
Interviewer	***Was that a surprise to you? Was it more of a strain than you thought it was going to be?***
Albany midwife	*I suppose it must of been because otherwise I wouldn't have taken the job in the first place.*

Interviewer ***Unless you thought: well I would like to do this for three years...***

Albany midwife *Yes, I suppose I thought it must be worth a try to see how it feels. I mean I lived with my partner and he is sometimes on call so I was aware of what being on call could mean, and I knew it would be restrictive. But I think that I had been surprised at the difficulties more on the number of levels really about saying you want to go off and you always feel that people will disapprove of that so if you want to go out and if you just want to go out to the pub with your friends. That is not really... and it doesn't seem to be as good as saying well you want to go to the theatre, somehow.*

Another midwife who left said that her new practice had good continuity, despite less on-call.

Albany midwife *I am on call 14 out of 28 days. I work with a partner and we take it in turns to do 14 days on call, 6 days, 9-5 and 8 days off. We can work it out between us. Our statistics for first year is 84% of women are seen by one of their two midwives. In three months I've been to 6 births. Five, I knew the women, one I didn't know her but she knew the other midwife. There are two women at each birth, one is known, the other possibly not. That was about the same at Albany. I am happy with the continuity where I am.*

Another Albany midwife had also resigned by the time she was first interviewed and a bad experience of 24 hour working was described as the cause of her resignation.

Interviewer ***Do you get to sit down and have a meal with your partner most evenings?***

Albany midwife *Yes, the vast majority.*

Interviewer ***What it is like working on call all the time?***

Albany midwife *The way that on call works usually is that it is unusual for me to be working for eight weeks and have those eight weeks solidly busy stretched. Now that has happened and that is when the decision to leave was made really and that happened September, October and November last year. I had a massively awful awful time where my partner and I saw each other once a week and it was just hellish, and I was incredibly busy all the time.*

Interviewer ***How did that happen? Were most of your women unwell?***

Albany midwife *It happened because I took on some extra women and various midwives went on holiday and I took them on. It also happened because I was back for seven weeks, but ended up having more women during the seven weeks then would normally happened for various reasons really but it happened.*

Interviewer ***So you were more involved in your days.***

Albany midwife *And it is hellish when that happens because you are running to keep up. Everything else goes, I mean you can see what the house is like and we were trying to do it up and we moved into an absolute hell-hole. And trying to do that as well as kind of giving energy to work. Everything else has to go when work needs the energy and you can do nothing and you can literally try and eat, drink and sleep, and if I can I will do the shopping but sometimes life just has to go by the wayside. Other times work is incredibly accommodating and no one bleeps you and you end up doing loads of things that you keep thinking "I am going to have to cancel I am sure I am going to have to cancel something at some point" and keep not having to, it is complete pot luck.*

At her exit interview conducted by phone, another midwife was asked why she left.

Interviewer ***Why did you leave Albany?***

Albany midwife *A variety of reasons. Mainly to stop doing 24 hr on call. I wanted to stop that intense way of working and have more space for myself, my friends and family. It was time to leave the group and I wanted a change. I had been there over 3 years. It was a good experience and I learnt a lot, but it was time for a change.*

Interviewer ***What are you doing now?***

Albany midwife *I'm doing the opposite of what I was doing. I'm working on wards. Doing shifts. I'm working in different hospitals. I'm enjoying the control of my life. It is a relief not to have the pressure. I won't do Albany style on call again.*

4.5 Views of health professionals on inter-professional working

A purposive sample of health professionals ranging in age and years of experience were interviewed and a wide range of views were expressed by medical and midwifery staff. Some staff said the Albany Practice were the same as any other midwifery practice, others that special procedures for communication with medical staff had been set up. Nevertheless, working relations with Albany did have subtle differences, because of their self-employed status, and because they had a reputation as being assertive and as outspoken advocates on behalf of their women. Over time, inter-professional communication had improved and most staff had a better understanding of how they worked and trusted their judgment.

4.5.1 Health professionals understanding of the aims and working arrangements of the Albany Practice

The majority, but not all of other health professionals in the Trust had a good understanding of the aims of the Albany Practice. However, there were differing views among other health professionals on what the key objectives were felt to be. Some health professionals expected that women cared for by the Albany would have fewer childbirth interventions, specifically caesarean sections and epidurals and more home births. However, the Albany midwives felt that it was 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. The medical staff varied in their views, depending on seniority. The majority of senior medical staff saw the group as a positive influence, but junior staff were more ambivalent and reported difficulties in dealing with women who had been encouraged to question health professionals about their care. The majority of midwives saw the Albany Practice as a good role model in the Trust, whose practice contributed to the high home birth rates in the Trust. For example, one hospital midwife noted the impact on the hospital midwifery workload when the intervention rates were lower and felt that the role of the Albany Practice in supporting 'normality' in childbirth contributed to good childbirth outcome statistics for the Trust as a whole.

Hospital midwife *You have a significant number of women who are going to have normal deliveries. We don't have to allocate more staff to look after those women cared for by Albany and that contributes to our figures at the end of the year.*

In summary, most Trust staff thought they had achieved what they set out to achieve. They saw the aims of the practice to be woman centred, advocating normal birth, and providing continuity of carer. However, some Trust staff saw the Practice as 'self-promoting' rather than advocating on behalf of women.

On the whole, medical staff were not aware of the specific working arrangements of Albany and many misconceptions expressed. For example, one of the paediatricians thought that the Albany midwives were visiting women at hospital in their own time.

Paediatrician *[*Albany*] midwives seem able to spend more time postnatally and more time supporting women in hospital afterwards. I don't see that amount of time from other*

midwives. [I'm] left with the conclusion that they have a smaller caseload or are doing this in their spare time. Very laudable. But I don't know if its practicable.

Midwives who worked for the Trust, thought that 24-hour-on-call required more dedication than they were prepared to offer. Some had worked 24-hour-on-call themselves and they raised several issues.

- Albany midwives were better than most group practices at attending their women in hospital.
- 24 hour-on-call was not liked by most midwives, but there were indications that they knew of others who did like 24 hour-on-call.
- They saw no benefit of working 24 hour-on-call.
- Concerns were expressed that the Albany working pattern may lead to working longer hours than were considered legal or safe.

Other practice and community midwives felt that complete continuity of care requiring 24 hour-on-call was not necessary. They felt that women's needs were met by seeing the same midwife before and after the birth and that who attended the birth was not important to women. Misconceptions about how the group worked were also expressed by other midwives. For example, one midwife suggested that Albany midwives were able to do 24-hour-on-call because they looked after each other's children (in reality the Albany midwives did not rely on fellow midwives for childcare). This midwife perceived that the Albany were a close knit group who provided professional support to each other and sadly felt she lacked similar support in her own work and at home for childcare commitments.

As one would expect a range of views were expressed about the importance of continuity of carer. All staff who were interviewed recognized the high level of continuity of carer and personal care that Albany provided. Some midwives also saw the Albany working pattern as safer for women and midwives as it would allow two midwives to go to a home birth, and that the midwives would know the house and the family. Whereas other community midwives often visited a strange house alone to assess whether a woman is in early labour.

Recommendation: There must be a need to review working practices of all community midwives with regard to personal safety.

Other midwifery and medical staff were concerned that poor outcomes may occur due to tiredness in any health professionals and that this may be more of an issue with the Albany midwives due to their working pattern. The Albany midwives themselves were aware that if they went for a long time without a break they became stressed. The midwives managed this issue by calling in their second midwife who took over much of the work. For example:

Albany midwife *I had been up [all night] and by 10 o'clock that morning ... I was definitely thinking ....so I had been there for eight hours that night and I was beginning to think 'I am going to get somebody else in. I have had enough' and then she [woman] said to me "I want to push" and so obviously I stayed and then by the time we got her sorted out you know I got home about 2 o'clock.*

Interviewer ***And did you feel safe?***

Albany midwife *I felt safe. Well, we always have two midwives at the birth, so that was fine and the midwife that was with me hadn't been up as long, and in fact I just had another baby with her within half an hour of each other, and no it was fine and I think for all of us that*

is the bottom line. You know even if it gets to four or five in the morning and it has been a difficult night, I mean, I have certainly been called at five o'clock and [midwife] saying 'I don't feel happy, I am tired and I don't feel well, and I don't feel safe, and I know you haven't had a full night sleep. But actually I need you.

To summarise, the issues of 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. It was acknowledged by all staff interviewed that continuity of carer was 'a good thing', with the result that the Albany midwives were seen as one of the most reliable midwifery practices for attending their births and that two midwives usually attended all births whether at home or in hospital. Concerns about Albany midwives making mistakes because of tiredness do not seem well founded.

Recommendation: It should be noted that the Albany midwives were more able to devote time to providing midwifery care because of the administrative support provided by the practice manager. As more midwives move out into midwifery group practices in the community, this level of support to the Albany Practice should be recognized.

4.5.2 Views of hospital midwives

Some hospital midwives declined to be interviewed, and those who did agree to be interviewed said that they thought they were more positive about Albany than their colleagues. A range of midwives from labour ward, antenatal ward and clinic, postnatal ward were interviewed. Most hospital midwives saw the aims of the Albany Practice as offering woman centred care, focusing on home birth and natural birth. Overall, they were seen to integrate well and attend training sessions and their contribution to guideline development had been recognised. Initially, relations with hospital midwives were 'them and us', but over time, the views of this group of midwives has changed with a greater understanding of their working pattern and closer collaboration in particular cases. The majority saw the benefits of continuity of care both for women and midwives and some gave examples of how caseloads could be run by midwives working within a hospital system for women with complications.

Hospital midwives were keen to point out that Albany was not the only initiative. For example the 'STEP' evidence-based practice breastfeeding project was running, and other midwifery practices specialized in care of particular client groups existed. King's College Hospital NHS Trust was seen to provide a wide range of services for women who had some degree of choice. There was a sense of frustration by some midwives that Albany were not higher profile as 'advocates for natural midwifery', but with a recognition that this also breeds resentment in other midwives.

On the whole, the majority of hospital midwives said they had little contact with the Albany midwives. For most hospital midwives this was seen as a result of the high quality of care they gave. The hospital midwifery staff praised the Albany midwives for the commitment to their women and for attending their women in hospital. In all areas of the hospital, antenatal clinic, scanning, labour ward and the post natal wards, the Albany midwives were known as the most reliable practice. Albany midwives had a reputation for attending their births promptly and their

women rarely needed extra help, for example with breastfeeding. Their communication systems were said to be better, and would bleep or call, and give information to hospital staff more often than other practices. Hospital midwives found that having a named midwife contact easy, and the practice manager also eased good communication. It was noted that they often called their women when they were on the ward – (phones by each bed).

The hospital midwives saw benefits for the women and felt that continuity and choice was available and valuable. However, they were concerned about equity of service provision. When asked if Albany met the needs of women, one midwife said *'For the chosen few, I think they work in a lovely way. But too few. Why shouldn't Mrs A or Mrs B get it. ... their case load is a tiny proportion of women we deliver. '* Albany were seen to have a good track record in encouraging breastfeeding. The postnatal staff were concerned that all the midwifery practices were focused on the birth only, and that postnatal ward staff had to look after practice women more than they should, but that Albany were better than most at attending their women in the post natal ward.

On the other hand, the Albany midwives were viewed as different, and of having different aims from other midwives in the Trust. Hospital midwives saw themselves as team players, working with doctors (unlike Albany), with their own specialist interests. Some hospital midwives saw Albany midwives as 'radical midwives' who took risks, and a number of midwives repeated stories of problems that had happened at home births. Some stated that Albany were 'rigidly natural birth' that sometimes went over the top.' Some saw the midwives serving own needs and not women's and were seen as 'bossy', although the questionnaire did not show them as significantly more 'bossy' than other midwives.

Hospital midwives felt that the Albany Practice was good for the Trust because they didn't need to allocate more staff to deal with breastfeeding problems and less medical input was needed for Albany women. This was seen as a cost saving, and that the Trust got 7 skilled and experienced midwives fairly cheaply. On the other hand other midwives perceived that the Albany was more expensive, due to the practice of 2 midwives usually attending a birth. There was an overall anxiety that staffing the midwifery practices would deplete core staffing too much.

In summary, compared with other midwifery practices, the Albany midwives had a good track record of attending their women in hospital, of having an excellent track record with breastfeeding and of communicating effectively with hospital midwives.

4.5.3 Views of Community and Group Practice Midwives

Most community midwives saw that the aims of continuity of care, women centred care, and normal birth had been achieved and that the service provided was excellent. The process of how the Albany midwives supported physiological birth and specifically home births was frequently mentioned in the interviews. For example, one community midwife said that Albany don't press women to avoid interventions.

Community Midwife	*Albany women have the same choices as other women about the birth. ...Choice is very important. Real choice, not just the women being presented with a red dress and a blue dress when they know there is a green dress. Women are not gullible and they know when they are being given false choices.*

But most midwives saw such success as too great a cost to the midwife. Community midwives referred to family commitments, particularly their children, for not wanting to be on call all the time. They were also concerned about not being able to drink alcohol. Some midwives in Oakwood cited how supportive the Albany midwives had been in setting up their own practice, and how the Trust's reputation was enhanced by the provision of innovative midwifery care.

Group Practice Midwife

The service Albany provide may be the best – but at what cost to the midwives of on call? Only recently has there been some turnover, but the Albany midwives always look really well. ..... The Oakwood practice was set up by the midwives as a group who wanted to work together. They looked at the Albany model but preferred the model of a group of midwives in Leicester. They don't do 24 hour-on-call and they don't see self-employed as essential. The existence of the Albany made it conceivable that this group of midwives could approach our Manager. Without the Albany they probably wouldn't have approached her.

Misunderstandings about the nature of the contract were expressed by some of these. Some felt that the Albany midwives were financially better off in a self-employed practice, and still viewed the group as independent midwives and alternative/'hippy'. For example, comments were made about Albany midwives 'helping themselves' to equipment in the hospital, demonstrating a lack of understanding of the contractual arrangements between the Trust and the Albany Practice.

Some midwives felt that the Albany model should be expanded, however, one very experienced midwife was concerned about replacement midwives in the Albany Practice being very young and inexperienced to do home births. Other midwives were happy with the way they themselves worked and feared that the Albany model would be imposed on them.

4.5.4 Views of Senior Paediatric and Obstetric staff

Generally, the consultants were well informed about the Albany contract and working pattern, and commented that they usually only saw Albany women when there was a problem which they acknowledged gave a distorted view. Generally, there was much support for the continuity of carer model and targeting women in need, but less support for self-employed status.

One consultant knew and praised Albany for aiming to give an important service and informed choice to '*a population not associated with informed choice .... not middle class women*'.. . One paediatrician commented on the high level of support given by Albany to parents. Another was positive about the benefits for families, reflecting on the dehumanising effect of lack of continuity during birth. *'There is a huge benefit of continuity of care, it's horrible having people flitting in and out, but it needs to be safe. Balance against a normal baby, satisfactory delivery. Without any doubt continuity of care is very, very valuable'*. There was an acknowledgement that the Albany Practice were able to spend more time with women before and after birth, and successfully achieving continuity, personalised care and natural childbirth. However, another consultant felt that the downside was that the Albany Practice were '*giving a Rolls Royce service'* that was inequitable if only a few women in the Trust could benefit.

The self-employed status was seen as a potential disadvantage for the Trust with comparisons being made to self-employed builders who may take their contract elsewhere. There was a concern expressed by one consultant that the self-employed status gave the Albany midwives

more leeway than other midwives in the Trust around following guidelines. Examples were given where protocols were not always adhered to, and how discussions with Albany midwives about problems in front of parents had not been helpful. Because of several recent events, there was a wish for more paediatric involvement in the training of all midwives in the management and recognition of the unwell baby.

Recommendation: Clear communication of the organization, aims, objectives and achievements of the Albany Practice should be communicated to all Trust staff. Greater communication and a regular forum for discussion and planning between all midwives and Obstetric and Paediatric staff prior to emergency situation may improve inter-professional working in this area.

Generally, senior medical staff saw that the Trust benefited from a group of confident enthusiastic midwives who were competent to do home deliveries safely and without anxiety. It was also seen to be better to have well informed women, who have been well cared for. There was a view that consultants had more influence than midwives in deciding what choices were available to women. However, some consultants saw a key role of the Albany Practice as *'shifting goalposts'* such as allowing VBAC at home. There was a general view from consultant staff that junior medical staff often did not acknowledge midwifery experience, which was contributing factor in inter-professional conflict and expressed regret at an opportunity missed, where experienced Albany midwives who could be involved in the training of junior doctors were not.

Recommendation: Explore how to increase multi-disciplinary training opportunities, both formal and informal.

4.5.5 Views of Junior Medical Staff

Many of this group of junior medical staff were negative about their experience of working with the Albany Midwives, who were seen as pushing natural childbirth regardless of women's interests. The Albany midwives were defined as 'independent' private practitioners providing a model of care designed for middle class women, inappropriately applied to a less articulate group.

Some of the junior staff also seemed to be repeating the above views, rather than basing them on their own experience. Staff recognized the benefit of continuity, but saw a downside of poor advice and the coercion of women. Junior staff found Albany women challenging and *'difficult to manage when they're in labour'* and were more anxious going into an Albany birth because *'they don't like doctors interfering*.' Junior staff cited examples where midwives formed a barrier between doctor and patient and don't treat (junior) doctors with respect. Generally, junior staff would like to see Albany split up and would not like to see such a service rolled out, citing the inequity of an agency midwife caring for 2-3 women in labour whilst 2 Albany midwives attend one woman in the next room.

The Albany midwives were sometimes seen as arrogant, which was underpinned by their different employment status. The senior and junior doctors focused on the outspokenness of the Albany midwives in their interviews and they were seen as feisty and independent in their spirit. Concerns were expressed by some medical staff that they were pushing at the boundaries of 'normal' midwifery practice.

Many interviews with medical staff included references to their unhappiness about disagreements with Albany midwives in front of women. Medical staff reported that Albany midwives referred to a consultant rather than more junior staff in an effort to avoid professional conflict. However, the Albany midwives see themselves as making an effort to fit in, for example, of contributing to the development of guidelines and audit in the Trust. There are clear problematic inter-professional relationships between Albany and junior medical staff. Such poor relationships arise from a lack of understanding of the organisation and role and responsibilities of Albany (and other) midwives, and frustration on the part of Albany midwives who need to consult with expert advisors, when complications arise. Some consultant staff in Paediatrics and Obstetrics also expressed concern about the arrogant behaviour of some junior medical staff, and that the impact of a reduction in junior doctor's hours and changes in training had resulted in junior staff having less expertise and experience. It is unclear whether such friction also occurs with other midwifery staff or is the result of experienced autonomous Albany midwives challenging inexperienced junior staff. Such problems can not enhance efficient communication needed in emergency situations and pose a risk to women and their babies.

Recommendations: Joint multidisciplinary action by senior medical and midwifery staff to improve joint understanding and working.

4.5.6 Views of Managers

For the womens' services manager (CW), one of the aims of setting up a contract with Albany was to be a catalyst and a force for change, and to provide an example of woman centred care and midwife led care that was pro-home birth and had a philosophy of maximizing physiological birth. Furthermore, the aim of some of the group practices has been to target midwifery care to a deprived population group and to respond to government policy initiatives such as Changing Childbirth.

Devolved management has left practices to organise themselves, within a framework of defined standards of care in pregnancy, birth and the postnatal period. One obstacle to providing continuity of carer in labour is the midwifery commitment to cover fixed sessions at GP antenatal clinics. Albany have avoided this problem by flexible working, running smaller clinics and providing antenatal care at home. This makes it easier to reschedule visits if the midwife needs to attend a birth. A noticeable difference in how groups have organized is that midwives in practices who have come from hospitals working a 37.5 hour week and find it difficult to adjust to a more flexible working pattern.

The Self employed model was negotiated within the Trust by CW who had a forward looking and opportunistic strategy. The business manager reported that benchmarking and costing are different processes, and had had difficulty finding comparable costings. Rolling out more self-employed practices could be problematic due to the initial management time involved in contract initiation and negotiation. The benefit of self employment is that once a contract is set up, very little management time is needed. In the last year, internal sickness was covered, Albany managed relations with GPs, and the group used statutory and clinical supervision well and fully.

The management team saw continuity of carer as a key benefit for women, although the team were aware that there is still insufficient evidence as to which aspects are most important. The presence of Albany reflects well on the Trust externally, and is seen as a factor in recruitment

and staff development. The presence of Albany has focused minds on business costs, and evaluating the service as a whole. But, the impact on the Trust Directorate as a whole, has not been large. Some managerial difficulties have been around when they felt that guidelines have not been followed and other midwives have expressed a view that different rules apply to the Albany midwives. One reason why this occurred may be due to knowing the women so well, where it is easier to give individualised care, whereas guidelines are good for dealing with the average and unknown.

Recommendation: There were several misconceptions held among Trust staff around the roles and responsibilities of Albany, the nature of the contractual relationship, cost of care and supervisory arrangements. Internal presentations by the Albany along with written summaries on the Trust intranet could provide additional information for new and existing Trust staff. This may be better presented within information about the midwifery practices as a whole.

4.5.7 Views of GPs and Health Visitors

The GPs and health visitors were very pleased with the service that the Albany Midwives gave to their list. The GPs were sceptical at first and one GP interviewed still did not seem to be clear who, and how to refer to the Albany Practice. He sent women who would like a home birth to the Albany and he sent others to the hospital. The Albany Practice manager explained that she then had to ring the hospital and retrieve the referral forms of these other women causing delay in booking. The Albany Practice manager met regularly with the GPs, but there seemed to be a misunderstanding about her role and responsibilities on their part.

The GPs saw the Albany Midwives as possessing expertise in home birth and natural childbirth and were happy to refer their women who wanted a home birth, they had had no complaints from women on their list. They had had doubts early on about women being pushed into homebirths but no longer had concerns. One doctor continued to see women for antenatal appointments if they wished. Contact between the Albany Midwives and GPs has decreased since the move to Peckham Pulse. GPs have been pleased with the Albany, because it has lightened their workload and made the women on their lists happy. It may have also helped fill their lists, but this was not said. Dr Huyn was also pleased that the Vietnamese women have been happy with the service.

The health visitors were positive about the impact that Albany Practice had on women's experiences of childbirth. Breastfeeding rates were high, and women were happy. For example, one Health Visitor said *'that you could tell who had had an* Albany *midwife as soon as you entered her home because she was more relaxed, competent and happier'*. There was some friction between the role and responsibilities of Albany and Health visitors around the (non) involvement of health visitors in antenatal and postnatal groups, and some tension around the handover of women at 28 days.

4.5.8 Summary - Inter-professional working

The majority of senior medical staff saw the group as a positive influence, but junior staff were more ambivalent and reported difficulties in dealing with women who had been encouraged to question health professionals about their care. However it was unclear whether such friction also occurred with other midwifery staff. There was a general view from consultant staff that junior medical staff often did not acknowledge midwifery experience, which was a contributing

factor in inter-professional conflict. Such problems can not enhance communication needed to provide effective and efficient care and pose a risk to women and their babies.

Some health professionals did express concerns that the Albany midwives 'pushed the boundaries'. An examination of reported incidents in 1999 found that it was hard to elicit whether cases were over-represented from the Albany Practice because of their visibility and clear accountability compared to other practitioners. Although RCOG guidelines for incident reporting in obstetrics were in place, there seemed to be variation in reporting NCEs in the Trust, and it was impossible to draw any firm conclusions with small numbers of incidents.

Generally, there was much support for the continuity of carer model and targeting women in need, but less support for self-employed status. Health professionals reported that working relations with the Albany midwives had subtle differences because of their self-employed status, and because they had a reputation as being assertive and as outspoken advocates on behalf of their women. A minority of health professionals did not have a good understanding of the working arrangements and contractual status of the Albany Practice.

All staff recognized the high level of continuity of carer and personal care that Albany provided. In all areas of the hospital, Albany midwives were known as the most reliable practice, and the majority of midwives recognised that the Albany Practice contributed to the high home birth rates and had a good track record in encouraging breastfeeding. Relations with hospital midwives have improved with greater understanding of working patterns and closer collaboration in particular cases. Hospital midwives were keen to point out that Albany was not the only initiative within the Trust, which was seen to provide a wide range of services for women.

Most community midwives felt that the aims of continuity of care, women centred care, and normal birth had been achieved and that the service provided was excellent. The GPs also saw the Albany Midwives as possessing expertise in home birth and natural childbirth and were happy to refer their women who wanted a home birth. They were pleased that their workload had lightened and women on their lists were happy with their midwifery care. Health visitors were also positive about the impact that the Albany Practice had on women's experiences of childbirth and reported that breastfeeding rates were high and women happy with their care.

In sum, Albany were seen as confident able midwives who encouraged normal birth and breastfeeding, and due to a semi-detached relationship with the Trust were able to act as an advocate on women's behalf. This inevitably sometimes led to differences of professional judgment and opinion with other health professionals and some medical staff suggested that their own medical practice benefited by discussion of these issues.

In 1999, three midwives left the Albany practice for a variety of reasons. The working pattern in the Albany Practice may suit midwives better at different periods in their working lives. The key to success is devolving autonomy and accountability to the group practice to organise their own working pattern. It should be noted that the Albany midwives were more able to devote time to providing midwifery care because of the administrative support provided by the practice manager. As more midwives move out into midwifery group practices in the community, this level of support to the Albany Practice should be recognized.

4.6 Has there been an impact on service provision/philosophy in the Trust?

The general view was that the impact was seen as limited. '*It may have affected others but not me*' was a sentiment often expressed. There was said to be little impact at ward level. The major impact has been seen to be on the women receiving the service. The key benefits for women were seen to be continuity, resulting in a relationship of trust, and the importance of women not falling through gaps in the system. Albany were seen as confident able midwives who encouraged normal birth and breastfeeding, and due to a semi-detached relationship with the Trust were able to act as an advocate on their behalf. This inevitably sometimes led to differences of professional judgment and opinion with other health professionals and some medical staff suggested that their own medical practice benefited by discussion of these issues.

Their outcomes were seen to contribute beneficially to maternity outcome data at King's as a whole, but other strategies were also noted to have also achieved this eg the STEP project and the other midwifery group practices. The development of the practices has stimulated attention to guidelines for midwife led care, and some midwives suggested that presence of the Albany Practice facilitated the establishment of Oakwood practice as a self-managing practice.

The Albany midwives used to publicise their work widely would like to be sharing their philosophy but feel the benefits may be outweighed a detrimental effect on professional relationships in the Trust. There is evidence that new practice developments are often the recipients of hostility from other staff (McCourt and Page 1996). In discussion, there was a range of opinion within the Albany midwives themselves as to the way forward. The group are beginning to give presentations again and want to be influencing King's provision. They acknowledge that Oakwood was developed from their model, but with variations and that many midwives do not want to work 24 hrs on call, but feel people dismiss caseload working too quickly without trying it, or understanding the benefits.

One midwife felt that the Albany has had no influence at all in the Trust, although she acknowledged that amongst the students at King's College and in the wider world of midwifery politics the influence of Albany had been greater. The group suggested that that their occasional heated discussions with medical staff over an issue of clinical judgement helped them to reflect on their own decisions. They felt that that their views arose from being advocates for women, not for the Trust or medical science, and that it is for this reason, that self-employment was seen as so important to maintain.

4.7 Unintended consequences

4.7.1 Inequity

There was a general concern expressed about the inequity of providing such a service to some women and not others in the Trust.

Hospital midwife	*For the chosen few. I think they work in a lovely way. But too few. Why shouldn't Mrs A or Mrs B get it? .... Their case load is a tiny proportion of women we deliver. If you have a fewer number of midwives looking after fewer women there is bound to be better rapport, better contact.*

The midwifery practices as a whole were all seen as improving the quality of midwifery care, while others thought that the Albany Practice were outstanding. There was a perception that existence of the midwifery practices meant that the wards had fewer midwives. This was

perhaps a greater problem for postnatal care, where all midwifery practices were criticised for prioritising births above postnatal care, and relying on the core staff in the wards. There was an underlying assumption that women who sought out the Albany Practice or who were informed about their wishes for childbirth were 'easier' clients.

4.7.2 Risk management processes

Some medical staff and midwives both in hospital and in other community teams did express concerns and cited some 'tragedy' stories. There were also concerns expressed by medical staff that the Albany midwives did not follow Trust guidelines. Examples were given where it was felt this had resulted in poor outcomes for women and for babies and cited inter-professional conflict over management of specific cases. There were concerns expressed by some community staff that the Albany midwives '*pushed the boundaries*' '*they don't suture when others would*', '*they take people home too early*', *'they don't do internal examinations so miss some information*'. Staff expressed concerns that women could feel coerced into 'natural childbirth' and that their real interests were overridden by the midwives' agenda.

Manager *A couple of times they have not followed policy and there was a problem. They encouraged women to go home after caesarean with not a totally well baby, but they know the women best, perhaps best for the woman. They tend to have a reputation for always practising differently.*

Some managers reflected on problem cases, but it was hard to elicit whether such cases were over-represented from the Albany Practice because of their visibility and clear accountability compared to other practitioners. Furthermore, guidelines are guidelines and in many situations, a clinician will use their clinical judgement and decide to take another course of action. Although RCOG guidelines for incident reporting in obstetrics were in place (see appendix), there seemed to be variation in reporting NCEs in the Trust, and it was impossible to draw any firm conclusions with small numbers of incidents. The midwifery practices report (p20 and 21) compared problems after a home birth and in 1999, Albany did report more problems than other practices after a home birth, but they were doing more home births than any other comparator practice ie 90 p/a compared to 73 in Brierley and 12 in Paxton Green. In 1999 Albany had 1 PPH transfer, 5 breastfeeding problems and 1 case of mastitis. They had fewer reported neonatal problems than other practices, one baby with jaundice and 1 admitted to SCBU.

Recommendation: The system of defining and reporting 'near miss' clinical incidents needs to be reviewed.

There were concerns raised about the three new recruits to the practice who had qualified 2 years previously, and some had not practised for all of those 2 years. There was a perception that midwives needed to have several years of hospital practice prior to working in the community. In summary, there are contradictions expressed by several staff in their interviews. Concerns that Albany midwives were 'pushing the boundaries' were expressed alongside a concern that it was iniquitous that not all women in the Trust received such a high standard of care.

Furthermore, some staff were concerned about the Trust carrying legal liability for the Albany Practice. Some medical staff were concerned that women become over dependent on their midwife, and had trouble establishing trust in other staff when the need arose. The self-sufficiency of the Albany midwives was criticised by some senior doctors who felt that they were often called late, when they would have preferred earlier consultation and an agreed plan

of action. Other midwives felt they did not feel as informed as they would about their practice would have liked greater contact to learn about how the Albany Practice worked.

4.7.3 Health professionals views on future service developments

The majority of staff would like to see some aspects of the Albany model of care rolled out and felt that the service was good for women. The majority of respondents felt that the level of continuity was desirable, although there were some doubts expressed about its relative importance and cost-effectiveness. The model was seen to give greater choice for midwives and women, resulting in more homebirths and more innovation. Some would like to have seen more ethnic diversity within the Albany Practice so as to reflect the population that it served.

Generally, younger midwives and students were more interested in working in a similar style to the Albany Practice, whether they were based in the hospital or the community. Older midwives were more inclined to want to continue in their chosen pattern, especially those based in hospital. Hardly any midwives interviewed wanted to work 24 hour on-call, but were puzzled by how the Albany midwives 'looked so well on it'. It was assumed that the majority of Albany midwives either had no childcare commitments or had levels of exceptional childcare support, or shared their own childcare with each other.

Self-employment was seen as unwise by most hospital midwives who liked working in a hospital structure. The majority of midwives were concerned about losing employment benefits such as sick and maternity leave and pension arrangements. Conversely, medical staff equated their situation to being a GP and thought it an unexceptional way to organise practice.

The Albany would like to see other practices working like theirs, and expressed disappointment that midwives were reluctant to try their way of working. However, they were pleased that Oakwood have adopted some aspects of their practice, and that there is flexibility in provision so that midwives are working in self-managing practices. They were pleased that homebirths and commitment to informed choice and woman centred care have been increasing in the Trust and that they may have played a part in influencing that development.

5.0 Comparative childbirth outcomes of the Albany Practice

It is difficult to compare activity and outcomes of community based maternity care and the Albany practice in particular. Ideally, with larger numbers, it would be possible to compare outcomes for standard primipara and standard multipara (see Appendix). The Midwifery Practices Report (Yearwood and Wallace 2000) provides more detailed comparative activity data on all the midwifery group practices. In the future, it should be possible to compare childbirth outcome data for women receiving various patterns of care throughout the Trust as a whole, taking into account variations in casemix and the socio-economic background of women.

5.1 Trends in childbirth outcomes for the Albany practice

Caution should be taken when comparing data in the tables below. Data is generated from multiple sources and may have slightly different definitions and denominators, nevertheless several consistent trends can be seen in the data which are indicative of more robust findings. It is extremely difficult to make good comparisons because home births are not included on the Euroking database.

The was a change in case mix following integration of the SELMP into King's College Hospital NHS Trust in 1997. In 1997, 73% of the caseload were Caucasian (SELMP Closing Report 1997), compared to 42% in 1999. This reflects the move to Peckham and reflects GP attachment to the Lister practice and other GPs in Peckham. Unfortunately, further comparisons on socio-economic status can't be made due to lack of data. Since 1997 the contract numbers have been met. There has been some variation in the percentage of primigravid women, this has now retuned to 1997 level of 43%, and this may be due to women returning for the birth of their subsequent babies.

Prior to integration, the home birth rate was 60%. In 1999, this was around 43%, which in the light of changes in casemix reflects the commitment of the Albany midwives to offer this option.

Table 1 Albany Practice: Trends in Childbirth outcomes 1994 - 2000

Demographic and process data	**SELMP 94-96 380 women**	**Albany practice 1/1/97-31/12/97 211 women**	**Albany practice 1/1/98-31/12/98 219 women 220 babies**	**Albany practice 1/1/99-31/12/99 206 women 208 babies**
Parity				
Multips	58%		47%	57%
Primips	42%		53%	43%
Ethnicity				
Caucasian	73%		44%	42%
Black A/C			41%	45%
Asian			7%	9%
Place of birth				
Home (inc BBA)	60%		30%	43%
Hospital	40%		68%	57%
Attendance at birth				
Primary m/w	95%		87%	89%
Other practice m/w	5%		11%	9%

Other hospital Other m/w/Dr BBA			 2%	2% 3%

SELMP Practice Closing Report 1997, Albany Practice Annual Reports 1998,1999,2000, KCH NHS Trust, Midwifery Practices Report 2000.

Extremely high attendances of the primary midwife at the birth have continued to be achieved, with a slight drop in attendance at birth by the primary midwife from 95% in 1994-7 to 89% in 1999. This may reflect new ways of working as the group took on new midwives. The on-call availability of the midwives in the practice facilitates this, but there may be other organisational issues that warrant further study. The intrapartum transfer rate is not available for Albany or King's College Hospital NHS Trust . This is difficult to define, as more women are leaving the option of whether to have their baby at home or in hospital until they are in labour.

Table 2 Trend in Albany Practice Outcome Statistics

Pregnancy and birth outcome data	**Albany practice 1/1/97-31/12/97 211 women**	**Albany practice 1/1/98-31/12/98 219 women 220 babies**	**Albany practice 1/1/99-31/12/99 206 women 208 babies**
Birth outcomes	211women 4 sets twins 3 mid-trim miscarriage 1 IUD	219 women 220 babies 1 set of twins	206 women 208 babies 1 late miscarriage 1 termination
SVD Waterbirths		79% 10%	77% 10%
Assisted birth Ventouse Forceps		4%	5%
Caesarean section ELCS Emergency		18%	18% 2% 16%
Induction		7%	5%
Augmentation		17%	
No pain relief	56%	69%	69%
Pool at all		10%	13%
Entonox at all		19%	10%
Pethidine		1%	1%
Epidural		16%	17%
Intact perineum (per 100 women delivering vaginally)	62%	65%	47%
1st degree tear 2nd degree tear 3rd degree tear	13% 20%	12% 16% 1%	25% 21% None
Episiotomy	5%	5%	3%

Feeding at birth			
Fully breastfeeding	87%	94%	93%
Mixed feeding	4%		1%
Bottle feeding	9%	6%	4%
Feeding at 28 days			
Fully breastfeeding	79%	75%	70%
Mixed feeding	10%	18%	20%
Bottle feeding	11%	7%	10%

Source: Albany Practice Annual Reports 1998,1999,2000.

Little data is available for 1997 as most was combined with 1998 data. The percentage of women who have a vaginal birth has remained consistent at 77%, the assisted delivery rate remains constant about 4%, as does the caesarean section rate at 18%. The percentage of women not using pharmacological pain relief at all has increased from 56% to 69%, with around 17% of women using epidural. The number of women using pethidine remains consistently low. The percentage of women reported to use the pool for birth has remained consistent at 10%.

The percentage of women with intact perineums has dropped from 62% in 1997 to 47% in 1999. This may be due to more accurate reporting of grazes which have been re-categorised as first degree tears. The percentage of women having second degree tears remains at around 20%, as does the very low episiotomy rate at 3%. The fully breastfeeding rates have increased to around 93% at birth and dropped to 70% at 28 days.

In summary, The Albany practice integrated into King's College Hospital NHS Trust in 1997 and moved from Deptford to Peckham to serve a GP caseload in Peckham. The ethnic background of the women changed to one that is representative of King's population as a whole. On several indicators such as the home birth rate, normal delivery rate, assisted delivery rate, non-pharmacological pain relief, intact perineum, the practice has maintained and promoted physiological birth. In addition it has promoted and maintained very high breastfeeding rates.

5.2 Comparative clinical outcomes with other midwifery practices

Along with examining trends for the practice over time, it is important to examine current process and childbirth outcomes. Traditionally, this has been done by comparing data for standard primps and Multips (SMMIS 1998), but the numbers are too small to select this group. The data for this section has been collated from routinely available process and outcome data available on EuroKing, from the Albany practice statistics for the year 1/1/99 – 31/12/99 and from the midwifery practices report. There are some discrepancies in the data which are due to imperfect data capture and differing definitions. It should be pointed out that the midwifery practices have varying caseloads including some that care for women with medical complexity, teenage pregnancy and mental health problems (Yearwood and Wallace 2000).

The Albany aims to encourage 'physiological pregnancy and birth'. Outcomes have been compared with those from the other midwifery practices, to make a more realistic comparison. Ideally, such comparisons should be made on standard Primip and Multip definitions (SMMIS 1998), but larger numbers would be needed.

The caseload of Albany practice reflects the local population at King's. Table 3 shows that in 1999, 42% of the caseload were caucasian and 45% were African or Caribbean, with a higher

percentage of Asian women than other practices and at King's in general. The Albany Practice achieved very high levels of continuity of carer at 89% for primary midwife attending the birth, compared to 64% of a midwifery practice midwife attending the birth. Thus the Albany Practice have achieved one of their key aims of providing a midwife at the birth, whom the woman and her partner have met before.

The home birth rates for 1999 show that 43% of Albany women had a home birth compared to 11% in the practices overall. Both these rates are high nationally and reflect a commitment by all midwives to provide this service. A total of 65% of women having a home birth with the Albany Practice were Caucasian and 72% were multiparous. The youngest woman having a home birth was 18 and the oldest 46 (Yearwood and Wallace 2000). The organization and delivery of care to facilitate such a high home birth rate in an area of high deprivation would benefit from further investigation.

Table 3 Comparative pregnancy and childbirth statistics

Pregnancy and birth data	**Albany practice 1/1/99-31/12/99 N=206 women 208 babies**	**King's midwifery practices 1/1/99-31/12/99 1258 women 1290 babies**	**King's College Hospital NHS Trust 1/1/99-31/12/99 4044 women**
Parity			
Multips	57%		
Primips	43%		
Ethnicity			
Caucasian	42%	43%	46%
Black	45%	40%	42%
Asian & Chinese	9%	4%	5%
Other			8%
Place of birth			
Home (inc BBA)	43%	11%	7%
Hospital	57%	89%	93%
Attendance at birth			
Primary m/w	89%	}64%	
Other Albany m/w	9%	}	
Other hospital			
Other m/w/Dr			
BBA	2%	9%	

Albany Practice Annual Reports 1999,2000, KCH NHS Trust Obstetric data 1999, Yearwood,J. Wallace,V. (2000) Midwifery Practices Report, King's College Hospital NHS Trust College Hospital.

Table 4 Albany Practice and midwifery practice Outcomes

Childbirth Outcome	**Albany practice 1/1/99-31/12/99 206 women 208 babies**	**King's midwifery practices 1/1/99-31/12/99**	**King's College Hospital NHS Trust 1/1/99-31/12/99 N=4044 women**
Birth outcomes	206 women 208 babies 1 late miscarriage 1 termination	1258 women 1290 babies 26 pairs twins 3 sets triplets	4044 women
SVD Waterbirths Per all births	77% 10%	67% (73% exc Ruskin)	63%
Assisted birth Ventouse Forceps Per all births	5%	8%	10%
Caesarean section ELCS Emergency Per all births	18% 2% 16%	24% 9% 16%	25% 9% 18%
Induction Per all births	5%	10%	11%
Augmentation Per all births		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 100 women delivering vaginally	47%	29%	31%

1st degree tear 2nd degree tear 3rd degree tear	25% 21% None	22% 14% 0.15%	12% 20% 0.5%
Episiotomy per 100 women delivering vaginally	3%	9%	15%
Feeding at birth Fully breastfeeding Mixed feeding Bottle feeding	 93% 1% 4%	 75% 9% 15%	
Feeding at 28 days Fully breastfeeding Mixed feeding Bottle feeding	 70% 20% 10%		

Source: Albany Practice Annual Reports 1999,2000, KCH NHS Trust Obstetric data 1999, Yearwood,J. Wallace,V. (2000) Midwifery Practices Report, King's College Hospital NHS Trust College Hospital.

There were some differences in childbirth outcomes between the Albany Practice and other midwifery practices (Table 4). A better comparison would be made in future if data from Ruskin Practice which cares for women with complex problems was excluded. For example, the caesarean section rate in Ruskin Practice was 50% in 1999. 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 section rate, lower induction rate, less use of pethidine and epidural. There was very little difference in instrumental delivery rates, emergency caesarean section rates, first degree tear rates. This may be due to definitional and reporting differences, or may warrant further investigation. The outcomes for neonates are unavailable for the Albany and for King's as a whole and it is important to examine these systematically. The denominator in the Euroking data excluded women who had a home birth, thus comparisons were not possible for some items.

5.2.1 Summary

Data has been collated from routinely available process and outcome data available on EuroKing, the Albany practice statistics for the year 1/1/99 – 31/12/99 and from the midwifery practices report (Yearwood and Wallace 2000). There are some discrepancies in the data which are due to imperfect data capture and differing definitions. It should be pointed out that the midwifery practices have varying caseloads including some that care for women with medical complexity, teenage pregnancy and mental health problems). Outcomes have been compared with the other midwifery practices, to make a more realistic comparison. Ideally, such comparisons should be made on standard Primip and Multip definitions (SMMIS 1998), but larger numbers would be needed.

The Albany Practice cares for women registered with a group of GPs in Peckham. The Jarman Index of deprivation for postcodes (SE1,SE15) is 64.31, one of the highest scores in the Trust. The caseload of Albany practice reflects the local population at King's. The caseload reflects the local population at King's. In 1999, 42% of the caseload were Caucasian and 45% were African or Caribbean, with a higher percentage of Asian women than other practices and at King's in general.

In 1999, 89% of women were attended during childbirth by their primary midwife and 98% were delivered by their primary midwife or another Albany midwife. This is a very high level of continuity, compared to other models of care. There is very little other comparable published

data, but in the one-to-one Practice at Queen Charlotte's Hospital 77% of women were delivered by their primary midwife and 88% attended by their primary midwife or another midwife in the practice (Green et al 1998). Thus the Albany Practice have achieved one of their key aims of providing a midwife at the birth, whom the woman and her partner have met before.

The home birth rates for 1999 show that 43% of Albany women had a home birth compared to 11% in the practices overall. Both these rates are high nationally and reflect a commitment by all midwives to provide this service. Childbirth outcomes were compared to the Midwifery Group Practices. A better comparison would be made in future if data from Ruskin Practice which cares for women with complex problems was excluded. The Albany Practice had a lower induction rate, higher vaginal delivery rate, a lower elective caesarean section rate, higher intact perineum rate, lower episiotomy rates, more use of the birthing pool, less use of pethidine and epidural higher breastfeeding rates at birth. The outcomes for neonates are unavailable for Albany and it is important to examine these systematically in future. The denominator in the Euroking data excluded women who had a home birth, thus comparisons were not possible for some items. The organization and delivery of care to facilitate these birth outcomes in an area of high deprivation would benefit from further investigation.

In addition to the examination of routine clinical data, it is important to examine women's experiences and evaluations of their care. This will be examined in the next section.

6.0 Women's evaluations of care provision

This section shows and discusses the questionnaire responses eliciting women's views of care. It is important to note the limitations of this data. The Maternity Services Questionnaire was not sent to a random sample of women who delivered in the Trust, as the aim was to elicit views from particular groups of women. Furthermore, non-response always introduces bias into a sample usually in favour of more educated respondents (as in this data). Thus clinical and childbirth outcome data has not been reported from the survey respondents but from all women who gave birth in the Trust in 1999 (sourced from the EuroKing data and the records of the Albany practice). Nevertheless, women's evaluations of care are important and these responses have been reported to compare Albany women with those who received care from the other midwifery practices.

6.1 Survey sample and response rates

4044 women delivered in Kings Health Care NHS Trust in 1999. The King's maternity services questionnaire was sent to 447 women who gave birth in 1999 and who met certain inclusion criteria.

6.1.2 Exclusion criteria

- women who lived outside the LSL HA (n ≈264)
- women who had stillbirths and neonatal deaths (n ≈72).

The Maternity Services Questionnaire was sent to the following women selected at random:

- 299 women who had hospital births between mid Oct - 1st Dec 1999 (just under 50% of women who delivered during this period)
- All 42 women who had home births mid Oct - 1st Dec 1999 (excluding Albany women)
- 106 women who were cared for by the Albany practice between 1/7/99-31/12/99 (98% of women who delivered during this period). One woman was excluded and nine women who had moved out of the area.
- Total number of women 447.

The first mailing of the questionnaire was sent by Pam Dobson in January and February 2000 with 1 reminder sent on the 14th March and telephone reminders to Albany women in May and June.

6.1.3 Sample and response rates

In 1999, a total of 4044 women were cared for by King's College Hospital NHS Trust College Hospital and a total of 447 (11%) women were sent a questionnaire. Table 5 shows that the overall response rate was 52%, the response rate was higher for Albany women (58%) compared to other women in the Trust (46%). However, in all groups, the response rate from women who had a home birth was around 30% higher than women who gave birth in hospital.

Table 5 Women who gave birth in 1999 : Survey sample and respondents

	Total population 1999	Surveyed	Response rate
Albany women	206	106	62 58%

Home birth women (excl Albany)	198	42	32 76%
All other women in the Trust	3640	299	137 46%
Total	4044	447	231 52%

In general, survey response rates are usually much lower from women who don't speak English, are illiterate or in lower socio-economic groups, thus women in higher socio-economic groups are over-represented in survey research (Jacoby and Cartwright 1990). Thus, a focus group with some Vietnamese women who were the main non-English language-speaking group served by Albany practice was also conducted.

Table 6 shows that caucasian women were over-represented in the survey respondents, however the percentage of caucasian women remained an accurate reflection of the Albany total population.

Table 6 Comparison of ethnicity of survey respondents with total population of women in 1999

Ethnicity **% Caucasian**	**All women cared for at Kings *** **%**	**Survey Respondents %**
King's College Hospital NHS Trust (incl Albany)	46	56
Albany Practice	42	42

source Euroking Obstetric Data 1999

To summarise: Women who had a home birth and women from the Albany Practice were over sampled in the survey and were thus over represented in the response, and this should be borne in mind when reading the results. However, the distribution of ethnicity in respondents from the Albany Practice remained an accurate reflection of the total sample of women that they cared for in 1999.

6.1.4 Data analysis

In the following analysis, the aim has been to explore women's experiences of two models of community based midwifery practice care. Information about the extent of pregnancy and childbirth interventions and outcomes have not been reported due to the non-representative nature of the sample. However, women's evaluations of different patterns of care do remain valid. The Albany Practice operates on a caseload model and the remaining practices operate on variations of this. **All the following tables compare responses from women cared for by the Albany Practice with women cared for by the Midwifery Practices.** The King's Total includes responses from all women cared for by King's NHS Trust. Two tailed significance tests have been reported in each table as appropriate. To achieve clarity in the following analysis, the responses of women cared for by area community midwives and by hospital core staff have been omitted. However, an overall analysis of the midwifery group practices has been presented in the latest Maternity Services Questionnaire Report (Dobson 2000).

6.2 Background information of respondents

6.2.1 Age

The youngest woman was 15 when she gave birth and the oldest was 44. The mean age was 31 at the time of the birth. The age range of respondents seen by the Albany midwives was not significantly different from the rest of King's.

Table 7 Age of Respondents

Age N=227	% Albany	% Midwifery Practices	% King's Total
Teenagers	6	9	4
20s	36	35	37
30s	55	54	56
40s	3	2	3

6.2.2 Parity

There was a non-significant trend for respondents from the Albany Practice to be multips compared to midwifery practices and King's as a whole. This higher proportion may be due to the Albany Practice being sought by women who have already had a previous baby with the practice (evident from the comments on the questionnaires).

Table 8 Parity of Respondents

Parity N=229	% Albany	% Midwifery Practices	% King's Total
Nullips	25	37	34
Multips	75	63	66

6.2.3 Ethnicity

The ethnic background of Albany respondents was significantly different from women from the midwifery practices. There were fewer caucasian women and more African women respondents from Albany. This reflects the population of the Peckham area and the Lister Health Service. In addition, more Vietnamese women attended the Lister Health Centre, where one of the Lister GPs is Vietnamese. Furthermore, there is also a Vietnamese Centre in Peckham. A total of 21% of all women in the Trust reported that their first language was not English, but there were no differences between groups.

Table 9 Ethnicity of respondents

Ethnicity N=229 chi square p=0.034	% Albany	% Midwifery Practices	% King's Total
Caucasian	42	59	56
African	30	10	16
Caribbean	15	15	14
Black other	7	4	4
Vietnamese	3	-	1
Asian (Other)	2	6	3
Other	2	6	6

6.2.4 Living arrangements

The majority of respondents lived with partners or family members and there were no significant differences between groups.

Table 10 Living arrangements

Do you live: N=229	% Albany	% Midwifery Practices	% King's Total
Alone	10	16	14
With your partner/husband/boyfriend (With or without children)	82	81	80
With family members	3	3	6
Other eg with children	5	-	1

6.2.5 Level of education

Similar percentages of women in all groups had no educational qualifications, and women with degrees were over represented among the respondents in relation to the general population. It should be recognized that questionnaires always generate a response bias in favour of the highly educated. However, this data is not available on routine systems and is a simple indicator of socio-economic status. It may be useful to collect this data routinely on EuroKing.

Table 11 What is the highest level of Educational qualification have you gained?

N=229	% Albany	% Midwifery Practices	% King's Total
None	7	6	7
GCSE level (CSE or O Level)	29	25	28
A Level or equivalent	23	18	21
Degree or equivalent (or above)	42	51	45

6.2.6 Postcode

The distribution of home addresses of the respondents from Albany women indicated that most came from the catchment area of the Lister Practice which serves women in Peckham and the surrounding parts of Camberwell and New Cross.

Table 12 Postal District

N=227	% Albany	% Midwifery Practices	% King's Total
Peckham	47	15	28
Camberwell	21	18	17
New Cross & North Lewisham	16	4	6
Outer Southwark (&Lewisham) inc Dulwich	12	34	28
Inner London (SE1/Guys/Walworth Rd)	5	2	2
SW London inc Brixton and Streatham	-	28	19

6.2.7 Provision of midwifery care

The respondents were classified by the provider of midwifery care. Table 13 shows that of the 231 survey respondents, 23% received care from core staff, 21% from area community midwives, 29% from the midwifery practices and 27% from the Albany Practice.

Table 13 Provider of midwifery care

Midwifery Provider	%	N
Core staff	23	52
Area staff	21	49

Midwifery Practices	29	68
Albany Practice	27	62
Total	**100**	**231**

6.3 Women's evaluations of care in pregnancy

A number of questions on the survey asked about service provision, content of care and informed choice.

6.3.1 Patterns of antenatal care

There were no differences between groups in the gestational age at booking. Albany respondents were significantly more likely to seek a midwife when first pregnant, and have a home booking. They were more likely to have ongoing antenatal care at home, equally likely to have ongoing antenatal care at the GP, and less likely to have antenatal care at King's College Hospital (Table 14).

Table 14 Patterns of antenatal care

When you first thought you were pregnant, whom did you first see about the pregnancy? N=231 (chi-square p=0.011)	**% Albany**	**% Midwifery Practices**	**% King's Total**
A midwife	16	2	5
A G.P.	79	94	89
Family Planning Clinic	5	4	6

Where did this first antenatal check take place? N=231 (chi-square p=0.000)	**% Albany**	**% Midwifery Practices**	**% King's Total**
At a community clinic or G.P.'s surgery	53	65	62
At the hospital	13	28	27
At home	34	4	10
Family Planning Clinic	-	2	1

Did you have any antenatal checks at any of the following: *yes response only*	**N=**	**% Albany**	**% Midwifery Practices**	**% King's Total**	**Significance Chi-square**
King's College Hospital	226	42	77	71	P=0.001
G.P.'s surgery or a community clinic	225	63	63	68	
Home	225	89	44	42	P=0.000

Significantly fewer Albany respondents reported a wait of over 30 minutes at the GP, and hospital antenatal clinic, although the reasons for this difference cannot be explained. There were significant differences in the provision of antenatal care. The majority of Albany respondents reported having appointments for a specified time and only 6% reported not having antenatal checks at home, compared to around 48% of respondents from the midwifery practices. Around 40% of women in all groups reported that the midwife failed to come at the time arranged and that a reason was given for this in the vast majority of cases.

Table 15 Waiting times for antenatal care

If you attended the antenatal clinic at King's College Hospital, did you ever wait more than 30 minutes to be seen by a midwife or doctor? N=169 chi-square p=0.05	% Albany	% Midwifery Practices	% King's Total
Yes	30	58	62
No	67	38	35
Can't remember	4	4	4

If you attended your G.P.'s surgery or a community clinic, did you ever wait more than 30 minutes to be seen by a midwife or doctor? N=190 chi-square p=0.05	% Albany	% Midwifery Practices	% King's Total
Yes	17	36	31
No	83	63	69
Can't remember	-	2	0.5

If you ever had any check ups at home, did the midwife usually make an appointment with you? N=198 (chi-square p=0.000)	% Albany	% Midwifery Practices	% King's Total
Did not have check ups at home	6	48	52
Yes, for a specified time	82	28	31
Yes, for a specified half day (e.g. morning or afternoon)	8	15	12
Yes, for a specified day	4	10	6

There were no significant differences in the number of antenatal appointments, and the majority of women felt they had the right number of appointments. One of the Albany women who would have preferred more visits said that this was only during the first few months.

Table 16 Number of antenatal appointments

Approximately, how many antenatal appointments with midwife, GP or hospital doctor did you have? N=216	% Albany	% Midwifery Practices	% King's Total
5 or less	16	18	19
5 –10	63	65	65
10 –15	16	14	12
>15	6	5	6

What do you think about the number of antenatal visits you had? N=216	% Albany	% Midwifery Practices	% King's Total

I had the right number of visits	85	89	87
I would have preferred more visits	12	12	12
I would have preferred fewer visits		4	2

6.3.2 Access to maternity care providers

Significantly more Albany women were given information about how to contact their named midwife compared to women cared for in the midwifery practices (Table 17). However, significantly fewer Albany women were given the contact numbers for labor ward at the hospital and for their GP surgery. This may be due to a communications system where the Albany midwives expected all women to contact them first if they were in labor. Nevertheless, it would seem important for women to be routinely given this information to improve their access to healthcare. Table 17 shows that significantly fewer Albany women had problems contacting their midwife. This ease of access is reflected by the response of 82% of Albany women who would contact a particular midwife if they were worried, compared to 37% of women in other midwifery practices. One Albany woman said that *'need to leave message for her and then contacted me almost immediately'.*

Table 17 Information provision about Access to maternity service providers

When you were pregnant, were you given the name and contact number of a midwife you could call on for help and advice? N=214	**% Albany**	**% Midwifery Practices**	**% King's Total**	**Significance Chi-square**
Yes, name only	14	5	9	
Yes, number of the midwife whose name I was given	84	34	49	P=0.000
Yes, number of a midwife different to the name I was given	11	5	6	
Yes, number to contact labour ward	24	52	49	p=0.001
Yes, number of GP's surgery	20	37	36	p=0.03
Yes, contact numbers for midwives in the practice	71	66	51	
No	-	2	4	
Can't remember	-	2	1	

If you tried to contact the midwife, were you able to speak to him/her? N=205 chi-square p=0.001	**% Albany**	**% Midwifery Practices**	**% King's Total**
Yes, with ease	86	51	53
Yes, with some difficulty	15	22	16
Yes, with great difficulty			0.5
No			
Did not try to contact him/her		28	32

During your pregnancy, which professional did you contact first if you were worried about anything or wanted to ask a question? N=209 (chi-square p=0.000)	**% Albany**	**% Midwifery Practices**	**% King's Total**

A particular midwife	82	37	47
Any midwife	6	45	27
GP/family doctor	8	15	22
A hospital doctor	2	3	3
Other		2	2

6.3.3 Informed choice in pregnancy and childbirth

Information is a key factor in making an informed choice. It was suggested by some medical staff that the information Albany provide to women differed to that provided by other midwives. But the questionnaire data suggests that information and advice and choices offered with Albany were rarely significantly different to that provided by other midwifery practice midwives.

When asked about the information regarding types of antenatal care there was no difference between Albany and other women. When Albany women were asked their views on information provision, they were equally likely to say they had enough information as other women on a range of topics, and when asked if they would have liked other information, were equally likely to say no as other women. When asked if, throughout their antenatal care they were involved, and able to ask questions, there was no significant difference between Albany and other women.

Table 18 shows that Albany women were significantly less likely to report being offered a choice of who provided antenatal care, but more likely to perceive that they were offered a choice of who would deliver their baby. This is a paradoxical finding, as Albany women are most likely to have their primary caregiver attend the birth.

Table 18 Choice of care provider in pregnancy and birth

Were you given a choice about who you could have your antenatal care with (for example midwife, GP, Obstetrician or combination of these)? N=231 (chi-square p=0.000)	**% Albany**	**% Midwifery Practices**	**% King's Total**
Yes	49	68	70
No	41	27	25
Can't remember	10	6	6

Do you feel that you were given a choice as to who would deliver your baby? N=214 (chi-square p=0.000)	**% Albany**	**% Midwifery Practices**	**% King's Total**
Yes	76	38	40
No	22	62	56
Can't remember	2	2	4

6.3.4 Choice of place of birth

All groups reported high levels of choice in place of birth (Table 19). Significantly more Albany respondents reported being offered a choice both about King's College Hospital and home, but significantly fewer reported a choice of another hospital. This may be due to geographical variations. Significantly more Albany respondents reported feeling involved about the decision about where to have their baby and no women reported that they didn't feel involved. This is reflected in the significantly smaller percentage of Albany women who felt they were not given a choice where to have their baby (1%), felt not involved in the decision

where to have their baby, given the opportunity to discuss wishes for the birth (2%), and who wished they had more time to discuss wishes for the birth (5%).

Table 19 Choice of place of birth

Were you given the choice of where you would like to have your baby? N=211 (chi-square p=0.02)	**% Albany**	**% Midwifery Practices**	**% King's Total**
Yes	99	85	87
No	1	13	11
Can't remember		4	3

If YES, which of the following were offered to you N=214	**% Albany**	**% Midwifery Practices**	**% King's Total**
King's College Hospital chi-square p=0.01	95	81	84
At home chi-square p=0.011	90	72	66
Other hospital chi-square p=0.008	6	24	22

Do you feel that you were involved in the decision about where you would have your baby? N=214 (chi-square p=0.007)	**% Albany**	**% Midwifery Practices**	**% King's Total**
Yes, fully	97	80	83
Yes, partly	3	4	10
No		11	8

During your pregnancy, were you given an opportunity to discuss your wishes about labour and delivery? N=213 (chi-square p=0.005)	**% Albany**	**% Midwifery Practices**	**% King's Total**
Yes	95	81	80
No	2	16	13
Can't remember	3	3	6

Looking back now, do you think you were given enough time to talk about your plans and wishes for labour? N=215 (chi-square p=0.005)	**% Albany**	**% Midwifery Practices**	**% King's Total**
I wish I had talked more	5	27	23
The amount was right for me	92	72	76
I think we talked too much	3	2	1

To summarise, all groups reported high levels of choice in place of birth, however there were large significant differences between Albany respondents and women receiving care from the practices. Albany women reported feeling more involved in decisions about where to have their babies, who would deliver their baby, and in decisions about labour and birth. They also reported that they felt they had had adequate time to discuss such issues compared to other women.

6.3.5 Information giving in pregnancy

One woman who transferred to Albany, wrote at length about her complaints of the hospital antenatal service.

> *" My first antenatal appointment was in the clinic at King's Hospital. I was so appalled by the service that (on a friend's recommendation) 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. The reasons I found King's hospital clinic so bad were:

- *A 90 minute wait - feeling v. nauseous! No explanation or apology given*
- *Midwife couldn't answer many basic questions and made no attempt to get answers. E.g. what is the blood test done with the 11-13 week scan for?*
- *Had run out of HEA pregnancy books and would have to wait 3 months for one.*
- *Ante natal yoga classes were full already - I insisted on going on waiting list and did get the classes which were excellent.*
- *My booking was not until 14 1/2 weeks - fortunately I knew the translucency scan had to be done before 13 weeks so I had contacted the scanning dept. myself and got an appointment in the nick of time. Otherwise I would have missed this key test.*
- *Most worrying of all, I believe I was given an HIV test without giving informed consent or receiving any pre-test counselling, as is required by the law. The midwife asked if I wanted all the routine blood tests.*
- *No mention of HIV specifically was made except a small note right at the end of a long booklet I was given. As an MA graduate in medical law, I hardly think this constitutes the legal requirement to gain informed consent following counselling".*

The above woman had received very few of the leaflets and information discussed in the section below.

Table 20 Written information provided in pregnancy

During your pregnancy were you given a copy of any of the following books or leaflets: (please answer all questions) YES ONLY ANSWERS included in this table. The data collected included: no, can't remember and don't know.	N	% Albany	% Midwifery Practices	% King's Total	Sig Chi-square
a. The Pregnancy Book	210	44	43	48	
b. Maternity Services Charter (leaflet)	204	18	27	22	P=0.01
c. Your Guide to Maternity Services (leaflet)	205	20	43	33	P=0.003
d. An Information sheet about Ultra Sound Scans	207	91	86	90	
e. King's College Hospital NHS Trust Maternity Information Guide	205	27	44	41	P=0.04
f. Information sheet about HIV test	212	78	77	75	

There were very few significant differences in information that women received. Albany women were less likely to receive leaflets about maternity services and equally likely to receive information about the content of care. This may be due to the high proportion of multiparous women, or that Albany midwives felt that the maternity services leaflets were not relevant. As one Albany respondent wrote on the front of her questionnaire:

> *"As this was the second pregnancy using the same midwife a lot of things weren't done out of choice, rather as seen as old ground to cover, rather than not offered. We just got on with it. My answers make it look like she didn't care -- In fact she was fabulous".*

Table 21 Pregnancy information provision

Regarding your pregnancy, do you feel that you were given enough information on the following? YES ONLY		N=	% Albany	% Midwifery Practices	% King's Total	Sig Chi-square
a.	Eating for a healthy pregnancy	215	75	74	76	
b.	Foods to avoid (e.g. liver, pates etc)	216	69	92	80	0.02
c.	Dental care	211	30	44	38	
d.	Smoking in pregnancy	215	71	76	74	
e.	Alcohol	214	81	83	83	
f.	Exercise	213	70	59	59	
g.	German measles	212	40	56	52	
h.	Listeriosis	208	33	45	41	
i.	Toxoplasmosis	208	31	48	40	
j.	Drugs & Medicines	206	77	64	63	
k.	Ultra sound scans	215	90	82	96	
l.	Blood tests	216	86	77	80	
m.	HIV	215	79	88	83	

There were very few differences in the topics discussed above. A small percentage (12%) of women would have liked additional information, but this was consistent across groups. When women were asked about their views of information given to them in pregnancy, the majority of respondents in all groups said they could ask questions they wanted to, felt they were well treated as a person and had explanations they understood.

Table 22 shows which aspects of care women wished to see changed. All women who responded to one or more items are included. Clinic waiting times was the aspect most women wanted to change. However, this was less important for Albany women than for those registered with other King's services. Changing the arrangements for ultrasound scans were more important for the Albany women than for other women. Albany women were less concerned about staffing levels, and timing of clinics than other women throughout King's . This may be due to the pattern of care and higher level of continuity of caregiver that Albany women received.

Table 22 Aspects of care women wish to see changed

Which aspects of antenatal care do you feel need most improvement? (tick as many as you like) N=204	% Albany N=49	% Midwifery Practices N=64	% King's Total	Significance Chi-square
Waiting times in the clinics	40	67	62	P=0.00
Consistent advice from health professionals	29	25	27	
Getting advice when needed	27	17	24	
Arrangements for ultrasound scans	27	11	15	P=0.05
Written information	21	25	20	
Staffing levels	17	39	30	P=0.001
Verbal information	15	16	13	
Arrangements for blood sampling	15	9	11	
Appointment arrangements	13	13	15	
Clinic facilities	13	17	13	
Timing of clinics	2	14	14	P=0.03
Other (please specify)	7	11	7	

Other comments by Albany women included '*Midwives were kind but were not very informative about antenatal care. Just skim the surface.*' Another comment by a woman who had sought out the Albany Practice said that *'being informed that there are midwives who specialize in home birth'* was an improvement she would like to see. She had found out about the Albany through a friend after refusing to have a booking at the hospital. Another woman said *' I would like more mothers to be able to get the care I got from my Albany Midwifery Practice.'*

6.3.6 Women's evaluations of staff attitudes in pregnancy

Overall, Table 23 shows that the antenatal care provision at King's was rated positively. Albany midwives were identified as significantly kinder and warmer than other practice midwives. All midwives scored highly on being considerate, supportive, polite and informative. Albany midwives were rated as significantly less rushed and less condescending than other midwives. Seven Albany women identified one negative adjective and no Albany women identified two or more. When looking at the questionnaires of the Albany women there is no clear reason for the criticisms. These adjectives include nothing about perceptions of competence.

Table 23 Women's perceptions of staff attitudes

We would like to know what you feel you were looked after before you had your baby. Please circle as many of the following that you feel describe the staff that looked after you N=225	**% Albany N=59**	**% Midwifery Practices N = 68**	**% King's Total**	**Sig Chi-square**
Kind	78	53	62	P=0.002
Supportive	77	74	72	
Warm	75	56	64	P=0.024
Considerate	74	65	67	
Polite	62	72	69	
Informative	60	69	57	
Sensitive	55	52	52	
humorous	45	40	39	
Rushed	2	25	14	P=0.000
Unhelpful	2	7	7	
Offhand	2	6	6	
Condescending	2	6	6	
Bossy	2	3	3	
Insensitive	2	3	2	
Inconsiderate	2	2	1	
Rude	-	2	1	
Unsupportive	-	2	-	

6.3.7 Care during pregnancy

Women booking with the Albany Practice came mainly from the Lister GP Practice and the Peckham area. There were no significant differences by age or parity, living arrangements, level of education compared to women cared for by the other Midwifery Group Practices. However, the ethnic background of Albany women was significantly different from women

from the midwifery practices. There were fewer Caucasian women and more African women respondents from Albany which reflects the population in the Peckham area.

There were no differences between groups in the gestational age at booking. Albany women were more likely to seek a midwife when first pregnant, have a home booking, and have antenatal care provided by Albany midwives combined with GP antenatal care if they wished. They were more likely to have specified appointments, resulting in less waiting time in the GP clinic reflected in fewer concerns about antenatal waiting times.

All Albany women received continuity of caregiver. This resulted in them being more aware of how to contact their midwife, and significantly more women did call their own midwife as a first port of call if they were worried. The benefits of an ongoing relationship may have resulted in more Albany women reporting that they had adequate time to discuss such issues compared to other groups. This was reflected in their lower level of concern about staffing levels, and Albany midwives were rated as kinder, warmer and less rushed than other practice midwives.

There were no significant differences in the number of antenatal appointments or in the information content that women received. However, Albany women were less likely to report being offered a choice of who provided antenatal care and more likely to report being offered a choice of who would attend the birth of their baby. All groups reported high levels of choice about where to have their baby, and more Albany women reported feeling involved in decisions around the place of birth, and in discussions of their wishes for labour and birth. Throughout the women's responses, there is a clear pattern of woman centred care being offered and of partnership with women, which may contribute to the positive evaluations of antenatal care and good clinical outcomes.

6.4 Women's evaluations of care during labour and birth

This section examines women's evaluations of their care. Details about birth outcomes reported in the survey are not reported here due to sampling and response bias. An analysis of the comparative clinical outcomes for all women giving birth in the Trust in 1999 are examined in section 5.

6.4.1 Place of birth

Overall, 43% of women from Albany practice had their babies at home in 1999 and 11% of women cared for by the midwifery practices had a home birth. In the Trust overall, the home birth rate was 7%. In this sample of respondents, the home birth rate was 48% for Albany women and 32% for the midwifery practice women. Thus although women having a home birth are slightly over represented in the Albany respondents they were a very much over represented group for the midwifery practices and the sample as a whole. This was intentional. The majority of women were successful in having their baby as intended and there were no differences between groups.

Table 24 Place of childbirth for respondents

Where was your baby born? N=231	% Albany n=62	% Midwifery Practices n=68	% King's Total n=49
King's College Hospital	52	68	73
At home	48	32	27

Table 25 Intended place of birth

Was your baby born where you had planned to deliver? N=225	% Albany	% Midwifery Practices	% King's Total
Yes	90	88	91
No	10	12	9

Four women from Albany responded that the place of birth changed from home to hospital due to wanting an epidural, for fetal distress and for delay in the first stage of labour. One woman wanted a hospital birth, but the baby came so fast, she had a home birth.

> *'We had been considering a home birth though we had planned to decide whether to transfer from home to hospital during the labour, but it was so fast there was insufficient time to transfer'*

6.4.2 Type of birth

From the EuroKing data, the caesarean rate for 1999 was 18% for Albany women, 24% for midwifery practices, and 25% for King's as a whole. Women who had a caesarean with Albany are over represented (24%), while women who had a caesarean with the practices (15%) and in King's as a whole (22%) are under represented among respondents. The reasons for this difference are unknown. The majority (around 70%) of all women felt that they had received enough information about the operation and there were no differences between groups. Around 20% of women in all groups would have liked more information about complications during pregnancy and **it is recommended that this is an area that may warrant more attention in the future.**

6.4.3 Home birth

Sixty-two respondents had home births. Albany women were no more likely to have planned a home birth than other women in the midwifery practices. The reasons given are in Table 26.

Table 26 Plans and reasons for home birth

Before your baby was born, did you plan to have your baby at home? N=59	% Albany N=27	% Midwifery Practices N=22	% King's Total
Yes	96	78	90
No	4	17	9
Don't know/can't remember and none respondents	1 (n=1)	-	2

Why did you have your baby at home (Tick all that apply) N=59	% Albany	% Midwifery Practices	% King's Total	Significance Chi-square
I wanted freedom to do things as I wished	93	73	83	
I wanted to avoid unnecessary technology	89	59	73	P=0.02
I wanted the same health professional to be there throughout	81	50	61	P=0.02

I felt home was more suitable	70	77	70	
I wanted my family members present	52	32	37	
Hospital couldn't provide the services I wanted	41	9	22	P=0.01
Emergency birth	11	23	15	
Concerned about rapid delivery	7	14	12	
Wanted a waterbirth	4	-	2 (n=1)	
Previous bad experience	-	5	2 (n=1)	

There were no differences between groups in many of the reasons given, however Albany homebirth women were significantly more concerned about avoiding unnecessary technology, wanted the same professional to be there throughout, and felt the hospital could not provide the service they wanted compared with other women having home births.

Table 27 Percentage of women reporting professional support for home birth

Did your doctors and midwives support you in your wish to have your baby at home? N=62 *(Tick one box for each line)*	Albany	Midwifery Practices	King'sTotal	Significance Chi-square
Practice midwives	70	64	63	
Hospital midwives	3	27	19	
GPs	20	50	36	P=0.04
Hospital doctors	7	18	16	

Overall, the majority of women reported support from their practice midwives, but fewer women reported support from hospital midwives, GPs and hospital doctors. Significantly fewer Albany women reported support from their GPs compared to women in other midwifery practices. This may be due to the fact that fewer women see much of their GP in the antenatal period.

Table 28 Information about home births

Were you given information about the following things: (Tick one box for each line) N=59	Women who reported 'Yes'			Significance Chi-square
	Albany	Midwifery Practices	King'sTotal	
i) The sorts of pain relief that would be available at home	92	82	85	
ii) The monitoring of the baby that would be available from home	96	73	83	P=0.05
iii) The sorts of emergency back-up (e.g. ambulance facilities if you need them) that would be available	96	50	71	P=0.002

Table 28 shows that although all women reported being well informed, significantly more Albany women were informed about pain relief, monitoring and emergency back up. Half of the women having home birth with the practices reported not being given information about emergency back up facilities. The practice of a 36 week birth talk by the Albany midwives may contribute to the high levels of information of the Albany women and it is suggested that this could be explored further.

Some Albany women with home births often wrote extensively on their questionnaires. One typical comment came from a woman who wrote of her homebirth:

> *'I would recommend the Albany midwives, whose continuous supportive care meant I just got on with dealing with, and organising life for the baby after it was born and never worried about the birth. I knew if anything went wrong, together we would do our best. Thankfully all went well. 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. The first home birth turned a little complicated, but I feel as positive about that labour as the second, more straightforward, labour. Thank you . [Albany midwives] and King's.*

6.4.4 Hospital birth

A total of 169 respondents had a hospital birth. The majority of women were made to feel welcome on delivery suite (78% in total) and there were no significant differences between Albany women and other women. Of the five Albany women who did not feel welcomed, one commented that the *'staff were too distressed by my screaming'*. Significantly more Albany women were taken straight to a delivery room than other women throughout King's and in the midwifery practices (chi square p = 0.03).

6.4.5 Continuity of caregiver during childbirth

All women were invited to complete this section. The response rate is low, particularly to the following question, because of the layout of the questionnaire did not identify a change of subject. Predictably, given the pattern of care, significantly more Albany women knew the name of their caregiver during birth, and almost twice as many women with Albany reported knowing their midwife well, compared to women with the midwifery practices. All women reported meeting midwives at antenatal classes and checks, but 19% of Albany women reported knowing their midwife with a previous child, compared to 2% in midwifery practices and 11% in King's as a whole.

More (73%) Albany women said it mattered to them that they had met their midwives before than other women. This replicates previous research where knowing a midwife prior to childbirth becomes more important to women once they have experienced it. Virtually all Albany women had the same midwife throughout their labour compared to other women in the practices. Fewer Albany women were seen by a doctor, and if they did, they were slightly more likely to know the doctor. Around 16% of all women felt that they had met someone who was unhelpful during labour, but there is no further data on who was unhelpful. Around 11% of all women felt that midwives were too busy to spend time with them during childbirth and there were no significant differences between groups.

There were no significant differences in the number of midwives who looked after the Albany women during birth compared to other women. This an important finding, because the evidence from this survey suggests that what the Albany is offering is a personal service, but not an exclusive one-to-one service during childbirth. It also suggests that to provide one-to-one support during childbirth, more than one midwife is necessary.

Table 29 Continuity of caregiver during childbirth

Do you know the name of the professional who gave you most of your care during labour? N=209 Chi square p=0.016	**% Albany N=56**	**% Midwifery Practices N=65**	**% King's Total**
Yes	98	86	81
No	2	14	19

About the midwives who cared for you in labour: N=219 Chi square p<0.000	**% Albany**	**% Midwifery Practices**	**% King's Total**
I knew one (or more) of them well	92	52	48
I had met one (or more) of them before	7	22	14

I had not met any of them before	2	25	38

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

Was one midwife able to be with you right through your labour (even if she was not in the room all of the time) N=218	% Albany	% Midwifery Practices	% King's Total
Yes	93	79	76
No	7	18	20

About the doctors who attended to your care in labour? N=215	% Albany	% Midwifery Practices	% King's Total
I knew one (or more) of them well	11	8	7
I had met one (or more) of them before	7	5	7
I had not met any of them before	27	39	45
I was not seen by a doctor	55	49	41

Altogether, how many different midwives looked after you during your labour and the birth? N=215	% Albany	% Midwifery Practices	% King's Total
One	10	20	17
Two	57	42	47
Three	26	26	24
Four	5	6	8
Five or more	2 (n=1)	6	5

6.4.6 Involvement of others during childbirth

Several questions asked about companionship during childbirth, and involvement of students. Nearly all women (96%) were accompanied in labour by a partner, a family member or a friend, but the companions of Albany women felt more welcomed than other women within King's. A total of 16% of women reported that they were worried to be left alone far in labour, and there were no significant differences across groups. But fewer Albany women reported that they were left alone 'far too much' compared to women cared for by the midwifery practices (7% vs 12%). When women were asked about students involvement in their care (Table 30), a similar percentage of women had a medical student (6%), but more Albany women had midwifery students (39 vs 27%). The majority of women in the midwifery practices were asked permission for students to be present and around 72% of women were happy for students to be involved in their care most of the time. There were no significant differences between groups.

Reccomendation: This leaves a significant minority of women in all groups who were not happy for students to be involved at all times and it is recommended that procedures for obtaining consent should be reviewed.

Table 30 Student involvement in care

Was a student (medical student or student midwife) involved in your care in labour? N=216	% Albany	% Midwifery Practices	% King's Total
Yes medical student	7	5	6
Yes, student midwife	39	28	27

If a student was involved in your care, were you asked permission? N=75	% Albany	% Midwifery Practices	% King's Total
Yes	92	86	80
No	4	10	15

Were you happy for a student to be involved in your care? N=75	% Albany	% Midwifery Practices	% King's Total
Yes, most of the time	75	74	72
Yes, some of the time	21	27	24
No	4	0	4

6.4.7 Involvement in decision making

Several questions asked about perceptions of involvement in decisions made during labour and birth. There was a non-significant trend for Albany women to be happier with their involvement than other women throughout Kings and fewer Albany women felt the need to be more involved with their care. More women reported that Albany midwives explained what was happening, told them enough about necessary interventions, and took enough notice of their views, and were kind and understanding. Of the three Albany women who said they were not taken notice of, one woman commented that this was the '*Theatre staff, anaesthetist in particular [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 -- midwife took it off after a few minutes'*.

Table 31 Women's involvement in decision making during labour and birth

Do you feel that you were involved in any decisions about your care in labour? N=215	% Albany	% Midwifery Practices	% King's Total
Yes, fully involved in all decisions	69	55	57
Yes, involved in most of the decisions	21	28	30
Involved in a few decisions	9	13	10
Not involved in any decisions	2	5	3

Would you like to have been more or less involved in the decisions about your care? N=215	% Albany	% Midwifery Practices	% King's Total
More involved	11	23	21
Less involved	-	-	-
I was happy with how involved I was	89	77	79

Thinking of all of the staff who looked after you during labour and delivery

Did they explain enough about what was happening N=211	% Albany	% Midwifery Practices	% King's Total
Yes always	79	66	69

Did they tell you enough about why things they did were necessary N=207	% Albany	% Midwifery Practices	% King's Total
Yes always	86	69	74

Did they take enough notice of your views and wishes N=820	% Albany	% Midwifery Practices	% King's Total
Yes always	82	69	70
Yes most of the time	13	26	24
No	5	5	6

Were they kind & understanding N=213	% Albany	% Midwifery Practices	% King's Total
Yes always	84	77	77
Yes most of the time	16	19	21
No	-	5	2

6.4.8 Pain relief in labour

An examination of the Euroking data for 1999 shows that 69% of Albany women did not use any pharmacological pain relief compared to 18% of women in the midwifery practices. A total of 13% of Albany women reported using the pool for pain relief and 1% used pethidine, compared to 21% in midwifery practices. In addition, 17% of Albany women had an epidural, compared to 25% in the midwifery practices. But it is unclear how many of the 17% of women who reported using an epidural also had a caesarean section.

On being asked if they felt that adequate pain relief was offered, significantly more Albany women said no pain relief was required, and there were no differences in the small percentage of women who said no. Most women had been given adequate information about pain relief and there were no differences between groups. One possibility for this difference is the pre-childbirth preparation and development of confidence that results due to the personal relationship between a woman and her midwives during pregnancy. However, the reason for this difference in women's views warrants further exploration and may make a valuable contribution to maintaining physiological childbirth.

Table 32 Women's views of pain relief during labour

Do you feel that you were offered adequate pain relief in labour? N=209 Chi square p= 0.000		% Albany	% Midwifery Practices	% King's Total
	No pain relief required	49	15	24
	Yes	47	79	70
	No	4	7	6

Do you think that you were given enough information in labour about the type of pain relief you chose? N=197		% Albany	% Midwifery Practices	% King's Total
	Yes	86	88	89
	No	4	5	4
	Don't know	6	2	3
	Can't remember	4	5	5

6.4.9 Women's evaluations of staff attitudes during childbirth

Nearly all the staff throughout the King's maternity service were described as considerate and supportive during labour (Table 33). The numbers are too small to conduct significance testing but negative adjectives were rarely used by the Albany women. Out of all the respondents, 47 women used negative adjectives about staff in labour, six Albany women made one or two criticisms, whereas there were 11 women who made three or more throughout the rest of the sample. The Albany women who were critical were often referring to people other than Albany midwives. One woman said that the hospital staff were bossy.

> *'it would have been nice if the hospital staff had left us alone (my midwife, partner and me) and not made my midwife look like she didn't know what she was doing. By hospital staff I mean the obstetrician. I must say the bossy attitude would put off a woman in labour and everyone else for that matter.'*

Another woman said that the theatre staff were insensitive, rude, and brutal and felt that *'communication between surgeon, theatre staff and midwives'* and herself could have been better. When asked if anything further could have been done by the staff to *'make your labour a better experience'* comments included the following:

> Seven Albany women who simply wrote 'No'
> *'No' all that is done was necessary and helpful*
> *'No', she was excellent at calming me down.*
> *'No', the home delivery I had with a supportive midwife was great.*
> *Best delivery I had enjoyed.*
> *'No', it was quite perfect.*
> *'No', they were wonderful.*

Table 33 Staff attitudes

We would like to know how you feel you were looked after while you were having your baby. Please circle any of the following that you feel best describe the staff that looked after you during labour: N=227	% Albany	% Midwifery Practices	% King's Total

	considerate	98	93	95
	supportive	82	82	78
	kind	77	65	74
	polite	66	63	61
	warm	64	59	61
	sensitive	62	60	61
	informative	53	60	52
	humorous	46	43	38

	rushed	2 n=1	10	9
	bossy	7 n=4	4	6
	insensitive	2	7	5
	unhelpful	2	9	5
	condescending	-	2	4
	offhand	2	4	4
	rude	2	4	4
	inconsiderate	-	4	2
	Unsupportive	-	6	2

6.4.9 Summary - Care during childbirth

Overall, 43% of Albany women had their babies at home in 1999 and 11% of women cared for by the midwifery practices had a home birth. Albany women were significantly more concerned about avoiding unnecessary technology, wanted the same professional to be there throughout, and felt the hospital could not provide the service they wanted compared with other women having home births. Although all women reported being well informed, significantly more Albany women reported they were informed about pain relief, monitoring and emergency back up. Half of the women having a home birth with the group practices reported not being given information about emergency back up facilities. The practice of a 36 week birth talk by the Albany midwives may contribute to the high levels of information of the Albany women and it is recommended that this should be considered as standard practice across the Trust.

A very high level of continuity was achieved, 89% of women were attended during childbirth by their primary midwife and 98% were delivered by their primary midwife or another Albany midwife. More Albany women said it mattered to them that they had met their midwives before than other women. Virtually all Albany women had the same midwife throughout their labour compared to other women in the group practices. Around 16% of all women felt that they had met someone who was unhelpful during labour, 11% of all women felt that midwives were too busy to spend time with them during childbirth, and 16% of women reported that they were worried to be left alone labour. However, fewer Albany women reported that they were left alone ‘far too much’ compared to women cared for by the group practices. Nearly all the staff throughout the King’s maternity service were described as considerate and supportive during labour, however, more Albany women reported that their midwives explained what was happening, told them enough about necessary interventions, took enough notice of their views, and were kind and understanding. A significant minority of women in all groups were not happy for students to be involved in their care and it is recommended that procedures for obtaining consent should be reviewed.

An examination of the Euroking data for 1999 shows that 69% of Albany women did not use any pharmacological pain relief compared to 18% of women in the midwifery practices. A total of 13% of Albany women reported using the pool and 1% used pethidine, compared to 21% in midwifery practices. In addition, 17% of Albany women had an epidural, compared to 25% in the midwifery practices. Most women had been given adequate information about pain relief, and on being asked if they felt that adequate pain relief was offered, significantly more Albany women said no pain relief was required. One possibility for this difference is that the personal relationship between a woman and her midwives during pregnancy facilitates pre-childbirth

preparation and confidence. The reason for this difference in women's views warrants further exploration and may make a valuable contribution to maintaining physiological childbirth.

From the EuroKing data, the caesarean rate for 1999 was 18% for Albany women, 24% for midwifery practices, and 25% for King's as a whole. The majority (around 70%) of all women felt that they had received enough information about the operation. Around 20% of women in all groups would have liked more information about complications during pregnancy and it is recommended that this is an area that may warrant more attention in the future.

6.5 Hospital postnatal care

6.5.1 Hospital postnatal care provision

Around 40% of all women went home within 24 hours, with 12% of women staying 5-6 days. There was no difference in length of hospital stay between Albany women and others.

How many hours or days after the delivery did you return home? N=514	% Albany	% Midwifery Practices	% King's Total
Within 12 hours	11	12	12
12 hours - 24 hours	29	29	28
24 hours - 2 days	4	22	18
3 - 4 days	43	17	24
5 - 6 days	14	7	12
More than 7 days	-	12	6

There were no differences in women's experiences of hospital postnatal care. The majority of women (68%) felt welcomed on the ward. It is of concern that around 25% of all women never felt the ward was quiet and restful. The Albany women had better knowledge of the midwives caring for them than other women. This may be due to the Albany practice midwives visiting the postnatal wards. For example, one Albany woman who stayed in for 3-4 days said she had not met the midwives before, was clearly referring to ward staff. She commented '*but Albany practice midwives visited daily'*. Around a third of women reported that it mattered a lot to know the midwives on the postnatal ward, but again another third said it did not matter to them. Around a third of women felt that midwives were too busy to spend time with them, but there were few differences between groups.

Table 34 Women's evaluations of hospital postnatal care

Whilst on the postnatal ward did you feel:	Women who never felt the following:		
	Albany	Midwifery Practices	King's Total
The ward was quiet & restful N=144	21	22	25
The ward was clean N=149	7	14	12
The ward was a safe & secure place N=141	7	5	7

About the midwives who cared for you whilst on the postnatal ward: N=150 Chi square p=0.02	% Albany	% Midwifery Practices	% King's Total
I knew one (or more) of them well	32	14	16
I had met one (or more) of them before	25	17	21
I had not met any of them before	43	69	63

Did it matter to you whether you knew or had met any of these midwives N=150	% Albany	% Midwifery Practices	% King's Total
Yes, it mattered a lot	36	31	23
Yes, it mattered a little	25	21	27
No, it did not matter	39	48	51

Did you ever feel that the midwives were too busy to spend enough time with you? N=147	% Albany n=27	% Midwifery Practices n=40	% King's Total
Yes, often too busy	37	50	40
Yes, sometimes too busy	37	28	33
No, not really	26	23	27

6.5.2 Advice and information in hospital

About a third of women reported being given different advice. For example, one Albany woman wrote that care in hospital after the birth *'needs a lot of improvement'*. She said :

> *'I was told I couldn't sleep with my baby next to me and was shown how to latch her on differently. The baby didn't want to sleep in her cot so I had to hold her in my arms and stayed awake all night. The next morning I was quite tired and when they heard what I'd been told, they said that most other women sleep with their babies beside them and fed them while in bed. I was also once again told to latch her on differently. A midwife also told me not to let my baby sleep on her back but on her side (quite ridiculous).'*

Another woman said that the paediatrician had told her '*to top up with formula even before I had been taught how to breast feed.*' She had found the staff 'not particularly' welcoming on her arrival. She said that she was given no advice or help on anything until her Albany midwife arrived the next day, and that the information she was given on her baby's progress was 'inappropriate'. Despite this, she was breast feeding when she went home '*only because much help given from Albany midwife*' [quote]. She felt that she was not included in the decision about when she went home but '*had to discharge us [self and baby] because paediatrician wanted to keep us in*'. She reported much support from Albany midwives and being much happier at home. Her description of those caring for her in the postnatal ward was very negative.

Table 35 Conflicting advice on postnatal ward

Were you ever given different advice about something by different members of staff? N=150	% Albany n=28	% Midwifery Practices n=42	% King's Total
Yes	32	38	37
No	68	62	63

Around a quarter to a third of women would have liked more advice on feeding in hospital. More Albany women wanted more advice on bathing their baby, but fewer Albany women wanted advice on handling their baby. Fewer Albany women felt they were given enough information about their baby's progress, but there were no differences between the third of all women who wanted more information about their own progress, but the numbers are small and should be interpreted with caution. **A large percentage of all women did not feel involved in decisions about their care on the postnatal ward (49%) and it is recommended this issue needs further attention.**

Table 36 Women who wanted more information or received no information in the postnatal ward

Did you receive enough help and advice on any of the following whilst you were on the ward?	N=	Wanted more			Not given any advice/help		
		Alb	Prac	Kings	Alb	Prac	Kings
Feeding your baby	14	21	34	22	7	2	6
Bathing your baby	14	19	2	5	27	42	30
Care of your baby's cord	14	4	22	14	32	24	23
Handling your baby	14	13	24	20	29	29	22

		No, Wanted more			No, given no information at all		
		Alb	Prac	Kings	Alb	Prac	Kings
Whilst you were on the ward were you given enough information about your baby's health and progress?	14	50	38	24	63	13	11
Whilst you were on the ward were you given enough information about your own health and recovery?	14	23	29	26	31	24	18

Do you feel that you were involved in any decisions about your care whilst on the ward? N=214	% Albany	% Midwifery Practices	% King's Total
Yes	42	49	51
No	58	51	49

6.5.3 Women's evaluations of postnatal care in hospital

Table 37 shows that a significant minority of women in all groups felt that they were not included in the decision to go home, although there was a non-significant trend for fewer Albany women report this. In addition, a significant minority of all women felt that they had stayed in hospital too long, (27% of Total) although significantly fewer Albany women reported this compared to women cared for by the midwifery practices. **Bearing in mind pressures on hospital beds, it would seem a priority to address this issue.**

Table 37 Decisions about postnatal transfer

Did you feel that you were included in the decision about when you went home? N=147		**% Albany**	**% Midwifery Practices**	**% King's Total**
	Yes	78	63	74
	No	22	34	20
	Can't remember	-	2	6

Did you feel that your stay in hospital was N=147 Chi-square =0.03		**% Albany**	**% Midwifery Practices**	**% King's Total**
	Too long	11	39	27
	Too short	7	10	10
	About right	82	49	62
	Don't know	-	2	1

Table 38 shows women's evaluations of hospital postnatal care. All women were less positive about their hospital postnatal care than their ante and intra-partum care. Albany women do not attribute significantly more or less positive adjectives to their hospital postnatal carers than other women at King's, but it is hard to disentangle to which staff they are referring.

Table 38 Women's evaluations of hospital postnatal care

We would like to know how you feel you were looked after while you were on the postnatal ward. Please circle any of the following that you feel best describe the staff that looked after you: N=148	**% Albany**	**% Midwifery Practices**	**% King's Total**

	kind	54	52	53
	Polite	50	48	50
	Supportive	36	36	35
	considerate	32	33	32
	Warm	21	38	32
	Humorous	18	14	21
	informative	14	19	23
	Sensitive	11	21	22
	rushed	39	57	51
	Bossy	32	10	14
	Unhelpful	29	26	23
	Offhand	21	19	20
	Unsupportive	21	24	19
	rude	18	17	16
	condescending	11	12	9
	Insensitive	4	26	9
	inconsiderate	4	14	14

The lack of difference in women's responses suggests that the postnatal ward staff make little differentiation between the women, whether they are cared for by Albany or the midwifery practices. There are fewer negative responses, and they seem to refer to conflicts of views between staff. For example, one Albany woman who had commented about differing advice for the feeding and sleeping of her baby (above) said those who cared for her after the birth were *'rushed, unhelpful, offhand, bossy and unsupportive'*.

Another woman who had explained her unhappiness with hospital staff at the birth described those who arranged postnatal care as *'rude, offhand, condescending and unsupportive*'. She commented that the hospital midwife also smelt of tobacco. This woman was quite explicit that she had good help from the Albany but not from the hospital (see comments above).

6.5.4 Postnatal care at home in the first 10 days

One Albany woman who had a homebirth commented *'I had a homebirth - midwives stayed a while on the day and visited next day'*. Significantly more Albany women were visited the same day compared with all other King's women. Significantly more Albany women were visited every day than women with the midwifery practices and fewer Albany women were visited every 2-3 days. No women said they were not visited at all. An Albany woman who was visited less frequently said that this was *'at my request as this was a second birth'*.

Table 39 Pattern of postnatal visits at home

When you first went home from hospital were you visited by a midwife? *N=215* Chi square p=0.009		**% Albany**	**% Midwifery Practices**	**% King's Total**
	On the same day	32	17	17
	On the next day	63	59	67
	After that	6	25	17

How often were you visited by a midwife in the first 10 days? N=222 Chi square p=0.015		% Albany	% Midwifery Practices	% King's Total
	Every day	28	13	17
	Every other day	51	43	49
	Every 2-3 days	21	43	24

Would you have liked to have seen a midwife: *N=228*		% Albany	% Midwifery Practices	% King's Total
	More often	18	6	10
	Less often	2	-	1
I was happy with the number of visits		81	94	89

More Albany women would have liked to have seen their midwives more compared to women with midwifery practices. The reasons for this are unclear, this may be because their expectations were higher. One Albany woman commented that *'if I needed more I only had to ask*'.

Table 40 Arrangements for postnatal care at home

Did the midwife or midwives make appointments with you for their visits? N=228 Chi-square p=0.001		% Albany	% Midwifery Practices	% King's
	Yes, a specified time	65	32	35
	A specified half day (i.e. AM/PM)	32	53	53
	Other (please explain)	-	7	5
	No	3	7	6

After you came home do you think the midwives were able to spend enough time with you? N=229		% Albany	% Midwifery Practices	% King's
	Yes, they always had enough time	82	78	78
	They sometimes had enough time	15	18	18
	They rarely had enough time	3	4	4
	No they never had enough time	-	-	1

Significantly more Albany women were visited at specific times than women with midwifery practices. Around 21% of women in total reported that midwives failed turning up for visits, and the majority of women (93%) were informed in advance by their midwife. There were no differences in the time that midwives were able to spend with women, and the majority of women (78%) reported that felt their midwives did have enough time.

Table 41 Continuity of caregiver at home

How many midwives visited you at home? N=229 Chi-square P=0.000		% Albany	% Midwifery Practices	% King's Total
	One	26	16	18
	Two	63	28	44

	Three	7	43	28
	Four	-	10	7
	Five or more	5	-	3
	Can't remember	-	3	1

Had you met any of them before? ***N=228*** **Chi square P=0.000**		**% Albany**	**% Midwifery Practices**	**% King's Total**
	Yes, all of them	93	63	57
	Yes, some of them	-	21	19
	No, none of them	7	16	24

Did it matter to you whether you had met them before? **N=227** **Chi square p=0.000**		**% Albany**	**% Midwifery Practices**	**% King's Total**
	Yes, a lot	78	49	43
	Yes, a little	12	32	26
	No, not at all	10	19	27

Significantly more Albany women were visited at home by one or two midwives compared to women with the midwifery practices. For example, 89% of Albany women saw 2 midwives only compared to 44% of women seen by group practices. When women were asked if they had met their midwife previously, all but one Albany woman had met all the midwives who visited her at home. This was a significantly more than all other women with the midwifery practices. When women were asked if it mattered that they had met their midwives before, significantly more Albany women said it mattered to them, compared to other women with the midwifery practices.

6.5.5 Help, advice and information in the postnatal period

There was a non-significant trend for more Albany women to report adequate help with feeding and handling compared to other women in the midwifery practices.

Table 42 Information and advice in the postnatal period

Were you given enough help and advice on any of the following since you have been at home?	**N**	**Enough**			**Not needed**		
		Alb	**Prac**	**King**	**Alb**	**Prac**	**King**
Feeding your baby	227	90	75	76	7	15	15
Bathing your baby	223	50	49	45	36	37	40
Care of your baby's cord	226	83	72	76	9	16	14
Handling your baby	225	66	47	50	24	41	39

Do you think you have been given enough information about any tests that you and your baby have had since you have been at home? N=227 (chi square p= 0.04)	% Albany	% Midwifery Practices	% King's Total
Yes, enough information	68	88	85
Would have liked more information	23	10	11
Not given information	2	-	1
Have not had any tests	7	2	4

Significantly more Albany women would have liked more information on the tests done on their babies compared with all women with midwifery practices and 23% would have liked more information on this specific topic. When asked what they would have liked more information about, a young Albany woman said that she *'Didn't receive all of my blood test results for myself and baby. Would like them to check up baby and for myself more after birth.'* She had been visited every 2-3 days and would have liked more visits. A midwife had made an appointment but failed to come, without first contacting her and then she was visited by one midwife, whom she knew well.

Table 43 Conflicting advice in the postnatal period

Since you have been at home have you been given different advice about something by different midwives? N=622		% Albany n=59	% Midwifery Practices	% King's Total
	Yes	12	16	12
	No	88	84	87

If Yes, did this *make you worried or confused?* N=28		% Albany n=7	% Midwifery Practices n=11	% King's Total n=28
	Yes	57	73	68
	No	43	27	32

Table 43 shows that around 12% of all women said they had been given conflicting advice, however there were no differences between groups. This did worry a substantial number of women (68%) but no group more than any other. Conflicting advice from caregivers has been an ongoing concern for women in the postnatal period throughout the UK, and increased levels of continuity of caregiver for Albany women has made no difference. This is a topic of concern for the majority of women in the Trust and could be investigated further.

But when women were asked to evaluate the information provision in the postnatal period, Table 44 shows that the majority of women felt that they had enough information on their babies' progress in general, and that there were no significant differences between groups.

Table 44 Women's evaluations of information provision

Do you think that you have been given enough information about you and your baby's progress since returning home? N=224		% Albany	% Midwifery Practices	% King's Total
	Yes	95	84	89
	No	5	16	11

Do you think that you have been involved in decisions about your care at home N=228		% Albany	% Midwifery Practices	% King's Total
	Yes fully involved	84	84	84
	Yes, involved slightly	16	13	13
	No, not at all involved	-	3	3

There were also no differences in how involved women felt about their care and Table 44 shows that the majority (84%) of women felt fully involved, with no Albany women reporting that they did not feel involved at all.

6.5.6 Infant Feeding

Drawing on Euroking data, in 1999, almost all Albany women breastfed at birth (93%) compared to 75% of women in the midwifery practices. This dropped to 70% fully breastfeeding at 28 days for Albany women. Further information about breastfeeding within the Trust can be found in the STEP project report (Grant, Fletcher and Warwick 2000).

6.5.7 Women's evaluations of postnatal care

Postnatal care at home was better evaluated than the care in hospital, but there were no significant differences between groups. Few Albany women made comments relating to postnatal care at home. Two of the three negative comments from Albany women were given by a young woman who found the after care rushed and unsupportive. She said that it would have been better if a '*GP or doctor could visit the baby at home for the first check up, instead of us taking the baby to the GP.'* She said that she didn't receive all of her blood test results for herself and the baby. She would '*like them to check up baby and for myself more after the birth'*.

Table 45 women's evaluations of care

We would like to know how you feel you were looked after while you were at home. Please circle any of the following that you feel best describe the staff that looked after you: N=226	% Albany	% Midwifery Practices	% King's Total

Supportive	85		81	81
Kind	83		79	78
Warm	75		78	74
Polite	70		74	71
Considerate	68		78	72
Sensitive	66		69	62
Informative	54		57	56
Humorous	43		43	46
Rushed	2	n=1	12	7
Bossy	2	n=1	3	1
Unsupportive	2	n=1	-	1
Unhelpful	-		3	1
Rude	-		3	1
Offhand	-		2	1
Insensitive	-		2	1
Condescending	-		2	3
Inconsiderate	-		-	-

6.5.8 Summary - Care after childbirth

All women were less positive about their hospital postnatal care than care during pregnancy and birth, and no differences in women's experiences of hospital postnatal care. Around 40% of all women went home within 24 hours, there was no difference in length of hospital stay between Albany women and others. It is of concern that around 25% of all women never felt the ward was quiet and restful and may explain why 27% of all women felt that they had stayed in hospital too long, although significantly fewer Albany women reported this compared to women cared for by the midwifery practices. Bearing in mind pressures on hospital beds, it would seem a priority to address this issue.

Around a third of all women would have liked more advice on feeding in hospital. The Albany women had better knowledge of the midwives caring for them than other women and this may be due to the Albany practice midwives visiting the postnatal wards. Just under half of all women did not feel involved in decisions about their care on the postnatal ward and it is recommended this issue needs further attention.

Postnatal care at home was better evaluated than the care in hospital, but there were no significant differences between groups. Significantly more Albany women received postnatal visits on the day they went home and had more regular visits at pre-specified times. They also had fewer midwives visiting in the postnatal period and all but one woman had met all the midwives previously. More Albany women valued having met the midwife before compared to women in the midwifery practices. However, there were no differences in how involved women felt about their care.

The majority of women felt that they had enough information on their babies' progress in general but significantly more Albany women would have liked more information on the tests done on their babies compared with other women in the practices. Around 12% of all women said they had been given conflicting advice, and this did worry a substantial number of women (68%). Conflicting advice from caregivers has been an ongoing concern for women in the postnatal period throughout the UK. This is a topic of concern for the majority of women in the Trust and could be investigated further.

Drawing on 1999 Euroking data, almost all Albany women breastfed at birth (93%) compared to 75% of women in the midwifery practices, and remained high at 28 days (70%). The processes of care that facilitate this warrant further investigation.

The majority of women felt that it was important to have care that was convenient, from skilled staff, to be treated kindly, given information, to be involved and treated with respect, and there were no differences between groups. However, significantly more Albany women said that it was important to receive care from someone you know compared with women with other practices. The majority of all women thought it important to choose where and with whom they had their care and significantly more Albany women thought it important for women to choose who they have their care with compared to other women.

6.6 Women's evaluations of care throughout pregnancy, birth and the postnatal period

The majority of women felt that it was important to have care that was convenient, from skilled staff, to be treated kindly, given the information, to be involved and treated with respect and there were no differences between groups. However, significantly more Albany women said that it was important receive care from someone you know compared with women with other practices. The majority of women thought it important to choose where and with whom they had their care and significantly more Albany women thought it important for women to choose who they have their care with compared to other women.

When asked if they would recommend the service to other women, the majority of all women (75%) said yes, but there were no differences between groups. Comments by the Albany women usually identified the Albany practice midwives, but not other aspects of care. One Albany woman said that she would recommend the Albany midwives but not the hospital clinic. Another woman said yes, *'except the post natal ward.'*. Another woman stressed that it was the Albany midwives and their '*continuous supportive care'* which she would recommend.

Table 46 evaluations of important aspects of care

Thinking back about your pregnancy, birth and after the birth, how important to you is it to have care:	**N=**	**Very important**			**Not important**		
		Alb	Prac	Total	Alb	Prac	Total
that is convenient	230	79	81	77	-	2	1
that is from skilled midwives and doctors	229	98	99	95	-	-	-
that is from someone you know **p=0.010**	222	58	35	43	2	18	14
where you are treated respectfully	229	85	96	90	-	-	-
that gives you the information you want	231	92	91	89	-	-	-
that involves you	231	97	91	91	-	-	-

where you are treated kindly	230	90	85	84	-	-	-

Some people want to be able to choose <u>where</u> they have their care and <u>with whom</u> . How important is it to you?	**N=**	**Very important**			**Not important**		
		Alb	**Prac**	**Total**	**Alb**	**Prac**	**Total**
To choose where	226	73	69	71	3	2	4
To choose with whom Chi-square p=0.01	226	78	54	61	5	4	5

A woman who had a home birth with Albany said :

> *"I would highly recommend the Albany practice, but I would certainly not advise someone to have the baby in hospital. I had my first there and felt completely unsupported. I was very adamant that I should not have to attend the hospital for anything, throughout my second pregnancy, and after some pressure and discovering the Albany practice, my wish was respected'.*

Another Albany woman who had a home birth said she would recommend the King's service based on her experience of labour with her second child who was born in hospital, but, having had her third child at home with the support of the Albany midwifery practice, *'I would always recommend a home birth, if it's all looking straight forward. It couldn't be beaten, the wonder of having your baby and then being able to get back into your won bed, at home with all your comforts and familiar things around you was great'.*

7.0 Conclusion

The success of the independent evaluation can be judged by reference to the following question.

1 Were the aims and objectives of both the Albany Practice and the Trust achieved?

The overall aims of the Albany Practice were to support 'normality' 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. Overall, the Albany Practice did achieve its objectives, specifically:

a) The Albany Practice was very successful at facilitating 'normality in pregnancy and birth. The home birth rate was very high and fewer women had childbirth interventions compared to other women who were cared for by the midwifery practices. Fewer women had pharmacological pain relief and fewer said they wanted it and breastfeeding rates at birth and latterly were high. In addition, one of the objectives of the Trust to improve childbirth outcomes in very deprived groups of women was also achieved.

b) The Albany Practice aimed to provide continuity of caregiver. Almost all Albany women were attended during childbirth by her primary midwife or another Albany midwife. Continuity of caregiver was also achieved through pregnancy and the puerperium, although there were no differences in how involved women felt with their care in the postnatal period. Albany women were more aware of how to contact their midwife and did so and Albany midwives were rated as kinder and warmer. More Albany women said it mattered to them that they knew their midwives and fewer reported being left alone in labour.

c) The Albany Practice aimed to provide informed choice. Women in different groups reported no differences in the information that they received in pregnancy, and Albany women reported less choice in who provided antenatal care, but more choice of who would attend their birth. All women reported high levels of choice about where to have their babies, and Albany women felt more involved in the decision. More Albany women who had a home birth reported being well informed about the issues involved compared to other women having a home birth. This may be because Albany women reported that their midwives had more time to discuss issues. A significant minority of women overall wanted more information about childbirth complications and Albany women wanted more information about tests done on their baby. Albany women valued choice more highly than other women.

d) The practice aimed to provide accessible and appropriate care. The practice is located in a local health and leisure centre and women booking with the Albany Practice came mainly from the Lister GP Practice and the Peckham area, one of the most deprived areas served by the Trust. There were no significant differences by age, parity, living arrangements and level of education compared to women cared for by other Midwifery Group Practices. However, the

ethnic background of Albany women was significantly different, there were fewer Caucasian women and more African women respondents from Albany which reflects the population in the Peckham area. Albany women were more likely to seek a midwife when first pregnant, have a home booking, and have antenatal care provided by Albany midwives combined with GP antenatal care if they wished. They were more likely to have specified appointments both in the antenatal and postnatal period, resulting in less waiting time in the GP clinic. They were more likely to call their midwife compared to other women if they had a problem.

e) Demonstrate 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, often made with considerable 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. Additional information about caseload working would need to be disseminated to all staff to improve understanding of the model of care.

f) Influence the philosophy in the Trust. Trust staff valued the benefits of continuity of carer recognised the achievements of maintaining and promoting normality. There has been some evidence of other midwifery practices modelling care on the Albany Practice. It is crucial that the key factors of success are disseminated to staff who wish to replicate the model.

The overall conclusion is that the Albany practice have been successful in achieving the objectives they set for themselves in agreement with the Trust. However, in the course of the evaluation other issues emerged that warrant further attention.

8.0 Implications for practice, policy and research

8.1 Implications for Practice

- There were several misconceptions held among Trust staff around the roles and responsibilities of Albany, the nature of the contractual relationship, cost of care and supervisory arrangements. Clear communication of the organization, aims, objectives and achievements of the Albany Practice should be communicated to all Trust staff.

- The examination of clinical incident data revealed inconsistencies and difficulties in drawing conclusions. The system of defining and reporting 'near miss' clinical incidents needs to be reviewed.

- A significant minority of women were not happy for students to be involved in their care and it is recommended that procedures for obtaining consent should be reviewed.

- A significant minority of women said they stayed on the postnatal ward too long. It is suggested that transfer arrangements are reviewed so appropriate and timely transfers to the community are improved.

- Community midwives raised concerns about personal safety. It is suggested that working practices of all community midwives with regard to personal safety are reviewed.

- It should be noted that the Albany midwives were more able to devote time to providing midwifery care because of the administrative support provided by the practice manager. As more midwives move out into midwifery group practices in the community, this level of support to the Albany Practice should be recognized.

- Greater communication and a regular forum for discussion and planning between all midwives and Obstetric and Paediatric staff prior to emergency situations arising may improve inter-professional working in this area.

- Several staff commented on the lack of inter-professional forums. It is suggested that multi-disciplinary training opportunities, both formal and informal are explored.

- Around 20% of women in all groups would have liked more information about complications during pregnancy and it is recommended that this is an area that may warrant more attention in the future.

8.2 Implications for research

Routine data management

- Measures of social deprivation would enhance casemix analysis and new indicators that use postcodes could be incorporated into routine data collection.

- In order to avoid bias, future analysis of Euroking data should compare outcomes for standard primips and standard multips. It is essential to include women who have a home birth on Euroking.

- It is important for future consumer satisfaction surveys to be a random cohort to ensure a representative sample. Special groups such as women having a home birth would need to be sampled separately.

Improving understanding the relationship between organisation and delivery of care and childbirth outcomes

- The views of the most deprived and excluded women are not represented in the maternity satisfaction survey because of non-response due to problems of social mobility, non- English speaking, literacy. Different methods should be considered to give such women a voice ie focus groups.

- The organization and delivery of care that has facilitated high home birth and breastfeeding rates in an area of high deprivation would benefit from further investigation.

- The relationship between continuity of caregiver and antenatal education and the high

beneficial childbirth outcomes could be explored in further research.

Improving the quality of postnatal hospital care

- Conflicting advice from caregivers has been an ongoing concern for women in the postnatal period throughout the UK. This is a topic of concern for the majority of women in the Trust and could be investigated further.

- Just under half of all women did not feel involved in decisions about their care on the postnatal ward and this issue needs further exploration.

Full report

Further 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: 0207 848 3512, email: Ann.pryor@kcl.ac.uk. Priced £10 including postage and packing. Cheques should be made payable to King's College, London.

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