AIMS

ASSOCIATION FOR
IMPROVEMENTS IN THE
MATERNITY SERVICES

Association for Improvements in the Maternity Services (AIMS) critique of

'The London Project: A confidential enquiry into a series of term babies born in an unexpectedly poor condition' by the Centre for Maternal and Child Enquiries (CMACE Report)

Summary

The AIMS critique of the CMACE Report includes the following concerns:

- why the report was requested by King's College Hospital
- the selection of cases that were sent to be reviewed
- the methods used to review them
- the validity of the conclusions that were drawn

The AIMS critique concludes that the CMACE Report:

- Reported on the excellent reputation of Kings, but failed to include the excellent reputation of the Albany Midwifery Practice, and omitted any details about King's community midwifery which also achieves excellent outcomes. It is possible that CMACE was not actually given access to previous reports about the Albany Midwifery Practice.

- Failed to consider the possibility that the 'cluster' of cases presented by King's could have been a chance event, and that the selection of data (including the time frame) may have contributed to the construction of such a 'cluster'.

- Failed to use the recommended term, Neonatal Encephalopathy (NE), which describes symptoms and instead uses Hypoxic Ischaemic Encephalopathy (HIE) which implies cause.

- Selected groups of babies with and without a problem who were cared for by the Albany Midwifery Practice and a group of babies who had a problem who were cared for by King's community midwives, but failed to include any babies cared for by the hospital.

- Used Confidential Enquiry methodology designed to look for trends in large groups of cases in order to help to identify practice changes to improve outcomes. This methodology was not appropriate for the comparison of small groups of cases.

- Misunderstood women's right to be supported to make their own decisions and not be pressured into having to accept care dictated by protocol and guidelines. The report contradicts itself saying that the midwives were not directive enough, yet is critical saying that "the choices the woman makes will to some extent reflect the preferences of her midwife"; it seemed that the report had clear medical views about what women should and should not be 'directed' to do.

- Assumed that the Albany Practice midwives needed further education that could be provided by them working in the hospital environment and failed to consider that King's staff could gain from what the Albany Practice midwives could teach them,

- Made unsubstantiated assumptions that outcomes could be improved by adherence to hospital protocols and guidelines, and included a suggestion of a homebirth risk assessment tool. However there is no evidence that place of birth was an issue in any of the cases considered.

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We would like to emphasise that the pursuit of high quality care has always been our primary concern. We therefore take extremely seriously any situation in which there is a suggestion that care has been inadequate, whoever is responsible. Any unusual apparent increase in adverse outcomes should of course be investigated fully, and care examined in a fair and transparent manner.

Background

The Albany Midwifery Practice was a self-employed midwifery group practice which was contracted by King's College Hospital (King's) to provide midwifery care for 216 women each year. The contract had been in place since 1997, over 11 years when King's commissioned a CMACE enquiry (CMACE Report). Following an adverse outcome for a baby under the care of the Albany Midwifery Practice in October 2008, King's College Hospital subsequently identified that during the 31-month period 31/03/06 to 31/10/08 there appeared to be an unusually higher number of babies from the Albany Midwifery Practice with what King's classified as Hypoxic Ischaemic Encephalopathy (see below). Therefore an internal audit was commissioned and CMACE was commissioned to carry out an independent review.

Context

Introduction

The introductory paragraphs (p3) of the CMACE Report focus exclusively on the medical care provided by King's maternity services, for example, ultrasound fetal management and fetal assessment. It would have been useful to have had more details about the community midwifery services provided by King's as well as which services were responsible for the above average homebirth rate. These should have formed part of the context for the CMACE Report.

The introduction (p3, 1.1) of the CMACE Report refers to the excellent reputation of King's Maternity Unit, but fails to balance this by referring to previous evaluations of the Albany Midwifery Practice that demonstrated excellent outcomes and satisfaction (Sandall et al 2001, Rosser 2003). Nor does it mention a report by Jill Demilew (Consultant Midwife at

King's), showing the many benefits to women and babies provided by the community midwifery practices including the Albany Midwifery Practice (Demilew 2007). This lack of balance gives an unfortunate impression of bias at the beginning of the CMACE Report. Is it possible that the CMACE team was not made aware of these three reports?

The authors of the enquiry recognised (p19) that their methodology was likely to stress negative aspects of a service rather than positive aspects. The authors therefore should have provided a fuller context for the CMACE Report, acknowledging that the Albany Midwifery Practice's perinatal mortality rate in the 10 years from 1997-2007 (4.9/1000) was lower than the national average and far lower than the average for Southwark borough (the area served by the Albany Midwifery Practice) as a whole (11.4/1000 from 2003-5, Southwark PCT 2007). Nor was there any mention that the Albany Midwifery Practice had a higher vaginal birth rate, higher intact perineum rate, higher use of the birthing pool, lower episiotomy rates, higher breastfeeding rates at birth, a lower elective caesarean rate, lower induction rate, and less use of pethidine and epidurals, than King's and the other midwifery group practices (Sandall et al 2001; Reed 2002). The CMACE Report failed to comment on the significance of the fact that the women cared for by the Albany Midwifery Practice in the cases selected for review were found to be in the most disadvantaged fifth of the population (9/12 of the Albany adverse outcome cases, and 8/10 of the other Albany cases as noted in Table 1, p8). Women in the most deprived groups are known to have the highest perinatal and maternal mortality and morbidity (CEMACH 2007) and therefore this information was highly relevant to any investigation of adverse outcomes.

The CMACE Report mentions that King's had already investigated each of the Albany Midwifery Practice cases that were referred to CMACE through its own risk management procedures, yet apparently it did not find any problems with the midwifery care except '*in a minority of cases'* (p4) . However, we are not told how many cases, what the issues were, or whether they were the same as those identified by CMACE. It is surprising that CMACE does not comment on the discrepancy between its own findings and those of King's.

Since there is no mention of Serious Incident Reports, we presume none of the problems had called for such action. It is puzzling that there is no mention of any prior involvement with midwifery supervisors, who would normally have been involved if there had been any serious question about quality of care by any of the Albany Practice Midwives**.** There is no indication of what had already been put in place to support the midwives if this indeed had been judged necessary. Without this contextual information, it is difficult to gain a more complete understanding of how King's managed its concerns and what sort of management changes might be needed in the future.

Methodology

Main aim of the CMACE Report

The CMACE Report was structured around its main aim *to 'gain a better understanding of why there appeared to be higher numbers of adverse outcomes in women cared for by the Albany so that any necessary changes can be made both for the Albany Group Practice and*

maternity care in general, to improve the safety of mothers and babies under the care of the King's maternity unit ' (p4). This aim excluded the possibility that the adverse outcomes identified could have been misdiagnosed, or have occurred by chance. The aim of the investigation should surely have been initially to ascertain the details about these apparently adverse outcomes and whether or not there was in fact a higher number of adverse outcomes among babies cared for by the Albany Midwifery Practice.

Selection of cases

It appears that CMACE agreed to examine selected cases provided by King's that fell within a period of 31 months. Thus King's set the time frame, and King's selected the cases. The basis on which they were chosen is not given anywhere. This is unique in our experience of any reputable study.

King's also made the diagnosis of Hypoxic Ischaemic Encephalopathy (HIE)[1] and this was apparently taken on trust by CMACE. There was no definition or grading of HIE given in the CMACE Report, no mention about the contested nature of HIE diagnosis, and no mention of any follow up of the cases. CMACE appears to have uncritically accepted King's initial methodology and endorsed its finding, that *'over a 31 month period the number of admissions of term infants with serious morbidities was comparatively 10 fold greater amongst women under the care of the Albany Group Practice than women cared for by other King's midwifery group practices or by hospital midwives'* (p4).

As no statistics for comparison are provided for King's or other community midwifery practices' admissions to the Neonatal Intensive Care Unit (NICU) there is no evidence for this statement, and in any case using the term '10 fold', with such small numbers is inappropriate and misleading. These small numbers are not amenable to statistical analysis, and therefore exact numbers should have been used. Not until page 6 is it stated that *'after careful consideration, tests of statistical significance were not applied to the data since the methodological features of the enquiry precluded such an approach'*. This should have been stated earlier in the CMACE Report, as is the usual practice. With this small number of cases, a Root Cause Analysis would have been a more suitable methodology (as recommended by the National Patient Safety Agency 2010).

HIE diagnosis

Much of the usefulness of any enquiry of this kind depends on an accurate diagnosis of HIE. The National Perinatal Epidemiology Unit in Oxford, England has in fact strongly recommended that the term be discontinued, and the term 'neonatal encephalopathy' (NE) adopted instead, as this better describes the condition without assuming a particular cause (Kurinczuk at al 2005). Several studies have challenged the view that all cases of NE are the result of adverse intrapartum events. According to a recent review of the evidence by

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1 Brain damage thought to be due to lack of oxygen during the birth process (see discussion below)

Graham et al (2008), NE is a rare outcome occurring in about 2.5 per 1000 births and in approximately 86% cases the cause is due to antenatal factors.

Therefore an accurate diagnosis, as well as follow up of cases, is essential. As already stated above, the CMACE Report does not define the level of HIE that was diagnosed in the Albany Midwifery Practice cases; it is normally graded from I (mild) to III (severe). This is important, as a recent review of 12 studies found that the proportion of infants with NE who went on to develop adverse outcomes was nil in stage 1 (mild), 32% in stage 2 (moderate) and almost 100% in stage 3 (severe) (Pin et al 2009). The National Neonatal Audit now requires follow up to the age of two years.

Lack of appropriate comparisons

The cases investigated by CMACE were from three groups as follows:

- Group A: women receiving care from the Albany Midwifery Practice who were identified as having adverse neonatal outcomes (11 cases of HIE and 1 of hypoglycaemic brain injury due to feeding difficulties).
- Group B: women receiving care from the Albany Midwifery Practice identified as not having HIE (10 non-HIE cases). These had been selected by King's but there is no information about criteria used for selection.
- Group C: women receiving care from other King's community midwives (11 cases with 'unexpected admission to NICU'). Again, these had been selected by King's but there is no information about criteria used for selection. It states that the babies 'unexpectedly required admission to NICU' but no other selection criteria are provided. The 11 babies in Group C were cared for by other community midwifery group practices but there is no information about whether the midwives cared for all women in their area or for low risk women only. Thus the cases selected from the King's community midwifery group practices had a different criterion applied (unexpected admission to NICU, not a diagnosis of HIE). If there were no diagnoses of HIE among the other group practices during the 31 months selected this should have been made clear.

As comparisons were to be made, we would have expected a comparison group of cases from community midwives where no problems were identified. We would also have expected two groups of babies from King's hospital care; one group that had been diagnosed with HIE and one where no problems had been identified to have been included in the enquiry. When research groups are chosen for comparison, it is normal to decide in advance and to state how this has been done to ensure fairness. Otherwise the readers might suspect that cases have been "cherry-picked" to create a particular impression.

Time frames

Given the relatively short time frame for the cases included in the enquiry, and given the population of women cared for by the Albany Midwifery Practice, it is unclear whether 12

babies over a particular 31 months would constitute a ‘cluster’ (Albany Midwifery Practice caseload of 216 women per annum means at least 550 babies over 31 months). There is no definition of how CMACE defines a ’cluster’, nor is there clarity about the selected time frame of 31 months. Professor Alison Macfarlane, Statistician and Professor of Perinatal Health at City University, London, and former advisor to CEMACH, has commented on the time frame: *’This is not long enough to allow the possibility for time trends to be investigated. If the compilation of the lists*[2] *was prompted by concern that morbidity might be rising, then a longer series of data should have been compiled’* (Macfarlane 2009).

Any health care facility may suddenly have a ’cluster’ of problem cases without apparent reason. On small numbers, rates are likely to be statistically insignificant and unreliable. Given that King’s had contracted the services of the Albany Midwifery Practice since April 1997, there is no obvious reason why a longer time frame should not have been used, with more reliable comparisons.

Qualitative arm of the enquiry

The enquiry also employed qualitative methodology which involved interviews and role play (p25) which is not described in detail. To our knowledge role play has not been used before in a confidential enquiry as a means of judging how staff may have behaved in the past, or would do in future. We know of no evidence for this assumption. Moreover, role play for a midwife obtaining consent for a test for bacteriuria is assumed to apply to how she would have obtained consent for home or hospital birth - an entirely different matter in entirely different circumstances. Decision about place of birth are often not a one-off event. The authors do not seem aware of the Department of Health Guide to Consent for Examination for Treatment (DH 2009) which states that *‘stressing and giving of consent is usually a process, rather than a one-off event’* (p16). We know from what women have told us that their views can change for medical and other reasons, and that they therefore value support from known and trusted midwives in reflecting on and evolving their decisions. We also note that there was no similar role play for medical and other staff, despite the recorded problems identified on p26-27 where *‘some hospital based staff express(ed) opposition to the whole concept of birth taking place outside of a hospital’s perimeters’* (p26-27).

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2 Professor Macfarlane was invited to comment from a statistical point of view on three successive versions of a list (each slightly different), compiled by King's and given to the AMP, of babies who had been transferred to the Neonatal Unit in 'unexpectedly poor condition' after birth. Professor Macfarlane concluded: 'In the absence of information about the sources of the data in these case series, the definitions and inclusion criteria used, the longer term outcome of the babies who survived, the extent to which the babies included and all babies delivered at King's had factors which were associated with neonatal encephalopathy and the lack of denominators and statistical power, it is impossible to draw any inferences. The lack of definitions and inclusion criteria call into question these case series as a sampling frame for any investigations to be undertaken in greater depth'.

Analysis

The CMACE Report utilises the usual CEMACH method of analysis using anonymous multidisciplinary enquiry panels, drawing conclusions by consensus and revealing the outcome of cases prior to decisions about standards of care. In the Confidential Enquiry reports this is to examine large numbers of cases and determine trends across all areas of maternity services. The aim of confidential enquiry methodology is to determine '*whether and to what extent there is a pattern of recurrent avoidable factors associated with adverse outcomes in a care system'* (p5); we question whether it is appropriate to apply a methodology used for large care systems in this case, which involved 7 midwives, and 12 adverse outcomes. The cases will also have involved care from doctors, as most of the babies were born in hospital under the care of King's (8 out of the 12 cases under investigation) but there is no scrutiny of medical care apparent in the case discussions in the CMACE Report.

Analysis by panels

There is no detail of the constitution and size of each multidisciplinary enquiry panel, though we are told that there were both doctors and midwives involved. Conclusions about care given were by consensus and this methodology has a number of limitations. Given power differentials, and findings of research (e.g. Fahy 2002, Murphy Lawless 1998, Kirkham 2004) it is possible that the medical view was more dominant than the midwifery view which may have led to a lack of understanding of an holistic midwifery approach.

Analysis by 'proforma'

The panels assessed all 33 cases against a '*semi-structured proforma*'. This proforma is not provided as part of the CMACE Report making it is impossible to judge the relevance and rigour of this selected tool. Such a tool is unlikely to be able to facilitate consideration of complex issues such as social and psychological factors, information-giving, choice and consent. The proforma was apparently agreed with King's beforehand, thus cannot be deemed to be independent or necessarily adequate in relation to community based midwifery, offering continuity of carer. It is possible that the proforma adopted medical definitions of care. For example, if the Albany Practice midwives did not use partograms and if this was part of the proforma, their notes would be automatically and uniformly judged to be of poor quality. However it should be noted that a Cochrane systematic review in 2008 concluded that routine use of the partogram as part of standard labour management and care '*could not be recommended on the basis of current evidence*' (Lavender et al 2008).

The midwife-woman relationship

Supporting women's decision making

As the CMACE Report recognises, the Albany Midwifery Practice had an ethos of woman centred care and informed choice. However the authors' comments in the CMACE Report indicate a fundamental misunderstanding of this way of working. The CMACE Report

discusses '*the choice agenda*' and discusses necessary criteria (such as information in an understandable format and time to assimilate it) for choice to be genuine and fully informed, but then continues: '*this is difficult to achieve and in reality a woman will often look to the health care professional for guidance and will follow the advice of that figure of authority...in the opinion of the authors of this report the choices the woman makes will to some extent reflect the preferences of her midwife'* (p 25).

The CMACE Report notes that women should be given *'both choice and guidance'*. A role play about screening for bacteriuria is discussed where *'the counselling provided appeared extreme in its non-directional manner'* (p25) and *'because of this extreme non-directional approach to counselling […] it is possible that the women concerned may detect a negative slant to the counselling they receive'* (p26). The table indicates however that overall 16 out of 22 Albany women had their urine screened during pregnancy, which seems a fairly high uptake in the face of a supposed *'negative slant'* from midwives. The authors reflect: *'it may be that a more direct form of advice-giving would be of benefit to the women being cared for at the Albany Group Practice'* (p26). This seems contradictory and results in a "no win" situation for the Albany Midwifery Practice – they are criticised for not advising, but also accused (without evidence) of *'a negative slant'* regarding obtaining women's consent for urine screening (p26) and at the same time are criticised for *'pushing for a homebirth '* (p11).

It is also suggested that the Albany Midwifery Practice midwives are in some way excluding others from the women's care by accompanying them to hospital appointments and that this should be stopped (p37). The CMACE Report fails to consider the implications of the wider context of the Albany model; the fact that women meet and discuss their decisions and choices with each other in antenatal and postnatal groups as well as with their own midwife, and that they appreciate their midwife's support in hospital. This is borne out by our experience at AIMS, especially during an unexpected transfer from home to hospital. This is often made in a situation where a women who had wanted a homebirth (sometimes because of dissatisfaction with previous hospital care) has developed worrying complications. These emergencies can result in mental trauma, including post traumatic stress disorder, of which we see many cases. Women who have received continuous support though this difficult transition often comment on how this enabled them to cope.

Alarmingly, the authors appear to be saying that it is unrealistic even to seek to provide the level of information needed for women to be able to make complicated decisions and that women should be 'directed' by the midwife. This paternalistic assumption is a complete departure from Government policy (DH 2007). It goes against the reports from national and local childbirth organisations and national surveys which recognise that women want detailed information in order to make decisions. Furthermore, if a midwife were to act in this way, she would be in breach of the Midwives Rules and standards (Nursing and Midwifery Council, 2004).

If this view of informed decision-making does indeed represent CMACE's policy, it would be of extreme concern not only to AIMS, but to other childbirth and women's groups.

Homebirth rates reflect ethos of care

Raised homebirth rates and low caesarean section rates are a good example of what can be achieved when women are provided with excellent information, support and continuity of carer. An area's or practice's homebirth rate gives a very good indication about the amount and level of information and support offered to women. A low homebirth rate suggests that little information is given and little discussion takes place about place of birth. King's has for many years prided itself on its relatively high homebirth rate; this is largely achieved by the community midwifery practices, with Brierley (a specialised homebirth service) and the Albany Midwifery Practice having the highest rates. The potential benefit of this is well recognised. For example, Jill Demilew's report notes*: 'There is clearly a lot of scope to increase more women to safely start their labours at home and continue to a homebirth. This should contribute to a further reduction in the overall Caesarean Section Rates'* (Demilew 2007).

It appears from the CMACE Report that King's is experiencing difficulty in relation to attitudes towards homebirth and that this has had a detrimental fall-out on the Albany Midwifery Practice (although only 6 of the 22 Albany births examined took place at home). The CMACE Report notes that *'interviews with various staff groups at King's College Hospital revealed highly polarised opinions on this matter, however with some hospital based staff expressing opposition to the whole concept of birth taking place outside of a hospital's perimeters and negative attitudes towards midwives who promote homebirth'* (p26-27).

The CMACE Report states: *'Planned homebirth is an option that many 'well informed' women will choose'* (p27): however the role of the midwife is to ensure that each and every woman is aware of her choices regarding place of birth. Every woman should be enabled to be fully aware of the information relevant to her decisions about place of birth, not just those characterised by health practitioners as *'well informed'*.

Ethos, workload and style

CMACE suggests that the Albany Practice midwives should spend more time working in King's labour ward, in order to familiarise themselves with the hospital environment and promote normal birth. It is unclear how this recommendation would facilitate the development of the Albany Midwifery Practice. And because the midwives had an all risk caseload, they were already working in the hospital and promoting normal birth in what appears to have been a hostile environment. The CMACE Report might have suggested that King's midwives spend time working with the Albany Midwifery Practice and other caseload midwives so they might better understand the ethos and value of community midwifery care. Experience of working in both settings should be two-way, and understanding would be better if all midwives and obstetricians in training were required to do work in a community setting. This is in line with the recommendations of the House of Commons Select Committee on Health report on Maternity Care (House of Commons 1991). Any suggestion that there is only a one-way learning gap could well reduce confidence in future CMACE reports.

Trust policies and procedures

The development of Trust policies and protocols is complex. They do not always reflect current research or national guidelines (O'Neill 2007), nor do they take into account individual medical or social circumstances or individual preferences, nor the experience and knowledge of experienced practitioners. They provide general guidelines based on statistical information and ostensibly protect the public from less knowledgeable practitioners.

There is an unsubstantiated assumption in the CMACE Report that damage to babies occurred as a result of midwives not following Trust policy, and that following Trust policy results in best practice. The CMACE Report states: *'In many cases, the case notes indicated that in particular the Albany Group Practice did not appear to follow the Trust policies and procedures as set out in their agreement with the Trust'* (p26). Clinical decision making in midwifery practice has many elements. For example, the individual woman's unique set of circumstances (physical, social, psychological), the midwife's knowledge and experience, research and local and national guidelines (Van de Kooy 2010). Taking all these factors into consideration enables the risks and benefits to be explored and the woman to be able to make her informed decision, which may not always be the same as that recommended by Trust policies and procedures. AIMS is frequently in contact with women making such decisions all over the UK, not just in the Albany Midwifery practice. Research has shown that this responsiveness to individual need, which results in the woman feeling in control of what happens to her, is something that is hugely valued by women (Magee and Askham 2007).

'Homebirth risk assessment tool'

The suggested remedy of a '*homebirth risk assessment tool'* seems simplistic and unlikely to be able to incorporate the complexities of decision making, especially the social and emotional factors. It is also of considerable concern that women deemed unsuitable for homebirth by a risk assessment tool, should be strongly advised against homebirths. AIMS and other childbirth organisations are frequently contacted by women with risk factors in their pregnancies who are seeking to avoid a directive approach, but are being pressurised to abide by hospital protocols. We are seeing increasing numbers of women opting out of care altogether because they are not able to secure supportive care, thereby possibly exposing themselves and their babies to even higher risk.

Continuity of care model

Given the evidence supporting caseload midwifery (Hatem et al 2008) and its popularity among women and midwives, it is puzzling that the CMACE Report is so negative about the style of caseloading developed by the Albany Midwifery Practice: There has been a great deal of feedback from women cared for by Albany Practice midwives and other midwives working alongside the Albany Practice midwives, that this model works well (AIMS 2009, Bliss 2010, www.albanymidwives.org.uk). The CMACE Report also appears to imply that the ethos of the Albany Midwifery Practice prevents the midwives from genuine teamworking: *'The AGP midwives seemed reluctant to call upon the skills of other professionals when clinical complications arose'* (p29). There is no detail from the findings that supports this.

Philosophy underpinning the CMACE Report

One of the problems with the CMACE Report is the clearly medical bias which inevitably dictated how the data were evaluated, the findings and the conclusions. There is now a great deal of evidence that social midwifery has many benefits across a wide spectrum of outcomes especially when care is community based and provided by known and trusted midwives (Hatem et al 2008). Obstetric expertise should be drawn on when needed if women are to receive the best and most appropriate care (O'Neill 2008). Overly medicalised care continues to impact negatively on care and outcomes, and cause dissatisfaction among women and families, and this needs to be the subject of wider public debate.

Recommendations

Despite its stated focus on conciliation, the Report itself does not promote a conciliatory ethos: there are continual overt and implied criticisms of the Albany Midwifery Practice. The midwives are accused of falsifying records, which if true would warrant referral to the NMC. For example the CMACE Report suggests (p13) that despite the fact that liquor was documented as clear, meconium must in fact have been present and (p15) that a baby could not have been born in the condition documented, given its subsequent condition on the arrival of the paediatrician. The Albany Midwifery Practice is accused of misrepresenting the difficulties they faced with King's (p 32) and of being more concerned about place and mode of birth than the morbidity and mortality of women and babies. Given the Practice's lower rates of perinatal mortality and the focus on preventing unnecessary interventions that are known to increase morbidity, this seems unfounded and inappropriate.

The CMACE Report suggests a series of remedial steps to address the breakdown in the relationship between King's and the Albany Midwifery Practice, and to improve outcomes throughout the Trust. The main recommendations appear to be integrating the Albany Midwifery Practice into King's through a shared *'code of practice*', shared learning, obligatory debriefing following adverse outcomes, better supervision, increased midwifery skills, improved audit and better record keeping by Albany Practice midwives, appointing a leader for the Albany Midwifery Practice, engaging all staff in risk management procedures, improving relationships, reducing the level of contact and continuity provided by the Albany Midwifery Practice and ensuring service-wide support for homebirth when deemed medically appropriate. It is even suggested that a code of practice should be agreed '*to encourage and if necessary enforce mutual professional respect'* (p37-38). None of these remedial measures have been put in place; instead the contract with the Albany Midwifery Practice was terminated by King's.

The CMACE Report makes the very important point that antagonism to homebirth increases risk; an observation that has already been made forcefully by the King's Fund report into safety in the maternity services (O'Neill 2008). This is obviously one of the central issues that needs to be addressed at King's. Any current difficulties are likely to be exacerbated rather than resolved by the termination of the contract between King's and the Albany Midwifery Practice, as this move will create more anxiety for women and their families and reduce the scope for women's informed decision making about place of birth.

Certainly multidisciplinary training, ongoing education and updating may increase dialogue and be mutually beneficial, but this needs to be in the context of mutually respectful relationships. Mutually respectful relationships cannot be enforced but must be nurtured through good leadership. Likewise, risk management may well improve by engaging all staff groups, but this will only occur if good working relationships exist. It may also be desirable to increase midwives' skills throughout the country (especially when women with potentially complicated conditions have homebirths), but there is no detail in the CMACE Report that supports a conclusion that the midwives under investigation were not highly skilled, nor does the CMACE Report suggest which skills midwives need. This would need to be examined with the Nursing and Midwifery Council, the Royal College of Midwives and the public. The CMACE Report suggests improving neonatal resuscitation skills for midwives whose cases were included in the CMACE Report, but it does not provide enough information to allow conclusions to be drawn about the level of resuscitation skills among community or hospital staff. However, it does suggest that that there is a management failure within this area that might have contributed to poor outcomes (p15-6, 20-21).

There is always room for improvement in record keeping (from women's notes, to databases of outcomes) throughout the maternity services. We are however concerned about the negative views regarding the inclusion of non clinical information, as this is important to women who may like to keep a copy of their notes. It is important also to the ongoing relationship and understanding between the woman and her midwife. It appears that the criticism of record sharing again reflects management failure.

It seems likely that the future holds more contractual arrangements between Trusts and practitioners, thus rather than terminating what was a unique contractual arrangement, it would have been more appropriate for King's to have addressed challenges, and clarified boundaries. The Albany Practice Midwives were highly effective (including cost effective): they had a higher caseload than King's midwives, high consumer satisfaction, low administration costs, and low perinatal mortality rates with an all-risk population.

AIMS is dismayed that the contract between King's and the Albany Midwifery Practice has been terminated, and strongly believes that far from being terminated, the Albany model needs to be reinstated and rolled out country-wide for the benefit of families and midwives.

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On behalf of the Association for Improvements in the Maternity Services, March 2010.

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