Review of CMACE Report

The methodology employed for this review has strengths and weaknesses.
The strengths were:

- Reviewers were blinded to outcome as they reviewed maternity notes
- Good outcome cases were mixed with poor outcome cases
- Comparison of standard hospital group practices included
- Reviewers were representatives across professional groups, external to the host organisation

The weaknesses were:

Because the Albany group work as independent midwives within a caseload model with a high home birth rate, reviewers should have included:

- Independent midwives, midwife homebirth specialists, midwives with expert knowledge in normality, experienced caseload midwives, midwifery academics
- There was an independent midwife and a consultant midwife (though not known whether she has expertise in normality) but none of the other groups.
- Only midwives should review midwifery care up to the point of transfer or involvement of obstetric opinion as they are the lead professional up to this point. At that point and onwards, an obstetrician and midwife should review care. Neonatologist should be involved from birth onwards, not before. The rationale for this is that each professional group should be involved when and where their expertise is called on and is needed. It is not appropriate for an obstetrician to judge homebirth care when he has never attended a homebirth.
- Though reviewers were blinded to outcome when reviewing the case, they were not blinded up to the point of their recommendation of whether substandard care contributed to outcome. After reviewing care, they were then told the outcome before submitting a recommendation. This exposed them to hindsight bias, well known in the literature to affect retrospective review (Zain et al, 1998). The true test of judgement is to make a recommendation on the care that is reviewed whilst not knowing the outcome.
- Having a panel where consensus is established before making a recommendation of whether substandard care contributed to outcome has a number of limitations. It is open to strongest, most confident voices dominating decision, masks professional hierarchy e.g. of obstetricians over midwives. Majority votes are clearly affected by the groups representativeness e.g. no's of doctors in comparison to no's midwives.

The more robust system is:
1. To blind reviewers to outcome throughout the process.
2. Only midwives reviewing homebirth care and hospital care up to the point of obstetric involvement. They would submit their recommendation for that element of the care. Then obstetricians and midwives scrutinise care to birth. Then neonatologist joins the review process for the post birth baby care
3. For Individuals then submit their recommendation on suboptimal or not, rather than a panel

The recommendation of many major avoidable elements in these cases made by the panels fails to recognise that HIE has an incidence of about 2.5% in term infants (Graham et al, 2008). In other words, in a hospital of 6000 births, 12-14 cases per year. Only about 15% of these are related to intrapartum events as the vast majority are known to be linked to antenatal causation (Graham et al, 2008). Thus out of 12 -14 cases in a 6000 birth hospital, about 2 cases will be related to intrapartum

events. That is why any review would not expect to conclude that of the 11 cases of HIE from Albany, most were down to intrapartum events. A 'quick and dirty' review like this one (and CMACE admit the limitations of this review at the beginning of the document) is not detailed and thorough enough to make these judgements and is almost certainly misleading in its conclusions on this basis alone. There are additional reasons why these conclusions of suboptimal care should be challenged.

Though it is acknowledged that Albany look after high risk women in relation to socio-economic deprivation, no allowance in made of that in the outcomes. There is a counter argument that could be made that their rates of preterm labour and growth restricted babies are low because of their caseload, social support model and antenatal groups. Research from the USA demonstrated this effect (Norbeck et al, 1996, Ickovics et al, 2007). In other words, they may be lowering the incidence of these serious morbidities.

Hindsite bias and lack of knowledge of research is evident in judgements of Major (identified factors probably contributed significantly to a poor neonatal outcome and that different management would probably have improved the outcome) which was cited frequently with aspects of care which are known to be poor predictors of outcome

- fetal heart monitoring
- the presence of meconium.

Both of these (abnormal heart traces [Hillan, 1992] and the presence of meconium[Heijst et al, 1995]) although are associated with poorer neonatal outcomes, are also poor predictors of outcomes in individual babies. In other words, they have many false positives (the abnormality is present but the baby is fine). They cannot be relied on as a basis for concluding they had a major impact. The only area where they may be some justification for concern about babies is to do with resuscitation but there is not enough detail in the review to make informed judgement.

Other areas were judgements of reviewers could be challenged:

- No adherence to NICE guidelines (not following a guideline is acceptable of a rationale is given and justified (Walsh, 2007)
- Partogram use is custom and practice not based on evidence (Lavender et al, 2009)

The Discussion component of the report is compromised by not mentioning that the Albany Group have been previously rigorously evaluated by Sandall et al (2001) and have been lauded nationally and internationally for their low Caesarea Section rate 18% compared with Kings overall rate of 25% in 1999 and in 2003 (13.5%), for high homebirth rate and remarkable breastfeeding rates (79% at 4 weeks in 2003), low epidural rate (17%) compared with other Kings group practices (25%)[1999] (Kings Fund, 2008).

In addition, there is no mention in the report of complaints from their clients, surely an important benchmark in evaluating maternity services today. The reviewers seem completely blind to the previous success of this model and its citation in many journal papers (two research publications this year on aspects of their work [Kemp & Sandall, 2008; Huber & Sandall, 2009]) and other reports. At the end of this paper is an extract from the Kings Fund Report on Maternity Care safety of 2008. In addition, their work has been presented at a number of International conferences over the past 10 years.

The discussion section fails to engage with the unique status of the Albany group as subcontracting into Kings of an Independent Practice. There is an assumption that they should be Kings employees first and behave like that. The reviewers themselves also fail to understand this different status,

commenting on their unprofessional note-taking and reluctance to participate in the Kings organisation.

Finally, the review does not recommend the termination of their contract but a series of ameliorative measures to improve the working relationships, clinical governance and training at the group's interface with the hospital. The Trust only has taken the unilateral step of terminating their contract.

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Kings Fund **Safe Births: Everybody's business:** AN INDEPENDENT INQUIRY INTO THE SAFETY OF MATERNITY SERVICES IN ENGLAND, 2008

The Albany midwifery practice (see box overleaf) has demonstrated that it is possible to achieve high rates of productivity and excellent outcomes through different ways of deploying staff. They have done this through radical revisions to the allocation of women to midwives and to the way in which the midwives are accountable for women in their care.

CASE STUDY: THE ALBANY PRACTICE

The Albany midwives make up one of nine midwifery group practices at King's College Hospital in south-east London. The midwives, who are self-employed and self-managed, provide midwifery care for women who live in and around Peckham, an area with high levels of deprivation. Individual midwives are allocated to individual women, securing continuity of care and carer. Each midwife has an individual caseload of 36 women, when acting as primary midwife, and another 36 women as secondary midwife, with cases referred by local GPs and, sometimes, by consultants at King's. The caseload is representative of the local population.

In 2003, the Albany midwives looked after 221 women, with outcomes as follows:

n 83 per cent of births were spontaneous vaginal deliveries
n 80 per cent of these women had no pharmacological pain relief
n the caesarean section rate was 13.5 per cent
n a known Albany midwife was present at 97 per cent of the births
n 98 per cent of babies were breastfed at birth and 79 per cent were breastfed at 28 days.

An evaluation of the Albany midwives' work, published in 2001, concluded that the practice was successful at facilitating normal pregnancy and birth, with high rates of home birth. They also achieved an improvement in childbirth outcomes in very deprived groups of women. Women felt they were provided with informed choice. Accessible and appropriate care was also provided.

Source: Sandall et al 2001