The Kings Fund

Ideas that change health care

Research paper

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The role of GPs in maternity care – what does the future hold?

An Inquiry into the Quality of General Practice in England

The role of GPs in maternity care – what does the future hold?

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Contents

Introduction

Pregnancy is a normal physiological process, and an important life and family event. There are many professionals involved in the care of pregnant women, their babies and their families, including obstetricians, anaesthetists, midwives and GPs. Today, there are two main models of care for pregnant women in the United Kingdom: midwife-led care for low-risk women and consultant-led care for high-risk women. The involvement of GPs in the care of pregnant women has dramatically declined.

This paper asks whether there still is a role for GPs in maternity care. We attempt to define a future role for GPs in pre-conception, antenatal and postnatal care and discuss the merits of shared care between GPs and midwives. We begin by setting out the history of GPs' role in maternity care in the United Kingdom and how policy has changed over the past 20 years. We summarise the current role GPs play in maternity services and what current guidance says about the role of the GP in maternity care. We conclude with a discussion of the potential role GPs could play in maternity care.

1 History and policy context

Historically, GPs played a significant role in delivering maternity care – including intrapartum care – at home and in community hospitals. The foundations of modern obstetric and midwifery practice were laid towards the end of the 19th century (Drife 2002), although the royal colleges were established only relatively recently. Obstetrics was considered an offshoot of surgery until 1929, when the British College of Obstetricians and Gynaecologists was founded. It did not become a 'royal' college (RCOG) until 1938. The Royal College of Midwives (RCM) was formed in 1947 and the Royal College of General Practitioners (RCGP) in 1952.

The start of the 20th century saw a rise in rates of hospital delivery: in 1927 just 15 per cent of deliveries in England and Wales took place in hospital, but by 1932 the figure had risen to 24 per cent (Loudon 2009). During the 1930s childbirth became much safer for women than it had been previously, with the discovery in 1937 of sulphonamides to treat puerperal fever, routine antenatal and postnatal care, and the use of ergometrine to stem postpartum haemorrhage. At this time GPs provided intrapartum care and used these medications during their home deliveries. Quality of care was generally not high, and there were many avoidable deaths (Loudon 2009).

The Confidential Enquiry into Maternal and Child Health (CEMACH) – now renamed the Centre for Maternal and Child Enquiries (CEMACE) – started its work in 1952, and has been credited with assisting the dramatic improvement in maternal and child health over the past 50 years. To put this in context, in 1935 the risk of maternal death was 1 in 200 pregnancies. Today it is 1 in 10,000. In 1954, the risk of stillbirth was 1 in 42 births, compared with 1 in 200 today. However, today more maternal deaths are due to indirect causes (non-obstetric conditions) than to direct causes (obstetric conditions), and the number of these indirect deaths has doubled since 1985. CEMACH's most recent report *Saving Mothers' Lives* tells us that obesity, heart disease and mental health problems are now major causes of maternal death in the United Kingdom (Lewis 2007). It also describes case studies of women who should have seen a doctor, rather than a midwife, and who died as a result.

By the 1950s, there were 400 GP maternity units in community hospitals. They tended to be rural and far away from district general hospitals. GPs worked closely with midwives, providing excellent continuity of care, and babies were delivered close to home. As newer, larger maternity units were built throughout the 1970s, the number of community maternity units declined. In 1970 there were 93,192 GP maternity unit deliveries, compared with just 11,120 in 1990 (Macfarlane and Mugford 2000). GP community units closed, merged or turned into midwifery-led units where GPs were no longer involved in intrapartum care. Currently, there are 243 obstetric units in the United Kingdom and 116 midwife-led units (either working alongside obstetric units or providing standalone services).

In 1992, the Health Select Committee's Inquiry into Maternity Services (Winterton 1992) criticised this shift towards hospital-based maternity care. It concluded that encouraging all women to give birth in hospital could not be justified on grounds of safety. It argued that there was no conclusive evidence that the medical model of care was widely applicable, and stated that women wanted continuity of care and greater choice in maternity services.

In 1993, the Department of Health published its response to the Select Committee Report. *Changing Childbirth* (Department of Health 1993) recognised a need for changes to how maternity care was delivered, putting women and their families at the centre of services and allowing them to make informed choices. This publication marked a sea change in policy, with the aim of giving women and families more power. Choice, continuity and control were key.

Changing Childbirth identified a reluctance among most GPs to be involved in intrapartum care, and attributed this to lack of experience and the difficulties of on-call commitments. Today, GPs no longer provide intrapartum care. This area of care is, rightly, considered too risky and subject to litigation to be carried out by non-specialists. GPs no longer receive sufficient obstetric training to ensure safety, they do not wish to encroach on their time off, and they do not feel they are paid enough to take on the responsibility (RCGP Maternity Care Group 1995).

Another major change in the role of GPs came about as a result of giving women direct access to a midwife in early pregnancy. *Changing Childbirth* was the first government document to state explicitly that women could self-refer to a midwife in early pregnancy. Despite this, many women continued to access care through a GP. In 1993 the Select Committee report *Choice in Maternity Services* criticised GPs' role as a first point of contact in pregnancy, saying that:

> *… although they [GPs] could play a valuable role in a woman's maternity care, they were not always fully versed in the different options for care available to pregnant women, and so frequently referred women directly to a consultant unit. This, in effect, curtailed choice for women experiencing a normal pregnancy who might prefer to be cared for through an NHS midwife-led programme in the community.*
>
> (House of Commons Health Select Committee 2003, p 9)

The report also expressed concern that some women were finding it hard to access maternity care without first visiting their GP and obtaining a referral.

In 2007, the Department of Health published *Maternity Matters*, which strongly endorsed midwifery-led care and encouraged women to self-refer to midwives as an alternative to signposting to midwives via GPs (Department of Health 2007a). It also set out the government commitment to introduce a national guarantee of choice, committing to offer a women a choice in the type of care and place of delivery (at home, in a birth centre or in an obstetric unit) by the end of 2009. However, research by the National Childbirth Trust at the end of that year found that only 4 per cent of women had the full range of choice of where to give birth (NCT 2009).

The decline in the role of GPs within maternity care has been further entrenched by a number of more recent policy changes – not least, by the new GP contract in 2004. Before the introduction of the new contract, GPs received approximately £100 for each pregnant woman they looked after, and more if they provided intrapartum care. This meant that an average practice, looking after 120 pregnant women a year, would receive more than £10,000 for this area of work – a substantial percentage of their income.

Under the terms of the new contract, money was no longer allocated on an 'item of service' basis for maternity services – it was included in the global sum paid to GPs.

In addition, also as a result of the new contract, many GPs have opted out of providing out-of-hours care. This has reduced the continuity of care offered to patients (see other Inquiry papers *A rapid view of access to care* and *Continuity of care and the patient experience*). It has also meant that GPs are unable to deliver continuity of care to pregnant women. The changes in out-of-hours provision also mean that more women with acute problems in pregnancy are attending A&E. If sick pregnant women have difficulty in accessing urgent GP appointments, especially in busy urban areas, they may instead present inappropriately at an A&E department with pregnancy-related problems.

The final policy change that has contributed to the decline of the GP's role in maternity care is the increasing use of children's centres, rather than GP surgeries, as the base for community midwife services. A paper published by the Department of Health (2007b) explicitly states that: 'Increasingly we would expect to see the Child Health Promotion Programme, maternity, health visiting and other parenting support services delivered from children's centres, especially in more deprived areas.'

This approach encourages care that is rooted in the community, and provides an interface between health, education and social services – all crucial if maternity services are to provide more equitable and safe services. But it also risks fragmentation of care and the breakdown in communication between midwives and GPs.

2 The current situation

The result of the changes highlighted in Section 1 is that GPs now have a very limited role in the care of pregnant women, although the situation varies significantly around the country, with more GP involvement in remote, rural areas.

Antenatally, the GP is usually the first health care professional that women go to see after they discover they are pregnant, despite the ability to self-refer to a midwife. Evidence from a large survey carried out by the National Perinatal Epidemiology Unit (NPEU) suggests that when women discovered they were pregnant, 83 per cent saw their GP first (Redshaw *et al* 2006). However, if a woman had been pregnant before, she was more likely than a woman who had not been pregnant before to see a midwife first (17 per cent versus 7 per cent). In 2007 the Commission for Healthcare Audit and Inspection (2007) had similar findings, with 78 per cent of women accessing maternity care from their GP initially.

Although a GP is usually the first point of contact for many women when they discover they are pregnant, this is not the case for all. For example, very vulnerable or itinerant women who are at higher risks of adverse outcomes from their pregnancies may not have access to a GP.

In some areas – particularly where there is a shortage of midwives – GPs are continuing to play a significant role in providing antenatal care. Interestingly, as long as women feel supported and informed by the professional they choose to visit, they do not place a high priority on choice of first-contact professional. However, they do have high expectations of their first contact with the health services after confirming pregnancy, and these include confirmation, support and information. Meanwhile, in terms of experience of early contact, women report that real engagement with the pregnancy takes place only after the booking in, when health services are satisfied that the pregnancy is viable, with some women reporting feeling 'abandoned' by the lack of health care professional input in the first trimester (Futures Company 2009).

There is some evidence from insight work commissioned by the Department of Health that women visit their GP in early pregnancy as confirmation despite accurate home testing. There is a strong perception that a health care professional will conduct a more reliable test to confirm the pregnancy. Anecdotally, one GP told the authors that women like confirmation of their pregnancy from a GP because it 'makes it real' and 'special, assuming the baby is wanted'. The GP may also be the very first person to offer congratulations on the pregnancy.

Although current midwifery practice encourages women to contact the midwife directly in the case of an urgent pregnancy-related problem, to reduce unscheduled and inappropriate A&E attendances, some pregnant women still consult their GP first in an emergency.

Guidance about the role of the GP in maternity care

Recent policy documents have failed to clarify the role of the GP in maternity services, with some ignoring GPs completely and others appearing ambivalent about their role.

The publication of the first NICE antenatal care guideline in 2003 (NICE 2003) emphasised the role of midwifery-led care for pregnant women, and barely mentioned GP care. The following year, the maternity services standards within the National Service Framework for Children, Young people and Maternity Services (Department of Health 2004), which set out minimum standards for care, made no mention at all of GPs caring for pregnant women. The 2008 version (NICE 2008) suggests GP- or midwife-led antenatal care for all women with uncomplicated pregnancies, but not shared care. NICE guidelines covering intrapartum care, caesarean section, diabetes in pregnancy and routine postnatal care of women and their babies do not mention care by a GP.

Nevertheless, the NICE antenatal and postnatal mental health guideline (NICE 2007) does see a clear role for the GP in maintaining the mental health of women during pregnancy and postnatally. GPs are supposed to ask a series of specific Whooley questions about their mental state ('Have you often been bothered by feeling down, depressed or hopeless?'; 'Have you often been bothered by having little interest or pleasure in doing things?'). These should be asked when the woman first presents in pregnancy, at the six-week postnatal check and at any other time if depression is suspected.

NICE's antenatal care guideline (NICE 2008) suggests: 'Midwife and GP led models of care should be offered to women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise.' This is the most supportive statement about involving GPs in the care of pregnant women in any recently published official guidance, although it contains no suggestion of what GP-led models of care might look like, and does not consider or encourage the possibility of care shared between midwives and GPs.

CEMACH's report *Saving Mothers' Lives* (Lewis 2007) reported on the findings of an examination of 295 maternal deaths that had occurred during 2003–5. For the first time, the Confidential Enquiry into Maternal Death appointed a GP, nominated by the RCGP, to the central assessor team. This involved commenting on the care provided by GPs in 66 of the cases. The key issues relating to GPs are shown in Table 1. They include the ability to identify and appropriately refer women with urgent problems, as well as understanding and dealing with other risk factors such as mental health, substance misuse and obesity.

Table 1: Issues for GPs identified in *Saving Mothers' Lives*

Clinical issues	• Identifying seriously ill women • Recognising 'red flag' signs and symptoms in women who need emergency referral: breathlessness, which may be due to pulmonary embolus – severe headaches, which may be suggestive of hypertension or subarachnoid haemorrhage – ectopic pregnancies, which continue to be missed, and can mimic gastroenteritis – puerperal fever, which is often thought of as a disease of the past – heartburn, which may be ischaemic heart disease • Recognising when women need fast-track referral for urgent conditions • Mental health problems in pregnancy and after delivery • Substance misuse and its effect on pregnancy • The health of refugee and asylum-seeking pregnant women • The risks of obesity in pregnancy
Communication issues	• Telephone consultations • Referral letters and providing complete information
Maternity services reconfiguration	• The increasing emphasis on midwifery-led care • Changes in out-of-hours primary care services

Source: Adapted from Lewis (2007)

The report made a series of recommendations for GPs (*see* the box below/overleaf/opposite). Many of these point to what a GP needs to do as part of providing high-quality care to women and their families, and how to communicate and work with others who are caring for the women – especially midwives.

Recommendations for GPs in *Saving Mothers Lives*

Communications

GPs should ensure they undertake a careful risk assessment during telephone consultations with, or concerning, women who are or who may be pregnant. If they are in any doubt they should see the woman or arrange an appropriate referral for her.

Whenever possible, the GP should give the woman's named midwife confidential access to her full written and electronic records.

GPs should ensure that any significant letters are copied into the woman's hand-held maternity record.

Midwives should ensure that all investigations that they initiate are copied to the GP.

Making urgent referrals

There needs to be a routine system in every maternity service by which GPs, midwives and obstetricians can communicate rapidly with one another and seek advice, if a woman's condition gives rise to concern. This might be by phone, fax or email. For this purpose, conventional referral letters are inadequate and take too long. Referral management systems must not impede access to urgent appointments.

A GP should make fast-track referrals directly to appropriate physicians if a woman has a serious medical condition such as congenital cardiac disease or epilepsy at the onset of pregnancy. He or she should not rely only on conventional referral pathways to an obstetrician or midwife, as this introduces delays that may compromise the woman's health.

Migrant women and women who do not speak English

A medical assessment of general health before or at booking of migrant women may prevent complications or even death in later pregnancy. This should include a cardiovascular examination, performed by an appropriately trained doctor. (This could be their usual GP.)

Relatives should not act as interpreters. Funding must be made available for interpreters in the community – especially in emergency or acute situations.

Obesity

GPs should record the Body Mass Index of pregnant women and those contemplating pregnancy, and should counsel obese women before and during pregnancy regarding weight loss or healthy eating.

Women with obesity are not suitable for GP midwifery-led care, because their pregnancies are higher risk. These women should be referred for specialist care because of possible co-morbidity.

Mental health and substance misuse

GPs should take detailed histories from pregnant women about any previous psychiatric illness and its severity, should enquire directly about substance misuse or addiction, and should check their previous records if there is any doubt.

GPs should communicate details of their patient's previous psychiatric history, including that of alcohol and drug misuse, not only with obstetricians but also with midwives – preferably with the woman's consent.

A GP should refer a pregnant woman with a significant mental health history to a psychiatric service – preferably a specialist perinatal service – during pregnancy, so that a management plan can be developed.

GPs should not work beyond their level of expertise in managing drug-using women. They should refer or seek advice from specialists in drug misuse.

Women who misuse drugs and alcohol should be managed by multidisciplinary teams comprising GPs, specialists in substance misuse (who may be GPs), specialist obstetricians and midwives, health visitors and social workers. Each woman must have a lead professional, and a lead agency, to take responsibility for the overall management and co-ordination of her care. This would not usually be the GP.

Social services and child protection

Close multidisciplinary and multi-agency support must continue to be provided for women who have had their baby removed into care by social services. This reflects the risk that removal of a child by social services is a high risk for suicide in women.

The RCOG Standards for Maternity Care (2008) is the report of a working party, written in conjunction with the royal colleges of midwives, anaesthetists, and paediatrics and child health. Although the RCGP was not invited to take part, the guidelines make a number of references to the role of GPs in the care of pregnant women. These recommendations are very similar to those made by CEMACH in *Saving Mothers' Lives*.

In terms of GP responsibilities, the most notable of these standards is pre-pregnancy care for women with existing medical conditions or significant family or obstetric history. The standard suggests that GPs should provide pre-pregnancy counselling and support for women of childbearing age with existing serious medical or mental health conditions that may be aggravated by pregnancy (specifically, epilepsy, diabetes, congenital or known acquired cardiac disease, autoimmune disorders, obesity or a history of severe mental illness). They should also collect data about these patients using the Quality and Outcome Framework (QOF). (Not all of these conditions are currently covered by QOF.)

3 What role could GPs play in maternity care?

For women with straightforward pregnancies, we believe that GPs have a role to play in the teams that care for pregnant women (pre-conception, antenatally and postnatally), as well as in giving generalist medical care throughout a woman's pregnancy – particularly if they are already supporting the woman to manage a long-term condition. In this section we set out some ideas about what that role could entail.

The GP's role in different areas of care

Pre-conception care

GPs and other practice staff are well positioned to provide care and advice pre-conception, or on discovering a pregnancy. This could include information about pregnancy and staying healthy (or, if the pregnancy is unwanted, options for termination), the role of the midwife, and risks associated with and timing of antenatal screening.

Pre-conceptually, the GP role could include discussing contraception, fertility issues, folic acid supplementation, lifestyle issues (such as obesity management, smoking cessation and alcohol consumption), rubella antibody screening, pre-existing conditions such as diabetes or epilepsy and genetic counselling (for example, for thalassaemia, sickle-cell trait and consanguinity). Pre-conception counselling for women with existing medical conditions (including obesity) was the number one recommendation in CEMACH's 2007 report (Lewis 2007).

Early antenatal care

Early antenatal care is an area in which GPs could play an important role. If a woman is equivocal about her pregnancy, she needs access to her GP to discuss her options and have a frank and confidential discussion. Her GP will usually be aware of family circumstances, and will hopefully already have a trusting relationship with her. Time for reflection and decision-making may be precluded by swift referral to a midwife. The management of miscarriage and hyperemesis are other areas where GPs take the lead role. They can also refer women for either midwife-led or consultant-led care, and can encourage lifestyle modifications.

The first visit presents an ideal time for the GP to refer for any gestation-critical early antenatal testing. For instance, thalassaemia screening needs to be carried out by 8-to-10 weeks' gestation. If the woman is not booked with a midwife until 10–12 weeks, this time period is likely to be missed.

Antenatal care

GPs can play an important role in antenatal care, by ensuring that all relevant information about a woman's medical history is shared with others, subject to the woman's consent, and by providing continuity of care – especially in the management of any ongoing medical conditions.

Women do not always share all their medical history with midwives, as was highlighted in *Saving Mothers' Lives* (Lewis 2007), and this can have critical implications for safe care – especially when it comes to mental health problems. A GP will often have accumulated knowledge about the women, her medical and family history, sometimes over many years. He or she will generally know more

about a woman's previous medical history, medication and family than any other health care professional, and will be the only health care professional who currently has a complete record of a woman's medical history.

This might change when a single electronic patient record is implemented, but – as other papers produced for the Inquiry into the Quality of General Practice in England show – continuity of care or information are not always delivered even within one general practice. It is probably more realistic to think of the knowledge about a woman and her circumstances as being accumulated by the practice as a whole, rather than by individual GPs. Also, some women will not have had much contact with their GP or practice before the first pregnancy, so the GPs knowledge of the woman and her family may be greater for subsequent pregnancies.

It is important that all those caring for the pregnant woman are aware of any current or past medical or social issues that might place her or the baby at greater risk. There is therefore a critical role for GPs in ensuring that all relevant information is communicated and shared with the midwives or obstetricians. Information must also flow the other way. For example, it is important that GPs are aware of the results of investigations and tests undertaken by midwifery and obstetric colleagues, to ensure safe, joined-up care.

Where a woman has serious pre-existing illnesses, her GP is likely to have more knowledge of the risks, and their significance for pregnancy, than midwives. Of course, complex, high-risk obstetric care should be provided by consultant teams. But if a GP has an established relationship with a woman, they could act as a guide and advocate, drawing on their knowledge and experience, to ensure the woman gets the care she needs. Co-ordination and advocacy are particularly important for women who have complicated medical histories in addition to being pregnant, and GPs or other primary care staff are well-placed to fulfil this task.

In women with ongoing medical conditions that are managed in primary care, there is a strong argument for the GP to have an ongoing role in the care of the woman. Continuity of care during pregnancy is highly valued by women, and makes a very important contribution to safety. The key point is that any health care professional who has built up a trusting and caring relationship with a woman is likely to pick up on potential problems earlier and therefore make pregnancy safer for the woman and her baby. Where women do receive care from a variety of professionals, communication and teamwork are key to ensuring continuity of care.

GPs can play an important role in identifying and referring women with acute problems during pregnancy. However, their reduced contact with women with uncomplicated pregnancies makes it more difficult for them to recognise abnormality and manage this appropriately. If they were more involved in routine antenatal care, they would more likely have the training and skills to deal with more urgent problems.

Postnatal care

Postnatally, GPs could play a role in advising about physical issues such as incontinence or back pain, assessing mental health and contraception. Generally, it is a GP who performs the six-week postnatal check, and this would be an opportunity to discuss a variety of issues, including contraception, back pain, incontinence, dyspareunia, mental health and preparation for any subsequent pregnancies.

Models of good practice: what might shared care look like?

There is an opportunity for GPs to be more directly involved in delivering antenatal care through a model of shared care with midwives, providing this is what a woman chooses. In many parts of the country there is a lack of available midwives and maternity professionals. Greater co-operation and teamworking, with a clear role for GPs, could contribute to a better standard of care for women and their families. A more active role for GPs in the care of pregnant women need not detract from the role of the midwife (who is fully trained to look after women experiencing a normal pregnancy) and the obstetrician (who is responsible for women with more complicated pregnancies).

Appendix 1 gives an example of a model of shared care for low-risk women currently being used in Tower Hamlets (reproduced with permission). When a woman finds out she is pregnant, she can either see her GP or can self-refer to a midwife. Following booking by a midwife, they see midwives and GPs alike during their pregnancy, with referral to obstetricians made if necessary.

How can quality of care be measured?

While it is possible to develop specific measures of high-quality maternity care (*see* the suggestions in Table 2, p19, which could form the basis of future indicators or audit standards), we believe that there are a number of activities that would support the delivery of high-quality maternity care by GPs.

Examples are as follows.

- Participate in continuing professional development and education related to the care of pregnant women and pre-conception care (for example, screening) to ensure that your knowledge is up to date.
- Make sure you are competent to deal with women who present feeling unwell in pregnancy, and that you know when and where to refer them.
- Participate in Maternity Service Liaison Committees in order to ensure that the services being commissioned locally meet the needs of local women.
- Meet regularly with community midwives caring for women on your registered list, and put in place protocols for sharing medical information.
- Establish a relationship with local obstetricians, and agree protocols for when and how acute pregnant women will be referred or transferred.
- Develop and agree a care plan for women with complex social or medical needs, and share this with others in the maternity team to ensure co-ordination of care for these women.
- Take part in significant event analysis or root cause analysis of maternal or perinatal deaths, and co-operate fully with any hospital enquiries into deaths or near misses.
- Audit your own practice using some of the suggested standards.
- There is also a need for the leadership of the profession (specifically, the RCGP) to support GPs in delivering high-quality maternity care. For example:
- Establish an evidence base on the quality of GP maternity care to inform future guidelines and standard setting.
- Explore the role of the GP in maternity care in the GP curriculum.
- Promote the dissemination of recommendations from CMACE reports to GPs.
- Table 2 summarises potential quality indicators for GPs undertaking maternity care.

Table 2: potential quality indicators for GPs undertaking maternity care

Description of measure or best-practice standard	Recommended metric (proposed target)	Source of data	Rationale for inclusion
1. Antenatal care and screening are offered according to current local guidelines	100%	QOF data	Demonstrates that the practice has adopted locally produced maternity care guidelines
2. The GP practice has a named health professional responsible for maternity care	100%	Practice self-report	Ensure quality of care, systems and updating the team
3. The GP practice has a meeting with its attached community midwife at least every three months	100%	Practice self-report	Opportunity for communication about policy, protocols and specific patients
4. The GP practice has a complete register of women currently pregnant	90%	Remote computer access	Able to identify pregnant women – for example, inviting pregnant women for swine-flu vaccines
5. Whenever possible, a GP should give a named community midwife confidential access to the woman's full written and electronic records, with the woman's consent	100%	Practice self-report	Improve midwife's awareness of possible significant medical, psychiatric and social History (see Lewis 2007)
6. The practice should be able to demonstrate how it plans to provide pre-conception counselling and support for woman of childbearing age with pre-existing serious medical or mental health conditions that may be aggravated by pregnancy. This includes obesity	100%	Practice self-report	To allow for optimisation of a woman's health for pregnancy, assessment of risk and referral to specialist services if appropriate (see Lewis 2007 and Quality Practice Award target
7. The GP practice will provide all women with information about antenatal screening at their first appointment	100%	Practice self-report	UK National Screening Committee agenda (see National Screening Committee 2010)
8. All receptionists and telephonists at a GP practice are able to give patients a contact telephone number for direct contact with a midwife	100%	Mystery shopper or self-report	Part of the Maternity Matters: Choice agenda (Department of Health 2007a). Telephone number should be listed at reception desk

9. All GP practices should be able to provide a full postnatal assessment, to include review of general health and delivery, assessment of anaemia, mental health, continence and provision or referral of full contraception service, to include long acting reversible contraception.	100%	Practice self-report	Health promotion

Source: King's Fund (2010)

4 Discussion and conclusion

Competently trained GPs could play an important role in shared care with midwives and obstetricians of pregnant women, particularly during the antenatal period. The GP's role in maternity care could involve:

- pre-conception care – especially for women with complex medical or social needs.
- counselling and health promotion in early pregnancy. This would include competence in managing bleeding and hyperemesis, obesity and smoking cessation management
- information about screening in pregnancy, as determined by the UK National Screening Committee
- a visit early in pregnancy to check the woman's general health, including a review of medical history from the medical records and an examination of the heart. The GP should then communicate in writing any issues of medical, psychiatric or social significance for the pregnancy, preferably with the woman's consent
- triage for emergencies during pregnancy and in the puerperium. This might involve signposting direct to hospital for conditions such as bleeding, but in other cases would involve face-to-face GP assessment. GPs need to be competent to recognise and manage conditions such as pre-eclampsia, sepsis, headache and breathlessness in pregnancy
- postnatal care, for follow-up of diabetes, hypertension, anaemia, mental health or conditions that may have complicated the pregnancy, as well as contraception advice and a postnatal examination.

If this suggested shared care role to work, there are a number of issues to be taken into account.

- **Incentives** It is not clear whether all GPs will want to play a greater role in maternity care – especially as their time is already so heavily committed. GPs should not be forced to do this work, but there are some basic tasks that every GP should feel competent to carry out. If GPs chose to take on additional activities in antenatal and postnatal care, this should be recognised and rewarded – perhaps through QOF or changes to GMS.
- **Clarification for women around care pathways** If women's care is shared between GPs and midwives there is scope for confusion about who is in charge and who a woman should turn to for care and advice – particularly if she feels unwell. Care pathways need to be developed locally so that women know when it is appropriate to consult a midwife or GP, and when to attend hospital.
- **Integration** GPs should work in liaison with new community-based services, such as children's centres, to avoid fragmented care. They need to be creative about how they integrate with these services and ensure that they encourage communication and information sharing, which is in the best interests of the women. A GP providing antenatal care should be an active member of a community midwifery team. Alternatively, active engagement with maternity services could be achieved by having a GP in every practice who specialises in this area.

- **Training** If GPs are to be involved with maternity care, they need to ensure that they are appropriately skilled and updated. GP postgraduate training may need to be extended to allow GPs to gain sufficient skills and knowledge about normal pregnancy. Placements should include experience in hospital-based antenatal clinics, as well as in the community (including in children's centres).

There are two key risks and challenges involved in increasing the role that GPs play in maternity care.

First, it might reduce the ability to provide continuity of care. However, it is already challenging for midwives to provide continuity of care. Very few areas operate a case-loading approach to midwifery (that is, where a single midwife takes full responsibility for the whole of a woman's care through the pregnancy and labour and postnatally). Due to the way in which midwives are deployed between the community and hospital settings, antenatal and postnatal care is often shared between different midwives.

Second, maternity services are under increasing pressures as a result of the demands of older motherhood, problems caused by fertility treatment, increased levels of obesity, survival of critical illness in childhood, and the challenges presented by some forms of social and cultural diversity (O'Neill 2008). The growth of knowledge and complexity of maternity care means that it is very difficult for GPs to retain their specialist skills, knowledge and understanding of maternity as a whole. Most newly qualified GPs have received little training in an obstetrics and gynaecology unit. Meanwhile, the teaching in obstetric units has often been of poor quality, and many GP training posts have been withdrawn and replaced by more innovative placements based in the community.

Despite these challenges, we believe there is a need to positively identify and define a role for GPs in maternity care, and to set out a model of shared care that can deliver better outcomes for women and their families.

Conclusion

Over the past 30 years, the role of GPs in maternity care has changed dramatically. The GP has been transformed from being the health care professional who guides women through their pregnancies, the first and main point of contact and, in some cases, the professional who provides intrapartum care, to someone who merely signposts women to midwife- or consultant-led care – in some cases without even seeing the woman in question.

However, the opportunity still exists for GPs to play an important role. This report sets out some suggestions of how GPs could contribute to the delivery of high-quality maternity care. GPs need to be adequately skilled to look after women safely, and this would require some changes to their training. In our view, GPs should not undertake intrapartum care but should be more involved in antenatal care, with particular responsibilities during the first trimester.

What is certainly true is that the current status of GPs in maternity care is in urgent need of clarification. The GP should be part of an effective team in which the roles, responsibilities and lines of communication are clear. Collaboration, co-operation, communication and competence are key.

Appendix 1 Model of shared care for low-risk women

Routine Antenatal Care Pathway

Contacts: Midwife | GP | Health Visitor | Hospital

Pregnancy Test

GP Contact

GP – See within 1 week of positive test

Direct contact with midwife

- Advise on healthy living. Give pregnancy book
- Conduct initial risk assessment. Food hygiene Introduce screening choices
- Advise on Healthy Start vitamins (including folic acid and vitamin D)
- Advise on benefits

GP: generate referral form – fax same/next day

Midwife: communicate with GP if direct

6–9 weeks, midwife booking (within two weeks of referral)

Topics covered:

- Demographics
- Medical/social/obstetric history
- Screening – reinforce information already given by GP regarding combined screening option
- Calculate BMI and refer to Active8 if ≥25
- Determine risk of interuterine growth restriction (IUGR)/need for Dopplers
-
- Start risk assessment
- Offer other screening bloods (except combined, as done at hospital with scan at 11–14 weeks)
- Take booking bloods (use T Quest if using EMIS to avoid lost results)
- Discuss or book anomaly scan option
- Take blood pressure and urinalysis
- Arrange glucoses tolerance test if indicated from history

Possible Complications (not exhaustive):

Bleeding:

<17 weeks refer to emergency gynaecology unit or A&E

≥17 weeks refer to labour ward

Substance misuse or HIV positive: refer to specialist midwife for full care (see guidelines)

Domestic abuse, complex child protection issues, teenagers in need: refer to gateway team for care and social services

Severe and enduring mental illness: see guidelines

Blood test results: see guidelines
Positive hepatitis B: take liver function tests and refer to hospital antenatal clinic within 2 weeks

Rhesus negative: fax result to antenatal clinic and request appointment at 28 weeks for Anti D prophylaxis

Anaemia: request full blood count, ferritin and haemoglobinopathy results, to determine actions needed

Raised random blood sugar: >7.0 arrange glucose tolerance test at 26 weeks

Positive haemoglobinopathies: lab send result to specialist nurse counsellor

HIV positive: virology to liaise directly with specialist midwife

VDRL (syphilis screening)test positive: refer to genito-urinary medicine

Urinary tract infection: treat as indicated

Rubella susceptible: offer postnatal vaccination

11–13 + 6 weeks – hospital

AN screening: Combined screening offered at Maternal Fetal Assessment Unit (dating scan offered if screening declined)
Midwife: Baby and Me @ Barts London Trust Clinic

Topics discussed:
- Check scan dates and confirm expected delivery date
- Review, print and document blood results
- Agree care pathway – midwifery or maternity team
- Agree care pathway – including choice of carer and venue for care
- Infant feeding
- Healthy lifestyles behaviours – smoking, diet, alcohol, exercises, benefits
- Parentcraft classes
- Identifying risk of depression
- Complete risk assessment
- Give Bounty bag at this visit

Complete antenatal assessment forms on CRS.

↓

16 weeks GP appointment

Heart and lung check (new immigrants and first pregnancy in UK only)
Review, record blood test results
Blood pressure, urinalysis

↓

20–22 weeks hospital

Anomaly scan offered

↓

20–32 weeks health visitor appointment

1:1 or group contact. Discuss healthy lifestyle options, breastfeeding, role of health visitor. Initial health needs assessment

↓

25 weeks (primips only) midwife appointment

Routine check up – blood pressure, urine and symphysis fundal height (SFH)

↓

28 weeks midwife appointment

Routine check up – blood pressure, urine and fundal height (check glucose tolerance test result if done)
full blood count and antibodies
Confirm has Anti D clinic appointment if Rhesus negative

Previous single Caesarean section: refer to midwife-led vaginal birth after caesarean clinic at hospital antenatal clinic as early in pregnancy as possible, to agree care plan for labour and birth

Positive screening: followed up by antenatal screening co-ordinator

Late booking: offer quadruple test 14–22 + 6 weeks

Heart murmur: request cardiac echography via InHealth and refer to Rehan Khan

Anomaly scan
Abnormalities: care planned via maternal fetal assessment unit consultant
Low placenta: scan date given for 34 weeks
Twins: refer for consultant-led care

Suspected intrauterine growth restriction

> than 2cms difference in gestation and cms: Book scan. Offer follow-up appointment for next week

Glucose tolerance test result

Fasting: 5.5–6.9mmol/l
120 mins: 7.8–11mmol/l (up to 29+6/40) or 9–11.0mmol/l after 30/40 refer to Monday midwife-led clinic in antenatal clinic for dietary and blood-sugar monitoring advice. Continue with community-led care.

Ranges above this, refer to Friday joint obstetric/diabetic service.

Rhesus negative

Attends hospital antenatal clinic for prophylactic Anti D if Rhesus negative

31 weeks (primips only) GP appointment

Routine check up blood pressure, urine and fundal height
Check blood test results

34 weeks midwife appointment

Routine check up BP, urine and fundal height. Check blood test results (if not already done).
Anti D at hospital antenatal clinic if Rhesus negative.
Discuss birth plan, onset of labour and analgesia. Give pre-birth information pack

36 weeks midwife appointment

Routine check up blood pressure, urine and fundal height. Check and document foetal presentation and position
Give information on infant feeding, care of newborn, vitamin K, newborn screening and general postnatal care.
Awareness of baby blues and postnatal depression
Confirm place of birth

38 weeks GP appointment

Routine check up blood pressure, urine and fundal height. Discuss options for care if pregnancy is prolonged.

40 weeks midwife appointment (primips only)

Routine check up blood pressure, urine and fundal height.
Discuss prolonged pregnancy management options

41 weeks midwife appointment

Routine check up blood pressure, urine and fundal height.
Offer membrane sweep
Book induction for 10 days after due date?

41 weeks +3 days.

If induction declined, refer to MFAU for fetal surveillance – U/S to check liquor, and CTG. Discuss with consultant and supervisor of midwives on call (via switchboard) if surveillance declined

Woman reports reduced fetal movements

Same-day referral to maternal fetal assessment unit or triage if weekend or after 5pm

Suspected pre-eclampsia

Discuss with labour ward consultant/registrar
Refer to maternal fetal assessment unit if asymptomatic or labour ward if symptomatic

Breech presentation

Book ultrasound scan at 36/40 weeks for presentation.
To be offered external cephalic version if confirmed

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