



NCT Document Summary:

The role of GPs in maternity care - what does the future hold? The Kings Fund {England}

The Kings Fund has published *The role of GPs in maternity care - what does the future hold?* commenting on the changing role of GPs in maternity care and providing recommendations on how it might be improved.

Summary

Over the past 30 years, GPs have gone from being the main point of contact to someone who merely signposts women to midwife- or consultant-led care. This Report suggests that, should GPs be trained so that they are adequately skilled to look after women safely, they could be more involved in antenatal care, particularly during the first trimester. This would require an urgent clarification of the GPs roles and responsibilities, as well as communication channels, within the multi professional maternity team. The Kings Fund does not recommend that GPs undertake intrapartum care.

Key Recommendations

The Report recommends that GPs be involved in the following areas of maternity care:

- **Pre-conception care**, particularly for women with complex medical or social needs.
- **Counselling and health promotion in early pregnancy**, including 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 general health check**, early in pregnancy, to review her medical history and examine her heart. Any **issues of medical, psychiatric or social significance for the pregnancy**, would be communicated to the maternity team in writing, preferably with the woman's consent.
- **Triage for emergencies during pregnancy and in the puerperium**: Whilst women would be directed straight to hospital in cases of bleeding, GPs should be involved in recognising

and managing conditions such as pre-eclampsia, sepsis, headache and breathlessness in pregnancy

- **Postnatal care**, the follow-up of conditions that may have complicated pregnancy - e.g. diabetes, hypertension, anaemia, mental health -, as well as contraception advice and a postnatal examination.

In order for this shared care role to work, the following must be taken into account:

1. **Incentives:** GPs should feel competent to undertake this area of work, even though they may choose not to, in view of time constraints. GPs that do choose to take on these additional activities should be recognised and rewarded, through QOF or changes to GMS.
2. **Clarification for women around care pathways:** In order to prevent confusion about who's in charge and who the women should turn to if she feels unwell, care pathways need to be developed locally so that women are aware when to consult a midwife, when to consult her GP and when to attend hospital directly.
3. **Integration:** GPs providing antenatal care should be active members of community midwifery teams. They should also creatively integrate their services with other community-based services, such as children's centres, in a way that encourages communication and information sharing.
4. **Training:** GP postgraduate training may need to be extended in order to ensure they have sufficient skills and knowledge pertaining to normal pregnancy. Placements should include experience in hospital-based antenatal clinics and in the community.

Key risks involved in increasing the role that GPs play in maternity care are:

- **Continuity of care:** It may reduce the ability of midwives to provide continuity of care, however, in reality, this is already a challenge.

"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."

- **Up-to-date skills and training:** The growing complexity of maternity care - as a result of older motherhood, fertility treatment problems, levels of obesity, survival of critical illness during childhood and some forms of cultural diversity¹ - makes it increasingly difficult for GPs to retain their specialist skills and understanding of maternity. Added to this, the training that GPs receive in obstetric units is limited and often of poor quality.

Main body of Report

History and policy context

- The beginning of the 20th century saw a rise in rates of hospital delivery: 24% in 1932.² During this period, GPs provided intrapartum care and used medications, such as sulphonamides, during home deliveries. With low quality of care, there were many avoidable deaths.²

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- Nowadays, more maternal deaths are due to indirect causes (non-obstetric conditions) than direct causes (obstetric conditions), with the number of these indirect deaths doubling since 1985. The Centre for Maternal and Child Enquiries (CEMACH) identified that obesity, heart disease and mental health problems are now major causes of maternal deaths in the United Kingdom.³ Worryingly, the CEMACH Report, *Saving Mothers' Lives*,³ included case studies of women who died as a result of seeing a midwife, rather than their GP.
- By the 1950s, there were 400 GP maternity units, located in community hospitals; Overtime, these were closed or turned into midwifery-led units, phasing out the involvement of GPs in intrapartum care.
- In 1993, the Department of Health published *Changing Childbirth*,⁴ which identified a reluctance of GPs to be involved in intrapartum care due to lack of experience and on-call commitments. Today, GP's no longer provide intrapartum care, and do not receive sufficient obstetric training to do so safely.
- *Changing Childbirth*⁴ explicitly permits a woman to self-refer to a midwife during early pregnancy. Despite this, many women continued to access maternity care via their GP. In 2003, the Select Committee Report, *Choice in Maternity Services*,⁵ criticized GPs role as first point of contact, reporting a tendency to curtail women's choice - referring them directly to a consultant-led units - as they were not fully aware of the range of care choices on offer.
- *Maternity Matters*,⁶ the 2007 Department of Health Report, strongly endorsed midwife-led care, encouraging women to self-refer directly to midwives.
- Additionally, the 2004 GP contract has disincentivised GPs to be involved in maternity care. Prior to this, GPs received approximately £100 for every pregnant woman they took care of, and more if they provided intrapartum care. The new contract no longer allocates funding on an 'item of service' basis, but instead includes it within a global sum.
- Many GPs have also opted out of providing out-of-hours care, making them unable to deliver continuity of care to pregnant women. This means that many women with pregnancy-related problems are presenting themselves inappropriately at A&E departments.
- Finally, with the increasing use of children's centres as the base of community midwife services - providing an interface between health, education and social services - GPs have become fragmented from maternity care.

The current situation

- In general, GPs now have a limited role in the care of pregnant women, although this varies across locations, particularly in remote areas.
- Despite the ability to self-refer to a midwife, 83% of women still use their GP as the first point of contact after discovering they are pregnant.⁷ (Although some very vulnerable or itinerant women may not have access to a GP).
- Women do not place a high priority on choice of first-contact professional; they do, however, have high expectations of health services and support following the confirmation of pregnancy, with some women feeling 'abandoned' by the lack of health care professional input in the first trimester.⁸
- Despite accurate home testing, there is a strong perception that health professional's will conduct a more accurate pregnancy test. Confirmation of pregnancy can 'make it real', with the GP often being the first person to offer congratulations.
- Current midwifery practice encourages women to contact their midwife directly in the case of an emergency; all the same, some pregnant women still contact their GP first or go straight to A&E.

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Guidance about the role of the GP in maternity care

- Recent policy documents have failed to clarify the role of GPs in maternity care, with GPs being wholly absent from some documents.
- For example, the 2003 NICE antenatal care guideline and the National Service Framework for Children, Young People and Maternity Services⁹ barely mentioned GP care.
- The 2008 NICE antenatal care guidelines advocated GP or midwife-led antenatal care for women with uncomplicated pregnancies, but not shared care.
- The 2007 NICE antenatal and postnatal mental health guidelines, do however, give GPs a clear role in overseeing the mental health of women during and after pregnancy, instructing them to ask questions about the woman's mental state when the woman first presents herself, at the six-week postnatal check and any other time that depression is suspected.
- CEMACH's Report, *Saving Mother's Lives*,³ identified key issues that GPs should be responsible for identifying to prevent maternal death. These are:
 1. **Clinical issues:** Serious illness, symptoms such as breathlessness, severe headaches, ectopic pregnancies (which can mimic gastroenteritis), puerperal fever and heartburn, urgent conditions requiring fast track referral, mental health problems, substance misuse, health of refugee and asylum seeking pregnant women and risk of obesity.
 2. **Communication issues:** Telephone consultations, referral letters and providing complete information
 3. **Maternity Services Reconfiguration:** Increasing emphasis on midwife-led care, changes in out-of-hours primary care services
- The Report also made a series of recommendations to GPs:
 1. **Communications:** GPs should undertake a careful risk assessment during telephone consultations and see the woman in the case of any doubt. Where possible, they should provide the named midwife with confidential access to the woman's written and electronic records. Significant letters should be copied into the woman's hand-held maternity record. Midwives should copy in GPs when they initiate any investigations.
 2. **Making urgent referrals:** A routine system - whether phone, fax or email (not conventional referral letters) - should be in place to ensure GPs, midwives and obstetricians can communicate rapidly with one another if the woman's condition gives rise for concern. If a woman has a serious medical condition, such as congenital cardiac disease or epilepsy, the GP should make fast track referrals directly to appropriate physicians.
 3. **Migrant women and women who do not speak English:** An early medical assessment of general health - including a cardiovascular examination - can prevent complications or even the death of pregnant migrant women. Funding must be made available for interpreters in the community: Relatives should not act as interpreters.
 4. **Obesity:** GPs should record BMI before and during pregnancy, counselling obese women regarding weight loss and healthy eating. Due to the possibility of co-morbidity, these women are not suitable for GP midwifery-led care, and should instead be referred to specialists.

5. **Mental health and substance misuse:** GPs should take detailed histories of psychiatric illness and ask directly about substance misuse. This information should be communicated to both obstetricians and midwives, if possible with the woman's consent. Pregnant women with significant mental health problems should be referred to specialist perinatal services; likewise women with substance misuse problems should be referred to specialists. These women should be managed by multi-disciplinary teams, with each woman having a lead professional, who would not usually be the GP.
 6. **Social services and child protection:** Multi agency support must continue for women who have had their baby removed into care by social services, as these women are at high risk of suicide.
- *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.)*

What role could GPs play in maternity care?

- **Pre conception care:** *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).*
- **Early antenatal care:** GPs may take a lead in discussing options with a woman who is equivocal about her pregnancy, miscarriage, hyperemesis, the encouragement of lifestyle modifications and the referral of critical early antenatal testing (such as thalassaemia screening).
- **Antenatal care:** Women do not always share their full medical history with midwives, which has critical implications for safe care. At least until the single electronic patient record is implemented, GPs have an important role in sharing important information with maternity teams, particularly midwives. This information should flow the other way, with GPs being informed about the results of tests or investigations. GPs also have a role in identifying and referring women with acute problems during pregnancy, however they need appropriate training to recognise abnormalities.
- **Postnatal care:** In general, GPs perform the six-week postnatal check, providing them with the opportunity to discuss contraception, back pain, incontinence, dyspareunia, mental health and preparation for any subsequent pregnancies.
- **Shared care:** *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)*
- **Quality of care** could be measured in a variety of ways, including GP practices having a named health professional responsible for maternity, quarterly meeting with the practices' attached community midwife and a complete register of women currently pregnant.

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NCT Comment

Birth is a normal physiological process and for the majority of women who are healthy women with a normal pregnancy they do not require medical involvement either at general practitioner or hospital consultant level. Some women benefit from the involvement of a GP or consultant or require specialist help from dieticians, substance abuse services or social services.

All women should be given individualised care and support to address their anxieties and fears. Women prefer social models of care which recognise birth as an important life event and which allow them to develop relationships of trust with their caregivers. For those women who are particularly anxious or vulnerable, it is especially important that they have the opportunity to really get to know the midwife who will be with them in labour, so that they can build up a trusting relationship. Great comfort can be gained from the security of receiving care from one or two known midwives who are experienced, calm, confident and empathetic.

Patterns of care which promote this include:

- A named midwife or small team of midwives having the main responsibility for a women's care from pregnancy through to the postnatal period ('midwife-led care')
- The continuous presence of a designated midwife during labour ('one-to-one' midwifery support)

A recent review of evidence concluded that midwife-led care improved women's experiences, providing them with more personalised care. Women were more likely to be cared for in labour by a midwife they had got to know, to feel in control during labour and were more likely to start breastfeeding. Being well supported during labour results in higher satisfaction of women giving birth and reduces feelings of trauma.

As well as providing emotional benefits, midwife-led care also results in a reduced use of regional analgesia, fewer episiotomies and fewer instrumental births and increases the chance of a spontaneous vaginal birth. Providing continuous, one-to-one personal support during labour reduces the need for medical interventions, including caesarean, forceps/ventouse and epidurals, and fewer babies need to be separated from their mothers in special care facilities. Therefore these patterns of care which allow women to form relationships of trust and feel supported also contribute to increasing normal birth rates.

For women, getting to know a midwife that they can trust and who will be with them through their pregnancy and birth until they can their partner feel settled and able to look after their baby is vital for every woman. Having lots of different people involved in care with a variety of different roles can be a hindrance to this. This is more difficult for women who are disadvantaged for social reasons. Some women know their GP well and want to maintain a relationship with them during their pregnancy and they have that choice. The midwife will explain this choice to them.

Now women are being encouraged to report their pregnancy early, ideally so they see a midwife at around 8 weeks pregnant giving them time to consider their screening options And the midwife to opportunity to decide what other support they will need. However still women on calling their GP surgery are booked in to see a GP rather than referred direct to a midwife, which delays the process.

The issue comes when a woman has pre existing health or social issues or her pregnancy is not proceeding normally and she develops ill health or social issues or her developing baby has developmental or medical problems.

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It is crucial that the midwife has access to the medical records of everyone that reports a pregnancy to her just as it is crucial that the GP is informed of the pregnancy of someone on their list. Where there are pre-existing medical problems the woman should be referred by the midwife to the appropriate service, which may be the GP or may be other services. All midwives should also be very familiar with signs and symptoms of serious pregnancy induced disease and women should be encouraged to call NHS direct, visit their GP to report these symptoms immediately to a midwife should they experience them. In the normal course of events pregnant women also sometimes became ill with non pregnancy related illnesses, influenza for example and they should be encouraged to visit their GP in the first instance, when this occurs. Some non pregnancy related illnesses are more serious in pregnant women either for their health or that of the baby and both GPs and midwives need to be aware of this.

It is not so much the lack of GP involvement that is the issue, it is the lack of systems to enable the information on the GPs records to be available to the midwife and the lack of the knowledge of the pregnancy that is with the midwife to be rapidly transmitted to the GP so s/he can flag up any issues and a means of dealing with them can be agreed with the woman by the midwife.

Expecting women to visit both midwife and a GP to make sure this information transfers seems an inefficient, expensive and inconvenient (for the woman) way of dealing with the absence of a decent system.

Though the report makes some useful suggestions, the preferred model of care would be to continue to provide choice of carer and to actively promote midwife led care to women. The issues are caused not by the principle of less GP involvement in maternity care but rather by the lack of supportive systems to make the role of the lead carer, midwife or consultant obstetrician, easier and seamless. A partnership needs to emerge between the health professionals involved in the care of pregnant women, when they are well and when they are unwell.

GP knowledge on maternity issues has fallen behind the current evidence and a considerable of re training is required to enable them to full fill their role in pregnancy in relation to the health of the women and the baby who have medical needs. Even more would be required if GPs are expected to deal with the pregnancy and birth and the post partum period as a midwife would.

In the current cost conscious climate the most effective solution would be to deal with the information flow system which could be done simply by providing the midwife with the medical record of the woman for the first visit and by a system of the midwife informing the GP of the pregnancy of one of his patients.

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