GENERAL PRACTITIONER/MIDWIFE MATERNITY CARE SCHEME

Report of pilot scheme at Rosebank Medical Practice

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Following the publication of the 'Winterton'[1] and 'Changing Childbirth'[2] reports and a meeting in 1994 with the clinical director, directorate midwife and clinical specialist (community midwifery) the doctors at Rosebank Medical Practice volunteered to host a pilot GP/midwife scheme of maternity care. This would involve all three surgeries in the practice. The scheme was introduced slowly, which enabled problems to be addressed as they arose. As no additional funding was available, the willingness of the midwives involved to develop the scheme in their own time was essential.

AIM OF THE SCHEME

Our aim was to provide a service which offers women with normal pregnancies, and no contraindications, the choice of a system of GP/midwife-led maternity care. This scheme would cover antenatal, intrapartum and postnatal care, aiming to provide the complete package from a small team.

Objectives

- To identify suitable patients for GP/midwife care
- To devise a system of referral to enable the medical records department at the Royal Lancaster Infirmary to generate case notes
- To liaise with the medical records department about GP/midwife cases and the hospital PAS (Patient Administration System) computer system
- To ensure that case notes are prepared for antenatal booking appointments at the surgery
- To develop a system that allows appointments of different lengths for antenatal bookings and review patients
- To identify room availability in the surgery for the clinic
- To roster two midwives to attend the antenatal clinic each week
- To facilitate a team approach, and wherever possible to roster a hospital-based midwife to the surgery antenatal clinic
- To enable patients to be cared for during labour and delivery by a midwife known to them
- To enable postnatal care to be given by a midwife known to the patient

PROBLEMS ENCOUNTERED

- Failure of some GPs to identify suitable, normal patients for the scheme; eg patients with previous caesarean section and past history of pulmonary embolism were referred in the early stages
- There was no facility available to register GP/midwife patients on the hospital PAS system
- Referral forms needed to be adapted to be identified as part of a new scheme
- Referral forms were not being sent to the hospital by GPs, and therefore case notes were not prepared for booking appointments at surgery
- Booking appointments were not always made at the surgery by patients
- The length of the appointment made with the midwife was not always correct. Our aim was 30 minutes for a booking appointment and ten minutes for a review antenatal visit. Initially it was unclear if this was due to:
  a doctors not giving patients the correct information
  b patients not understanding the information given
  c incorrect information being received by the receptionist
  d a combination of these
- The availability of a hospital-based midwife within the team was very limited due to staffing difficulties within the maternity unit
- Some GPs recommended this scheme to patients without giving information about other available patterns of care
- Midwife time was spent preparing packages of leaflets ready for antenatal bookings at the surgeries
- An increase in midwife time was needed at surgeries to undertake bookings
- Most of the patients were cared for in labour/delivery by a midwife previously unknown to them
- Postnatal care was given by both known and previously unknown midwives

PROGRESS TO DATE

A protocol has been devised for the scheme. It seems robust enough to be used by any local practice, in conjunction with the RLI. Of the 16 patients booked under this scheme in 1995, five patients were referred antenatally for consultant opinion. The reasons for this were:

- One had an 'early bleed' – she was returned to the scheme but then left the area
- One was referred because of her past medical history but failed to keep the appointment. She had a spontaneous onset of labour at term followed by a normal delivery
- One had a breech presentation at 36 weeks' gestation, and subsequently was delivered by caesarean section
- Two became 'post dates' but following the induction of labour both had a normal delivery

Four patients were referred during their labour

- One because of failure to progress in the first stage of labour – she was delivered by caesarean section
- One because of failure to progress in the second stage of labour – she was delivered by ventouse extraction
- One had a fetal brachycardia in second stage but had a normal delivery
- One had meconium-stained liquor but had a normal delivery

One patient delivered outside the area.

The remaining six patients had total GP/midwife maternity care, spontaneous onset of labour followed by normal delivery.

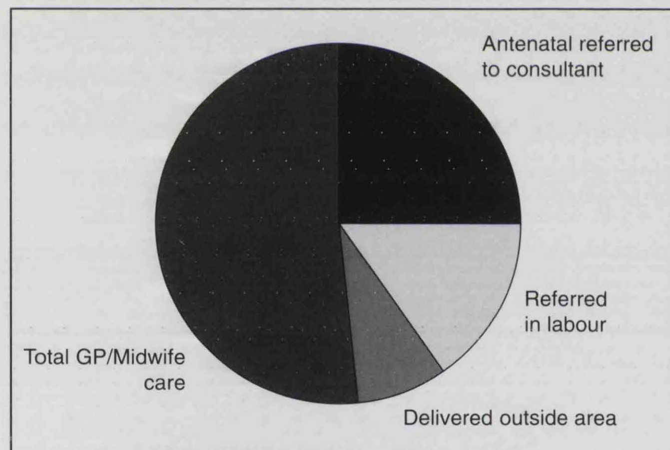
Of the 12 patients who were delivered by a midwife, two had previously met that midwife. The other ten were delivered by a midwife unknown to them.

Antenatal care was given by a GP and a midwife in all cases except the one whose breech presentation was diagnosed at 36 weeks' gestation.

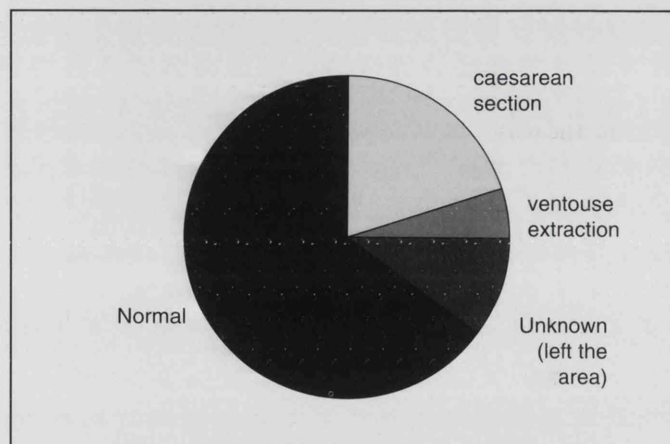
Patients were not able to meet all the midwives on the team due to the shortage of midwives in the maternity unit. Postnatal care was given by midwives both known and unknown to patients.

VIEW TO THE FUTURE

We intend to promote the team approach at the Rosebank Medical Practice by involving hospital-based midwives in the surgery antenatal clinics.



Statistics of Maternity cases in 1995



Mode of delivery

Availability of this scheme in the future, as required by 'Changing Childbirth', depends on

a adequate resources

b midwives accepting greater flexibility in their work practice

Usage of the scheme will depend on

a GP attitudes

b women being given information to make an informed choice

c women selecting it

COMMENTS FROM PATIENTS

Antenatal

Patients preferred attending the surgery for antenatal care rather than having to travel to a hospital clinic where they had waited varying lengths of time during previous pregnancies.

Most women met no more than three midwives throughout their pregnancy and always saw the same doctor – this was acceptable to all patients.

Women were reassured by knowing that they could see a consultant obstetrician if they wished or if a problem arose.

Intrapartum

Those delivered by a midwife previously unknown to them said that they had been involved in decisions regarding the care given in labour, and that all midwives had been helpful to them.

Women delivered by a midwife known to them considered it an added bonus and appreciated the continuity.

Postnatal

All women commented that it was good to be seen by a midwife they already knew.

They said they felt more able to discuss problems and seek advice from a midwife known to them.

Patients were happy with a flexible pattern of postnatal visiting which promoted continuity of care.

Where there had been problems patients reported that all midwives had been helpful.

GP PERSPECTIVE ON GP/MIDWIFE SCHEME

A common opinion of patients about maternity care has been that they would prefer more care to be practice-based rather than attending hospital. There was some confusion when the system was set up in the practice, resulting in inevitable teething problems. These were mainly of an administrative nature, particularly appointment times and preparation of patient-held records.

Once the problems were overcome the scheme seemed to run smoothly from the practice viewpoint. Patients said that they preferred to attend the surgery throughout the antenatal period. There was no significant increase in work for doctors,

although the receptionists were involved in making additional appointments for the midwives.

In response to patient demand, the practice plans to continue this pattern of care as an option for patients, if they are multigravida with a previous normal obstetric history. The questions of money and manpower remain a thorny issue as these need either to be transferred from the hospital or newly provided by the health authority.

CONCLUSION

Initially much time was spent developing a system to generate the case notes, establishing an appointments system in the surgeries and orientating the GPs and midwives involved.

The system is now working well within the surgeries, with antenatal care being given mainly by three community-based midwives.

To achieve the objectives of this scheme it will be necessary to involve the hospital-based midwives in the team at the surgery antenatal clinics. This will enable patients to meet the midwives in the team who will, ideally, care for them during labour and delivery. If the staffing situation improves in the maternity unit this situation will be addressed and patients would then benefit from the continuity of care throughout their maternity experience.

As there has been no additional funding for this project midwives have spent their own time preparing packages of information for patients and also working on solutions for problems encountered. Although this has sometimes been time-consuming, midwives feel that it has been time well spent and have gained increased job satisfaction by providing a system of care that patients are asking for.

Patients who have experienced both patterns of care give the impression that they prefer the GP/midwife scheme and would like to see it continued.

REFERENCES

1 Winterton report: House of Commons Health Committee Second Report on Maternity Services 1992

2 Changing Childbirth: Report of Expert Maternity Group HMSO 1993

Further reading

Midwifery Teams and Caseloads Caroline Flint Butterworth-Heinemann 1993

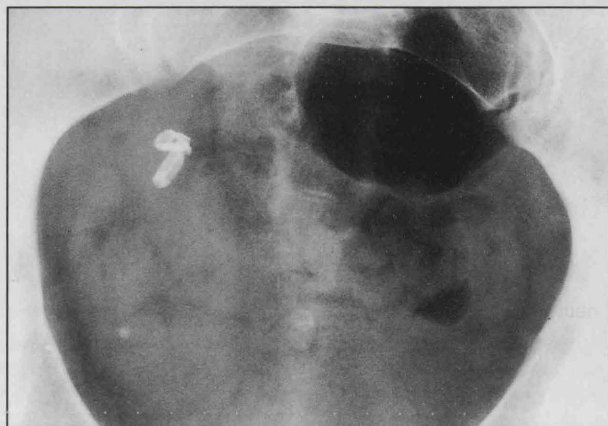
Midwives, Research and Childbirth Vols 1 & 2 S Robinson, A Thompson (eds) Chapman & Hall 1991

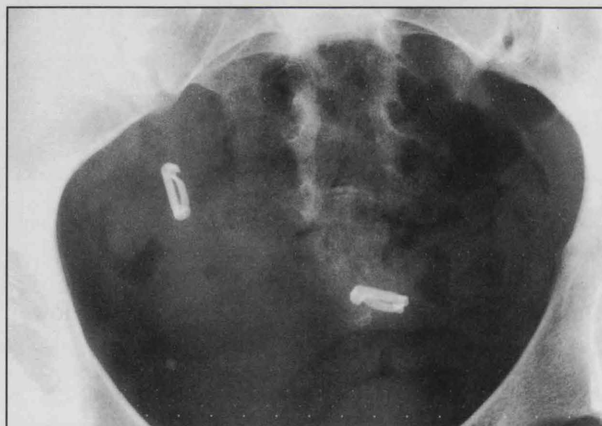
The Legal Aspects of Midwifery Bridgit Dimond Books for Midwives Press 1994

Acknowledgement

Thanks to Mr I Page, Consultant Obstetrician and Gynaecologist, Dr P Batty GP, and Mrs M Drazek, Director of Midwifery, for their help and guidance during the preparation of this article.

THE OVARIES WERE NOT OBSERVED





These pictures form part of larger radiographs taken on two separate occasions in the same patient. Tubal ligation clips are clearly visible which show how mobile the tubes and ovaries can be. We tend to think of ovaries as being placed on either side of the uterus but they are, in fact, highly variable. This can be a problem in pelvic ultrasound scanning and may explain why some reports state "the ovaries were not observed".