

# National enhanced service

## Intra partum care

### Introduction

1. All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

### Background

2. Women wish to have greater continuity and choice of maternity care and it is Government policy to promote such choice and continuity. Such continuity and choice may be provided for women delivering at home or in hospital. There is no evidence that appropriately selected low risk women have worse labour outcomes if they choose to deliver at home. Continuity of care improves labour outcomes, and reduces intervention.
3. It is crucial that those providing intra partum care work as a team, to agreed guidelines to which patients' representatives have contributed. There is evidence of a general withdrawal of GPs from intrapartum care which is related to a number of factors. GPs continue to provide hospital intrapartum care in less than 10% of UK maternity units, but this does include a number of stand-alone maternity units for which they provide valuable formal and informal support. This provides valuable back-up to the midwives working in those units and enhances their viability and therefore women's choices in terms of place of delivery. Some GPs also continue to attend selected home births to provide continuity, support and midwifery back-up.

### Service outline

4. This national enhanced service will fund practices to be able to:
  - (i) **develop and maintain a register of pregnant patients**, to whom they will be providing intra partum care. This will specify where care will be provided and at what level. Patients could be:
    - (a) registered on the practice list; and/or;
    - (b) on another practice's list
  - (ii) **support the woman and the midwife** by providing advice, support, continuity of care and neonatal and maternity resuscitation
  - (iii) **provide a number of practical skills** in addition to neonatal and maternal resuscitation which may include one or more of:
    - (a) induction of labour for post-maturity
    - (b) interpretation of cardiotocographs
    - (c) augmentation of labour with Syntocinon
    - (d) instrumental delivery (ventouse and/or low forceps)
    - (e) repair of episiotomy or perineum tear

- (iv) **state where care is expected to be provided**, either at home or in hospital
- (v) **make and keep appropriate records of care provided**, either in writing or electronically, in the patient's hand-held maternity record, the lifelong GP record, and in the hospital record if delivery occurs in hospital
- (vi) **involve as appropriate and with maternal consent the woman's midwife, family (or other lay carer), support workers, and other clinicians**. This will include regular communication with these individuals
- (vii) **ensure that the woman is booked for delivery, and provide labour care (including monitoring of mother and foetus), in line with locally agreed clinical guidelines based on national guidance which is evidence-based**. Such guidelines will be endorsed by the local maternity services liaison committee or similar representative committee
- (viii) **ensure the provision of appropriate verbal and written information about the woman's choices, local guidelines, and other relevant material**, to allow the woman to be fully informed of progress and of her choices as they occur both before and during labour
- (ix) **undertake continued professional development (CPD)**, including maternal and neonatal resuscitation and Advanced Life Support in Obstetrics course
- (x) **undertake an annual review and audit of their care**. They will compare their care and outcomes at least annually with other carers, both locally and nationally, providing similar care
- (xi) **contribute to local guideline development and to the local MSLC or similar representative committee**
- (xii) **work with local midwives who would be the principal carers at delivery and be funded to do so by the local maternity provider in contract with the PCO**. Any equipment that the GP might need would be provided by the local Trust as contracted with the PCO, eg ventouse equipment for delivery, appropriate CTG machines.

It will also provide the practice with a fee to provide a neonatal check within twenty-four hours of birth.

## Accreditation

5. Except as specified in paragraph 6, practitioners providing intrapartum care will hold the Diploma of the RCOG plus recent intrapartum experience. (The acceptability of such experience will be determined at annual appraisal and revalidation.)
6. Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

## Costs

7. Each practice contracted to provide this service will receive £200 per patient plus £50 per neonatal check. These prices will be uprated by 3.225 per cent in 2004/05 and again in 2005/06.

## References

The following references were used in writing this specification.

Association for Community Based Maternity Care. *National Survey of UK maternity units: Midwife and GP input*. 2003 (unpublished data)

Smith LFP. GP trainees' views on hospital obstetric vocational training. *Br Med J* 1991; **303**: 1447-50

Smith LFP. Reviewing maternity services - the work of the Audit Commission: a GP's view. *Changing Childbirth Update* 1997; 9: 14.

Smith LFP, Reynolds JL. Factors associated with the decision of family physicians to provide intrapartum care. *Can Med Assoc J* 1995; 152: 1789-97

Tucker J du V, Florey C, Howie P, McIlwaine G, Hall M. Is antenatal care apportioned according to obstetric risk? The Scottish antenatal care study. *Journal of Public Health Medicine* 1994; 16: 60-70