



Maternal suitability for models of care, and indications for referral within and between models of care

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in [Appendix A](#).

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 2009

Current: March 2018

Review due: March 2021

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women's Health Committee in March 2009 and reviewed in March 2018.

Funding: The development and review of this statement was funded by RANZCOG.

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1. Patient Summary

All providers of maternity care must work collaboratively, recognising the knowledge, skills and experience that each professional group possesses. Collaborating teams should have a designated clinical leader, and clear decision making pathways. Such arrangements should aim to recognise the potential for, and to avert, adverse outcomes for mothers and babies. It is important for women and their families that care is provided in an environment of interdisciplinary harmony. Continuity of care is desirable within each model of care but should not inhibit escalation to an alternative care model should complications arise during pregnancy.

2. Introduction

This multidisciplinary guideline has been developed to assist those involved in provision of maternity care to deliver best-practice evidence-based maternity care across multiple models of care.

2.1 Health practitioners providing maternity care

These guidelines have the intention of making best use of the knowledge, skills, and experience that each of the professional groups provide to maternity care (General Practitioners [GP], General Practitioner Obstetricians, Midwives, Specialist Obstetricians, and Maternal Fetal Medicine subspecialists).

During a pregnancy, referral may be required to a specialist in another discipline, for example to a Geneticist, Physician, Anaesthetist, Surgeon, Paediatrician, Infectious Diseases Specialist, or Psychiatrist. Referral will usually be the decision of the primary health care team and will depend on the level of the particular expertise available within the team.

2.2 Models of care

The following models of care are supported:

a. Shared care models

- GP Obstetrician and Hospital Midwives and designated Aboriginal and Torres Strait Islander healthcare workers
- GP, Hospital Midwives and Specialist Obstetrician or GP Obstetrician

b. Team care models

- Hospital Midwives & Obstetricians (GP or Specialist) within the Public Health System
- Hospital Midwives, Specialist Obstetricians and Maternal Fetal Medicine sub-specialist within the Public Health System

c. Private care models

- Private Obstetrician (GP or Specialist) and Private Hospital Midwives
- Private Midwife, Private Obstetrician (GP or Specialist) and Hospital Midwives

2.3 Health care settings

a. Six level classification of maternity health care facilities

At present, there is a lack of uniformity in the classification of Maternity Health Care Settings across Australia and New Zealand.

Increasingly, a "six level" classification is being adopted as follows:

a. Level 1

Staffing

) Midwives, General Practitioner

Resources

) Antenatal and postnatal care for women with no identified risk factors.

- Antenatal care
- No planned birthing or neonatal care
- Postnatal care

b. Level 2

Staffing

- Midwives, General Practitioner Obstetrician

Resources

- Antenatal, intrapartum, and postnatal care to women without complicating factors that increases the obstetric risk.

May or may not have GP or specialist obstetricians, anaesthetists and paediatricians available

May provide care within a stand-alone midwifery unit

May or may not have a Level 1 neonatal service

Level 2 maternity services do not undertake care of women with a factors that increase obstetric risk including:

Pre- or post-term labour or birth

Induction or augmentation of labour

Planned caesarean section

Vaginal birth after caesarean section

Instrumental birth

Care requiring continuous electronic fetal monitoring

c. Level 3

Staffing

- Midwives, GP or Specialist Obstetricians

Resources

- May provide care for women with no identified risk factors, or except after consultation and development of a plan of care by an obstetrician or GP obstetrician associated with the service facility.

Level 3 services that are not staffed by specialist obstetricians, paediatricians or anaesthetists, and do not have 24 hour access to operating theatre and pathology services.

Level 3 services usually do not undertake:

- Planned preterm birth
- Caesarean section for placenta praevia
- Planned vaginal birth of women with a multiple pregnancy
- Other complex births

d. Level 4

Staffing

- Midwives, Specialist Obstetricians

Resources

- May provide care for women at or beyond 34 weeks gestation with no identified major risk factors.

Obstetricians, paediatricians and specialist anaesthetists must be available 24 hours.

Collaborative care is provided by midwives, junior medical officers and obstetricians.

Level 4 maternity services are typically supported by a Level 3 neonatal service.

Level 4 maternity services do not usually undertake planned:

- Caesarean section for major placenta praevia or suspected placenta accreta/percreta
- Planned birth of twins with additional risk factors such as growth discordance, or monochorionic twins
- Triplets or higher order multiples.

e. Level 5

Staffing

- Midwives, Specialist Obstetricians

Resources

- As for Level 4 maternity service plus may provide care for women at or beyond 32 weeks gestation with a higher level of complexity.

Collaborative care is provided by midwives, junior medical officers, obstetricians and paediatricians.

Level 5 maternity services do not usually undertake the care of women with/who require:

- Known or suspected placenta accreta/percreta
- Triplets with other risk factors or higher order multiples
- Complex multidisciplinary care.

f. Level 6

Staffing

- Midwives, Specialist Obstetricians and Sub-specialist services
- Physician, Genetics, Specialist Haematology availability

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Resources

- May provide care for all women regardless of clinical risk. Collaborative care is provided by midwives, junior medical officers, obstetricians and maternal-fetal medicine specialists and neonatologists.

b. Three level classification of health care facilities

Many institutions use a “three tier” classification based on the level of neonatal care available:

- Level 1
 - No Special Care Neonatal unit
- Level 2
 - Special Care Neonatal unit
- Level 3
 - NICU

c. Descriptive classification of health care facilities

These do not translate exactly into the six levels described above but are still useful concepts.

- Remote or Rural Centres
- Provincial Centres
- Metropolitan Centres
- Tertiary Centres
- Birth Centres co-located with a facility capable of providing emergency obstetric and neonatal care.

The College believes that the additional risks incurred with Home Birth or ‘Free-standing’ Birth Centres (without adjacent obstetric and neonatal facilities) makes them unsuitable Health Care settings for the vast majority of women who are known to be risk averse with respect to avoidable risks. The College acknowledges that a small minority of women will choose to birth in these centres, even if appropriately informed of the potential limitations to emergency care that can be provided and the consequent increased risks of adverse outcomes.

2.4 Guideline flexibility

There is necessarily a balance between strict adherence to the guidelines and a need for flexibility in specific or unusual circumstances and the clinical circumstances of the woman or fetus. The principle of patient autonomy (the right to accept or refuse medical advice) must also be considered when interpreting these guidelines.

When guidelines are not adhered to, it is important that the practitioner document the reasons for future reference. When this occurs regularly, for example in response to a local health care environment or resource issue, there should be reference to local hospital or practice guidelines.

2.5 Informed consent

In adopting these guidelines, it is important to acknowledge that women and their families may choose not to follow a recommended course of action.

When these situations occur, the clinical record should reflect this in such a way subsequent clinical audit can identify the issue. This will allow identification of recurring problems, including the provision of inaccurate information about risk, or difficulties in providing information in such a way that it can be understood.

Information should always be provided appropriate to the patients' social and cultural background, and in an unbiased manner. Written information is often helpful, particularly when language is an issue, but should not replace careful and considered discussion.

3. General principles

3.1 All models of care are collaborative

There is no place in maternity care for "professional independence". All providers of maternity care must work collaboratively, recognising the knowledge, skills and experience that each professional group possesses.

Clear decision making pathways are required within the collaborating team, recognising the imperative of a designated clinical leader.

3.2 Timely consultation & referral is imperative

Providers of maternity care should strive to recognise the potential for, and to avert, adverse outcomes. Although timely consultation will not always be possible, it should always be sought.

All referrals should be subject to intermittent multidisciplinary audit, to allow review of the appropriateness and timeliness of referral and response, as well as outcomes for mother and baby.

3.3 Interdisciplinary harmony

It is important for women and their families that care is provided in an environment of interdisciplinary harmony. This should be a priority at all levels of care, extending to hospital administrative structures, representative professional bodies, and to Government.

Strategies to facilitate interdisciplinary harmony include:

- Structuring maternity care in multidisciplinary teams
- Encouraging team members to work together rather than being separated in place and time.

3.4. Continuity of care

Continuity of care is desirable within each model of care and has been shown to improve maternity outcomes. This continuity should not in any way inhibit escalation of the care model should such be indicated in the event of complications.

3.5 Within the same model of care or to another model of care?

Where consultation can occur within the same Model of Care, disruption will be minimised. Collaborative models should have the inherent advantage of agreed policies for management of complications.

Indications for further assessment:

Below is a link to guidelines for consultation and referral which includes a list of indications for medical assessment within the Model of Care, where the medical practitioner has not previously seen the woman, or where there has been a change in the nature or severity of a particular condition.

The following coding is used for clinician referral:

- G/O: GP (with a recognised postgraduate qualification in obstetrics) or Specialist Obstetrician where a GP with suitable qualifications is not available, referral should be to a specialist Obstetrician
- A: Specialist Anaesthetist
- P: Specialist Paediatrician
- O: Specialist Obstetrician
- S: Maternal Fetal Medicine Sub-specialist or Senior Obstetrician at Level VI facility

Australian College of Midwives, [National Midwifery Guidelines for Consultation and Referral](#), 3rd Edition, Issue 2, 2015.

Ministry of Health, [Guidelines for Consultation with Obstetric and Related Medical Services \(Referral Guidelines\)](#), 2012.

4. Links to other College statements

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)

[https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-\(C-Gen-15\)-Review-March-2016.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-(C-Gen-15)-Review-March-2016.pdf?ext=.pdf)

Stand alone primary childbirth units (WPI 15)

[https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Workforce%20and%20Practice%20Issues/Stand-alone-primary-childbirth-units-\(WPI-15\)-Review-March-2017.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Workforce%20and%20Practice%20Issues/Stand-alone-primary-childbirth-units-(WPI-15)-Review-March-2017.pdf?ext=.pdf)

5. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

<https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets>

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair
Dr Joseph Sgroi	Deputy Chair, Gynaecology
Associate Professor Lisa Hui	Member
Associate Professor Ian Pettigrew	EAC Representative
Dr Tal Jacobson	Member
Dr Ian Page	Member
Dr John Regan	Member
Dr Craig Skidmore	Member
Associate Professor Janet Vaughan	Member
Dr Bernadette White	Member
Dr Scott White	Member
Associate Professor Kirsten Black	Member
Dr Greg Fox	College Medical Officer
Dr Marilyn Clarke	Chair of the ATSI WHC
Dr Martin Byrne	GPOAC Representative
Ms Catherine Whitby	Community Representative
Ms Sherryn Elworthy	Midwifery Representative
Dr Amelia Ryan	Trainee Representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 2009 and was most recently reviewed in March 2018. The Women's Health Committee carried out the following steps in reviewing this statement:

-) Declarations of interest were sought from all members prior to reviewing this statement.
-) Structured clinical questions were developed and agreed upon.
-) An updated literature search to answer the clinical questions was undertaken.
-) At the March 2018 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.¹⁷ Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.