The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

CATEGORY: CLINICAL GOVERNANCE ADVICE

Shared Maternity Care in Australia

This Safety and Quality Statement has been developed and reviewed by the Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG) and approved by the RANZCOG Board and Council.

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: November 2011
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Background: This statement was first developed in November 2011and most recently reviewed in February 2021.

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Table of Contents

Shared Maternity Care represents collaborative maternity management between various caregivers, combining the skills of Midwives, General Practitioners, Obstetricians, and subspecialists to provide optimal woman-centred care according to her needs, location, and preferences.[1]
The advantages of shared care include

- Reduced travel requirements and cost for pregnant women
- Increased continuity of care from pre-conception through to postnatal and infant care[2].
- Multidisciplinary collaborative care.

1. Definitions

1.1 Shared Care

A cooperative arrangement whereby the antenatal and postnatal care of the pregnant woman is shared between the primary obstetrician, midwife or maternity unit and other shared care providers[3].

1.2 Primary Care Provider

A primary care provider is the practitioner or maternity unit who will provide intrapartum care and should be one of the following:

- MFM specialist/subspecialist
- Specialist Obstetrician
- Public Maternity Unit
- GP Obstetrician with Diplomate or advanced Diplomate training
- Registered Midwife

Shared care may include either telemedicine or face to face consultations, but clear communication is necessary with the woman and her family regarding the practitioner and type of review proposed.

1.3 Shared Care Provider

A shared care provider is a health practitioner who contributes to the standard antenatal and postnatal care of a woman under the direction of the primary care provider.

This includes, but is not necessarily limited to:

- Specialist Obstetricians sharing care with an MFM
- General Practitioners
- Registered Midwives
- Aboriginal Health Workers

1.4 Shared Care Program

Each primary obstetric care provider should set up appropriate structures and guidelines to offer a shared obstetric management programme to the pregnant women in their care. This might dictate who is eligible to provide shared care via credentialing and what aspects of care each practitioner will be responsible for. The primary care provider is also responsible for maintaining the coordination, standards and evaluation of the shared care programme.
All women in a shared care programme should have her share care providers and their contact details recorded in her medical records.

It is the responsibility of the primary carer to notify all share care providers of any changes in a woman's care plan, and for the share care provider to notify the primary carer of any abnormal findings detected during a shared care visit.

1.5 Models of Shared Care

These include but are not restricted to

- Primary care: MFM in a tertiary hospital. Shared care with Obstetricians and midwives in a regional hospital
- Primary care: Specialist Obstetrician. Shared care with the woman's usual GP
- Primary care: Specialist Obstetrician. Shared care with a midwife
- Primary care: GP Obstetrician. Shared care with the woman's usual GP
- Primary care: GP Obstetrician. Shared care with a midwife or aboriginal health worker in a remote location
- Primary care: Midwife. Shared care with an obstetrician or GP obstetrician

1.6 Registration and Scope of Practice

In keeping with professional and community expectations each provider of maternity care within the shared care model should ensure that they are

- registered within their professional college or organisation
- registered with the Medical Board of Australia
- have adequate training and experience in maternity care
- covered by professional indemnity insurance
- up to date with all CPD requirements as specified by their college or organisation
- aware of their scope of practice and their professional limitations[4]
- aware of the required referral pathways when complications occur

Whilst the CWH, DRANZCOG or DRANZCOG advanced qualification is desirable for general practitioners providing shared maternity care it is recognised that this is not a prerequisite for a shared care program or for the provision of good antenatal and postnatal care.

1.7 Maintaining Skills and Ongoing Learning

All shared care providers should commit to undertaking appropriate ongoing training in maternity care and to comply with the policies and guidelines of the shared care programme. Continuing professional development (CPD) may include locally arranged events, perinatal review meetings, involvement in a programme of quality improvement and the activities accredited and required for complying with their professional colleges' or organisations' CPD programmes.

Perinatal review meetings, case discussions and other relevant hospital based educational activities should be open to all shared care providers.

2. *Shared Care in Practice*

The organisation of and participation in a shared care program is voluntary. Shared care programs are local entities, and their form, structure, guidelines and management are at a local level. There is no need for conformity at a regional, state or national level other than adherence to good antenatal and postnatal obstetric practice.

The primary care provider should formulate guidelines on maternity visit schedules and content, including investigations. All pregnant women are suitable for a degree of shared care. Diplomate and fellowship trainees working in maternity units should be informed of the shared care programme offered by that unit. They should comply with any pre-arranged shared care plan and offer shared care where appropriate to all pregnant women.
The primary care provider will develop the policies and guidelines for shared care, including the criteria for inclusion of women in the shared care programme. Such policies and guidelines should reflect the local, cultural, and financial position of the woman and the geographical challenges of the community, ensuring the provision of evidence-based principles of good obstetric care. This will need to take into account the facilities available in the community and the local health facilities.

The degree of complexity of care undertaken by a shared care provider will vary according to the obstetric competence of the shared care provider, practice location and patient demographics.

All practitioners involved in shared maternity care should recognise that the timely referral or request for advice in the management of pregnant and postnatal women presenting with complications including psychosocial problems is essential. Where appropriate, referrals should be within the local shared care programme.

If the primary care provider considers that a pregnant woman is no longer suitable for shared maternity care, the shared care provider should be notified prior to the next planned antenatal or postnatal visit.

The primary carer provider may change throughout a woman's pregnancy. This may be due to the development of obstetric complications, a change in a woman's location or preferences or the unavailability of the previous primary carer. Where transfer of care occurs, all shared care providers should be informed and their suitability to continue in that role determined given the change in circumstances. It is the responsibility of the initial primary carer to notify existing shared care providers and the responsibility of the new primary carer to establish the new shared care programme.

3. *Postnatal Care*

Every woman should be encouraged to attend for a postnatal check usually at 1-2 months after the birth to determine the well-being of both the mother and her infant.
This should include a debrief and mental health assessment, cervical screening if due and contraceptive advice. Both the mother and infant should be examined, any concerns addressed, and infant vaccination discussed and arranged.
This visit can be conducted by the primary carer or the shared care provider depending on the complexity of a woman's pregnancy and birth, the presence of neonatal complications and her preference with consideration of her concerns, geographic location and the available resources and skills.

4. *Communication*

Within a shared care programme, communication between the various caregivers is paramount to ensure consistency of care and advice given to expectant mothers. All parties involved in the care of a mother and her baby should be consulted where appropriate and informed of decisions and management plans for her obstetric and postnatal care.
Shared care programs should have shared maternity records (either hand-held or on-line). All relevant clinical information and decisions should be recorded in this record as the pregnancy progresses.
Shared care providers who will be expected to provide postnatal care should be updated in a timely manner with details relating to the birth and post-partum course as well as any neonatal concerns, to assist the shared care provider to debrief and provide ongoing care during postnatal visits. Where possible discharge summaries should be generated at the time of discharge from the birthing unit and forwarded to the shared care provider. The woman should be given clear instructions regarding follow up arrangements.

5. Assessment of Shared Care Programmes

Shared care programmes should have a regular ongoing assessment of:

- Patient satisfaction
- The effectiveness of the programme as indicated by outcome-based parameters

- The effectiveness of the provision of the service to ensure that all caregivers commit to multidisciplinary care and are fulfilling their responsibilities as set out by the primary caregiver

6. Conclusion

A properly established shared obstetric care programme (as outlined) can deliver optimal care for pregnant women with a high degree of safety and satisfaction for the mother, her baby and other family members. It fosters good continuity of care and utilises the resources of the shared care providers in obstetric care.

7. References

1. Australian Government Department of Health. Pregnancy Care Guidelines – Core practices in pregnancy care. Department of Health. Canberra; 2019 [Accessed from: https://www.health.gov.au/resources/publications/core-practices-in-pregnancy-care]
2. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5
3. Australian Government Department of Health. National Maternity Services Plan. Department of Health. Canberra; 2011 [Accessed from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/pacd-maternityservicesplan-toc]
4. Wernham E, Gurney J, Stanley J, Ellison-Loschmann L, Sarfati D. A Comparison of Midwife-Led and Medical-Led Models of Care and Their Relationship to Adverse Fetal and Neonatal Outcomes: A Retrospective Cohort Study in New Zealand. PLOS Medicine; 2016: 13(9): e1002134. [Accessed from: https://doi.org/10.1371/journal.pmed.1002134]

Links to other College statements

1. Consent and provision of information to patients in Australia regarding proposed treatment (C-Gen-2a)
   https://ranzcog.edu.au/statements-guidelines/general/consent-provision-information-patient

2. Credentialing for General Practitioner Obstetricians and Rural Non Specialist Obstetricians practising Obstetrics in Australia (WPI-23)
   https://ranzcog.edu.au/statements-guidelines/workforce-and-practice-issues/credentialing-in-obstetrics-and-gynaecology-(wpi-2

3. Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)
   https://ranzcog.edu.au/statements-guidelines/general/evidence-based-medicine,-obstetrics-and-gynaecolog

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics
Associate Professor Ian Pettigrew	Member and EAC Representative
Dr Kristy Milward	Member and Councillor
Dr Will Milford	Member and Councillor
Dr Frank O'Keeffe	Member and Councillor
Professor Sue Walker	Member
Professor Steve Robson	Member
Dr Roy Watson	Member and Councillor
Dr Susan Fleming	Member and Councillor
Dr Sue Belgrave	Member and Councillor
Dr Marilyn Clarke	ATSI Representative
Associate Professor Kirsten Black	Member
Dr Thangeswaran Rudra	Member
Dr Nisha Khot	Member and SIMG Representative
Dr Judith Gardiner	Diplomate Representative
Dr Angela Brown	Midwifery Representative, Australia
Ms Adrienne Priday	Midwifery Representative, New Zealand
Ms Ann Jorgensen	Community Representative
Dr Rebecca Mackenzie-Proctor	Trainee Representative
Dr Leigh Duncan	Maori Representative
Prof Caroline De Costa	Co-opted member (ANZJOG member)
Dr Christine Sammartino	Observer

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 November 2011 and was most recently reviewed in September2020. 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.
- At the September 2020 committee meeting, the existing consensus-based recommendations werereviewed and updated (where appropriate) based on the available body of evidence and clinical expertise.

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests ofmembers, 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 thisstatement.

Members were required to update their information as soon as they become aware of any changes to theirinterests 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 theprocess of updating this statement.

Appendix C: Full Disclaimer

Purpose

This Guideline has been developed to provide general advice to practitioners about women's health issues concerning Shared Maternity Care in Australia and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case. 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 person and theparticular circumstances of each case.

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