Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Operational Framework**

Maternity shared care

Queensland Government

Document title:	Maternity shared care operational framework
Publication date:	December 2021
Document number:	MN21.27-V3-R26
Document supplement:	The document supplement details development processes and implementation activities and is integral to and should be read in conjunction with this guideline.
Amendments:	Full version history is supplied in the document supplement
Amendment date:	December 2021
Replaces document:	MN16.27-V2-R21
Author:	Queensland Clinical Guidelines
Audience:	Health professionals in Queensland public and private maternity and neonatal services
Review date:	December 2026
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Cultural acknowledgement

We acknowledge the Traditional Custodians of the land on which we work and pay our respect to the Aboriginal and Torres Strait Islander Elders past, present and emerging.

Disclaimer

This guideline is intended as a guide and provided for information purposes only. The information has been prepared using a multidisciplinary approach with reference to the best information and evidence available at the time of preparation. No assurance is given that the information is entirely complete, current, or accurate in every respect.

The guideline is not a substitute for clinical judgement, knowledge and expertise, or medical advice. Variation from the guideline, taking into account individual circumstances, may be appropriate.

This guideline does not address all elements of standard practice and accepts that individual clinicians are responsible for:

- Providing care within the context of locally available resources, expertise, and scope of practice
- Supporting consumer rights and informed decision making, including the right to decline intervention or ongoing management
- Advising consumers of their choices in an environment that is culturally appropriate and which enables comfortable and confidential discussion. This includes the use of interpreter services where necessary
- Ensuring informed consent is obtained prior to delivering care
- Meeting all legislative requirements and professional standards
- Applying standard precautions, and additional precautions as necessary, when delivering care
- Documenting all care in accordance with mandatory and local requirements

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Recommended citation: Queensland Clinical Guidelines. Maternity shared care operational framework. Guideline No. MN21.27-V3-R26. Queensland Health. 2021 Available from: http://www.health.qld.gov.au/qcg

Table of Contents

List of Tables

Abbreviations

ACM	Australian College of Midwives
DFV	Domestic and family violence
EPDS	Edinburgh Postnatal Depression Scale
GP	General practitioner
PHR	Pregnancy health record
PMC	Primary maternity carer

Definitions

Maternity care collaboration[1]	A dynamic process that facilitates communication, trust, and decision making pathways to support health professionals to collaboratively provide safe, woman-centred maternity care. This ensures the woman can be an active partner in their care. Collaboration includes clearly defined roles and responsibilities for all health care providers involved in care, especially for the health care professional the woman nominates as the primary maternity carer (PMC).
Consultation[2]	A collaboration between healthcare professionals, or healthcare professionals and the woman for the purpose of reviewing and providing clinical care. Consultation can occur face to face, by videoconference, telehealth, telephone, or email.
Primary maternity carer	A health care professional nominated by the woman, who is responsible for providing and coordinating the majority of the care. The PMC may be a: o General practitioner (GP) o GP obstetrician o Obstetrician o Private midwife practitioner o Midwife in a public or private hospital setting
Referral	• Communication, preferably in writing, from the health care professional making the referral for: o Consultation (e.g. request for an opinion or specialised service where responsibility for the maternity care remains with the PMC) *or* o Transfer of care (e.g. responsibility for maternity care is transferred from the PMC to a higher acuity maternity service/clinician). The PMC may continue to provide care within their scope of practice, in collaboration with the specialist team (e.g. the team may consist of obstetrician, physician, maternal-fetal medicine specialist, mental health practitioner, psychiatrist, diabetes educator, dietitian, physiotherapist, pharmacist, other allied health professionals) • An additional referral may be necessary if the woman chooses to change her PMC during the course of care. • Includes all relevant personal and clinical information to enable an informed consultation, or safe and timely transfer of care.
Shared care	The establishment of a co-operative and collaborative relationship, with a set of guidelines and responsibilities for all providers of antenatal care with the goal of the safest outcomes for the woman and baby.[3] The PMC is the lead carer for antenatal and ongoing postnatal care, with the birthing facility health care professionals providing care during labour, intrapartum and the initial postpartum period.

1 Purpose

This operational framework is designed to support effective communication and a clear understanding of the respective roles and responsibilities of the health care professionals providing woman-centred maternity shared care in Queensland. Specific aspects of clinical care are not included in this operational framework.

2 Maternity care options in Queensland

Regardless of the model of care, maternity services can be provided in a variety of settings including in the community, hospital or in the home, and be from a variety of healthcare providers. Maternity shared care is dependent on availability and geographical location within Queensland. It can be provided by private midwives, private obstetricians, general practitioners (GPs), hospital (public and private) maternity care providers including obstetricians, midwives and other members of the health care team, or a combination of multiple models.[4] Refer to Queensland Clinical Guideline *Standard care.*[5]

2.1 Care trends for pregnant women in Queensland

In Queensland, there are a variety of healthcare professionals that women may engage with for their antenatal care. Trends demonstrate that more women are utilising a shared care approach with the public healthcare system (inclusive of midwifery and medical care) and their GP. Some facilities in Queensland provide antenatal care under a formal arrangement between the birthing facility and private midwifery carers.

Table 1 Queensland women by antenatal care received

Type of care	**2015 %** n=60,749	**2016 %** n=61,683	**2017 %** n=59,207	**2018 %** n=59,479	**2019 %** n=59,366	**2020 %** n=58,472
Private medical practitioner (PMP) and						
Private midwife	0.06	0.05	0.04	0.07	0.08	0.07
Public hospital midwife	0.31	0.29	0.28	0.45	0.59	0.50
Public hospital medical	0.17	0.10	0.06	0.09	0.13	0.10
General practitioner (GP)	0.70	0.68	0.44	0.58	0.77	0.99
Private midwife and						
Public hospital midwife	0.10	0.06	0.05	0.03	0.03	0.06
Public hospital medical	0.17	0.19	0.20	0.12	0.07	0.05
GP	0.07	0.07	0.08	0.12	0.10	0.10
Public hospital and						
Hospital midwife, medical & GP	24.50	24.67	26.23	27.42	28.47	30.50
Hospital midwife and GP	3.52	3.41	2.83	2.81	3.61	4.40
Hospital medical and GP	2.68	4.09	3.61	3.33	3.51	3.27
Combination of providers						
PMP, private midwife, hospital midwife/medical, GP	0.78	0.90	0.95	0.99	1.18	1.35
No share care arrangement						
Hospital midwife and medical	21.75	23.41	25.83	25.88	24.92	22.48
Private medical practitioner	26.10	25.01	24.19	22.90	21.58	21.02
Private midwife	0.75	0.80	0.61	0.70	0.58	0.55
Public hospital midwife	9.96	10.59	10.39	10.42	11.16	11.42
Public hospital medical	6.16	3.05	2.47	2.38	2.08	2.00
GP	2.58	2.53	1.67	1.62	1.06	1.05
Unknown	0.008	0.009	-	-	-	0.01

Source: Perinatal Data Collection, Department of Health (Extracted June 2021) Department of Health (Queensland)-Statistical Services Branch, 2021.

2.2 Maternity shared care partners

Table 2. Maternity shared care partners

Aspect	Consideration
Shared care partners	• Multiple healthcare providers may be involved, depending on their area of expertise, and care provided within a variety of models (e.g. acute or community health settings) • May be privately funded, or funded by State or Commonwealth governments • Additional support workers may be engaged to provide complementary care (e.g. doula, Indigenous healthcare worker, or other culturally appropriate services) o Encourage engagement with chosen complementary care supports during antenatal, intrapartum and postnatal episodes of care
Responsibilities shared by all partners	• Each partner [1,2]: o Works within their scope of practice and the limits of their competence, and maintains adequate knowledge and skills in maternity care to provide safe care o Follows up the results of investigations they have ordered and communicates care required and initiated o If follow up is required, communicates and acts promptly about outcomes of consultations with the woman and other healthcare providers o Coordinates timely transfer of care to another practitioner or facility o Uses the pregnancy health record (PHR) or electronic medical record (follow local protocol) to communicate, assessments, care decisions and plans (e.g. screening tools, tests, investigations, results) o Works in partnership with the woman during the maternity episodes of care to facilitate shared and informed evidence based decision-making o Provides culturally safe and appropriate care
Private practitioners not sharing care	• If a woman plans most or all of their care with a private practitioner (midwife, GP obstetrician or obstetrician) and shared care with the hospital is not the preferred model of care, then: o The PMC provides the birthing facility with a copy of the maternity health record, PHR or midwifery notes by at least 36+0 weeks gestation

3 Providing shared care

The goal of shared care is continuity of care regardless of the PMC or facility that provides maternity services. This helps to avoid fragmentation of care and services, improves satisfaction with their maternity experience and leads to better outcomes.[6-11]

Table 3. Providing shared care

Aspect	Consideration
Context	• Most women can be offered shared antenatal care • The decision is a joint one made by the woman, the PMC and the birthing facility health care professionals[12] • Aboriginal and Torres Strait Islander women may choose to be accompanied by an Indigenous health worker or their doula • Early identification and referral of physical, psychosocial and mental health is integral to all aspects of maternity care o Recommend routine screening using recognised tools (e.g. Safer Baby Bundle, Edinburgh postnatal depression scale (EPDS), SAFE Start, domestic and family violence screening (DFV))
Women with complex care needs	• Access to maternity shared care is optimal when all care providers[1,4]: o Are familiar with relevant risk factors o Follow consultation and referral/management guidelines o Collaborate and refer in a timely fashion o Continue to assess the risks throughout the pregnancy o Support continuity of care o Provide clinical handover including rapid escalation when required
Perinatal mental health	• Refer to appropriate services as indicated by the screening assessment tools[13]
Consultation and referral	• Advise options for maternity care as early as possible • Providers of shared care recognise the importance of timely referral, to avert or prevent adverse maternal and/or neonatal outcomes[14] o If circumstances change, refer back to other models of care • Discuss referrals with the woman including allowing time for questions and/or concerns and document in the PHR • Use agreed/recommended consultation and referral guidelines[2,12,14] o In Queensland use the Australian College of Midwives (ACM): *National midwifery guidelines for consultation & referral*[2] o Clinical Prioritisation Criteria (CPC) o Refer to Appendix A: Supporting documents o
When recommended care is declined	• A woman has the right to decline any or all recommended care (e.g. appointments, screening tests, investigations, interventions, advice)[15] • If the PMC is a midwife, follow ACM: *Guidelines for consultation and referral* regarding appropriate action[2] • If the woman chooses a course of action that is outside clinical advice, scope of practice or organisational policy of the PMC[15]: o The woman's right to autonomy is upheld and is treated respectfully irrespective of choices o The woman's informed choice is documented • Refer to Queensland Health guidance *Partnering with the woman who declines recommended maternity care*[15]

3.1 Pregnancy health record

The PHR is the recommended mechanism for facilitating continuity of care and information exchange (clinical handover). It acts as a prompt to PMC for key actions during pregnancy.[16] The PHR is aligned with the Queensland Clinical Guidelines. The PHR may be electronic, or paper based depending on local services. Hard copies are available from local Queensland Health maternity services. If electronic records are used, follow local protocols for timely and accurate information sharing and maintenance of continuity of care.

Table 4. Pregnancy health record

Aspect	Consideration
Aim	• Facilitate the woman's participation in their care • Facilitate communication between care providers • Promote early and appropriate use of antenatal services • Promote a minimum standardised evidence based framework of antenatal care for women birthing in Queensland • Promote early universal standardised screening and referral • Inform care givers of important diagnostic and treatment decisions
Clinician use	• The PHR is the substantive record of the pregnancy and is filed in the birthing facility medical record after birth o A copy can be provided to the PMC • Follow local arrangements for obtaining and commencing the PHR (either paper based or electronic) • Follow local arrangements to ensure information is shared between all of the healthcare providers • Record information each visit in the PHR or electronic medical record to meet the care provider's duty of care in diagnostic and treatment decisions o If telehealth or other non-face-to-face platform is used, record information in medical record and advise other health care providers of relevant information • Use to document unplanned assessment or emergency care during the antenatal period
Information for women	• Advise the woman: o To carry the PHR at all times and present this at all appointments with PMC and hospital maternity services, and other healthcare providers o That the PHR is the only complete health record maintained by the birthing facility and becomes part of the birthing facility's health care record after birth (photocopies may be given to the woman, if requested)

3.2 Primary maternity carer responsibilities

Table 5. Primary maternity carer responsibilities

Aspect	Consideration
Communicating with the birthing facility	• Refer to the intended birthing facility (before 12+0 weeks gestation whenever possible) • Use the locally preferred referral tool (e.g. maternity booking-in referral form, GP smart referral or electronic booking referral template) • Inform the birthing facility of the chosen PMC • Complete the PHR at each visit to communicate care decisions and results • Participate in multidisciplinary case conferencing and clinical handover as required (including by video/teleconference if necessary) • Review the birthing facility discharge summary with the woman o Offer a copy if they do not have one
Professional development	• Qualified, registered and credentialed, with recency of practice maintained, as relevant to their profession/practice o GP completion of the Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (DRANZCOG) and/or Certificate of Women's Health (RANZCOG) is recommended (but not compulsory)[12] for the provision of maternity care o Midwives in private practice are endorsed by the Nursing and Midwifery Board of Australia to prescribe scheduled medicines[17] • Has current knowledge and skill in maternity care (e.g. routine antenatal care, newborn resuscitation, management of obstetric emergencies, breastfeeding) • Is familiar with and follows the guidelines and policies of the participating birthing facility • Participates in programs offered by the birthing facility[12]: o Orientation programs and resources o Training or up-skilling opportunities (e.g. adult and neonatal life support) o Credentialing or accreditation process in order to participate in maternity shared care arrangements (if required) o Hospital GP upskilling/alignment programs, where geographically available

3.3 Birthing facility responsibilities

Table 6. Birthing facility responsibilities

Aspect	Consideration
Communicating with PMC	• Acknowledge receipt of booking-in referral • If required, commence the PHR and ensure documentation is completed at all clinical contact • Offer multidisciplinary case conferencing and clinical handover as required (including by video/teleconference where available) • Document inpatient care provided during the antenatal, intrapartum and postnatal period[12] • Facilitate timely and accurate clinical handover and documentation to PMC • Advise woman to take PHR to all healthcare appointments and episodes of care
Labour and birth	• Provide care to the woman and baby during, and after labour and birth • The PMC may or may not be involved according to individual and local policy agreements
Clinical handover at discharge	• Provide a discharge summary outlining intra- and postpartum events[12] to the PMC (and to the GP if the GP is not the PMC) preferably within 5 days of birth o If the woman is unable to return home after birth because of distance or other circumstances, provide a copy of the discharge summary to GP providing interim postnatal care • A discharge summary enables providers to engage in prompt and targeted follow up • Provide a copy of the PHR and the discharge summary to the woman
PMC support	• Provide processes for PMC to access o Birthing facility orientation programs and resources o Training or up-skilling opportunities o Credentialing or accreditation process for maternity shared care arrangements o GP up-skilling/alignment program o Information about shared care roles and responsibilities o Collaborative practicing rights at the woman's chosen birthing facility (where appropriate/available)
Ongoing postnatal care	• Queensland Health facilities offer initial postnatal contact in the first weeks after birth as per their local arrangements • A midwife PMC may provide care for up to six weeks postpartum (or as negotiated between PMC and woman) with referral to the woman's: o GP for ongoing care of the woman and family o Preferred community child health service • Follow local protocols and pathways for referral and formal handover to primary and community health care (e.g. GP, local community child and family health services) • Offer hospital based postnatal outpatient appointment(s) (as required) to women who have experienced specific problems during pregnancy or childbirth o If there have been unexpected outcomes offer opportunities for debriefing, discussion and/or counselling o Arrange gynaecology follow-up as indicated • If problems are identified, advise the PMC in a timely manner (e.g. using phone, discharge summary, letter) to allow for follow up and support • Refer as required for contraception and future pregnancy planning

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Appendix A: Supporting documents

The documents listed below can be used in conjunction with this operational framework:

Document/tool	Availability
Australian College of Midwives: National midwifery guidelines for consultation & referral (4th edition Issue 2, 2021)	https://www.midwives.org.au
Centre of Perinatal Excellence: *Mental health care in the perinatal period – Australian Clinical Practice Guideline* (2017)	http://www.cope.org.au
Clinical Prioritisation Criteria	Antenatal | Clinical Prioritisation Criteria https://www.health.qld.gov.au
Department of Health: *Pregnancy care guidelines.* (2020)	https://www.health.gov.au
Health Pathways	HealthPathways | Healthcare Improvement Unit https://www.health.qld.gov.au
Maternity booking-in referral form	https://www.health.qld.gov.au
National Health and Medical Research Council (NHMRC): *National guidance on collaborative maternity care* (2010)	http://www.nhmrc.gov.au
Queensland Health Pregnancy Health Record	Contact the local birthing facility for ordering details
Queensland Health: *Partnering with the woman who declines recommended care.* (2020)	https://www.health.qld.gov.au
Royal Australian and New Zealand College of Obstetricians and Gynaecologists: *Maternal suitability for models of care, and indications for referral within and between models of care* (2018) C-Obs 30	https://www.ranzcog.edu.au

Acknowledgements

Queensland Clinical Guidelines gratefully acknowledge the contribution of Queensland clinicians and other stakeholders who participated throughout the guideline development process particularly:

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Ms Amanda McCartney, Clinical Midwife, Antenatal Clinic Coordinator, Redcliffe Hospital
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Funding

This clinical guideline was funded by Healthcare Improvement Unit, Queensland Health