CONSULTANTS

Process evaluation of the GP Antenatal Shared Care Program

Central and Eastern Sydney Primary Health Network

Final Report

August 2024

Acknowledgements

We also acknowledge the talent and artistry of Emma Walke, who designed the artwork for our acknowledgment of Aboriginal and Torres Strait Islander peoples. The design shows a story of connection to country and people, representing the breadth of work we do with Aboriginal and Torres Strait Islander communities across Australia. The colours represent the land, and the lines in between represent the water that connects us all.

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ARTD consultancy team

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Contents

Abbreviations, acronyms and common terms

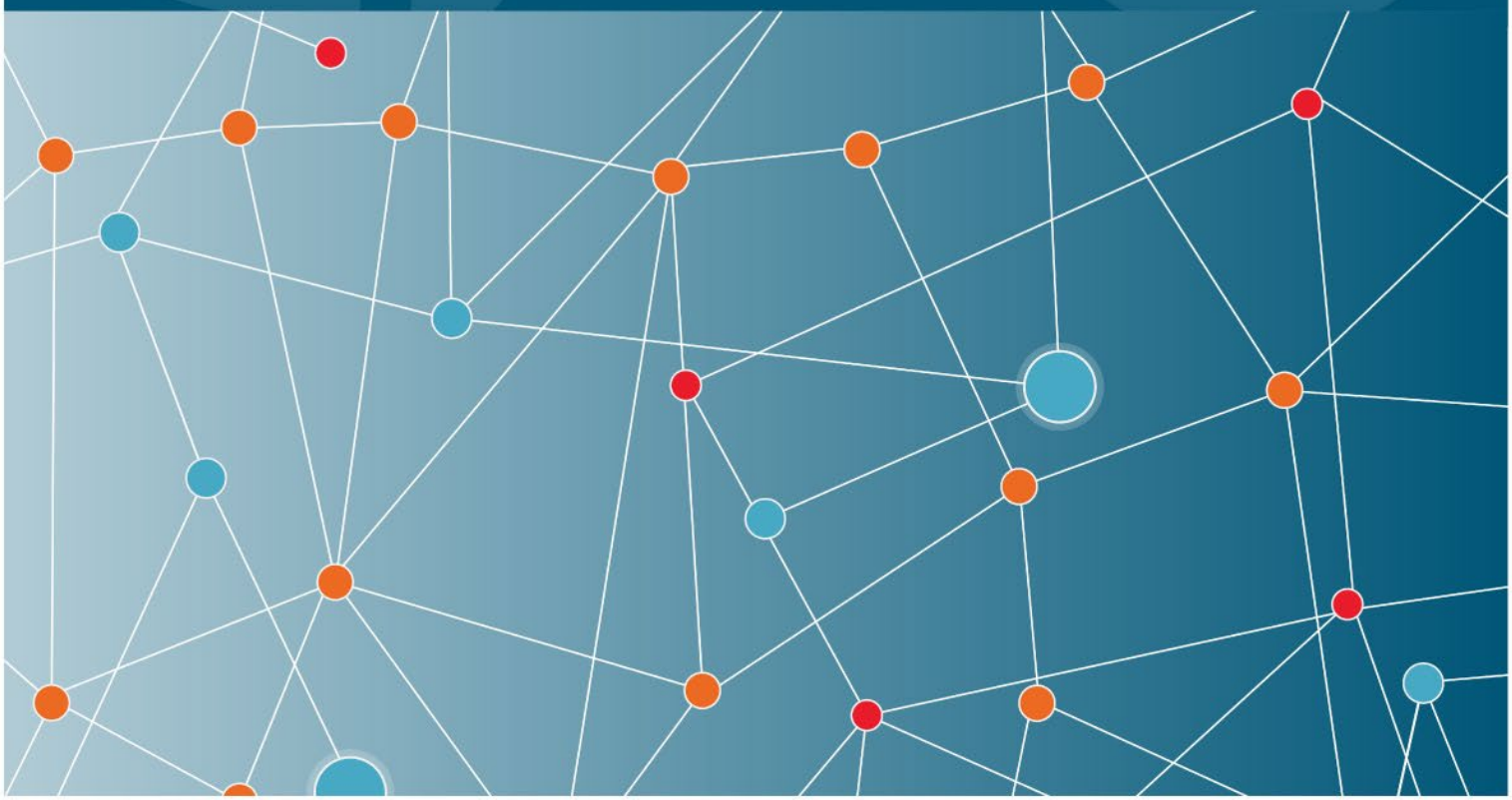
Accreditation	The requirements, including CPD, that GPs must fulfil to earn and maintain their status as affiliated GP ANSC providers
ANSC	Antenatal Shared Care
Antenatal	The period between conception and birth
Bulk billing	A payment system in Australia's Medicare program where patients receive medical services without out-of-pocket costs
CALD	Culturally and Linguistically Diverse
CESPHN	Central and Eastern Sydney Primary Health Network
CMC	Clinical Midwife Consultant
CPD	Continuing Professional Development
EMR	Electronic medical record
FTE	Full-time Equivalent
GP	General Practitioner
Hyperemesis Gravidarum	Severe nausea and vomiting during pregnancy that lasts for more than a few days
Intrapartum	The period spanning childbirth, from the onset of labour through delivery of the placenta
IT	Information Technology
MAPS	Maternity Antenatal Postnatal Service
MGP	Midwifery Group Practice
MH	Mental Health
Multiparous	A person that has given birth to more than one child
PHN	Primary Health Network
Postpartum	The period spanning between the delivery of the baby to when the mother's body has returned to its pre-pregnant state
Preeclampsia	A serious condition of pregnancy usually characterised by high blood pressure, protein in the urine and severe swelling
Primiparous	A person who has been pregnant and has given birth once
RACGP	The Royal Australian College of General Practitioners
RHW	Royal Hospital for Women
RPA	Royal Prince Alfred Hospital
SGS	St George and Sutherland Hospitals
Triennium	A specified period of 3 years

Yellow card	An antenatal record card issued by the Antenatal Clinic or GP to the woman for the purpose of recording medical checkups and test results

A note on language used in this report

We recognise that not all those who become pregnant and give birth identify as female. Nevertheless, we have used the terms 'woman' and 'women' in this report to include pregnant women, non-binary people experiencing pregnancy, labour and birth, and other people associated with the pregnancy and birth, including babies, and the partners, families and communities who support these individuals. This use of language is not ideal, but it is concise and consistent with the national strategy document, *Woman-centred care: Strategic directions for Australian maternity services* (Council of Australian Governments, 2019).

Summary



Snapshot

What we did

Mapping
Describing activities and outputs of GP ANSC within CESPHN

Comparing
Scanning literature, similar programs and key strategy documents

Consulting
Talking to stakeholders: GPs, hospital executive, liaison midwives, PHN staff

What we found

1 Model provides choice, reduces burden on hospitals

Stakeholders regard GP ANSC as a valuable option for maternity care. For women, it offers the convenience of local care with a known and trusted provider. Participating GPs are highly motivated to provide continuity of care throughout the pregnancy and beyond. Hospitals benefit from being able to redirect scarce resources to 'high risk' pregnancies and reduce workload for antenatal clinic staff members. Choice is a guiding principle for national maternity strategy in Australia.

2 Fewer women are choosing this model than previously

Despite these benefits, the number of women choosing GP ANSC has fallen over the past five years. This is not just happening in CESPHN but also in neighbouring metropolitan regions and in other countries, including the United Kingdom and New Zealand, due to a variety of factors. It is notable that the evidence for midwifery -led care has built substantially over the past 20 years, whereas there has been relatively little research attention to GP ANSC since the 1990s.

3 PHN has key role in maintaining safety, quality, credibility

A robust process for credentialling GPs who want to provide shared care is seen as critical to ensuring the model's quality and maintaining its credibility as a safe option. The advisory committees for the three programs run by CESPHN devote considerable effort to ensuring that continuous professional development offerings are relevant and accessible. Effectiveness and efficiency of accreditation could potentially improve through greater collaboration with hospitals and other PHNs.

4 Improved systems for communication are essential for sustainability

Communication is heavily reliant on the 'yellow card' system. There do not appear to be reliable mechanisms for ensuring that essential information is available to both GPs and hospital staff. Often, GPs are not informed of the outcome of the initial antenatal clinic visit or when women are moved to a new model of care. Poor communication creates frustration for the care team and can lead to uncertainty and anxiety for women.

What we suggest

Build cohesiveness
Consider alternative governance models such as one operations committee to provide oversight across the region; make program protocols consistent wherever possible

Streamline CPD
Define core professional learning and essential updates and develop some common training across programs; consider annual updates for CPD points

Strengthen CMC liaison roles
Ensure participating GPs have easy access to timely advice from hospital staff to build genuine collaboration around women's care.

Utilise information systems
Serious efforts need to be made to leverage the capacity of existing systems for sharing information such as referrals, test and imaging results, and discharge summaries.

Build goodwill – and visibility
Add value for active and passionate GPs through mentoring and networking with each other and clinic staff; consider offering practical skills sessions within hospitals

Listen to patients
The reasons for falling participation in (and attrition from) the model are not well understood. Systematically collected patient experience data could provide insights.

Executive Summary

About 15% of pregnant women in Australia currently choose General Practitioner Antenatal Shared Care (GP ANSC) programs as their model of maternity care. In these programs, they receive antenatal care from GPs and from public hospital antenatal clinics. The number of antenatal visits to each provider is governed by protocols which differ from one hospital to another. Women give birth in a public hospital and receive intrapartum and early postpartum care from hospital-based midwives and obstetricians. GPs look after mothers and babies once they return home from hospital.

Three GP ANSC programs are operating in the Central and Eastern Sydney Primary Health Network (CESPHN) region, involving around 800 participating GPs and five hospitals. In the 2023 calendar year, the proportion of births with ANSC as model of care at birth admission ranged from just under 4% at St George Hospital to 51% at Royal Hospital for Women. CESPHN provides non-clinical supports (one full-time equivalent staff member) and hospitals provide clinical supports (liaison midwives). There has been no formal review of the GP ANSC programs in the CESPHN region since they began.

What we did

CESPHN commissioned ARTD to conduct a mixed-methods evaluation focusing on program processes and outputs. **Primary data sources** were interviews with 86 stakeholders: GPs, midwives, hospital executives, and PHN staff. **Secondary data sources** were program data and documents; policy and strategy documents; and relevant academic and grey literature.

Through the evaluation, CESPHN aimed to understand what GP ANSC contributes to the maternity care system, to clarify resourcing requirements and uptake, and to identify strengths and opportunities for improvement. The purpose was to ensure that the programs are well positioned to continue offering woman-centred clinical care into the future.

What we found

Role of GP ANSC in the maternity care system

Most stakeholders view GP ANSC as a valuable option for maternity care for women who have 'low risk' pregnancies and a known and trusted primary care provider. Advantages include convenience, continuity, and personalised care. It allows hospitals to manage workloads for antenatal clinic staff and to redirect scarce resources to 'high risk' pregnancies. Importantly, this model of care contributes to a greater level of choice and autonomy for women, which is a guiding principle under national maternity strategy.

Participating GPs are passionate about providing ANSC and many of these we interviewed had a great deal of relevant experience. It is a satisfying and rewarding aspect of their practice and part of a larger commitment to holistic, continuing care across the lifetime.

Nevertheless, the number of women selecting this option has fallen over the past five years. A similar trend has been observed in New Zealand and the United Kingdom, due largely to changes in national policy and funding arrangements. The reasons for the dropping participation rate in CESPHN are not fully understood and are worth further exploration.

GPs would like to see this change investigated and discussed. Some stakeholders attribute it to the rise in availability and popularity of midwifery-led models of care and to those with private health insurance opting for obstetric care. Some stakeholders feel the value of the model is not well recognised and it is not promoted sufficiently. There is also a perception among GPs that, during the booking appointment at the antenatal clinic, midwives may be discouraging women from selecting this model of care.

Governance

The advisory committee for each of the three programs has an important role in overseeing GP ANSC. Each committee operates independently and is supported by CESPHN staff. Stakeholders say the quarterly committee meetings are collaborative, respectful spaces in which hospitals' operational information and concerns are shared, GPs' difficulties discussed, and priorities set for key activities such as continuous professional development (CPD).

Policies and protocols vary between programs. Hospitals base their GP ANSC policies and schedules of visits on national guidelines and review them regularly with input from GP Advisors. This is considered rigorous, and efforts have been made to ensure that protocols are easily accessible. However, the lack of consistency creates confusion for GPs providing shared care across multiple programs and increases administrative burden for CESPHN.

Accreditation

Stakeholders regard accreditation as critical for ensuring the quality of GP ANSC. The PHN is well placed to provide this oversight through the advisory committees and administrative functions. GPs who want to provide shared care within the CESPHN region are expected to register with one or more of the programs and complete an orientation session. To remain registered, they need to demonstrate they have accumulated at least 12 Continuous Professional Development (CPD) points – which equates to six hours' worth of directly relevant training – over a defined three-year period ('triennium').

Each advisory committee creates an CPD plan through a collaborative process, with input from participating GPs. The committees take care to ensure that essential content is offered regularly whereas other topics are varied and not repeated too often. It is generally agreed that the quality of the CPD offered is very high, with relevant topics, excellent speakers, and a variety of delivery options to ensure it is accessible.

There is potential to improve CPD by offering face-to-face skills practice in hospitals, which would add value for the most active and committed GPs, make the program more visible and strengthen connections. Regular, succinct updates on hospital protocols could be delivered via webinars, recorded, and stored on the website, with links provided in emails to GPs. A more coherent rationale for the choice of CPD topics could enhance the credibility of the programs. Further, there is no consistency across PHNs in the number of CPD points required

for GPs to remain registered with a shared care program. Accreditation requirements could be revised to consider how regularly or frequently a GP provides antenatal shared care.

Communication between GPs and hospitals

Information pertaining to a woman's care is passed between the GP and the hospital through various means. The main mechanism is a yellow card (a trifold, printed template) on which the woman's details are recorded along with space for GPs and antenatal clinic staff to make handwritten notes during appointments. The effectiveness of the yellow card relies on the woman to carry it with her to each appointment and health professionals to use the card to communicate essential information to each other.

Only basic information is recorded on the yellow card. More details are available from referral letters, pathology and imaging results, and discharge summaries; however, often these are not easily accessible when required as there is no reliable way to ensure that both the GP and the hospital receive these. Hospitals do not necessarily inform the GP of the outcome of the initial booking visit, so they may not be aware that a woman has chosen shared care. Communication can also break down when women are transferred to hospital-led models of care during the pregnancy. The provision of discharge summaries following births is highly variable, even within programs; GPs do not always receive this information.

Efforts are under way at two hospitals to make better use of electronic information sharing systems, but the issue of ensuring reliable means of communication remains challenging. It is essential to take this seriously as poor information sharing raises medico-legal risks and evidence from the literature suggests it is associated with poorer patient experiences.

Role of liaison midwives

The GP liaison midwives, who are highly qualified and senior clinical midwife consultants (CMCs), provide another important mechanism for communicating between hospitals and participating GPs. Under the Memoranda of Understanding with CESPHN, Local Health Districts (LHDs) have agreed to fund these roles at each hospital. The liaison midwives have a dedicated email address, fax number and mobile phone number, and their contact details are displayed on the GP ANSC website run by the PHN. They also have details for each of the participating GPs so they can contact them if necessary.

There appears to be potential for utilising these roles more effectively. Liaison midwives say relatively few GPs contact them regularly and proactively, whereas some GPs say the liaison midwives are not well known. Both groups say the other group is difficult to contact directly, and from the GP perspective it is sometimes more efficient to page the on-call registrar than to leave a message for the liaison midwife. Some executives have acknowledged that relying on one person to pick up the phone when the GP calls is a 'weak link' in the system.

National maternity strategy emphasises the importance of genuine collaboration among the health professionals caring for pregnant women. To achieve this, it is vital that participating GPs feel comfortable that they can call the hospital for advice and receive a prompt and collegial response. In turn, hospital staff need an efficient way to contact GPs when required.

Perceived patient experiences

The care delivered by GPs was often described by stakeholders as 'holistic' or as 'lifetime' continuity of care. Rather than focusing exclusively on pregnancy and birth, GPs can take a longer-term view, considering family context and medical history, providing ongoing support with mental health and chronic physical conditions, and ensuring that children receive health checks and vaccinations on schedule. Most stakeholders agreed that having a strong relationship with a trusted GP could enhance the patient experience. However, some stakeholders questioned whether continuity – at least during the pregnancy and birth – could be achieved in the current system where the woman is likely to see multiple different midwives and obstetricians at hospital visits, during the birth and afterwards.

Patient experiences are largely invisible to the PHN as it has no direct contact with women who receive GP ANSC. It has no way to collect data systematically on patient experiences. It is therefore reliant on feedback from GPs and hospitals via the advisory committees and other sources such as formal complaints and investigations into adverse outcomes.

What we suggest

Based on the stakeholder consultations, a scan of the evidence on GP ANSC, and discussions with two neighbouring PHNs, we would like to offer some suggestions for improvement.

Administration and accreditation

Running three separate advisory committees, each with its own processes and its own set of orientation and CPD events each year, creates a large administrative burden for CESPHN. The three-yearly cycle of ensuring all GPs have met their accreditation requirements is also time-consuming for PHN staff and potentially burdensome for GPs. Although it is important for the committees and the PHN to be responsive to GPs' requests for specific topics to be included in the training, it is likely that there are common elements that could be covered across the whole PHN (and, perhaps, in cooperation with neighbouring PHNs that are running similar programs). Practical skills sessions in hospitals would make the program more visible. Greater transparency and consistency in CPD requirements are also likely to improve the credibility of the model of care among hospital staff. Therefore, we suggest:

- Building greater cohesiveness among the three programs running within CESPHN to streamline operations and reduce unnecessary inconsistencies. This might include:
  - Considering alternative governance models, such as one operations committee to provide oversight of GP ANSC across the region (meeting frequently), supplemented by advisory committees for the three individual programs (meeting less frequently, with terms of reference to include strategy and stakeholder engagement)
  - Examining the rationale for protocols across programs and consulting stakeholders around the possibility of eliminating variation wherever possible (i.e., where these are not directly related to operational differences among the hospitals)

  - Defining core CPD content and essential updates to knowledge that all GPs in the region need to have and developing some common training across programs (in addition to, or instead of, existing content for individual programs)
- Requiring CPD points to be accumulated (and updated) annually, to avoid excessive workload pressure for CESPHN staff and reduce demands on GPs at the end of the triennium, and to ensure that GP training is spread across the three-year period rather than concentrated in a shorter period.
- Offering protocol updates for GPs via short videos, webinars or explainers, and making the GP ANSC website an up-to-date repository for all information pertaining to the programs, with updated links sent regularly to GPs via email.
- Investigate the possibility of offering practical skills sessions within hospitals, and encouraging GPs to participate, offering these across programs to get the numbers required to make them viable.
- Consulting with neighbouring PHNs to arrive at a shared position on, and rationale for, GP accreditation requirements.

Communication

Almost all stakeholders commented on the need to improve communication systems to ensure that essential information is shared reliably and efficiently between GPs and hospital staff. This is the major issue facing GP ANSC and is not unique to CESPHN – it is a long-standing problem that is beyond the power of any one PHN or program to solve completely. Nevertheless, serious efforts need to be made to address this issue as far as possible, as it affects trust among health professionals, is a barrier to collaboration, and has the potential for negative impacts on patient experiences and outcomes. Some hospitals are already working with GPs to use HealthLink for referrals and secure communications and results are promising. Therefore, we suggest:

- Encouraging hospitals and GPs to leverage the existing capacity of information sharing technology such as HealthLink and Powerchart to facilitate secure transfer of referrals, antenatal and postpartum discharge summaries, and other relevant information.
- Monitoring developments in the Single Digital Patient Record project being undertaken by NSW Health and advocating for the inclusion of relevant clinical information about the antenatal, intrapartum and postpartum care provided in NSW public hospitals, and for GPs to have access to (or secure transfer of) this information.
- Strengthening the liaison midwife roles, giving them the time and resources they need to act as a reliable conduit for information, both spontaneously and systematically.

Sustainability

Participating GPs have noted the decline in the numbers of women choosing GP ANSC and would like this to be discussed and investigated. There appears to be a cultural shift towards midwife-led care, prompted by the strong evidence base and supported by hospital policies

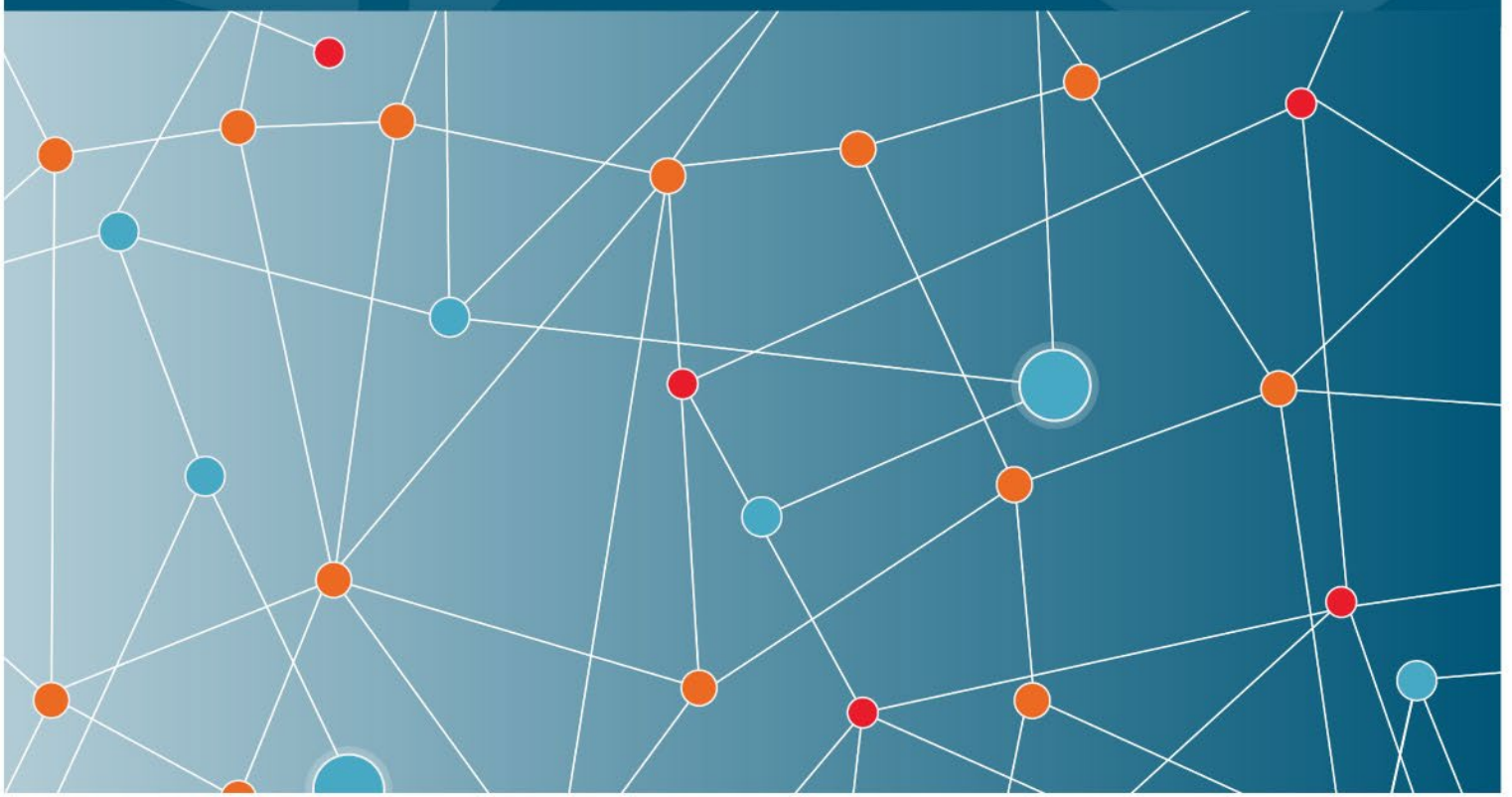
and national and state-level strategies. Nevertheless, GP ANSC remains a valuable option in the broad scheme of maternity care choices and there are actions that CESPHN (perhaps in collaboration with other PHNs and professional organisations) could take to strengthen its position in the medium to long term.

- Exploring ways to reward and motivate highly active and passionate GPs, for example through opportunities for clinical placements, mentoring, or recognition;
- Ensuring that the register of participating GPs is accessible to all midwives during booking visits to the hospital antenatal clinics;
- Building active networks of participating GPs and links with midwives to increase a sense of shared goals, collaboration and trust;
- Identifying any specific concerns that antenatal clinic and birthing unit midwives may have about GP ANSC and, where possible, addressing these concerns;
- Learning about women's experiences of GP ANSC, through qualitative research and/or systematically collected patient experience data;
- Utilising the findings of published research to design ways to improve patient experiences for women receiving GP ANSC.

Conclusions

Overall, the three GP ANSC programs within the CESPHN region comprise a well-established model of care, with effective governance and accreditation mechanisms. The model's major asset is a large cohort of committed, knowledgeable primary care providers, who have access to high quality CPD via events delivered by the PHN along with the flexibility to attend other relevant training. There is enormous goodwill among stakeholders, including hospital executives and liaison midwives, and shared goals around maintaining the model as a safe, credible option for women who are experiencing normal, 'low risk' pregnancies. The model enables women to choose to have their antenatal care in a community setting, freeing up hospital resources for those who need more specialised medical attention. The program is working well, however some suggestions for improvements are offered, particularly in the areas of administration and accreditation, communication, and sustainability.

Report



1. Introduction

General Practitioner Antenatal Shared Care (GP ANSC) is one of the most common types of maternity care provided in Australia, accounting for around 15% of models of care.[1] Pregnant women receive antenatal care from a GP who works with hospital staff under an established agreement.[2] They give birth in the local public hospital, receiving intrapartum and early postpartum care from hospital-based staff. GPs look after mothers and babies once they return home from hospital.

Three GP ANSC programs have been operating in the region covered by Central and Eastern Sydney Primary Health Network (CESPHN) for more than 20 years. These programs are delivered at the following public hospitals in partnership with Local Health Districts (LHD):

- Royal Prince Alfred (RPA) and Canterbury hospitals, in partnership with Sydney LHD;
- Royal Hospital for Women, in partnership with South Eastern Sydney LHD;
- St George and Sutherland hospitals, in partnership with South Eastern Sydney LHD.

Across the three programs, around 800 GPs are registered and actively participating, some in more than one program. Hospitals provide clinical supports (GP liaison midwives) and CESPHN provides non-clinical supports (one full-time equivalent (FTE) staff member).

Prior to this project, there had been no formal review of the GP ANSC programs since they began. Consequently, CESPHN commissioned ARTD to conduct a process evaluation of GP ANSC program administration, governance, and infrastructure. Examining program delivery within the context of changing patterns of maternity care and funding of primary care, the process evaluation (also known as 'the review') aimed to:

- Explore the role and uptake of GP ANSC in the region;
- Examine how similar programs are supported by other metropolitan PHNs;
- Identify how CESPHN can best support partners to deliver care effectively and efficiently;
- Provide evidence to inform decision making.

The review was designed to create a better understanding of the program's contribution to maternity care in the region. It aimed to clarify the program's resourcing requirements and uptake, identify strengths and opportunities for improvement, and suggest ways to capitalise on existing goodwill and updated knowledge to ensure the program is well positioned to continue offering woman-centred clinical care into the future.

[1] Australian Institute of Health and Welfare (2023) Maternity models of care in Australia, 2023. Web report.

[2] Coalition of Australian Governments (2019). *Woman-centred care: strategic directions for Australian maternity services.* Canberra: Department of Health.

2. Evaluation methods

The evaluation was guided by 12 key evaluation questions (Table 1) which were structured around four domains based on the Organisation for Economic Development (OECD) evaluation criteria.[3]

Table 1: Key evaluation questions and domains

Domain	No.	Question
Relevance	1.	What can be learned from evaluations of GP ANSC programs elsewhere about the key design, delivery and contextual factors that contribute to woman-centred care?
	2.	Does the education (CPD) available through the programs meet the needs of GPs for enhanced knowledge and skills in antenatal and postnatal care? Are there opportunities for improvement in content and/or delivery methods?
	3.	Do the current governance processes (including GP accreditation requirements and advisory committee input to clinical guidelines) support the programs effectively, and how could these be improved?
Coherence	4.	To what extent are the programs catering for the preferences of a diverse range of pregnant women/people? (Who is using the programs, and why? Who is not using the programs, and why?)
	5.	From the perspective of service providers, do the programs meet the needs of pregnant women/people for flexibility and informed choice of care?
	6.	How well do the programs align with existing healthcare services? What role do they fill in the range of choices available in the CESPHN region?
Effectiveness	7.	To what extent do the programs meet the needs of participating GPs in terms of facilitating and building their strong interest and expertise in antenatal care?
	8.	To what extent do program processes facilitate respectful communication and collaboration among health professionals caring for pregnant women/people?
	9.	To what extent do the programs improve patient experience and relationships (as observed by service providers) through continuity of care and appropriate follow-up care with a familiar provider?
Efficiency	10.	Are there opportunities to improve resource use, management, and administration of the programs to meet the needs and aspirations of all parties?

[3] OECD (2021). *Applying evaluation criteria thoughtfully*. Paris: OECD Publishing.

Domain	No.	Question
	11.	Do the programs reduce the number of antenatal hospital visits for routine/low risk pregnancies?
	12.	What can be learned from other Australian GP ANSC programs to improve efficient delivery of GP ANSC in the CESPHN region?

Evaluation activities included:

- A scan of the relevant academic literature on the delivery of GP ANSC;
- An environment scan of websites and public documents for similar programs in Australia;
- Consultations with other metropolitan PHNs in NSW regarding the delivery of GP ANSC in their regions and how PHNs support these programs;
- Analysis of routinely collected program data;
- Consultations with stakeholders through surveys and interviews.

Excluded from the review were:

- The work practices of individual health care providers within the programs;
- Self-reported patient experiences and outcomes of care.

Key stakeholders for the review included participating (and previously participating) GPs, GP liaison midwives, other hospital midwives who have regular contact with the programs, clinical directors (medical and midwifery), staff specialists, CESPHN staff and members of the Advisory Groups for each of the three programs.

A detailed description of evaluation methods can be found in Appendix 1.

3. Literature scan

In this section we summarise the most relevant findings from our rapid scan of the grey and academic literature. The purpose of the scan was to provide contextual information around GP ANSC and its role in the broader maternity care system. Consequently, we sought specific types of documents such as government policy and strategy within Australia and in selected countries with similar health systems, position statements from professional organisations, and articles providing evidence or commentary on the delivery of GP ANSC and outputs such as numbers of births under this model, and the experiences of GPs and patients.

3.1 Policy context

Government policy documents

First 2000 days strategic framework[4]

Published by NSW Health in 2019, this framework is a policy document that emphasises the critical importance of the first 2000 days of a child's life, from conception to age 5, in shaping their future health and well-being. GPs are positioned as critical for achieving two elements of the framework vision: continuity of care, and universal access to healthcare both antenatally and postnatally. The framework refers to relationships with GPs as vital and calls for NSW Health professionals to collaborate closely with GPs in their districts.

Australian Living Evidence Collaboration - *Pregnancy Care Guidelines*[5]

The Australian Pregnancy Care Guidelines were commissioned by the Department of Health and Aged Care (DoHAC) in 2023 and are maintained as 'living' guidelines by the Living Evidence in Australian Pregnancy and Postnatal Care (LEAPP) project. The most recent version was published in April 2024.

The guidelines emphasise that '*midwives, obstetricians and GPs can all make valuable contributions to collaborative antenatal care*'. The guidelines highlight several factors that can enhance a woman's antenatal care experience that align with strengths of GP ANSC. These include:

- creating a welcoming physical environment
- establishing rapport and trust
- ensuring continuity of care and privacy
- involving partners when agreed upon
- understanding the woman's community
- offering flexible appointment scheduling.

[4] NSW Health, 2019, The First 2000 Days Framework

[5] DoHAC, (accessed 2024), Australian Pregnancy Care Guidelines

The guidelines provide a definition of continuity of care that addresses both the ideals that GP antenatal care aims to achieve and the common challenges it encounters:

> *Continuity of care is a shared philosophy that involves a common understanding of care pathways by all professionals involved in a woman's care, aiming to reduce fragmented care and conflicting advice.*[6]

Coalition of Australian Governments (COAG) - *Woman-centred care: strategic directions for Australian maternity services* [7]

Four values – safety, respect, choice, and access - have been agreed upon by Australian governments to establish principles and to set strategic directions for maternity care in Australia[8]. All these values and principles (see Figure 1) apply to all models of care; however, the following principles are especially notable with reference to GP ANSC:

- Women are provided with and can readily access information about all locally available maternity services (choice)
- Women have access to continuity of care with the care provider(s) of their choice including midwifery continuity of care (access)
- Women have access to appropriate maternity care where they choose from conception until 12 months after birth (access)
- Women's safety and experience of maternity care is underpinned by respectful communication and collaboration among health professionals (respect)
- Women access care from a maternity care workforce that is responsive, competent, resourced, and reflects cultural diversity (safety).

In a nutshell, these principles suggest that any GP ANSC model of care should facilitate the provision of information about the services available, a choice of provider, continuity of carer, access to care in a location of the person's choosing, access to care from conception through to the end of the child's first year, respectful communication and collaboration among health professionals, and a well-trained and well-resourced, diverse and responsive workforce.

[6] Ibid., Section 5.1

[7] Coalition of Australian Governments (2019). *Woman-centred care: strategic directions for Australian maternity services.* Canberra: Department of Health.

[8] Ibid.

Figure 1: Principles of woman-centred care (COAG, 2019)

Position statements

Royal Australian and New Zealand College of Obstetricians and Gynaecologists – *Statement on Collaborative Maternity Care* – 2016[9]

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Statement on Collaborative Maternity Care provides guiding principles for the practice of collaborative care. Several of these principles align well with the concept of GP shared care, for example:

- Belief that the best outcomes in maternity care can be achieved by the contribution of different care providers.
- Mutual trust and respect for each profession's perspective and way of thinking.
- Understanding of different professions' scope of practice.
- Willingness to devote time and energy to develop the collaborative model.

[9] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2016). *Statement on collaborative maternity care*. https://midwives.org.au/common/Uploaded%20files/_ADMIN-ACM/Collaborative-Maternity-Care-C-Obs-33-Review-March-2016.pdf

However, one principle that may not align as well with GP ANSC is that *collaboration should be structured in a way that enhances inter-professional harmony by working spatially and temporally together, rather than in isolated professional groups*.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists – *Obstetric and gynaecology services in rural and remote regions in Australia*[10]

This Royal Australian and New Zealand College of Obstetricians and Gynaecologists' (RANZCOG) document provides recommendations for maternity care in rural and remote areas. The document emphasises the importance of rural GP obstetricians having a leading role in developing maternity service policies, protocols, and guidelines to ensure the appropriate level of care.

The recommendation highlights that optimal outcomes can only be achieved through collaboration among healthcare providers. It encourages well-defined shared care arrangements between members of the collaborative care team, according to locally agreed protocols. Each rural and remote healthcare service offering maternity services should establish risk assessment and referral criteria for all women and newborn babies.

Royal Australian College of General Practitioners – *Maternity care in general practice*

The Royal Australian College of General Practitioners (RACGP) position statement underscores the vital role of general practitioners (GPs) in delivering comprehensive and collaborative care throughout the antenatal and postnatal periods. The RACGP advocates for integrating GPs into various maternity care models, fostering collaboration with midwives, GP obstetricians, public and private obstetricians, and child health nurses to ensure continuity of care for women and their families.

According to the statement, GPs are crucial in early pregnancy care, providing education, risk identification, and management of early pregnancy and its complications, as well as collaborating with other care team members to manage pre-existing or emerging conditions during pregnancy. The RACGP also emphasises the importance of GPs in screening, managing, and referring for mental health issues and intimate partner abuse, which may be exacerbated during pregnancy and the postpartum period.

The RACGP stresses that all GPs should be able to recognise red flags in pregnancy and recommend appropriate actions, regardless of their level of antenatal care training. For GPs involved in formal shared care arrangements, the RACGP suggests implementing a nationally consistent electronic pregnancy record, integrated into current software systems, to improve communication and promote a team-based approach.

[10] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2020). *Obstetric and gynaecology services in rural and remote regions in Australia*. https://ranzcog.edu.au/wp-content/uploads/2022/05/Obstetric-and-gynaecology-services-in-rural-and-remote-regions-in-Australia.pdf

3.2 Evidence base

3.2.1 Prevalence of GP ANSC in Australia and in selected, comparable countries

When the GP ANSC model of maternal care was first promoted in NSW[11], its primary aim was to reduce the burden on hospital-based antenatal clinics by distributing the antenatal care workload between hospital midwifery clinics and midwives[12]. A NSW ministerial taskforce in 1989 found that the health system was not effectively utilising the capacity of GPs and midwives to provide care to women with low-risk pregnancies, and included recommendations to increase shared care arrangements and to introduce midwifery clinics[13] In Australia, GP ANSC currently accounts for 15% of all models of care, which is the second most common category of maternity care models after public hospital maternity care, which accounts for 41% of models of care.[14]

Unlike in Australia, where GP ANSC continues to play a prominent role in the maternal care system, countries including the New Zealand and the UK have seen a significant decline in models of care involving GPs. In **New Zealand,** two events precipitated a dramatic decline in GP involvement in maternal care. The first was legislative: the introduction of the 1990 Nurses Amendment Act enabled midwives to provide maternal care without the supervision of doctors. The second was the introduction of the Lead Maternity Carer (LMC) model in 1996. The LMC is now the only public model of maternal care offered to women in New Zealand. In the LMC model, women nominate either a midwife, General Practice Obstetrician (GPO) or specialist obstetrician to manage their care. The funding arrangements for the LMC model do not support GPs providing shared care, which has led to a significant reduction in GP involvement in maternal care in New Zealand.[15] In 2017, only 0.2% of women opted for a GP as their LMC, down from 2.7% in 2008, while the proportion of women choosing midwives as their LMC increased from 89.7% to 94.1%[16]

There is limited publicly available data on the prevalence of GP ANSC in the **United Kingdom.** However, evidence from several sources points to a significant decline in the

[11] The Royal Hospital for Women. (n.d.). *Threads of time*. https://www.seslhd.health.nsw.gov.au/sites/default/files/groups/threadsRHW.pdf

[12] Gunn, J. (2002). Shared antenatal care – where has it been and where is it heading? *Australian Family Physician, 32*(3).

[13] Wiegers, T. A. (2003). General practitioners and their role in maternity care. *Health Policy, 66*(1), 51-59.

[14] Australian Institute of Health and Welfare. (2023). *Maternity models of care*. https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care-in-focus/summary

[15] Miller, D. L., Mason, Z., & Jaye, C. (2013). GP obstetricians' views of the model of maternity care in New Zealand. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 53(1), 21–25. https://doi.org/10.1111/ajo.12037

[16] NZ Health. (2019). *Report on Maternity 2017*. https://www.health.govt.nz/publication/report-maternity-2017

provision of antenatal care by GPs, including a 2017 position statement by the Royal College of General Practitioners in the UK (RCGP) which states that *GPs are less likely to provide routine antenatal care which has now largely devolved to community midwives.*[17]

In 2017, a notable shift in policy away from GP ANSC and towards midwife-led care is presented in the *NHS 2017 National Maternity Review Report*. In the vision statement, midwife-led care is regarded as the preferred model of care:

> *Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.*[18]

The report included data from focus groups held with members of the United Kingdom's Royal College of General Practitioners. The GPs believed that declining involvement of GPs was detrimental to the maternal care system, but also that less involvement was unavoidable due both to the additional expertise required and to competing time pressures.[19] In a 2015 opinion article in the British Medical Journal, a GP expressed the view that GP involvement in antenatal care in the UK had largely been eradicated due to an increased reluctance by medical indemnity providers to cover antenatal care by GPs.

An article published by the Royal Australian College of General Practitioners (RACGP) argued that **Canada's** geographic vastness and the challenges it faces providing healthcare to regional remote communities bear closer similarity to Australia's context than the UK or New Zealand. However, our search for publicly available data on the prevalence of GP ANSC in Canada yielded few results.[20] One useful data source is a 2018 population-level cohort study of low SES women in British Colombia. The study found that 32% of women received GP ANSC and found that women's decisions regarding maternal models of care were largely driven by availability, because access to midwifery-led care was found to be limited.

3.2.2 GPs views on the role of GP ANSC

Studies from both Australia and abroad show that an overwhelming majority of GPs believe that GPs should continue to provide antenatal care to patients, and that GPs play an important role in providing care during pregnancy. In a 2015 survey of 165 GPs In **New Zealand,** 95% of respondents believed that GPs should provide some maternity services, and 90% would consider providing antenatal and postnatal care. The incompatibility between

[17] The Royal College of General Practitioners. (2017). The role of the General Practitioner in Maternity Care. https://www.rcgp.org.uk/getmedia/d98432c6-0db3-4a12-9ea9-9a32e68c3cfa/RCGP-position-statement-GPs-role-maternity-care-2017.pdf

[18] NHS. (2016). National Maternity review. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[19] Ibid

[20] Henrie, D. (2018). Which way forward for GP shared maternity care? NewsGP, RACGP. https://www1.racgp.org.au/newsgp/clinical/which-way-forward-for-gp-shared-maternity-careq

New Zealand's LMC model and the GP model was the primary barrier to providing antenatal care, while the opportunity to provide continuity of care as well as holistic care during pregnancy were the primary motivators.[21] In the **UK**, a 2017 statement by the RCGP asserts that *GPs have an important role in providing care during pregnancy and the postnatal period* due to their unique role providing ongoing care through a woman's life, their access to a chronological medical record, and the benefits for patients of receiving care from a provider with which a rapport has already been established. This sentiment is mirrored by Australian GP Dr Wendy Burton in an article[22] published by the Royal Australian College of General Practitioners:

> *The best of the GP model, in my opinion, provides broad-based, comprehensive, evidence-based, long-term, relationship-building intergenerational care. It's about seeing women before, during and after pregnancy.*[23]

3.2.3 GPs shared care in rural and remote areas

In rural and remote areas where access to specialist obstetric services is limited, GPs and GPOs play a particularly significant role in providing maternal care. The capacity for GPs to help meet demand in rural areas is still relevant in countries where GP ANSC no longer plays a significant part in the maternal care system. For example, in New Zealand, a survey of GPs referenced a shortage of local maternal care support in rural areas as a primary reason for them wanting to see more GPs practising antenatal care in the future.[24]

A 2014 systematic review of qualitative studies examined women's experiences of maternal care models in rural areas of Australia, England, Scotland, and Canada. GP ANSC care was associated with personalised and continuous care, with GPs playing a crucial role as educators and informants of maternal care choices in rural areas.[25] Similarly, a qualitative study of women receiving GP ANSC in regional Western Australia found high levels of satisfaction with GPOs, and thematic analysis identified four key aspects of care that women

[21] Miller, D. L., Mason, Z., & Jaye, C. (2013). GP obstetricians' views of the model of maternity care in New Zealand. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 53(1), 21–25. https://doi.org/10.1111/ajo.12037

[22] Henrie, D. (2018). Which way forward for GP shared maternity care? NewsGP, RACGP. https://www1.racgp.org.au/newsgp/clinical/which-way-forward-for-gp-shared-maternity-care

[23] Ibid.

[24] Miller, D. L., Mason, Z., & Jaye, C. (2013). GP obstetricians' views of the model of maternity care in New Zealand. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 53(1), 21–25. https://doi.org/10.1111/ajo.12037

[25] Hoang, H., Le, Q., & Ogden, K. (2014). Women's maternity care needs and related service models in rural areas. Women and Birth, 27(4), 233–241. https://doi.org/10.1016/j.wombi.2014.06.005

valued: woman-centred care experience, GPOs' skills, support from the healthcare team, and the healthcare environment. However, no comparison group was included in the study.[26]

3.2.4 Communication

The literature is clear that open **communication** channels between GPs and the antenatal clinic is key to the success of GP ANSC. In both Australia and abroad, fragmented communication is commonly cited as a challenge in the implementation of GP ANSC, owing to factors such as antiquated health records systems and healthcare professionals operating in silos. In the UK, research presented in the 2016 National Maternity Review found that the maternal care system faced a siloed culture between GPs and midwives, which manifested in communication breakdowns, poorly executed handover of care, and inadequate mechanisms for deciding collaboratively how to tackle situations such as escalating to more specialist care.[27] The review concluded that, to improve the quality of shared care, investments are needed in data collection and sharing systems, including implementing electronic records accessible to all providers of maternal care.[28]

Similar difficulties with communication – leading to fragmentation of care - were identified in the *Australian Birth Experience Study:*

> *A content analysis of women's experience with GP ANSC found that the primary limitation of the model was a 'great divide between community and hospital' which incapsulates a perceptible lack of collaboration that would place the onus of sharing information between the GP and hospital on the woman: "I constantly had to repeat my circumstances and thought this info would have been passed on. It was frustrating and made me feel unimportant."*[29]

A study of women's experiences of GP ANSC in the Illawarra region of NSW had similar findings: some women received inconsistent information and a lack of continuity of care, received different advice from GPs and hospital staff, and needed to fill information gaps between the GP and hospital. An article by the Medical Council of NSW also identifies fragmented communication as an issue with GP ANSC that has resulted in poor outcomes for women and babies,[30] and clinical governance advice for GP ANSC by RANZCOG emphasises

[26] Roxburgh, C., et al. (2022). Satisfaction with general practitioner obstetrician-led maternity care in rural Western Australia. *Australian Journal of Rural Health*, 30(2), 135–148. https://doi.org/10.1111/ajr.12783

[27] NHS. (2016). *National Maternity review*. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[28] Ibid.

[29] Pelak, H., Dahlen, H. G., & Keedle, H. (2023). A content analysis of women's experiences of different models of maternity care. *BMC Pregnancy and Childbirth*, 23(1), 864. https://doi.org/10.1186/s12884-023-06130-2

[30] Medical Council NSW. (2021). *Communication is key to shared care success*. https://mcnsw.org.au/communication-key-shared-care-success

that *communication between the various caregivers is paramount to ensure consistency of care and advice given to expectant mothers,* and that maternal care records should be shared among providers.[31]

3.2.5 Patient experiences

There is a general lack of research comparing **women's experiences** of maternal care under the different models of maternal care that are available in Australia. [32] A 2021 scoping review comparing clinical and/or experiential outcomes across models of maternal care in Australia identified only eight studies that met inclusion criteria (comparing at least two maternal care models in Australia after 1998 on at least one clinical, neonatal, or experiential outcome). None of these studies directly compared GP ANSC with other models of maternal care.[33]

One study was a randomised controlled trial carried out between 2007 and 2010 in Melbourne, in which women were allocated to receive either caseload midwifery care or 'standard care' (GP ANSC was bundled together with hospital-based care under this category). The study found that women receiving caseload midwifery care were more satisfied with their care overall than those receiving standard care, and specifically, were more satisfied with the emotional support they received, the competency of their care and the degree to which they were kept informed. However, given that only 17% of participants in the 'standard care' condition received GP ANSC, it is not possible to infer how satisfied women in that sub-group were with the care they received.[34]

Several qualitative research studies have examined women's experience of GP ANSC. The BEST study, cited above, involved content analysis of open text responses from a national, cross-sectional survey of women who had a baby in Australia between 2016 and 2021. Women receiving GP ANSC reported both positive and negative aspects of their care. They appreciated the continuity of care with their GP in the community, particularly when navigating fragmented hospital care. They also valued the post-partum support provided by their GP. However, some felt their GPs lacked sufficient knowledge about maternity care to be helpful, and others found the model confusing, not knowing who to turn to for assistance. The study noted that women who had pre-existing relationships with their GPs or formed personal connections with them reported more positive experiences overall, consistent with research showing high satisfaction with GP care in rural Australia.

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[31] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2021). *Shared Maternity Care in Australia - clinical governance advice*. https://ranzcog.edu.au/wp-content/uploads/2022/05/Shared-Maternity-Care-in-Australia.pdf

[32] Pelak, H., Dahlen, H. G., & Keedle, H. (2023). A content analysis of women's experiences of different models of maternity care. *BMC Pregnancy and Childbirth*, 23(1), 864. https://doi.org/10.1186/s12884-023-06130-2

[33] Talukdar, S., Dingle, K., & Miller, Y. D. (2021). A scoping review of evidence comparing models of maternity care in Australia. *Midwifery*, 99, 102973. https://doi.org/10.1016/j.midw.2021.102973

[34] Forster, D. A., et al. (2016). Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care. *BMC Pregnancy and Childbirth*, 16(1), 28. https://doi.org/10.1186/s12884-016-0798-y

A survey of 142 women receiving GP ANSC in the Illawarra region of NSW found that overall, women were highly satisfied with their care: women strongly agreed or agreed that they felt confident with their doctor, in control of their pregnancy, and involved in the care. The most common reasons for dissatisfaction related to the women's experiences during hospital visits, namely the long waiting times, and unfriendly and rushed staff. Inconsistent information and a lack of continuity of care were concerns. Further, over half of the women in GP ANSC had not received information about breastfeeding or the nutritional supplementation of iodine.[35]

Research examining women's experiences with GP-led or GP shared care in rural areas in Australia and abroad have found that satisfaction levels were high and were mediated by the pre-existing rapport between the GP and the patient. [36,37] However, it can be difficult to draw conclusions about GP ANSC from some of these studies as many focus on the work of GPOs, whose training in obstetrics is more comprehensive than the training required for GP ANSC.

3.2.6 Patient outcomes

In the international literature, GP ANSC models are typically not examined as a separate comparison group. For example, a 2016 Cochrane systematic review of randomised-controlled trials found that women who received consistent care throughout pregnancy and birth from a small group of midwives were less likely to give birth pre-term and needed fewer interventions during labour and birth than women who received care through other models (either obstetrician-provided care, GP-led care, or shared models of care).[38] The review does not compare outcomes between the latter models of care; they are grouped together as a control against which midwife-led continuity models of care are compared.

A notable exception is a 2018 retrospective cohort study of 57,782 women with low SES in British Columbia, Canada, which compared birth outcomes among women who had received either midwifery-led care, GP care (operationalised as having at least 3 antenatal checkups with a GP), or obstetrician-led care. To account for confounding variables, a modelling approach controlling for correlations at a family and community level was utilised. The study found that GP care was associated with higher rates of small-for-gestational-age birth and preterm birth and lower birth weights than midwifery-led care.[39]

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[35] Lucas, C., et al. (2015). Review of patient satisfaction with services provided by general practitioners in an antenatal shared care program. *Australian Family Physician*, 44(5), 317-21.

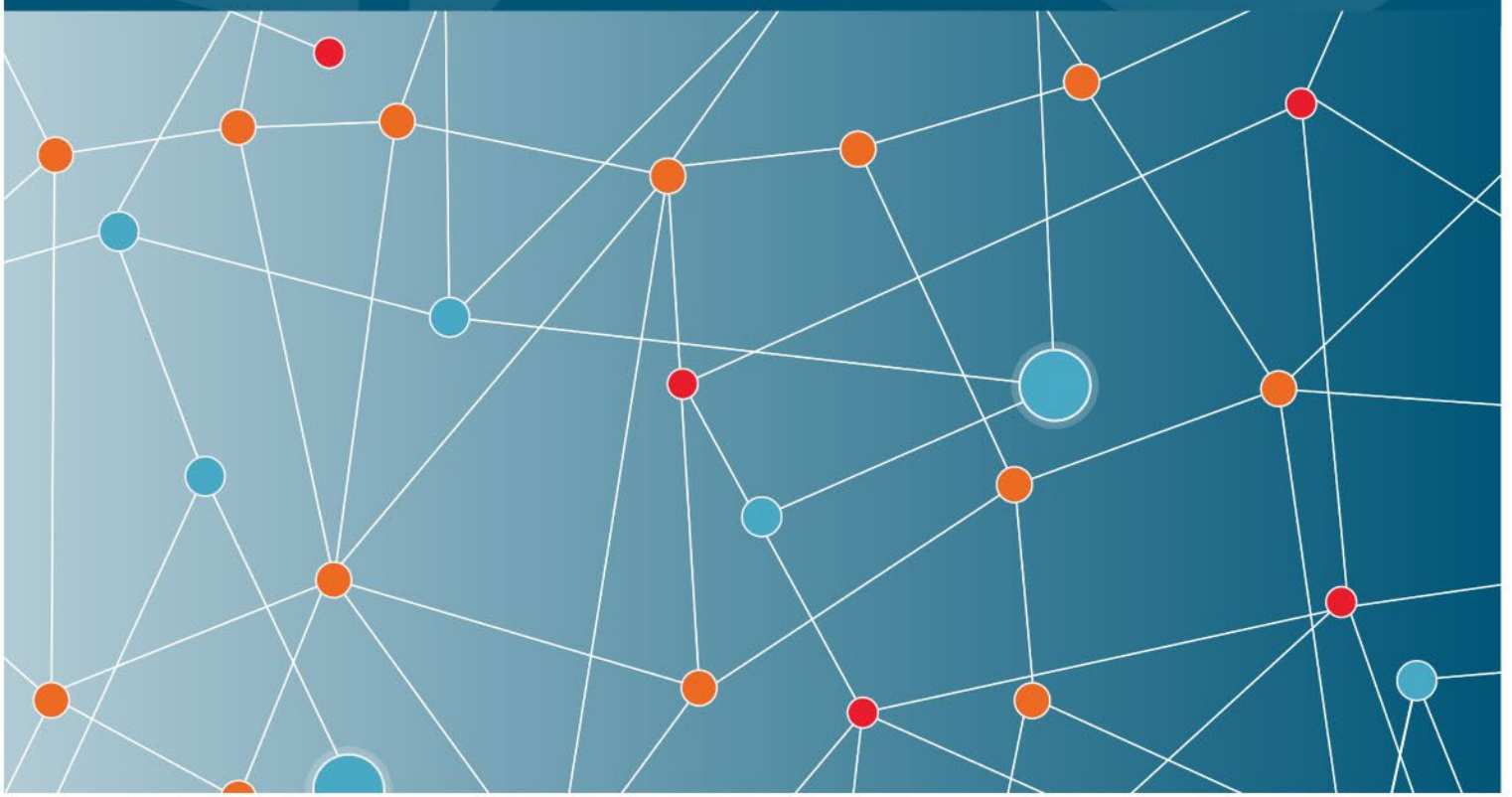
[36] Hoang, H., Le, Q., & Ogden, K. (2014). Women's maternity care needs and related service models in rural areas. *Women and Birth, 27*(4), 233–241. https://doi.org/10.1016/j.wombi.2014.06.005

[37] Roxburgh, C., et al. (2022). Satisfaction with general practitioner obstetrician-led maternity care in rural Western Australia. *Australian Journal of Rural Health, 30*(2), 135–148. https://doi.org/10.1111/ajr.12783

[38] Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, Issue 4. https://doi.org/10.1002/14651858.CD004667.pub5

[39] McRae, D. N., et al. (2018). Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. *BMJ Open, 8*(10), e022220. https://doi.org/10.1136/bmjopen-

Findings



4. Overview of GP ANSC in CESPHN

In this chapter we summarise the quantitative data available on program inputs, activities and outputs, based on information provided to the evaluation team by CESPHN.

4.1 Inputs

According to program documents, CESPHN employs 1 FTE **project officer**, currently shared among three CESPHN staff, to provide non-clinical support for the programs. Responsibilities of this role include administrative support for the three advisory committees, collaboration with stakeholders including the partner hospitals, and support for participating GPs such as provision of program orientation, monitoring of accreditation requirements, organising CPD education, and liaison between ANSC GPs and hospitals. CESPHN also maintains a website dedicated to the programs and communicates regularly with all stakeholders.

Memoranda of Understanding (MOUs) were signed with Sydney LHD (for the RPA/Canterbury program) and SESLHD (for the RHW and SGS programs) in 2021, replacing earlier service agreements. These are almost identical in their provisions for the three programs (Table 2). Each covers the aims of the program, the affiliation (i.e., registration and accreditation) processes for GPs, and the respective roles of the LHD, the PHN, and the program's advisory committee. The provisions for risk management and quality assurance set out procedures for resolving complaints against GPs, addressing complaints by GPs about the programs, and incident monitoring, including communication of any changes to protocols following critical incidents.

Under the terms of the MOUs, the five partner hospitals provide clinical support to the program by the employment of GP **liaison midwives**. The FTE for these positions varies across the programs. The main responsibilities of the role include clinical support for ANSC GPs, initiating actions on clinical incidents or issues, advocacy for GP ANSC model of care and collaboration with key stakeholders.

Table 2: Common elements of the Memoranda of Understanding between CESPHN and LHDs for GP ANSC

Shared vision	What the LHD has agreed to provide	What the PHN has agreed to provide	Systems and structures
The program aims to: • Provide pregnant women with flexibility, choice and continuity of care • Cater for the preferences and needs of women from a range of cultural and diverse backgrounds • Enhance the skills of GPs caring for women during pregnancy • Promote communication between GPs and the participating hospitals	A **GP liaison midwife**, whose main roles are to: • Advocate for the model amongst LHD staff • Provide clinical support to ANSC affiliated GPs • Escalate clinical matters raised by the GP • Work collaboratively with CESPHN to identify educational activities, resource development and orientation of new ANSC GPs • Attend quarterly Program Advisory Committee meetings • Provide clinical governance in conjunction with relevant Executive staff.	A **project officer**, whose main roles are to: • Process GP applications for appointment as an Affiliated ANSC provider • Work collaboratively with LHD GP Liaison Midwives in facilitating orientation and affiliation of new ANSC GPs, GP education and resource development • Confirm appointments and revoke appointments with the approval of relevant LHD Executive staff • Maintain the list of affiliated ANSC GPs • Liaise with affiliated ANSC GPs • Develop and provide ongoing ANSC specific CPD programs • Provide executive support to the LHD GP ANSC Program Advisory Committees • Prepare and distribute the GP ANSC newsletter and other resources if required	**Accreditation** Affiliated ANSC GPs must: • Detail experience in caring for low-risk pregnant women • Adhere to the relevant ANSC clinical protocols • Attend an intake session • Nominate an affiliated ANSC GP as a supervisor (if they are a GP Registrar) • Accrue at least 12 CPD points in either antenatal and/or postnatal specific educational activities over each RACGP triennium **Program advisory committee:** • Advises LHD regarding the operation of ANSC protocols • Provides feedback regarding the improvement of the protocols and the ANSC program

Shared vision	What the LHD has agreed to provide	What the PHN has agreed to provide	Systems and structures
		• Maintain the GP ANSC webpages on the CESPHN website.	• Provide advice on managing GPs who have not followed ANSC protocols • Advise on strategies to ensure compliance by GPs with ANSC protocol and other aspects of the ANSC program

4.2 Activities

Key program activities for which quantitative data are available are the number of participating GPs and the delivery of CPD events. Both are reported over the past five years.

4.2.1 GP participation

Across the three programs, around 800 GPs are registered and actively participating, some in more than one program. The number of participating GPs has remained steady over the past five years (Table 3). The RPA/Canterbury program is the largest in terms of GP numbers.

Table 3: Number of participating GPs by program and calendar year

Program	2019	2020	2021	2022	2023
RHW	325	331	387	420	390
RPA/Canterbury	638	534	608	630	540
St George/Sutherland	300	275	311	339	286
TOTAL	**1263**	**1140**	**1306**	**1389**	**1216**

Note. Some GPs are registered with more than one program

4.2.2 Educational events

Between 2019 and 2023, CESPHN offered a total of 67 CPD educational events across the three programs (Table 4). These included 24 intake/orientation sessions for GPs wishing to join. Typically, these were offered at least once per year at each program, with the exception of SGS which had no group-based intake sessions for new GPs in 2019 or 2020. (At that time, the liaison midwife for SGS conducted individual orientation sessions for GPs who wished to join the program, at their practices.) Obstetrics/gynaecology updates were typically well attended. There were 7 of these events for RHW (mean attendance 133, range 112-180), 11 for RPA/Canterbury (mean attendance 112, range 51-187) and 9 for SGS (mean attendance 78, range 20-125). In addition, a variety of relevant, specialist topics were offered, including information about pre-eclampsia/hypertension, diabetes, breastfeeding and infant feeding.

Clinic placements – offered only at RHW – occurred in 2019 and then ceased for three years due to COVID-19, resuming in 2023.

Table 4: Continuous professional development by program, year, and type of event

Program	Year	CPD event type	Number of events	Total attendance
Royal Hospital for Women	2019	Intake/orientation	2	274
		Ob/gyn update	2	241
		Ob clinic placement	7	17
		Ob tutorial	2	33
	2020	Intake/orientation	1	25
	2021	Intake/orientation	2	18
		Ob/gyn update	1	117
	2022	Intake/orientation	2	28
		Ob/gyn update	2	278
	2023	Intake/orientation	2	33
		Ob/gyn update	2	296
		Ob clinic placement	2	7
		TOTAL	**27**	**1367**
Royal Prince Alfred/Canterbury	2019	Intake/orientation	3	51
		Ob/gyn update	3	215
	2020	Intake/orientation	2	48
		Ob/gyn update	1	102
	2021	Intake/orientation	2	33
		Ob/gyn update	3	292
	2022	Intake/orientation	1	59
		Ob/gyn update	1	177
		Breastfeeding workshop	1	92
		Fertility optimisation workshop	1	68
	2023	Intake/orientation	2	64
		Ob/gyn update	2	184
		TOTAL	**22**	**1385**
St George/Sutherland	2019	Ob/gyn update	2	97
		Preeclampsia update	1	25

Program	Year	CPD event type	Number of events	Total attendance
		Infant Feeding Workshop	1	26
	2020	Ob/gyn update	1	125
		Infant feeding update	1	104
		Hypertension update	1	116
	2021	Intake/orientation	1	20
		Ob/gyn update	2	184
	2022	Intake/orientation	2	21
		Ob/gyn update	2	219
	2023	Intake/orientation	1	19
		Ob/gyn update	1	98
		Prenatal diagnosis and first trimester update	1	20
		TOTAL	**17**	**1074**

4.3 Outputs

Compared with the Australian average of around 15%, there has been a very high proportion of births within the ANSC model of care at RHW – close to half of all births at this hospital have had ANSC recorded as the model of care at the birth admission. This proportion has remained steady over the past five years (Table 5).

In contrast, the proportion of births within the ANSC model of care has declined substantially at Sutherland (falling from 22.0% in 2019 to 8.5% in 2023), RPA/Canterbury (13.6% to 4.6%), and St George (12.7% to 3.9%). All these hospitals are now well below the national average of births with ANSC models of care. At St George/Sutherland, the biggest fall in numbers occurred between the 2020 and 2021 calendar years, followed about a year later by a similar large fall at RPA/Canterbury. It is notable that these were years of COVID-19 lockdowns and restrictions; however, other factors might also be at play, such as changes in strategy, policy and the range of maternity care choices available (see Section 4.1 for context).

Table 5: Proportion of births within ANSC model of care (at birth admission) by hospital and calendar year

Program/hospital	2019 (%)	2020 (%)	2021 (%)	2022 (%)	2023 (%)
RHW	45.1	48.9	51.3	47.4	51.4
RPA/Canterbury*	13.6	13.2	10.7	5.7	4.6
St George	12.7	11	4.1	3.2	3.9
Sutherland	22.0	13.6	8.3	9.8	8.5

Note. *Separate data for these two hospitals was unavailable, therefore combined totals are shown

5. Role of GP ANSC within the broader maternity care system

Most stakeholders view GP ANSC as a valuable option for maternity care for women who have 'low risk' pregnancies and a known and trusted primary care provider. Advantages include convenience, continuity, and personalised care. It is empowering for GPs and allows hospitals to manage workloads for antenatal clinic staff and to redirect scarce resources to 'high risk' pregnancies. Importantly, this model of care contributes to a greater level of choice and autonomy for women, which is a guiding principle under national maternity strategy.

Nevertheless, stakeholders recognise that the number of women selecting this option has fallen over the past five years. The reasons for the dropping participation rate in CESPHN are not fully understood and are worth further exploration.

GP ANSC has been operating in the region covered by CESPHN for around 20 years. According to various stakeholders, the initial impetus for introducing GP ANSC was **cost** sharing between hospitals and primary care. This view is consistent with the evidence from the literature and environment scan. Potentially, GP ANSC takes pressure off the outpatient antenatal clinics by shifting care provision for 'low risk' pregnancies to community settings. Many, but not all, stakeholders agree that the model is reasonably effective in this respect.

The model is seen as suitable for women whose pregnancies are considered '**low risk**'. Eligibility criteria vary between hospitals but women with certain pre-existing conditions that might create additional risk during pregnancy and birth are generally excluded from GP ANSC (and may also be excluded from midwifery-led models). In addition, stakeholders felt the model was particularly appropriate for women who had good relationships with their GPs, and/or multiparous women.

Importantly, GP ANSC contributes to a greater level of **choice** for women, which is a guiding principle under the national maternity strategy. Stakeholders felt it was important for women to have a variety of options for care. Provision of antenatal care in community settings was seen as 'normalising' pregnancy (as opposed to medicalising it). It is notable that Australia, unlike other comparable countries such as New Zealand and the United Kingdom, does not have a well-developed system of community-based maternity clinics staffed primarily by midwives. Consequently, GPs – along with private obstetricians – are the main providers of antenatal care outside of public hospitals.

Moreover, GP ANSC is seen by some stakeholders as a key example of how a more **integrated** healthcare delivery system could potentially operate. The GP is in a unique position to look after people at all stages of life, providing care from family planning to preconception, optimising the woman's health throughout the pregnancy and then moving

on to provide postpartum support. According to one stakeholder, GP ANSC 'hopefully gets us closer to the point where everyone has a trusted GP'.

For a small number of women who are not eligible for free hospital treatment and do not have private health insurance (e.g., asylum seekers) GP ANSC may be the only affordable option, even though they do not receive a Medicare rebate for the GP visits.

The following sections present stakeholders' views on the advantages and disadvantages of GP ANSC for women, GPs and hospitals.

Survey analysis

GP survey respondents believe that the GP ANSC eligibility requirements are suitable and appropriate for pregnant women/people, with 84% of respondents strongly agreeing or agreeing with the sentiment (Table 23).

5.1 Advantages of GP ANSC

5.1.1 Advantages for pregnant women/people

Continuity of care. Many different stakeholders used the term *'continuity of care'* to describe the ongoing, holistic healthcare provided by a GP to their regular patients. This continuity has advantages in pregnancy as the GP has knowledge of the woman's family situation and medical history. If the woman has chronic conditions or mental illness, the GP can continue to provide appropriate support during the pregnancy and afterwards. Because they see the woman more often, the GP is arguably more likely than hospital staff to pick up on changes in physical or mental health or other issues such as domestic and family violence that might lead to increased risks. They may also be willing to discuss the '*niggly issues that happen in pregnancy that a clinic might rush through or dismiss'*. This valuable knowledge of the woman and her context can enhance patient experiences and promote better outcomes for women and babies. Following the birth, stakeholders spoke of a more *'seamless transition to primary care and postnatal care'* if the GP has also been involved in antenatal care.

> *When I hear midwives say for continuity we should be looking after people, well sure that is continuity during labour but, after they leave hospital, we potentially look after them forever. (GP)*

Trusting relationship. When a woman has an established relationship with a GP, continuing this relationship throughout the pregnancy can lead to more personalised and tailored care. This is especially important for women with vulnerabilities such as mental illness, where the GP can advocate for the woman in her connections with the hospital staff. Stakeholders said that the GP ANSC *'cements'* these existing relationships, creating *'a special level of trust which enriches the pregnancy'*. After the baby is born, the new parents can rely on the GP practice to

look after them. Thus, GP ANSC builds on the advantages of having a known and trusted health professional during pregnancy and for ongoing family health care.

> *If the GP is known to the woman before she falls pregnant, there's a pre-existing relationship that can then be built on, so there's already established trust. There's a shared understanding that's developed over time of the woman's preferences … her medical history is all known. Then it's just a transition into caring for the pregnancy itself, and there is the comfort and knowledge that they know that person … (Neighbouring PHN)*

> *It helps create a relationship with the GP whom they may go on to see long term. All the things that come up with having a newborn baby at home, vaccinations and kids getting sick … once you're in with a GP in the practice and they get to know you, they'll obviously look after you. (Liaison Midwife)*

Convenience. From a logistical point of view, GP ANSC is likely to be easier and more convenient for many women because they usually have a GP close to where they live. According to stakeholders, this proximity and familiarity with the practice reduces anxiety and *'avoids hassles with parking and parking fees or public transport'*. It also avoids long waiting times at the antenatal clinic. A major advantage for women – particularly those who already have children – is the ability to schedule antenatal appointments locally, at convenient times, at the GP practice. Where the woman does not drive (which is often the case with patients in the Canterbury hospital catchment), being able to schedule appointments after business hours or on weekends means that other family members do not have to take time off work to transport her to clinic appointments. Many GP practices have efficient communication systems (such as text message reminders).

> *It is a good option, particularly for women who have other children, [especially if] they don't have private health insurance but want more of a personalised model for care. We can provide that in terms of scheduling appointments, and they have continuity of care with us because they know us. (GP Advisor)*

> *I feel like it's popular for those return customers. There are some logistic elements to it that I think are quite good. So, depending on the GP availability of appointments, something as simple as proximity to home and parking and access. When you're running around with a little one already … [it] makes it more convenient, one hundred percent. (Liaison Midwife)*

5.1.2 Advantages for GPs

Empowerment. Stakeholders said that GPs who are actively and regularly involved in ANSC can provide a standard of care that is at least equal to that provided by a midwife, with the added advantages of a broader medical knowledge and ongoing contact with the patient following the birth. Stakeholders also acknowledged that many GPs are knowledgeable, committed, diligent, and highly motivated. Further, stakeholders said, 'if GPs don't know something, they'll ask'. Such GPs are highly regarded by stakeholders.

Some GPs feel strongly that they should be part of the health professional team caring for their patient during her pregnancy; they see it as a 'normal' thing to do, an important component of healthcare for the woman and her baby. Being registered with GP ANSC programs and undertaking regular, relevant CPD education helps to ensure that these GPs remain updated. Many enjoy the opportunity to renew and extend their knowledge and skills. In this way, the GP ANSC programs empower GPs to perform to their full scope of practice and take on work that many consider to be interesting and enjoyable. As one stakeholder put it, *'it's rewarding to see patients who are well and be part of their whole [life] journey'*.

> *Compared to a lot of GP work it's a pretty happy, positive part of my job. I like the continuity – you see the mum when she is pregnant, see them all the way through [the pregnancy], and then see the kids. (GP)*

Income. Although this was a minority view, a few stakeholders mentioned that the revenue generated from ANSC was an advantage for GPs. One example was a GP who said that offering ANSC was 'good business' and helped to build a reputation: *'just for people to know that we offer it gives a warm impression of the practice'*. It is worth noting that many others said the low Medicare rebate did not make this type of work worthwhile, financially speaking.

5.1.3 Advantages for hospitals

Cost savings. GPs who help to manage 'low-risk' pregnancies in the community shift some of the costs to the primary care system, saving money for the hospitals and allowing them to redirect scarce resources to women with 'higher-risk' pregnancies who may require more specialist care. Additional cost shifting occurs when GPs order the necessary tests early in pregnancy from private pathology providers; the costs of these tests are then paid via (Commonwealth-funded) Medicare, taking pressure off (state-funded) hospital budgets. (One stakeholder said hospitals sometimes asked GPs to do this later in pregnancy as well).

When asked about the value of the model from the hospital's point of view, stakeholders tended to emphasise cost savings, although other benefits were also mentioned. For example, GP ANSC was described by one executive as 'a sustainable investment' from the hospital's point of view; a GP Advisor described the model as *'a bargain for the hospital, and the longevity of the model demonstrates it is of value to the community'*. A liaison midwife was

more reserved, saying that *'if the women are happy and have good birth experiences, then it's good value'* (emphasis added).

Workload management. A related issue was the importance of GP ANSC in relieving workload pressures in antenatal clinics and reducing long waiting times for patients. Some stakeholders said this was part of the initial impetus for GP ANSC when it began. The view that GP ANSC helps reduce burden on hospitals was shared by many stakeholders, and some even said that antenatal clinics simply did not have the capacity to see all pregnant women. For example, one stakeholder told the evaluation team that shared care had *'made a big difference to hospitals at the start'*. Hospitals were *'now in a good place with waiting times in clinics'* but if shared care was reduced, this would place pressure on antenatal clinics in future.

> *We really value that partnership with the GPs … [if resources for ANSC were not maintained] we would open ourselves up for more problems and, potentially, risk … it would probably then fall to other clinicians such as our junior medical officers which would then have a negative influence on their workload (Executive)*

Quality care. Another advantage for hospitals was being able to rely on GPs registered with the programs to provide high quality antenatal care in the community. One stakeholder summed up this point: *'women can receive care close to home in the capable hands of an expert with a trusting relationship and turn up well-prepared [for birth] and safe and well cared for'*. Some said GP ANSC was a safer arrangement than a busy, overloaded antenatal clinic, because GPs could *'pick up changes in women that the clinic might not appreciate'*. Having access to the full medical history meant that GPs could continue management of pre-existing chronic conditions, whereas the clinic might make *'unnecessary referrals'* to specialists.

5.2 Disadvantages of GP ANSC

5.2.1 Disadvantages for women

Birth and mothercraft education. An appointment with the GP (about 15 minutes) is shorter than the average appointment time at the antenatal clinic (about 30 minutes), and women may therefore *'lose out on the in-depth provision of information'* about normal birth, breastfeeding and mothercraft. It can be difficult to get through all this information during the GP appointment as well as covering the necessary checks.

First-time mothers may have additional education needs to prepare them for the birth and the first few weeks of caring for the baby. GPs may be less confident to provide this education or may not have time during consultations. One stakeholder suggested that *'women save up questions for the midwives, who then have to do the education'*; another said, *'if women receive only partial information or conflicting advice, it can be confusing'*. One even claimed that the lack of mothercraft education available in GP ANSC was *'part of why it has a bad reputation with midwives'*, although we must note that the midwives we spoke to were

generally positive about the model overall. Some GPs acknowledged that education was time consuming, particularly during the early visits, making consultations very long.

Another, related, issue was that women might miss out on antenatal classes at the hospital, along with the opportunities these classes provide to meet other parents.

Access. Many of the advantages of GP ANSC for women rely on them having existing relationships with GPs who are registered with the programs. If their current GP is not part of the program, and they wish to have shared care, they will need to find a new GP. One hospital executive requested a list of participating GPs for the antenatal clinic so that midwives could help patients to make these connections. (In fact, such a list already exists and is regularly updated by CESPHN, so perhaps the issue is more around accessibility and utilisation of this information within the hospital.) Further, the model is only available while the pregnancy remains 'low risk'. As soon as any complications occur, the woman may be transferred to hospital care, which can be confusing or upsetting.

Cost. It can be difficult to find GPs who bulk bill. This is especially the case for antenatal care; several GPs told us that the current Medicare rebate was inadequate and 'disrespectful' of their time and expertise. (Under current Medicare, GPs do not receive a bulk billing incentive for the antenatal care item number, resulting in substantially lower remuneration for these visits compared with standard consultations.) Where GPs do not bulk bill, some of the costs of care are transferred onto patients directly through out-of-pocket (gap) payments. This is also a barrier for disadvantaged women to participate in the program. In contrast, antenatal care via the public hospital system is completely free of charge, or a patient with private health insurance and financial means could choose private obstetric care.

Unfamiliarity with hospital setting. Hospitals are moving towards midwifery-led models of care, which are increasingly popular with women who have 'low risk' pregnancies because they promise continuity of carer. Women in the GP ANSC programs have fewer visits to the hospital and therefore less opportunity to meet the midwives and obstetricians who might be caring for them during labour and birth. Some women would prefer to build a relationship with these health professionals before they arrive at the hospital for the birth of the baby.

> *These women, we don't get to know or see very often and the patient doesn't get to know us and then they come in for their delivery. I wonder if that affects their trust of the system a bit because they haven't had much to do with us. (Executive)*

Poor communication. The lack of shared systems (see Chapter 8) can lead to communication breakdown between the GP and the hospital. If information is not passed on, and health professionals are not genuinely collaborating around the woman's care, her experience can be 'disjointed' or even 'fractured', according to stakeholders.

Variable quality of care. The quality of care provided is highly dependent on the individual GP's commitment to keeping up to date with relevant knowledge and skills. Stakeholders acknowledged that the levels of expertise and experience were more variable with GP ANSC

compared with antenatal clinics, which 'are dealing with pregnancy all day, every day'. While midwives have access to highly specialised knowledge and skills, GPs (by definition) see a broad range of patients. Some GPs might not provide ANSC regularly and might therefore not have the same level of visibility over issues that do not occur very often in pregnancy, to which a midwife has more exposure, creating some risk from rarer complications. One stakeholder wondered whether this issue could be addressed through more in-depth or practical workshops as part of CPD education.

5.2.2 Disadvantages for GPs

Poor communication. All stakeholders, but particularly GPs, highlighted serious difficulties with two-way communication, especially around imaging or test results. GPs would like more information, and more timely communication of important information, from the antenatal clinic and easier access to hospital-based imaging and test results for their patients. Most would prefer to be able to maintain their usual, digital patient records rather than writing on the yellow card, which is a duplication of effort (see Chapter 8 for more details). Time spent 'chasing up communications' was also a source of dissatisfaction for GPs.

Insufficient support and lack of collaboration. When the GP and hospital staff work effectively together in a collaborative team around the woman's care, the work can be professionally rewarding for GPs. This does not always occur, however, and when collaboration is lacking GPs can feel professionally isolated and inadequately supported by the hospital. GPs are aware that the antenatal clinics have supports available to women that they themselves cannot offer. Compared with clinics, GPs have less immediate access to specialist advice from obstetricians, multidisciplinary teams, testing, imaging, and other hospital resources. Access to these resources makes it easier for midwives to provide more streamlined care, especially when risks or concerns arise and need to be investigated.

> *Probably our ability to access private specialist advice is a little bit harder cause we're not in the same room. So like if I have a question or something about a patient, I have to try and get on to the OBGYN or a midwife, which takes like a lot of time. And if they're busy it can be quite difficult. I also think in GP, we are much more isolated and we don't have the same support network. (GP)*

Further, there is a risk that GPs can experience a lack of respectful interaction with hospital staff, which can leave them feeling *'disempowered'* or *'marginalised'*. There can be tensions in the relationships between hospital and primary care professionals which prevent a cohesive team environment from developing. Stakeholders perceive that midwives are not always supportive or positive about ANSC. There is also a perception that hospitals are ready to expect GPs to *'stuff up'* and to blame them for poor outcomes. If GPs struggle to interact successfully with hospital staff and do not feel appreciated or respected, they may decide it is *'too hard'* to continue working in this space.

Burden of administration. Protocols for GP ANSC are not standardised across programs; each hospital has its own versions. It can be difficult for GPs to keep track of the multitude of

different policies, guidelines and referral pathways, especially if they work in more than one program. Things that might seem straightforward to the clinic staff – because they deal with these things every day – can be complicated and time consuming for a GP to find and check information. Considerable effort is required to keep up to date with changes in protocols, on top of the CPD expectations. It is important to bear in mind that, for most participating GPs, ANSC is a small part of their day-to-day practice.

If I'm not getting any women who are electing to do shared care, then why would I keep up with [the CPD]? (GP)

Managing to keep up to date with changes in protocols and systems at the hospital. There's enough sharing of information and clinical updates and things that we need to do at the hospital, but if you miss the email update, sometimes you [only] find out later down the track … (GP)

Barriers to continuity. A minority of GPs said that in an ideal world, GPs would be able to help deliver babies in hospital; they accepted that this was not possible because of *'red tape'*.

5.2.3 Disadvantages for hospitals

Poor communication. Once again, communication was regarded as the major challenge. It is more difficult for GPs to access timely communication since they are not within the hospital setting, and there are risks around key information being missed or not shared in a timely manner. The '*disconnect of information*' is challenging for GPs and hospitals and creates frustration for both parties.

Lack of evidence. Hospital executives are aware that the evidence base for GP ANSC is not strong. As our literature scan found, there are relatively few studies examining the outcomes of shared care, compared with the rapidly growing evidence base that demonstrates the benefits of midwifery-led models such as MGP. Consequently, hospitals are more likely to devote resources to supporting midwifery-led models that provide continuity through the antenatal, intrapartum and immediate postpartum periods.

The evidence to suggest that shared care is the right thing to do is absolutely needed if we are going to invest in and promote this model of care. (Executive)

Unrecognised risks or problems. The variability in quality of GP ANSC is a disadvantage for hospitals. Any potential complications that are not recognised early can create risks (and costs) when the woman presents to the hospital later in pregnancy or during labour. As one stakeholder pointed out, the '*role of the PHN is to mitigate these risks through accreditation, protocols, midwife support, etc'*. One way to do this is to ensure that accreditation requirements provide assurance of quality care; another is to ensure that hospitals have the

means to check whether a GP is in fact registered with a program by ensuring that the register of participating GPs is up-to-date, easily accessed and regularly utilised.

> *… and then they come into the hospital with a bundle of issues or problems and it's a little bit too late to intervene. All of a sudden we have to jump in and look after that woman a bit later in the pregnancy … Maybe some things could have been preventable but now we have to deal with the outcome for the patient and the baby. (Executive)*

> *[Hospital] obstetricians would say, some GPs are good but how do I know she will be seeing a 'good' GP? (Neighbouring PHN)*

Survey analysis

62% of midwives who responded to the survey were supportive of women choosing to participate in the GP ANSC program. However, 25% of respondents strongly disagreed with the statement, *"I am supportive of women/people choosing to participate in the GP ANSC program"*, indicating reservations about the programs (Table 29).

6. Program administration and governance

The advisory committee for each of the three programs has an important role in overseeing GP ANSC. Each committee operates independently and is supported by CESPHN staff. Stakeholders say the quarterly committee meetings are collaborative, respectful spaces in which hospitals' operational information and concerns are shared, GPs' difficulties discussed, and priorities set for CPD events.

Policies and protocols vary. Hospitals base their protocols, policies, and schedules of visits on national guidelines, and review them with input from GP Advisors. This is considered a rigorous procedure, and GP Advisors say that strong efforts have been made to ensure that protocols are easily accessible. However, the lack of consistency creates complications for CESPHN staff and confusion for GPs providing shared care across multiple programs.

6.1 Administration

Most stakeholders told us that CESPHN is effectively managing program administration. Positive relationships with PHN staff significantly enhanced stakeholders' program experience, with project officers described as responsive, competent, and accommodating. However, stakeholders expressed concern regarding staff turnover, which is perceived to negatively impact the program. One stakeholder noted, *'there is no one keeping an eye on how things are going'*, highlighting concerns about continuity and oversight.

> *[The Project Officers] have been really fantastic in the effort and energy they put into that role, and what they bring to the Advisory Group meetings is really quite immense. (GP Advisor)*

GPs generally expressed satisfaction with program administration. Most GPs reported receiving regular communication from the PHN via emails and newsletters and they valued these updates, considering them essential for staying informed about protocol and ANSC changes or updates. However, some concerns were raised:

- Information overload: Some GPs noted that the PHN newsletter contains a large volume of information, potentially leading to important updates being overlooked.
- Visibility of ANSC updates: One GP suggested making the ANSC section stand out more within the newsletter.
- Email customisation: A recommendation was made to tailor emails to specific hospitals, reducing the time spent filtering irrelevant information.

Regarding the website, GPs find it a valuable resource for locating contacts, accessing referral forms and obtaining ANSC updates, including process changes. However, a few GPs reported

challenges with the website, including difficult navigation, a clunky interface, and trouble finding specific information, with one suggesting better integration between the PHN website and HealthPathways to improve usability.

While stakeholders perceive program administration to be functioning effectively, there is evident administrative strain on staff members. The inefficiencies primarily stem from a lack of automation in key processes and inconsistencies across the three programs. Many tasks are still performed manually, including application processing, applicant tracking, communication with participating GPs, and recording attendance for orientation sessions. These manual processes increase staff workload.

Suggestions from staff for improving the efficiency of processes included:

- Reducing duplication in the CPD events across the three programs, particularly those delivered online
- Increasing consistency in the way the orientation programs are delivered across programs
- Harmonising systems for the different advisory committees to prevent 'doubling up' on the administrative support work required for each committee

Survey analysis

Most (54%) of the GP respondents agreed that the program is being managed efficiently (Table 18:), however, only 38% of midwives agreed with this statement and 50% strongly disagreed or disagreed (Table 19).

6.2 Governance

Each of the three programs in CESPHN has an advisory committee with representatives from the hospital executive (medical and midwifery), the liaison midwives, and GP Advisors, who provide the perspective of the participating GPs. Meetings are facilitated by CESPHN staff. Stakeholders agree that these committees have an important role in overseeing GP ANSC and are collaborative, respectful spaces in which hospitals' operational information and concerns can be shared, GPs' difficulties discussed, and priorities set for key activities such as GP training. There may be opportunities to improve efficiency from the PHN perspective as each of these committees operates independently, with different processes. In addition, this governance mechanism could be more visible to GPs who are not on the committee.

Policies and protocols vary across the hospitals in details such as the timing of specific checks and the thresholds for defining whether a woman has a particular condition (e.g., gestational diabetes) which may be a complication of pregnancy that excludes her from the model of care. Hospitals base their protocols, policies, and schedules of visits on national guidelines, and they are reviewed regularly by hospital executive with input from GP Advisors. This is considered a robust procedure, and GP Advisors say that strong efforts have been made to ensure that protocols and guidelines are easily accessible. However, the lack of consistency across the three programs creates confusion for GPs providing shared care across multiple programs. GPs would like to see greater transparency around how these protocols and policies are determined.

For comparison, a neighbouring PHN has consistent and uniform clinical guidelines across the programs operating in its region. The PHN provides a quick guide for GPs, which is available via the ANSC website. Analytics show significant engagement with the website, and GPs report finding it useful. This PHN is actively seeking feedback on how to improve the website. The website content includes promotions for CPD events, safety notices, and links to guidelines, policy, and HealthPathways. The PHN now sends links rather than emailing documents directly, promoting the website as the source of up-to-date information and reducing the likelihood of important information being lost in inboxes.

6.2.1 Advisory committees

The GP Advisory Committees play an important role in facilitating communication and collaboration between hospitals and GPs. The committees provide GPs with access to specialists and create a forum for hospital representatives to listen to feedback from GP Advisors. This structure ensures that GPs feel heard and contributes to a useful platform for reviewing risks and patient satisfaction. The committees serve multiple functions, including reviewing protocols annually, troubleshooting clinical issues, coordinating education for GPs, and providing oversight on safety and quality. Meetings typically include discussions on policies, open days, and CPD planning.

> *I think it's important for everyone to bring their viewpoints to the table … I think we should have more time to have some of those spicy and important discussions … especially when you get all these high-ranking people in the same room, or in the same Teams call. (GP Advisor)*

GP Advisors have expressed a desire for more focused discussions during meetings, particularly on important issues such as declining patient numbers within the program. They suggest allocating more time to core business and reducing the number of guest speakers on topics they consider only vaguely related.

GP Liaison Midwives recognise the value of GP Advisors on the committees, noting their knowledge and engagement. They believe there is potential to further enhance the benefits of this resource for the program.

Executives view the committee meetings as productive, beneficial, and worthwhile. Despite the challenges of attending after a busy day, obstetricians and midwives in executive roles appreciate the opportunity to interact with GPs, building connections and fostering relationships. The meetings are described as regular, well-organised, and providing a collaborative and respectful space for open discussions. This forum allows for civilised conversations about difficulties encountered and adverse events. Other stakeholders highlighted the engagement with midwifery managers and key obstetric consultants as a strength in overseeing the program.

> *I can be confident that we're sharing contemporary and operational, logistical knowledge [around] how the hospital is working, in that forum … and I think it's quite a responsive committee. (Executive)*

However, it's worth noting that, apart from GP Advisors, other GPs' awareness of and engagement with the Advisory Committees is limited. Most GPs we interviewed were unaware of the existence of the committees or had limited knowledge of their functions. One GP reported attending one meeting but not returning due to perceived political dynamics and entrenched positions.

The CESPHN staff have also identified inconsistencies across the three different programs which could be streamlined to reduce administrative burden. For example, there are different orientation or intake procedures for GPs who join the programs, which creates a challenge for staff in explaining the processes to GPs who apply to more than one program (which is common). The Advisory Committees *'operate in silos … I think there could be more cross over to prevent doubling up on work'*. The lack of uniformity causes some challenges in workload, administration and management of the program from the CESPHN staff perspective.

Overall, while the committees serve important functions in governance, communication, and quality improvement, there are opportunities to enhance their effectiveness and ensure consistent awareness and engagement across all GPs. It is worth noting that there are alternative ways to organise committees; for instance, a neighbouring PHN has a larger advisory group that meets three times annually to discuss broader issues, and a smaller operations group that meets monthly.

Survey analysis

46% of GP survey respondents strongly agreed or agreed that the input from the advisory committee strengthens the GP ANSC program, and 46% neither agreed nor disagreed (Table 23). The mid-point rating could be attributed to GPs' lack of awareness of the advisory committee and what the committee's role entails. This was a common sentiment that we heard in GP interviews.

6.2.2 Clinical governance

The governance and clinical guidelines for the GP ANSC program are a crucial aspect of its operation, with various stakeholders providing insights on their implementation and effectiveness. Care guidelines are based on national guidelines (peak schedule) and are regularly reviewed by GP Advisors and obstetricians on the Advisory Committees. They are shared via HealthPathways. Clinicians are expected to adapt and apply the guidelines based on the individual needs of each woman. Hospital executives stress that these are intended as guidance rather than strict rules.

The engagement of GPs with the program's guidelines and protocols presents both opportunities and challenges. While GP Advisors believe that significant efforts have been made to make protocols and guidelines easily accessible through dedicated website areas, there is no way to verify whether GPs are actively reading or implementing these guidelines. The lack of consistency across the three programs also complicates management for PHN staff and creates difficulties for GPs working across multiple hospitals, as it can be difficult to keep track of varying protocols. GPs expressed interest in better understanding the basis for guidelines, how they can influence their development, and their role in disseminating relevant information to other GPs.

Further, GP Advisors have identified a need for a formal process to follow up with GPs outside the program who are not adhering to guidelines, as current approaches rely on informal collaboration between GP Advisors and midwives.

GP Liaison Midwives have expressed a desire for a more structured approach to managing serious clinical incidents, particularly in deciding when to transfer a woman to another model of care. Currently, these decisions are made on a case-by-case basis rather than following strict exclusion criteria. Some midwives consider the eligibility criteria for women entering the GP ANSC model to be quite broad and are planning to develop a more detailed list, given the number of comorbidities they encounter.

> *We've got a higher number of women that have medical issues that are medically complex, so we're just going to make sure, you know, we're ensuring the right women are going out to the [GP ANSC] model. (Liaison midwife)*

Overall, effective clinical governance is in place. There are opportunities for improvement in terms of consistency across programs, ensuring GP engagement with guidelines, and facilitating GP input into guideline development and updates.

Survey analysis

In the GP-targeted survey, 67% of respondents strongly agreed or agreed that the protocols and guidelines are relevant and easy to understand. One third of respondents disagreed or were neutral, suggesting a need to improve communication around guidelines (Table 22). This finding is echoed in interviews, as reported above, where some GPs reflected that the processes and guidelines across the different hospitals vary and lack consistency.

From the midwives perspective, opinions around whether the program is supported by appropriate clinical governance mechanisms vary considerably, and it is worth noting that half of the respondents neither agreed nor disagreed with the statement.

6.3 GP registration and accreditation

Stakeholders regard GP registration and accreditation as critical for ensuring the quality of GP ANSC. The PHN is well placed to provide this oversight through the advisory committees and administrative functions. GPs who want to provide shared care within the CESPHN region are expected to register with one or more of the programs and complete an orientation session. To remain registered, they need to demonstrate they have accumulated at least 12 Continuous Professional Development (CPD) points – which equates to six hours' worth of directly relevant training – over a three-year period ('triennium').

Each advisory committee creates a CPD plan through a collaborative process, with input from participating GPs. The committees take care to ensure that essential content is offered regularly whereas other topics are varied and not repeated too often. It is generally agreed that the quality of the CPD offered is very high, with relevant topics, excellent speakers, and a variety of delivery options to ensure it is accessible.

There is potential to improve CPD by offering face-to-face skills practice in hospitals, which would add value for the most active and committed GPs, make the program more visible and strengthen connections. Regular, succinct updates on hospital protocols could be delivered via webinars, recorded, and stored on the website, with links provided in emails to GPs. A more coherent rationale for the choice of CPD topics could enhance the credibility of the programs. Further, there is no consistency across PHNs in the number of CPD points required for GPs to remain registered with a shared care program. Accreditation requirements could be revised to consider how regularly or frequently a GP provides antenatal shared care.

GP registration and accreditation is considered essential for quality control and maintaining the credibility of the program. Stakeholders agree that GPs should accumulate relevant CPD points, but there are differing views about whether the current requirements are sufficient. Whilst most GPs believe 12 CPD points over three years is a reasonable and achievable expectation, some liaison midwives and executives are less convinced that this provides the

additional expertise required to maintain high quality antenatal care. Among some stakeholders, including some GPs, there is a desire for more consistency in training requirements, potentially including a set curriculum and core requirements focused on essential information, latest research, and protocols.

> *It's encouraging trust between the LHD and GPs, that women can trust going to their GP and having safe care, equivalent to what they might get at the hospital, by making sure the GP has done their hours and we're checking … it means it's a credible program and that women should feel safe selecting that option and letting all those other benefits come from that. (Neighbouring PHN)*

> *Six hours of CPD is simply not enough to stay abreast of the contemporary maternity setting. (Executive)*

> *Given the rate of change in protocols and evidence in the maternity space, it is nonetheless challenging to keep GPs up to date. It's hard enough to keep the midwives up to date. (Midwife)*

GPs and other stakeholders would like there to be greater transparency around accreditation and training requirements. There is no consistency across PHNs in the number of CPD points required to remain registered; in neighbouring regions, accreditation requirements are more relaxed or more stringent. It may be helpful to work together with neighbouring regions to define the essential, core information and skills to deliver GP ANSC and agree on the content of CPD and a consistent set of accreditation requirements (i.e., number of CPD points accumulated over a given period).

Accreditation requirements could also be revised to include consideration of how regularly a GP provides antenatal shared care (e.g., a certain number of shared care appointments booked annually) as there is a view among some stakeholders that GPs who are most active are also most likely to provide high-quality care.

> *We get more and more GPs saying they want to be part of it and we keep saying, well, wait a minute, if there are so many GPs, how many women are they going to see each year? Don't you think someone needs to curtail this somehow in the interests of quality? It has come up repeatedly. (Executive)*

6.3.1 Continuous professional development

The CPD for GPs in the GP ANSC program is generally well-received and effectively managed. CESPHN staff report high-quality content and excellent speakers, with topics collaboratively

determined based on GP suggestions. The Advisory Committee maintains a balance between essential core topics and new material. Midwives corroborate the high quality of CPD provided and acknowledge that events are well attended. However, some midwives perceive that 'relatively few' GPs attend CPD events, in the sense that each event attracts a small proportion of the total number of registered GPs. This perception is worth noting because it may affect trust in the program. Stakeholders suggested making certain CPD events compulsory for maintaining registration.

GP Advisors and most participating GPs find the education talks relevant and well-delivered. The feedback mechanism ensures ongoing relevance of CPD offerings and the responsiveness to GP needs is seen as a strength of the program. However, some GPs, particularly those with recent training, may find certain sessions less useful, highlighting the challenge of catering to a diverse group with varying levels of experience and knowledge.

The format and timing of CPD sessions also appear to influence their effectiveness. There's a perception, that whole-day sessions (as offered at RHW) are preferred by GPs over after-hours webinars or in-person events. The approach varies across locations, with some offering only online or dinner events (Sutherland Hospital), while others provide a combination of face-to-face and webinar options (RPA). This variation in delivery formats across different locations suggests an opportunity for standardisation or at least sharing of best practices.

> *Because it's after work, a lot of the GPs come already quite tired. So for the first few talks they are interested, but after the main course everyone just dwindles, people are not really interested. So yes, you do have the numbers, but I don't think the information is going through. (Executive)*

There is an unmet need for regular updates on hospital protocols. This information is provided online and in emails but numerous stakeholders said they would also like to see it included in the training offered by the PHN. One option could be short webinars that are recorded and accessible through the website for those who cannot attend in real time. While protocol updates would have to be hospital-specific, similar webinars could be provided across the PHN to update GPs on changes to clinical guidelines when new evidence becomes available about the best ways to manage various aspects of pregnancy care.

Skills sessions

One important aspect of CPD which has declined since COVID is the opportunity for face-to-face skills sessions within hospitals, which would add value for the most active and committed GPs, make the program more visible to hospital staff and strengthen connections.

There is significant interest in enhancing GP engagement with hospitals through practical educational sessions. After a break due to COVID, RHW has recently reintroduced clinical placements for small groups of GPs. A neighbouring PHN runs bi-annual face-to-face skills and refresher sessions.

This approach could foster better integration and teamwork between GPs, midwives, and obstetricians, potentially addressing the "us versus them" mentality some GPs' experience. Key suggestions from within the CESPHN program include:

- Developing more inclusive educational sessions that bring together GPs, midwives, and obstetricians. (GP)
- Reintroducing face-to-face training, including clinical teaching at the bedside, which is seen as more effective for upskilling GPs. (GP Advisor)
- Exploring practical training opportunities, such as rotations in antenatal clinics or clinical placements with hospital tours and demonstrations. (Executive)
- Considering smaller group learning sessions, which could be more intensive and engaging but would require more organisational effort. (GP)

While these approaches show promise for improving GP skills and integration with hospital teams, they require significant time, planning, and organisational capacity for the PHN. CESPHN attempted to offer face-to-face skills training in February 2024 but was unable to obtain enough GP interest to make it viable. The challenge lies in balancing these more intensive, tailored approaches with the competing pressures on GPs' time. It might be easier to ensure enough GP interest to make running these sessions viable if they were offered across hospitals and perhaps even across neighbouring PHNs.

Managing the registration and accreditation processes

Currently, each program runs its own program of CPD, which creates a substantial administrative burden for CESPHN staff. This is compounded by the fact that GPs can also choose to attend events run by other training providers to complete their accreditation CPD requirements, and record keeping for these external events is a time-consuming, manual process. It may be more efficient to require accumulation of points – and submission of evidence - annually. This is the approach adopted by a neighbouring PHN to avoid the intense workload involved in verifying accreditation requirements at the end of each triennium. It also ensures that GPs are encouraged to spread their CPD more evenly rather than accumulating it over a shorter time towards the end of the period.

There is potential for economies of scale if the three advisory committees could work together to devise a shared set of CPD offerings across the region. There is also potential to promote events that are offered by neighbouring PHNs and to work together to achieve coverage of a wider range of topics each year. Since all GPs have to register their CPD points with the Royal Australian College of GPs (RACGP) it may be worth investigating whether there is any way to obtain this data directly from the college rather than pursuing individual GPs to provide evidence of attendance at relevant events.

Communication around accreditation and CPD requirements has room for improvement. While most GPs find the process straightforward, one GP reported feeling pressured about maintaining their accreditation.

Survey analysis

There is some ambivalence among midwives regarding the training requirements for GP ANSC, demonstrated by the fact that 50% of respondents to the midwife survey neither agreed nor disagreed that the GPs have the additional training needed to deliver the program (Table 21). This corresponds with some interview sentiments, where midwives (as well as a few GPs within the program) felt that not all GPs were delivering the program at the same, high standard. In contrast, 81% of respondents to the GP survey strongly agreed or agreed that the GP accreditation requirements are appropriate (Table 22).

7. Communication

This chapter presents their views on how essential information is shared between hospitals, GPs and women, and the role of the GP liaison midwives. Stakeholders' suggestions for improving communication are also presented.

7.1 Sharing essential information

Information pertaining to a woman's care is passed between the GP and the hospital through various means. The main mechanism is a yellow card (a trifold, printed template) on which the woman's details are recorded along with space for GPs and antenatal clinic staff to make handwritten notes during appointments. The effectiveness of the yellow card relies on the woman to carry it with her to each appointment and health professionals to use the card to communicate essential information to each other.

Only basic information is recorded on the yellow card. More details are available from referral letters, pathology and imaging results, and discharge summaries; however, often these are not easily accessible when required as there is no reliable way to ensure that both the GP and the hospital receive these. Hospitals do not necessarily inform the GP of the outcome of the initial booking visit, so they may not be aware that a woman has chosen shared care. Communication can also break down when women are transferred to hospital-led models of care during the pregnancy. The provision of discharge summaries following births is highly variable, even within programs; GPs do not always receive this information.

Efforts are under way at two hospitals to make better use of electronic information sharing systems, but the issue of ensuring a reliable means of communication remains challenging. It is essential to take this seriously as poor information sharing raises medico-legal risks and evidence from the literature suggests it is associated with poorer patient experiences.

7.1.1 Difficulties identified by stakeholders

Difficulties with communication were widely discussed by stakeholders during interviews and were also highlighted in the survey responses. Poor communication was consistently noted as one of the biggest challenges facing the GP ANSC programs. Stakeholders said that existing systems were not working well and needed to be improved.

During the first visit to the GP after a positive pregnancy test, options for antenatal care are discussed and the woman is referred to the local hospital for a booking appointment. During that appointment, she chooses between the available options for antenatal care, which vary depending on the level of specialist care she is likely to need. If her pregnancy is considered

'low risk', she will have the option of GP ANSC and other options such as Midwifery Group Practice (MGP) or Maternity Antenatal Postnatal Service (MAPS) may also be offered. At this visit, the woman is given a 'yellow card' which is the personal health record of her pregnancy. This tri-fold template has space for all health professionals involved in her care to write notes about the checks completed at each appointment with the GP or the antenatal clinic.

The communication system relies on women to carry the yellow card with them to every appointment. Some stakeholders are satisfied with the yellow card (e.g., *'it's a set of standard questions, very brief, shorthand – it's not bad, but just a snapshot'*); however, they are in the minority. Most GPs would prefer to receive more detailed information back from hospital visits but instead it is up to women themselves to *'fill the gaps in communication'*. One GP said they handled this by having *'a tight follow-up plan with the patient'* as soon as possible after the clinic appointment so the patient can relay details of what they discussed with the midwives. Test results are supposed to be noted on the yellow card but are not always documented, or not with sufficient detail. Sometimes a paper copy of the results is shared via the woman. If the yellow card is lost or forgotten, there is a risk of miscommunication between the health professionals involved in the woman's care.

The yellow card was actually very meaningful [back when the program started] … And women used to hang on to their yellow card… These days, most women either don't have one or don't care… And to be fair, I don't think a physical card in the time when everyone's got a phone and an app [is] clever. I'm not suggesting we should go back to [the yellow card], but it's certainly a requirement that nothing else has replaced. (GP)

We can't be relying on the woman [to pass information to her GP]. They might miss something important. There are no [clear] lines of communication between us and the GPs. It needs to be better. (Executive)

Everyone has a will to share information, but we have no shared systems, no mechanisms. (GP)

GPs would like to know everything that's going on, but it's impossible to do that. (Midwife)

Following the booking appointment, GPs are not necessarily informed whether the woman has chosen shared care or another model of care. Systems vary between hospitals and programs. The antenatal clinic might try to contact the GP by phone or fax, sometimes an email is sent, or there might be no attempt to pass on the information at this point. If the woman has chosen GP ANSC, it is up to her to make a follow-up appointment with the GP at

the correct time according to the protocol. If, during the pregnancy, her risk status changes and she is transferred to hospital care, it is not necessarily standard practice to inform the GP that this patient is no longer in the ANSC program. The patient herself might not realise the implications of being told, 'we're taking over your care'.

GPs and others noted that not being notified what model of care the patient is under has medico-legal implications. One hospital executive acknowledged that there was *'no clear direction or policy on how we communicate our review to the GP'* and believed this should be re-examined. At least some of the hospitals involved do have systems in place to pass this information to the GPs, which indicates it can be done.

> *Medico-legally, it's important because otherwise we could be thinking the patient has chosen midwife-led care. [If] they're actually in GP shared care and they've missed a lot of appointments, that opens up a massive risk for safety. (GP)*

Once a woman has given birth and has been released from hospital, a discharge summary can be prepared to communicate all relevant details to the GP. However, stakeholders described the discharge summaries as *'inconsistent'* and *'hit and miss'* as they do not always arrive, particularly from hospitals that still use paper-based systems. Midwives say the electronic discharge summaries are *'not that useful'* and tedious to complete because the information is standardised on a form. Attempts to send discharge summaries electronically are complicated by differences in software between healthcare providers. If the GP's name or contact details are not entered correctly in the hospital system, this can prevent delivery to the surgery and defeat the best intentions. Sometimes poor outcomes (e.g., still birth) are not communicated, *'therefore the GP is not notified which makes it an uncomfortable postnatal appointment for the patient'*.

> *The quality of the discharge summary is generally poor … I've had a couple of cases recently where [the patient] was discharged with pre-eclampsia, no discharge summary, I'm calling the registrar, can't get bloods, can't get anything. It's terrible … there might be stillbirth, or the baby dies shortly after delivery … then [the patient] turns up to my appointment and I've got no idea that it even happened. (GP)*

Shared information technology systems (or at least the ability to transfer information securely from one system to another) would go a long way towards addressing the communication difficulties but must be accompanied by a willingness to make the system work. As one midwife put it, *'IT systems need to function well, and clinicians need to use them effectively … there are so many parts of the process that if there is one failure in the chain it can all fall down'*. Breakdowns in communication can cause time-consuming administrative work in chasing information, which is frustrating for all parties. A recent study of birth experiences in

Australia found that communication problems among health professionals were associated with more negative patient experiences.[40]

> *We use completely different IT systems. I would love to see a situation where GPs had access to a woman's complete pregnancy record within the hospital, her labour and birth summary. (Executive)*

> *Despite all our electronic systems of communication, the actual final communication at times is woeful. (Executive)*

Discussions in the academic literature, uncovered during our scan, show that the communication challenge is not new; it dates to at least as far back as the 1990s. Considerable efforts have been made to overcome difficulties in the past, sometimes with little success. One stakeholder lamented that *'we can't even share pathology results from the hospital reliably, even after a three-year project to solve this problem'*. Nevertheless, GPs were very positive about recent efforts at two hospitals to make better use of electronic systems to share information, suggesting this new approach is heading in the right direction.

7.1.2 Ideas for improving communication

Stakeholders offered many suggestions for improving communication. Some of these are outside the power of any one hospital or PHN to implement, such as an electronic replacement for the yellow card, with comprehensive information and links to test and imaging results. A portable electronic medical record (EMR), which could be stored on women's phones, was another idea that was floated.

Other stakeholders pointed to the potential of the Single Digital Patient Record being implemented by NSW Health to integrate clinical information across public hospitals, laboratories and administrative systems. They wondered whether there was a possibility of giving GPs access to this system, which is expected to be rolled out by 2028.

In the short term, it may be more promising to build on current efforts to use existing systems more effectively. One option for improvement is encouraging and training hospital staff to use the full capability of EMR systems used in NSW Health to store inpatient and outpatient records.

For example, both partner LHDs and many GPs have access to HealthLink software which can facilitate electronic referrals and exchange of patient information via a secure message delivery network. Stakeholders say the inbuilt forms 'lack detail' but are at least concise, secure and reliable. The use of HealthLink to support the GP ANSC program at RPA was

[40] Pelak, H., Dahlen, H. G., & Keedle, H. (2023). A content analysis of women's experiences of different models of maternity care. *BMC Pregnancy and Childbirth*, 23(1), 864. https://doi.org/10.1186/s12884-023-06130-2

noted by stakeholders as a success; the hospital has invested time and resources to help participating GPs set up systems that will allow them to access relevant information and send electronic referrals. Some believe that communication has improved as a result of these efforts and would like to see a similar approach at other hospitals.

Another idea suggested by stakeholders was leveraging the capacity of Powerchart software to share discharge summaries from antenatal clinic visits with GPs so that they can access a written record of what was discussed during the appointment and any recommendations for follow-up tests. This idea has been raised in advisory committee meetings.

Occasionally, good examples of specific teams were highlighted by stakeholders to illustrate the point that it is possible to establish collaborative ways of working and communicating. For example, the perinatal infant team (high risk) at Sutherland Hospital was noted by one GP as an example of good hand-over and follow-up processes and liaison with GPs.

… with each [antenatal clinic] visit, when it's recorded in Powerchart, there is that option of generating what's called an antenatal discharge summary - not the overall discharge summary, but just that visit, and that can go out and give a lot of information to the GPs. (GP Advisor)

I'm sure there's a way that you can make it so that it isn't very onerous for midwives [to send an antenatal clinic discharge summary to the GP] … it's not going to add a lot of time to their clinic or their day. (GP)

Survey analysis

Similar to the feedback from interviews, survey respondents did not respond favourably to statements about the communication within the program. Majority of GPs and midwives disagreed or were neutral regarding the statement that there is 'clear communication between the GP and the hospital staff if risk factors emerge during the pregnancy of a patient in the GP ANSC program' (GPs: 63%; Midwives: 89%) (Table 25).

Respondents also largely disagreed or were neutral with the following statements, highlighting that communication continues to be a challenge within the program:

- GPs receive relevant and timely information from the hospital staff regarding antenatal care of GP ANSC patients (GPs: 82%; Midwives: 67%) and
- GPs receive relevant and timely information from the hospital staff regarding postpartum care of GP ANSC patients (GPs: 62%; Midwives: 66%)

56% of midwives agreed that the communication between the hospital staff and GPs around the needs of patients in the GP ANSC program is open and respectful, in comparison with GPs where the reflections are more evenly spread, with only 36% agreeing and 30%

disagreeing with the statement (Table 25). The feedback from GP interviews corroborates this data where GPs expressed concerns regarding the hospitals' and midwives' support of the program. They also reported challenges in reaching midwives at the clinics, noting that when contact is made, the midwives can sometimes seem irritated. However, from the midwives' perspective, majority (78%) strongly disagree or disagree that GPs regularly and clearly communicate with the hospital staff as required (Table 28).

Across other communication domains, 62% of GPs agreed that their patients understand the ANSC model of care and knows what it entails, compared to 44% of midwives who agreed with the statement (Table 25). GPs were less assured that their communication regarding patient care is being received and understood by hospital staff, with majority (34%) responding neutrally to the statement (Table 26).

GP responses towards effective systems in place varied between hospitals. Majority of GPs who deliver the program at RPA, Canterbury and Royal Hospital for Women agree that there are effective systems in place to enable them to communicate important information about patient care to hospital staff, whilst GPs who work within St George and Sutherland hospitals disagree (Table 27).

7.2 Role of GP Liaison Midwives

The GP liaison midwives provide an important mechanism for communicating between hospitals and participating GPs. Under the Memoranda of Understanding with CESPHN, LHDs have agreed to fund these roles at each hospital. The liaison midwives have a dedicated email address, fax number and mobile phone number, and their contact details are displayed on the GP ANSC website run by the PHN. They also have details for each of the participating GPs so they can contact them directly if necessary.

There appears to be potential for utilising these roles more effectively. Liaison midwives say relatively few GPs contact them regularly and proactively, whereas GPs say the liaison midwives are not well known. Both groups say the other group is difficult to contact directly, and from the GP perspective it is sometimes more efficient to page the on-call registrar than to leave a message for the liaison midwife. Some hospital executives have acknowledged that relying on one person to pick up the phone when the GP calls is a 'weak link' in the system.

National maternity strategy emphasises the importance of creating genuine collaboration among the health professionals caring for pregnant women. To achieve this, it is vital that all participating GPs feel comfortable to call the hospital for advice and confident that they will receive a prompt and collegial response. In turn, liaison midwives need a reliable and efficient way to get in touch with GPs when required.

GPs need access to timely advice when they have concerns about possible risks or complications arising. The liaison midwife role has been designated to meet this need. It is seen by stakeholders as critical to the effective functioning of the programs, with an important *'unofficial'* role to play in governance, *'especially when things go wrong'*.

> *I guess that if the funding were withdrawn today for the CMCs, for instance, I think there's a high likelihood that the number of GPs participating in the ANSC program would drop significantly. (Executive)*

Most GP Advisors and some GPs gave positive feedback regarding the liaison midwives' contributions to GP ANSC. For example, one GP said the liaison midwife was *'a great resource for GPs to understand how to organise care'*, and another said the midwife helped with administrative processes and flagging risks, for people the GP was *'worried about'*. One GP Advisor said the liaison midwife was trusted to follow up on issues.

> *GP liaison midwives are gold in terms of communicating. If we're worried about someone or a result or something, we just pick up the phone and you know they will chase it up. We use them a lot and they encourage it and they're fantastic at what they do. (GP Advisor)*

Other GPs pointed out that liaison midwives were not always available to take their calls and they would prefer a more reliable mechanism for communicating quickly with the hospital when advice is required. Some GP Advisors said they preferred to page the on-call registrar if they needed help in navigating hospital protocols 'in the moment', although they still saw the role of liaison midwife as important. However, one highly experienced GP said they had had *'no dealings'* with the liaison midwife and another had tried to contact them but found they were *'always on hold'*. One hospital executive acknowledged that relying on one person (who may work part-time) to pick up the phone was a *'weak link'* in the communication chain and more resources were probably needed.

The value of the liaison midwife role depends in part on how often it is used; if GPs contact the midwife regularly, the role is seen as more valuable. The way in which hospital staff respond to calls may also influence perceptions around the value of the role. One GP said they called the birthing unit or antenatal clinic when they needed advice, but *'they never seem happy to chat. [It's like], Why are you calling me?'*

GP liaison midwives believe they offer *'lots of avenues of communication'* including a dedicated email address, the individual's work email address, mobile phone and fax numbers. They also have the mobile phone numbers of the participating GPs so can call them directly to discuss a patient's situation. From their perspective, it can be difficult to talk to GPs directly on the phone and so it can involve a great deal of time chasing up or clarifying information that the hospital needs from GPs. Liaison midwives also said there were relatively few frequent callers who got in touch proactively, and they wished they heard from more GPs. The GPs who contacted them regularly were '*not the GPs [they] are concerned about*'.

8. Perceived patient experiences

The care delivered by GPs was often described by stakeholders as 'holistic' or as 'lifetime' continuity of care. Rather than focusing exclusively on pregnancy and birth, GPs can take a longer-term view, considering family context and medical history, providing ongoing support with mental health and chronic physical conditions, and ensuring that children receive health checks and immunisations on schedule. Most stakeholders agreed that having a strong relationship with a trusted GP could enhance the patient experience. However, some stakeholders questioned whether continuity – at least during the pregnancy and birth – could be achieved in the current system where the woman is likely to see multiple different midwives and obstetricians at hospital visits, during the birth and afterwards.

Patient experiences are largely invisible to the PHN as it has no direct contact with women who receive GP ANSC. It has no way to collect data systematically on patient experiences. It is therefore reliant on feedback from GPs and hospitals via the advisory committees and other sources such as formal complaints and investigations into adverse outcomes.

The word '**holistic**' was used often by stakeholders in reference to the care that GPs provide. Rather than focusing exclusively on the pregnancy and birth, a GP can take a longer-term view. This includes the ability to:

- Consider family context, history of previous pregnancies and births;
- Identify and treat pregnancy-related health problems that require early intervention, such as preeclampsia or hyperemesis, which may otherwise result in hospital admissions;
- Be supportive with pre-existing mental health conditions, and alert to any changes to mental health during pregnancy and after the baby is born;
- Provide ongoing management of chronic conditions and preventive management of potential problems (such as weight management to avoid gestational diabetes);
- Where required, provide counselling for fertility, termination or miscarriage care.

Having the choice of a **caregiver who is familiar and trusted** can be helpful for women who are navigating big changes in their lives, where they may feel vulnerable. Participating GPs reflected on the value of being able to guide a woman through the 'journey' of pregnancy, having more time to deal with 'niggly issues' that arise in pregnancy 'that a clinic might rush through or dismiss'. They felt this approach to care created a special level of trust and enriched the woman's experience.

Other stakeholders agreed that a strong relationship with a known GP could enhance the patient's experience. Various stakeholders said there were few complaints from women about the care received. For example, a GP Liaison Midwife noted that women rarely changed out of GP ANSC unless they were forced to by risk factors.

It's not a common outcome by way of a woman's choice. It's usually because a risk factor will have arisen, so [for example] she has become a diabetic and the baby is small or there's something we need to monitor … (Liaison midwife)

Numerous stakeholders described the holistic, cradle-to-grave approach offered by GPs as '**continuity of care**'. This was acknowledged to be continuity over the lifetime rather than during pregnancy and birth specifically, as it is generally conceptualised (for example, in the literature and in the national maternity strategy). Continuity of care was regarded by stakeholders as important, regardless of which model of care was chosen.

However, some stakeholders questioned whether continuity – at least during the pregnancy and birth – could be achieved in the current system where the woman is likely to see multiple different midwives and obstetricians at hospital visits, during the birth and afterwards. Until recently the protocols at RHW required alternating visits to the GP and the antenatal clinic, which did not foster continuity of care. This appears to be part of the rationale for the hospital's new model of GP ANSC, which will involve more GP visits and fewer clinic appointments. An alternative way to improve continuity was suggested by stakeholders from another hospital; this would involve changes in the clinics so that women in shared care saw the same midwives across multiple appointments, combined with improvements in communication and documentation.

Patient experiences are likely to vary also depending on the woman's **needs**. According to stakeholders, GP ANSC seems to be particularly appropriate for women who:

- Have a trusting relationship with a GP
- Have a 'low risk' pregnancy – this model of care is not accessible if there are certain complications, although GP could still be involved and would be 'an invaluable resource' to assist hospital team
- Are younger, first-time mothers
- Have had a baby (multiparous) and feel confident about knowing the hospital system, although GPs feel it should be open to first-time mothers as well
- Have pre-existing mental health conditions – because they might feel safer with their GP
- Do not have access to Medicare (because it is cheaper than paying for hospital care).

Those who have a child already will be more familiar and comfortable with what is happening, and it is more likely that their needs for information and support can be met by an experienced GP, whereas a first-time mother may require additional education and support. If there is a shift from 'low risk' to 'high risk' status during pregnancy, the system is not well set up to ensure that this change is communicated to the GP and the woman may not even realise that she has been transferred out of shared care into another model. Even while a woman is in labour, her status may change, introducing a sense of uncertainty and loss of control which could profoundly affect her perceptions of the pregnancy and birth

experience. Thus, there are many factors that influence patient experiences, not all of which are under the GP's control.

One thing that GPs can control is the **quality** of the care they provide. This depends on the provider's skills and knowledge. If a woman experiences poor antenatal care, it can create confusion and anxiety towards the end of the pregnancy and people can feel *'lost in the system'* because they do not understand what is going on (GP Liaison midwife).

Patient experiences are largely invisible to the PHN as it has no direct contact with women who receive GP ANSC and is not in a position to systematically collect data on patient experiences. It is therefore reliant on feedback from GPs and hospitals via the Advisory Committees and other sources such as formal complaints and investigations into adverse outcomes.

[If] you have continuity, I think it improves the experience … if they've got someone good caring for them, absolutely, it makes their experience a million times better. (Liaison midwife)

Every woman's birth is a trauma. They all have a story. They're all very vulnerable. They lose autonomy. Someone else is running things, and they come back with a story and a big change in their life. That is very stressful, and some need a little bit of help, some need a lot of help. And GPs do a lot of the heavy lifting in that department. (GP Advisor)

Survey analysis

Overall, GP and midwife survey respondents agree that the program is meeting the needs of patients. However, midwives' levels of agreement were lower than GPs across all statements, and significantly lower for the following (Table 30):

- The GP ANSC program provides an important option of care for pregnant women/people (GPs: 97% agreement; Midwife: 62% agreement),
- The GP ANSC program meets the holistic health needs of many different pregnant women/people (GPs: 92%; Midwife: 62%),
- Women/people in the GP ANSC program receive consistent care and appropriate follow-up before and after their babies are born (GPs: 80%; Midwife: 38%) and
- The GP ANSC program enhances continuity of antenatal and postpartum care compared with standard low-risk maternity care in the hospital antenatal clinic (GPs: 91%; Midwife: 62%).

8.1.1 Cultural appropriateness and inclusivity

A few stakeholders mentioned that having a GP from the same cultural group could help with rapport and communication. Stakeholders said having a GP with the same cultural background could provide a 'safe space' for patients and greater awareness of cultural issues. Some GPs speak multiple community languages, and shared religion can also be a source of support for women.

> *Now it's Ramadan and with all the fasting, if the GP is savvy in the norms of the culture, then they can give good medical advice around it. (GP Advisor)*

> *The cultural and linguistic aspects, it's a selling point for women who are from a different background. If they've got a GP who speaks their language or is from the same general cultural background, then there's already that implicit understanding which just makes communication a bit easier for both. (Neighbouring PHN)*

However, finding a GP who is part of the program and also culturally and linguistically compatible can be challenging. Ideally, antenatal clinics would have access to a list of participating GPs that includes information about cultural background and languages spoken. Conversely, if the GP does not speak the patient's language well, it can make communication more difficult (unless they are familiar with the free telephone interpreter service).

It is also the case that some CALD groups have higher risk factors in pregnancy and so a smaller proportion may be eligible for GP ANSC. New migrants may not be aware of this option, and their preferences are likely to depend on their experiences of health systems where they lived previously.

Survey analysis

In the surveys, 75% of GPs and 50% of midwives strongly agreed or agreed that the GP ANSC program enhances the availability of culturally appropriate care for diverse groups of pregnant women/people (Table 30).

9. GP experiences of providing shared care

Participating GPs are passionate about providing ANSC and many of these we interviewed had a great deal of relevant experience. It is a satisfying and rewarding aspect of their practice and part of a larger commitment to holistic, continuing care across the lifetime.

GPs have noticed that participation rates are falling and they would like to see this investigated and discussed. Some stakeholders attribute this the rise in availability and popularity of midwifery-led models of care and to those with private health insurance opting for obstetric care. Some stakeholders feel the value of the model is not well recognised and it is not promoted sufficiently. There is also a perception among GPs that, during the booking appointment at the antenatal clinic, midwives may be discouraging women from selecting this model of care.

Section 3.1 summarises stakeholders' general observations of the advantages and disadvantages for GPs. In this section we report on direct, personal observations from the GPs and GP Advisors who were interviewed, as well as insights from the GP survey.

The GPs we spoke to were passionate about providing antenatal and postpartum care. Their years of experience varied from five to 20 years; five interviewees had more than 20 years' experience in this area. There was a great deal of variation in the number of patients they saw for shared care, but there was general agreement that this had reduced in recent years, particularly since COVID. They would like to see this investigated and discussed.

These GPs find shared antenatal care a very satisfying aspect of their practice. They value being part of the larger team that supports the woman through her pregnancy and birth and beyond. It is interesting and professionally satisfying to develop their skills and enjoyable to care for a person who is well and has a 'low risk' pregnancy. Most consider it part of normal care of the whole person over the lifetime. They believe strongly that their services are needed as personalised and convenient alternative to public antenatal clinics, enhancing the range of choices available to women for their pregnancy care.

GPs are acutely aware that a woman's point of contact with hospital is crucial to the choices they make about models of care. There is a strong perception that midwives at the antenatal clinics influence women's choices and they are *'funnelling women through to the midwives' clinic'* or at least endorsing midwife-led models of care. The view that GP ANSC is now underutilised because of a cultural shift towards midwife-led care was prevalent.

Maybe women see midwives as peers and prefer this type of care? (GP)

Other potential reasons why participation is dropping were discussed. GPs thought that perhaps women were not aware of this option and had suggestions for promoting the

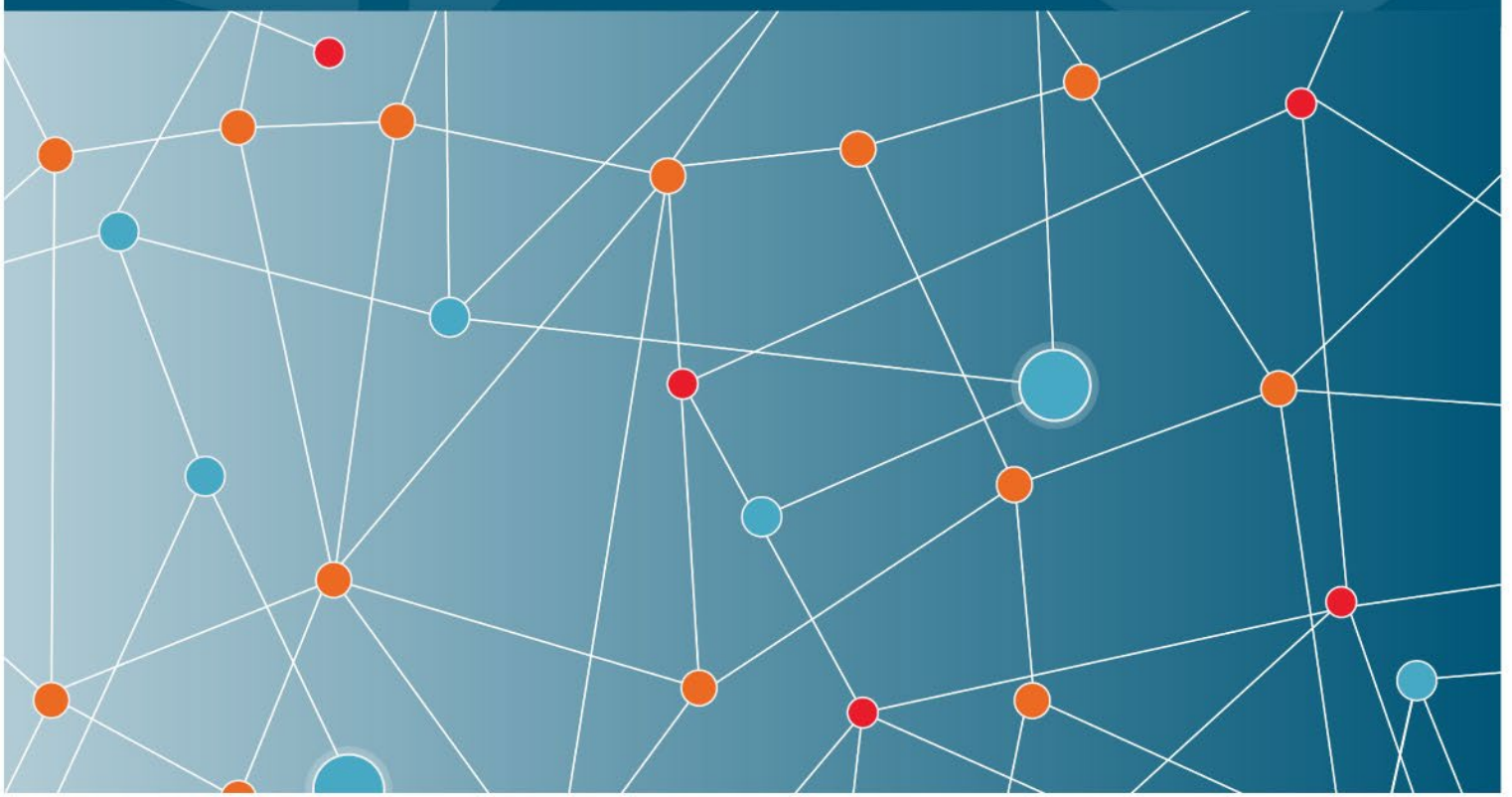
programs more actively. Some had observed a trend to first-time mothers *'going private'* (that is, using health insurance to obtain private obstetric care).

> *Patients do not understand the value of it, the hospital needs to reinforce the value so that patients understand it is a good option for them. (GP)*

There was some interest in strengthening ties among the network of GPs who provide ANSC, and in building stronger links with midwives to enhance their trust and confidence in the programs. The network of GPs is *'not transparent'* to those within it, so they are not necessarily in contact with each other. Greater transparency around which GPs have a special interest in this type of care could help women, midwives, and other GPs find those with appropriate skills.

According to the interviewed GPs, a relatively small proportion of patients have shared care all the way through to the birth without being transferred into another model of care. For example, a GP might start seeing 25 patients each year but only follow five of them through. This means that, depending on when they are collected, statistics on births by model of care might underestimate the extent of the antenatal care provided by GPs. Further investigation is needed to ascertain how statistics on the uptake and use of GP ANSC are collected and reported at national, state and local levels.

Discussion



10. Discussion

In this chapter we summarise findings for the key evaluation questions (Table 6), acknowledge limitations of the study, and offer some suggestions for improvement that might be considered by CESPHN and the program's advisory committees.

Table 6: Findings for key evaluation questions

No.	Question	Findings
1.	What can be learned from evaluations of GP ANSC programs elsewhere about the key design, delivery and contextual factors that contribute to woman-centred care*?	• GP ANSC has received limited research attention since a flurry of interest and publications in the 1990s. There are few studies comparing patient experiences and outcomes from GP ANSC compared with other models of maternity care, and findings are not straightforward. • Nevertheless, the existing literature is clear that open communication channels between GPs and the antenatal clinic are key to the success of GP ANSC. • The UK's 2016 National Maternity Review concluded that, to improve the quality of shared care, investments were needed in data collection and sharing systems, including implementing electronic records accessible to all providers of maternal care. • Research examining women's experiences with GP-led or GP shared care in rural areas highlighted the importance of a rapport between the GP and the patient; strong pre-existing relationships were associated with high levels of patient satisfaction. • Recent findings from the *Australian Birth Experience Study* showed that women valued continuity of care with their GP in the community, particularly when navigating fragmented hospital care, and appreciated the post-partum support provided by their GP. However, some found the model confusing and did not know who to turn to for advice and assistance (the hospital or the GP).
2.	Does the education (CPD) available through the programs meet the needs of GPs for enhanced knowledge and skills in antenatal and postnatal care? Are there opportunities for improvement in content and/or delivery methods?	• The CPD program is a particularly strong component of GP ANSC in CESPHN, with its collaborative planning and responsiveness to GP needs. • There may be room for improvement in standardising CPD content and delivery formats across programs, facilitating practical skills training for those who want it, and further tailoring content to meet diverse GP needs. • There is an unmet need for regular updates on hospital protocols. This information is provided online and in emails but numerous stakeholders said they would also like to see it included in the training offered by the PHN.

No.	Question	Findings
		One option could be short webinars that are recorded and accessible through the website for those who cannot attend in real time.
3.	Do the current governance processes (including GP accreditation requirements and advisory committee input to clinical guidelines) support the programs effectively, and how could these be improved?	• The advisory committees play an important role in overseeing GP ANSC and are collaborative, respectful spaces in which hospitals' operational information and concerns can be shared, GPs' difficulties discussed, and priorities set for key activities such as GP training. • There may be opportunities to improve efficiency from the PHN perspective as each of these committees operates independently. This governance mechanism could be more visible to GPs. • Clinical governance is well-established, with an emphasis on tailored and personalised care. GP Advisors have input into protocols and policies, but other GPs would like greater transparency around how protocols are decided. Inconsistencies across programs can make it difficult for GPs to keep track of, and adhere to, different protocols and policies that guide patient care. • Accreditation processes are highly valued by stakeholders as essential for maintaining quality care. There may be opportunities to streamline administrative processes, improve communication, and potentially standardise requirements across programs.
4.	To what extent are the programs catering for the preferences of a diverse range of pregnant women/people? (Who is using the programs, and why? Who is not using the programs, and why?)	• A few stakeholders mentioned that having a GP from the same cultural group could help with rapport and communication. However, it appears that people from a wide variety of backgrounds benefit from the model. • According to stakeholders, GP ANSC seems to be particularly appropriate for women who: ○ Have a trusting relationship with a GP ○ Have a 'low risk' pregnancy – this model of care is not accessible if there are certain complications ○ Are younger ○ Have had a baby (multiparous) and feel confident about knowing the hospital system, although GPs feel it should be open to first-time mothers as well ○ Have pre-existing mental health conditions – because they might feel safer with their GP ○ Do not have access to Medicare (because it is cheaper than paying for hospital care).

No.	Question	Findings
5.	From the perspective of service providers, do the programs meet the needs of pregnant women/people for flexibility and informed choice of care?	• Stakeholders felt it was important for women to have a variety of options for care. • Having the choice of a caregiver who is familiar and trusted can be helpful for women who are navigating big changes in their lives, where they may feel vulnerable. • Participating GPs reflected on the value of being able to guide a woman through the 'journey' of pregnancy. They felt this approach to care created a special level of trust and enriched the woman's experience. • Provision of antenatal care in community settings was seen as 'normalising' pregnancy (versus medicalising it).
6.	How well do the programs align with existing healthcare services? What role do they fill in the range of choices available in the CESPHN region?	• Most stakeholders viewed GP ANSC as a valuable option for maternity care for women with 'low risk' pregnancies and a known and trusted primary care provider. • Advantages for women include convenience, continuity, and personalised care. • Importantly, this model of care contributes to a greater level of choice and autonomy for women, which is a guiding principle under national maternity strategy.
7.	To what extent do the programs meet the needs of participating GPs in terms of facilitating and building their strong interest and expertise in antenatal care?	• Participating GPs are passionate about providing ANSC and many of these we interviewed had a great deal of relevant experience. • The GP ANSC programs empower GPs to perform to their full scope of practice and take on work that many consider to be interesting and enjoyable. • GPs have noticed that participation rates are falling and they would like to see this investigated and discussed. • There was some interest in strengthening ties among the network of GPs who provide ANSC, and in building stronger links with midwives to enhance their trust and confidence in the programs.
8.	To what extent do program processes facilitate respectful communication and collaboration among health professionals caring for pregnant women/people?	• Poor communication was consistently noted as one of the biggest challenges facing the GP ANSC programs. Breakdowns in communication can cause time-consuming administrative work in chasing information, which is frustrating for all parties. • Shared information technology systems (or at least the ability to transfer information securely from one system to another) would go a long way towards addressing the communication difficulties. One option for improvement is encouraging and training hospital staff to use the full capability of EMR systems used in NSW Health to store inpatient and outpatient records.

No.	Question	Findings
		• The use of HealthLink to support the GP ANSC program at RPA was noted by stakeholders as a success; the hospital has invested time and resources to help participating GPs set up systems that will allow them to access relevant information and send electronic referrals. Some believe that communication has improved as a result of these efforts and would like to see a similar approach at other hospitals.
9.	To what extent do the programs improve patient experience and relationships (as observed by service providers) through continuity of care and appropriate follow-up care with a familiar provider?	• The care delivered by GPs was often described as 'holistic' or as 'lifetime' continuity of care, with a longer-term view than pregnancy, labour and birth. • Most stakeholders agreed that having a strong relationship with a trusted GP could enhance the patient experience. However, some questioned whether continuity could be achieved when the woman is likely to see multiple different midwives and obstetricians at hospital visits, during the birth and afterwards.
10.	Are there opportunities to improve resource use, management, and administration of the programs to meet the needs and aspirations of all parties?	• Most stakeholders are highly satisfied with the efficiency, administration and management of the programs. • Suggestions for improvements include: ○ Reducing duplication in the CPD events across the three programs, particularly those delivered online ○ Increasing consistency in the way the orientation programs are delivered across programs ○ Harmonising systems for the different advisory committees to prevent 'doubling up' on the administrative support work required for each committee ○ Providing more focused, visible and customised communications to GPs to ensure that updates capture their attention and information is easily accessible
11.	Do the programs reduce the number of antenatal hospital visits for routine, low risk pregnancies?	• Stakeholders recognise the valuable role that GP ANSC plays in allowing hospitals to manage workloads for antenatal clinic staff. • By shifting care to the community, the model helps reduce waiting times in antenatal clinics. • Scarce hospital resources can be redirected to those who need them (that is, women with higher risk pregnancies who require more specialist care).
12.	What can be learned from other Australian GP ANSC	• There is no standard for the number of CPD hours required to maintain accreditation; neighbouring PHNs

No.	Question	Findings
	programs to improve efficient delivery of GP ANSC in the CESPHN region?)	have more stringent or more relaxed requirements. Agreement on a standard, along with core content for CPD, could enhance the credibility of GP ANSC with hospital staff and patients. • Skills updates are provided as part of standard CPD offerings in one neighbouring PHN. • It is possible to have consistent and uniform clinical guidelines across the programs operating in a PHN region, as demonstrated by one neighbouring PHN. • Use of a website – regularly updated, with a quick guide to protocols and policies – has proved successful as the main communication mechanism with GPs in a neighbouring PHN. Sending links to the website, rather than attaching documents to emails, promotes the website as the main source of up-to-date information and reduces the risk of losing important information in crowded email in-boxes.

10.1 Limitations

This project focused on the processes of GP ANSC in the CESPHN region, which we defined as the inputs, activities and outputs. Investigation of patient experiences and outcomes was outside of the scope; however, our literature scan highlighted the need for studies to examine outcomes for GP ANSC in Australia as a distinct model of care.

The literature and environment scan was not intended to be conducted with the scope or rigour of a systematic review. We searched for the most relevant and current grey literature (policy documents, position statements of professional organisations) from Australia and selected countries deemed to have comparable healthcare systems (Canada, New Zealand, UK). We also sought academic literature that could shed light on the delivery of GP ANSC, but we found very little relevant information. Studies, reviews and commentaries published in journals were included if they provided relevant information on the status of GP ANSC and/or the factors that contribute to quality care for this model. The review should not be considered exhaustive or comprehensive but as a means to provide essential contextual information to aid interpretation of findings from the stakeholder consultations.

The consultations were successful in reaching a wide range of stakeholders. Members of advisory committees, hospital-based midwives and participating GPs were given the opportunity to participate. All GPs who requested an interview (via the survey) were contacted for an appointment, but not all were available. We were only able to interview a few hospital-based obstetricians, despite efforts to engage them in the consultation process.

Distribution of the midwife survey was targeted and a large proportion of those who were sent the survey link chose to take part. In contrast, survey invitations were sent to all

participating GPs (approximately 700) and the response rate was relatively low, with 78 completed surveys. Consequently, there is a risk that GP survey findings may not represent the full range of GPs' views.

10.2 Options for consideration

Based on the stakeholder consultations, a scan of the evidence on GP ANSC, and discussions with two neighbouring PHNs, we would like to offer some suggestions for improvement.

10.2.1 Administration and accreditation

Running three separate advisory committees, each with its own processes and its own set of orientation and CPD events each year, creates a large administrative burden for CESPHN. The three-yearly cycle of ensuring all GPs have met their accreditation requirements is also time-consuming for PHN staff and potentially burdensome for GPs. Although it is important for the committees and the PHN to be responsive to GPs' requests for specific topics to be included in the training, it is likely that there are common elements that could be covered across the whole PHN (and, indeed, in cooperation with neighbouring PHNs that are running similar programs). Practical skills sessions in hospitals would make the program more visible. Greater transparency and consistency in CPD requirements are also likely to improve the credibility of the model of care among hospital staff. Therefore, we suggest:

- Building greater cohesiveness among the three programs running within CESPHN to streamline operations and reduce unnecessary inconsistencies. This might include:
  - Considering alternative governance models, such as one operations committee to provide oversight of GP ANSC across the region (meeting frequently), supplemented by advisory committees for the three individual programs (meeting less frequently, with terms of reference to include strategy and stakeholder engagement)
  - Examining the rationale for protocols across programs and consulting stakeholders around the possibility of eliminating variation wherever possible (i.e., where these are not directly related to operational differences among the hospitals)
  - Defining core CPD content and essential updates to knowledge that all GPs in the region need to have and developing some common training across programs (in addition to, or instead of, existing content for individual programs)
- Investigating the possibility of accumulating and updating CPD points annually to align with RACGP accreditation. This approach could help avoid excessive workload pressure for CESPHN staff at the end of the triennium, make record keeping more straightforward for GPs, and ensure that GP training is spread across the three-year period rather than concentrated in a shorter period.

- Offering protocol updates for GPs via short videos, webinars or explainers, and making the GP ANSC website an up-to-date repository for all information pertaining to the programs, with updated links sent regularly to GPs via email.
- Investigate the possibility of offering practical skills sessions within hospitals, and encouraging GPs to participate, offering these across programs to get the numbers required to make them viable.
- Consulting with neighbouring PHNs to arrive at a shared position on, and rationale for, GP accreditation requirements.

10.2.2 Communication

Almost all stakeholders commented on the need to improve communication systems to ensure that essential information is shared reliably and efficiently between GPs and hospital staff. This is the major issue facing GP ANSC and is not unique to CESPHN – it is a long-standing problem that is beyond the power of any one PHN or program to solve completely. Nevertheless, serious efforts need to be made to address this issue as far as possible, as it affects trust among health professionals, is a barrier to collaboration, and has the potential for negative impacts on patient experiences and outcomes. Some hospitals are already working with GPs to use HealthLink for referrals and secure communications and results are promising. Therefore, we suggest:

- Encouraging hospitals and GPs to leverage the existing capacity of information sharing technology such as HealthLink and Powerchart to facilitate secure transfer of referrals, antenatal and postpartum discharge summaries, and other relevant information;
- Monitoring developments in the Single Digital Patient Record project being undertaken by NSW Health and advocating for the inclusion of relevant clinical information about the antenatal, intrapartum and postpartum care provided in NSW public hospitals, and for GPs to have access to (or secure transfer of) this information.
- Strengthening the liaison midwife roles, giving them the time and resources they need to act as a reliable conduit for information, both spontaneously (e.g., responding to a GP's call when they have a patient in their office and want to check a test result or a protocol) and systematically (e.g., ensuring GPs receive emails or other secure communications following the booking appointment and if there is a transfer out of shared care prior to the birth admission, ensuring secure exchange of pathology and imaging results).

10.2.3 Sustainability

Participating GPs have noted the decline in the numbers of women choosing GP ANSC and would like this to be discussed and investigated. There appears to be a cultural shift towards midwife-led care, prompted by the strong evidence base and supported by hospital policies and national and state-level strategies. Nevertheless, GP ANSC remains a valuable option in the broad scheme of maternity care choices and there are actions that CESPHN (perhaps in

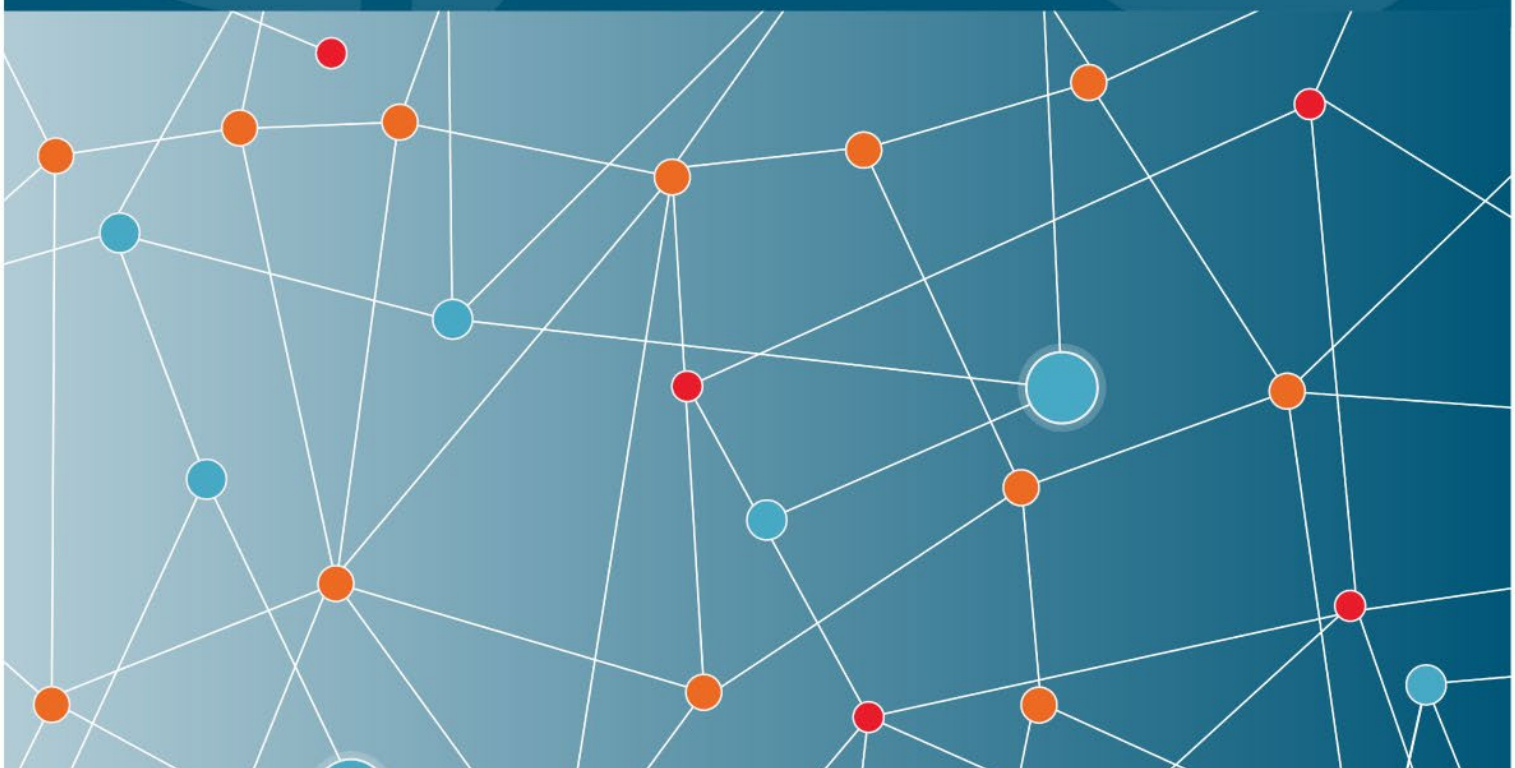
collaboration with other PHNs and professional organisations) could take to strengthen its position in the medium to long term.

- Exploring ways to reward and motivate highly active and passionate GPs, for example through opportunities for clinical placements, mentoring, or recognition;
- Ensuring that the register of participating GPs is accessible to all midwives during booking visits to the hospital antenatal clinics;
- Building active networks of participating GPs and links with midwives to increase a sense of shared goals, collaboration and trust;
- Identifying any specific concerns that antenatal clinic and birthing unit midwives may have about GP ANSC and, where possible, addressing these concerns;
- Learning about women's experiences of GP ANSC, through qualitative research and/or systematically collected patient experience data;
- Utilising the findings of published research to design ways to improve patient experiences for women receiving GP ANSC.

10.3 Conclusions

Overall, the three GP ANSC programs within the CESPHN region comprise a well-established model of care, with effective governance and accreditation mechanisms. The model's major asset is a large cohort of committed, knowledgeable primary care providers, who have access to high quality CPD via events delivered by the PHN along with the flexibility to attend other relevant training. There is enormous goodwill among stakeholders, including hospital executives and liaison midwives, and shared goals around maintaining the model as a safe, credible option for women who are experiencing normal, 'low risk' pregnancies. The model enables women to choose to have their antenatal care in a community setting, freeing up hospital resources for those who need more specialised medical attention. On the whole, the program is working well, however some suggestions for improvements are offered, particularly in the areas of administration and accreditation, communication, and sustainability.

Appendices



Appendix 1. Evaluation design & methods

This appendix presents a description of the evaluation approach, including purpose, scope, key evaluation questions, evaluation design and evaluation methods.

A1.1 Purpose and guiding principles

The purpose of the process evaluation of GP ANSC in the CESPHN region was to:

- Explore the program's role and uptake in the CESPHN region within the context of current models of antenatal care;
- Examine how GP ANSC programs are supported by PHNs elsewhere in Australia, in areas comparable to the CESPHN region;
- Identify how CESPHN can provide appropriate support to partners to deliver the GP ANSC programs effectively and efficiently;
- Provide evidence to inform decisions about future implementation and potential redesign.

The evaluation aimed to achieve a greater understanding of the program's contribution to the broader maternity care system in the region, to clarify the program's resourcing requirements and uptake and identify strengths and opportunities for improvement to ensure the program is well positioned to continue offering woman-centred clinical care into the future.

A1.2 Scope and focus

The process evaluation was divided into two components:

Part A aimed to conceptualise the role and position of GP ANSC within the region and within the broader Australian and international context, by mapping the processes and activities of the three programs in CESPHN and comparing these with information gathered from:

- A scan of the relevant academic literature on the delivery of GP ANSC;
- An environment scan of key public documents and websites pertaining to maternity models of care in Australia;
- Consultations with other metropolitan PHNs in NSW and nationally regarding the delivery of GP ANSC in their regions and how PHNs support these programs.

Part B evaluated the implementation processes of the three programs within the CESPHN region by collecting and analysing existing, routinely collected program data and conducting stakeholder consultations.

There were two important **exclusions** from the scope of this evaluation. First, the focus was on program design and implementation in a broad sense. It did not delve into the work practices of individuals within the program, nor did it examine routinely collected outcomes

data for patients. Second, the scope of the stakeholder consultations specifically excluded people receiving maternity care through the programs.

A1.3 Evaluation design

A3.1.1 Mixed methods design

The key evaluation questions aimed to assess the effectiveness of the systems, processes, and structures supporting GP ANSC ("what works") and to explore the underlying reasons for their effectiveness or ineffectiveness ("why" and "how"). To adequately address these questions, a mixed methods design was employed, incorporating both primary and secondary data sources.

A3.1.2 Key evaluation questions

The key evaluation questions for this evaluation are arranged according to criteria developed by the Organisation for Economic Cooperation and Development (OECD) to support the process of deciding on evaluation questions.

Based on project requirements and the program we have structured the evaluation questions around the following criteria:

- Relevance – is the program doing the right things?
- Coherence – how well does the program fit into its environment?
- Effectiveness – is the program achieving its objectives?
- Efficiency – how well are resources being used?

Table 7: Key evaluation questions

Criteria	No.	Questions	Data sources
Relevance	1.	What can be learned from evaluations of GP ANSC programs elsewhere about the key design, delivery and contextual factors that contribute to woman-centred care*?	Desktop review, literature scan, environment scan
	2.	Does the education (CPD) available through the programs meet the needs of GPs for enhanced knowledge and skills in antenatal and postnatal care? Are there opportunities for improvement in content and/or delivery methods?	Desktop review, environment scan, consultations

Criteria	No.	Questions	Data sources
	3.	Do the current governance processes (including GP accreditation requirements and advisory committee input to clinical guidelines) support the programs effectively, and how could these be improved?	Desktop review, environment scan, consultations
Coherence	4.	To what extent are the programs catering for the preferences of a diverse range of pregnant women/people? (Who is using the programs, and why? Who is not using the programs, and why?)	Desktop review, consultations
	5.	From the perspective of service providers, do the programs meet the needs of pregnant women/people for flexibility and informed choice of care?	Consultations
	6.	How well do the programs align with existing healthcare services? What role do they fill in the range of choices available in the CESPHN region?	Desktop review, literature scan, consultations
Effectiveness	7.	To what extent do the programs meet the needs of participating GPs in terms of facilitating and building their strong interest and expertise in antenatal care?	Literature scan, consultations
	8.	To what extent do program processes facilitate respectful communication and collaboration among health professionals caring for pregnant women/people?	Desktop review, literature scan, consultations
	9.	To what extent do the programs improve patient experience and relationships (as observed by service providers) through continuity of care and appropriate follow-up care with a familiar provider?	Literature scan, consultations
Efficiency	10.	Are there opportunities to improve resource use, management, and administration of the programs to meet the needs and aspirations of all parties?	Desktop review, consultations

Criteria	No.	Questions	Data sources
	11.	Do the programs reduce the number of antenatal hospital visits for routine/low risk pregnancies?	Desktop review, environment scan, consultations
	12.	What can be learned from other Australian GP ANSC programs to improve efficient delivery of GP ANSC in the CESPHN region?)	Environment scan, literature scan, consultations

A1.4 Evaluation methods

A4.1.1 Primary data collection

Interviews with key stakeholders

During April and May 2024, ARTD carried out online semi-structured group interviews with GP Advisors, GP Liaison Midwives, and hospital executives from Royal Prince Alfred (RPA) and Canterbury hospitals, Royal Hospital for Women (RHW), and St Goerge and Sutherland Hospitals. **Table 8** presents the number of interviews conducted with each group.

Table 8: Number of interviews by stakeholder group

Group	Number of attendees
Participating GPs	
GPs	13
Royal Prince Alfred (RPA) Women and Babies/ Canterbury Hospital	
GP advisors	3
GP Liaison Midwives & Antenatal Clinic Midwifery Managers	4
Executives	3
Royal Hospital for Women	
GP advisors	3
GP Liaison Midwives & Midwifery Unit Managers	1
Executives	1
Obstetricians	1
St George Hospital	

Group	Number of attendees
GP advisors	4
GP Liaison Midwives & Antenatal Clinic Midwifery Managers	3
Executives	3
Central and Eastern Sydney Primary Health Network	
Key staff	6
Total	**45**

Surveys of participating GPs and hospital midwives

Two brief, online/mobile-based surveys were developed and distributed during the data collection phase of the evaluation: one for GPs currently or previously involved in the GP ANSC program, and one for midwives currently involved in the ANSC. The survey was hosted online on the Qualtrics platform.

Both surveys were distributed by CESPHN. The GP survey link was distributed to GPs via the PHN newsletter and follow-up emails, and the midwives survey link was distributed via email. Surveys were completed by 79 GPs currently/previously involved in GP ANSC and 13 midwives currently involved in GP ANSC. A more detailed breakdown of respondents is provided in Table 9.

Table 9: Survey respondents

Group	Number of respondents
GPs	
Total GPs	79
Midwives	
Royal Prince Alfred (RPA) Women and Babies/ Canterbury Hospital	*6*
Royal Hospital for Women	*2*
St George Hospital	*5*
Total midwives	13
Total	**92**

A4.1.2 Secondary data collection

Program document and data analysis

To map the inputs, activities, and outputs of the GP ANSC program, CESPHN provided ARTD with program documents and access to program data. This included:

- Memorandums of Understanding (MOUs) between CESPHN and participating LHDs
- Hospital data (including rates of participation and number of births with GP ANSC between 2018 and 2022)
- Program data (including GP participation data, and program event data, e.g. CPD events).

Literature scan

A literature scan of academic and grey literature was conducted to contextualise and supplement findings from the primary data. In particular, we searched for research articles examining the delivery of models of antenatal care involving GPs in Australia and abroad (focusing on the UK, New Zealand and Canada), as well as academic and grey literature capturing the experience and perspectives of GPs, midwives and women receiving care.

The scan included systematic reviews and peer-reviewed and/or government-published articles, as well as communications from key professional organisations. Where possible, the search focused on literature published within the last five years to ensure the most current evidence was considered. However, due to a dearth of recent publications relating to GP involvement in antenatal care, the search was expanded to include relevant literature from the last 10-15 years.

Environment/policy scan

An environment scan was conducted to establish the policy context for GP Antenatal Shared Care (ANSC). The scan examined various documents, including State and National policy documents pertaining to antenatal care, policy documents from international governments, and position statements from key professional organisations, including the Royal Australian College of General Practitioners (RACGP), the Australian College of Midwives (ACM), and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Appendix 2. Survey methods and analysis

A2.1 Methods

This project included two online surveys of two stakeholder groups:

- GPs who are currently or were previously involved the GP ANSC program, and
- Midwives who are currently involved in the GP ANSC program.

The GPs' survey contained 16 items and the Midwives' survey contained 10 items.

A1.2.1 Design

The GP ANSC surveys were developed by ARTD in close consultation with CESPHN. The survey was pilot tested internally by ARTD and further refined based on feedback from the CEPSHN prior to the survey's release. The survey was hosted on ARTD's online Qualtrics survey platform.

ARTD did not apply the forced response setting to most survey questions, so therefore respondents were able to skip questions without answering them. The only questions that required a response were the initial questions about respondents' current involvement in the survey, which hospital they worked at and how long they had been involved in the program.

A1.2.2 Distribution

ARTD provided an anonymous link to CESPHN for each survey. CESPHN distributed the GPs' survey link through the PHN newsletter and followed up with GPs via email two weeks later to invite them for their response. CESPHN also distributed to Midwives' survey, but to a select and smaller list of participants through email. Both surveys were open for three weeks.

There were 79 respondents to the GPs' survey and 13 respondents to the Midwives' survey.

A1.2.3 Profile of respondents

GP survey respondents

The majority of survey respondents (92%) stated they were currently involved in the GP ANSC program (Table 10:).

Table 10: GP respondents' involvement in the program

GP's involvement in the program	N	%
Yes, currently involved*	73	92
Not currently, but I was previously involved	6	8
No	0	0
Total	79	100

Note. *n=2 respondents selected this response but did not answer any further questions.

Of the GPs who **are currently involved** in the program, most work with Royal Hospital for Women (65%) (Table 11). About half have been involved in the program for over 10 years (Table 12:).

Table 11: GPs' survey responses - hospital/s where they deliver the program

Hospitals where GPs deliver the program	N	%
Royal Hospital for Women	46	65
Royal Prince Alfred (RPA) Women and Babies	32	45
St George Hospital	28	39
Sutherland Hospital	18	25
Canterbury Hospital	17	24
Total*	71**	

Note. *Multiple responses were possible; therefore, the total percentage will not equal 100%. **n=2 respondents selected they were currently involved but then did not answer any further questions, therefore they have not been included in the total.

Table 12: GPs' survey responses - length of time delivering the program

Length of time delivering the program	N	%
0-2 years	5	7
3-5 years	12	17
5-10 years	17	24
10+ years	37	52
Total	71	100

Of the GPs who said they were **not currently involved** in the program but were previously involved, most worked with Royal Hospital for Women (67%) and half were involved in the program for 3 to 5 years (Table 13: and Table 14:).

Table 13: GPs' survey responses - hospital/s where they had delivered the program

Hospitals where GPs had previously delivered the program	N	%
Royal Prince Alfred (RPA) Women and Babies	4	67
Royal Hospital for Women	2	33
St George Hospital	2	33
Canterbury Hospital	1	17
Sutherland Hospital	1	17
Total respondents*	6	

Note. *Multiple responses were possible; therefore, the total percentage will not equal 100%.

Table 14: GPs' survey responses - length of time they had delivered program

Length of time GPs had previously delivered the program	N	%
0-2 years	0	0
3-5 years	3	50
5-10 years	1	17
10+ years	2	33
Total	6	100

Midwives' survey respondents

Most midwives who responded to the survey worked at St George Hospital (38%), closely followed by Canterbury Hospital (31%) (Table 15:). The respondents were mainly experienced midwives, with most working at their hospital for 5 years or over (61%) (Table 16). Most of the midwives (77%) who responded to the survey said they worked within the outpatient antenatal clinic (Table 17:).

Table 15: Midwives' survey responses - hospital

Hospitals where midwives work	N	%
Royal Prince Alfred (RPA) Women and Babies	2	15
Canterbury Hospital	4	31
Royal Hospital for Women	2	15
St George Hospital	5	38
Sutherland Hospital	0	0
LHD/ District Level	0	0
Total	13	100

Table 16: Midwives' survey responses – length of time working at hospital

Length of time working at hospital	N	%
0-2 years	1	8
3-5 years	4	31
5-10 years	3	23
10+ years	5	38
Total	13	100

Table 17: Midwives' survey responses - main area of work

Midwife respondents' main area of work	N	%
Outpatient antenatal clinic	10	77%
Midwife Continuity of Care Program (e.g. MGP or MAPS)	3	23%
Birthing unit	2	15%
Other (please specify)	0	0%
Total respondents	13	

A2.2 Survey data tables

A2.2.1 Delivery of the program

Table 18: GPs' survey responses regarding delivery of the program

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
The GP ANSC program is managed efficiently	6	10	28	44	20	32	7	11	2	3	63	100
The GP ANSC program has all the resources it needs to run effectively	3	5	21	33	22	35	13	21	4	6	63	100

Note. *Total does not include missing data from 10 respondents.

Table 19. Midwives' survey responses regarding delivery of the program

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
The GP ANSC program is managed efficiently at this hospital	0	0	3	38	1	12	3	38	1	12	8	100
The GP ANSC program has all the resources it needs to run effectively at this hospital	1	12	2	25	1	12	3	38	1	12	8	100

Note. *Total does not include missing data from 5 respondents.

A2.2.2 Education and training

Table 20. GPs' survey responses regarding education and training

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
The education content suits the needs of GPs delivering the GP ANSC program	9	14	40	63	6	10	7	11	1	2	63	100
The education delivery suits the needs of GPs delivering the GP ANSC program	9	14	39	62	7	11	5	8	3	5	63	100
The GP ANSC program's training opportunities enhance GPs' skills to deliver the program effectively	8	13	37	59	9	14	7	11	2	3	63	100

Note. *Total does not include missing data from 10 respondents.

Table 21. Midwives' survey responses regarding GP training

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
Participating GPs have the additional training they need to deliver the program	0	0	2	25	4	50	1	12	1	12	8	100

Note. *Total does not include missing data from 5 respondents.

A2.2.3 Protocols, guidelines and accreditation

Table 22. GPs' survey responses regarding protocols, guidelines and accreditation

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
The GP ANSC program protocols and guidelines are relevant and easy to understand	5	8	37	59	10	16	10	16	1	2	63	100
The GP accreditation requirements are appropriate for managing participation in the GP ANSC program	6	10	45	71	8	13	3	5	1	2	63	100

Note. *Total does not include missing data from 10 respondents.

Table 23. GPs' survey responses regarding eligibility requirements and advisory committee

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
The GP ANSC eligibility requirements are suitable and appropriate for pregnant women/people	10	16	43	68	8	13	1	2	1	2	63	100
The input from the advisory committee strengthens the GP ANSC program	4	7	23	39	27	46	4	7	1	2	59	100

Note. *Totals do not include missing data from 10 respondents and 14 respondents respectively.

Table 24. Midwives' survey responses regarding clinical governance mechanisms

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
The GP ANSC program at this hospital is supported by appropriate clinical governance mechanisms	1	12	1	12	4	50	1	12	1	12	8	100

Note. *Total does not include missing data from 5 respondents.

A2.2.4 Communication

Table 25. GPs' and Midwives' survey responses regarding communication

		Strongly agree & agree		Neither agree nor disagree		Strongly disagree & disagree		Total*	
		N	%	N	%	N	%	N	%
The patient understands the ANSC model of care and knows what it entails	GP	40	62	15	23	10	16	65	100
	Midwife	4	44	1	11	4	44	9	100
There is clear communication between the GP and the hospital staff if risk factors emerge during the pregnancy of a patient in the GP ANSC program	GP	24	37	16	25	25	38	65	100
	Midwife	1	11	1	11	7	78	9	100
GPs receive relevant and timely information from the hospital staff regarding antenatal care of GP ANSC patients	GP	12	18	18	28	35	54	65	100
	Midwife	3	33	1	11	5	56	9	100
GPs receive relevant and timely information from the hospital staff regarding postpartum care of GP ANSC patients	GP	25	38	13	20	27	42	65	100
	Midwife	3	33	2	22	4	44	9	100
There is open and respectful communication between the hospital staff and GPs around the needs of patients in the GP ANSC program	GP	23	36	22	34	19	30	64	100
	Midwife	5	56	2	22	2	22	9	100

Note. *Totals do not include missing data.

Table 26. GPs' survey responses regarding communication

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
Effective systems are in place to enable me to communicate important information about patient care to hospital staff	5	8	26	40	12	18	14	22	8	12	65	100
I am confident that my communication regarding patient care is being received and understood by hospital staff	4	6	19	29	22	34	12	18	8	12	65	100

Note. *Total does not include missing data from 8 respondents.

Table 27. GPs' survey responses regarding communication by hospital

	Hospital	Strongly agree & agree		Neither agree nor disagree		Strongly disagree & disagree		Total*	
		N	%	N	%	N	%	N	%
Effective systems are in place to enable me to communicate important information about patient care to hospital staff	RPA	12	40	7	23	11	37	30	100
	Canterbury	7	44	6	38	3	19	16	100
	RHW	26	62	6	14	10	24	42	100
	St George	9	35	5	19	12	46	26	100
	Sutherland	3	19	2	12	11	69	16	100

Note. *Totals do not include missing data.

Table 28. Midwives' survey responses regarding communication

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
It is clear from the patient's records that she has/they have chosen GP ANSC	2	22	1	11	2	22	3	33	1	11	9	100
GPs in the program regularly and clearly communicate with the hospital staff as required regarding the antenatal care of their patients	1	11	0	0	1	11	5	56	2	22	9	100

Note. *Total does not include missing data from 4 respondents.

A2.2.5 Experiences of midwives

Table 29. Midwives' survey responses regarding support of the program

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total*	
	N	%	N	%	N	%	N	%	N	%	N	%
I am supportive of women/people choosing to participate in the GP ANSC program	1	12	4	50	1	12	0	0	2	25	8	100

Note. *Total does not include missing data from 5 respondents.

A2.2.6 Perceptions of patient experiences

Table 30. GP and Midwives survey responses regarding patient experiences

	Group	Strongly agree & agree		Neither agree nor disagree		Strongly disagree & disagree		Total*	
		N	%	N	%	N	%	N	%
The GP ANSC program provides an important option of care for pregnant women/people	GP	62	97	1	2	1	2	64	100
	Midwife	5	62	1	12	2	25	8	100
The GP ANSC program meets the holistic health needs of many different pregnant women/people	GP	58	92	3	5	2	3	63	100
	Midwife	5	62	1	12	2	25	8	100
Women/people in the GP ANSC program receive consistent care and appropriate follow-up before and after their babies are born	GP	51	80	9	14	4	6	64	100
	Midwife	3	38	2	25	3	38	8	100
The GP ANSC program assists in reducing the number of visits of pregnant women/people to the antenatal clinic	GP	53	83	7	11	4	6	64	100
	Midwife	7	88	1	12	0	0	8	100
The GP ANSC program enhances continuity of antenatal and postpartum care compared with standard low-risk maternity care in the hospital antenatal clinic	GP	58	91	3	5	3	5	64	100
	Midwife	5	62	0	0	3	38	8	100
Women/people in the GP ANSC program appreciate the convenient and flexible options provided	GP	57	89	5	8	2	3	64	100
	Midwife	5	62	2	25	1	12	8	100
The GP ANSC program enhances the availability of culturally appropriate care for diverse groups of pregnant women/people	GP	48	75	14	22	2	3	64	100
	Midwife	4	50	3	38	1	12	8	100

Note. *Totals do not include missing data.

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