phn CENTRAL AND EASTERN SYDNEY

An Australian Government Initiative

St George and Sutherland Hospital GP Antenatal Shared Care Protocol

The GP Antenatal Shared Care Protocol was produced by Sutherland Division of General Practice and St George Division of General Practice (now Central and Eastern Sydney PHN) in collaboration with the South Eastern Sydney Local Health District (SESLHD).

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Overview & GP Requirements

Aim

The Antenatal General Practitioner Shared Care Program aims to provide a high standard of antenatal care for women who have a low-risk pregnancy. The women are cared for by the antenatal services at St George (SGH) or Sutherland (TSH) hospital in conjunction with their accredited General Practitioner (GP).

Objectives

- To provide choice, continuity of care and greater accessibility for women by seeing their GP during pregnancy.
- To enable registered GPs to provide a high standard of antenatal care to women who are considered suitable for Antenatal Shared Care.
- To provide GPs with a recommended 'Best Practice' standard of antenatal care.
- To reduce demands on hospital outpatient services.

Registration, education, and GP requirements

To be eligible as a member of the Antenatal Shared Care Program in South Eastern Sydney Local Health District (SESLHD) the GP needs to fulfil the requirements for registration:

- Current medical registration.
- Current membership of a Medical Defense Association.
- Attendance at an orientation,
- 12 points of Central and Eastern Sydney PHN (CESPHN)-delivered or endorsed Antenatal Shared Care educational activities for each triennium. CESPHN will monitor the number of points achieved by each GP. If GPs attend an activity conducted by a party other than CESPHN, they must inform CESPHN by email (ansc@cesphn.com.au) so the points may be approved and recorded.

Quality management

Quality management activities will be conducted periodically by the Women's Health and Antenatal Care Advisory Committee.

Clinical Contacts & Communication

Contact Numbers

	SGH	TSH
URGENT Clinical Concerns	• Ph: 9113 1111 and ask for the Obstetric Registrar • Birth Unit – Ph: 9113 2125	• Ph: 9540 7111 and ask for the Obstetric Registrar • Birth Unit – Ph: 9540 7981
Non-urgent administrative concerns	SESLHD-StGeorge-GPSC@health.nsw.gov.au	SESLHD-seslhd-tsh-gpsc@health.nsw.gov.au
Early Pregnancy Assessment Service (EPAS)	• Monday-Friday (closed public holidays) • https://www.healthlink.com.au/ • Text full name, date of birth and mobile phone number to: 0447 577 685 • Pt will receive a call back from that mobile number after 7:30am the following weekday, and within 24 hours to advise of appointment details	• Monday, Tuesday and Thursday 0800-1630 by appointment only • https://www.healthlink.com.au/ • Contact 9540 8958 • GP referral required via the E-Referral system. • For urgent concerns advise women to present to nearest Emergency department
Antenatal Clinic	Ph: 9113 2162	Ph: 9540 7240

Antenatal Care Record

- The Antenatal Record, also known as the 'yellow card', is the official hospital record (and sometimes the only one available at the time the woman is admitted). The Yellow card will be issued to the woman at her initial visit to the Antenatal Clinic.
- This medical record is the key to clear communication of routine pregnancy care between the GP and the hospital.
- The record should be completed in a uniform manner using only standard and widely accepted abbreviations. Entries in the Antenatal Record Card should be written legibly and signed.
- Women should be encouraged to carry the antenatal record with her at all times
- Should the woman forget her card at a visit, the relevant details should be copied onto a letterhead, or printed from electronic clinical notes, and given to her to keep with the card
- GPs should add their details to the antenatal card so it is easily visible.
- All pathology tests, vaccinations and ultrasound results are to be recorded on the front side of the Antenatal Record Card.
- Pathology investigations or ultrasounds ordered by the GP or the ANC, need to have the results documented in the Antenatal Record Card. The results need to be cc'd to both to the Antenatal Clinic and the GP.

Suitability for Antenatal Shared Care

- Women considered suitable for GPSC are women who: Are assessed as being **'low risk' in their pregnancy or 'Category A' as per the National Midwifery Guidelines for Consultation and Referral**
- Women who are Category B or C as per these guidelines have an identified medical condition, pregnancy complication or psychosocial needs that require a higher level of multidisciplinary input and require hospital-based models of care. Some examples of these conditions are below
- If a woman is not suitable for GP shared care, then arrange initial investigations as below and refer to the hospital antenatal clinic where other models of care are available.

Examples of women who are *not* suitable for GPSC (this list is not exhaustive):

- Hypertensive disorders
- Previous significant obstetric complications (pre-eclampsia, preterm birth, stillbirth)
- Twin Pregnancies
- Complex psychosocial needs or substance misuse
- BMI >35
- Uterine or cervical concerns
- Pre-existing or Gestational Diabetes medicated
- Infectious diseases such as HIV, Hepatitis B
- Medical conditions such as Epilepsy, Cardiac concerns, renal disease etc…

If a woman is referred to the hospital and GPSC is requested, the hospital will review the medical record and assess the woman's suitability for GPSC. GP's will receive a letter to advise if the woman has been accepted, or excluded from the GPSC program. If you are unsure if the woman is suitable for GPSC, please contact the hospital.

Frequency of GPSC Visits

- The below is the standard frequency of visits for GPSC women. More frequent visits or referrals may be necessary. If the woman develops complications, e.g. hypertension or diabetes, her care will be transferred back to the Antenatal Clinic for the remainder of her pregnancy.
- If a GP participating in Antenatal Shared Care is unable to see his/her patient (i.e. during holidays or sickness), she should be referred back to the Antenatal Clinic or to another colleague who is also registered with the Antenatal Shared Care Program.
- If a woman is seen by the hospital and a plan made to not return to GPSC, a letter will be emailed to the GP practice to advise. Similarly, if a GP feels a woman is unsuitable for Antenatal Shared Care a letter should be sent to the clinic.

Visit / Gestation	Location
Initial Visit	GP
10-14 weeks	Booking Visit - Hospital
20-22 weeks	Hospital
24 weeks	GP - Optional appointment at clinicians' discretion
28 weeks	GP (Rh neg -Hospital)
31 weeks	GP
34 weeks	GP (Rh neg or NBAC – Hospital)
36 weeks	Hospital
37 weeks	GP (NA if multiparous)
38 weeks	GP
39 weeks	GP
40 weeks	Hospital
41 weeks	Hospital

Initial GP visit

Refer to health pathways 'Antenatal – Initial Assessment' for overview of requirements at initial GP appointments.

Consider pre-eclampsia and preterm birth risk factors which may prompt earlier referral to the hospital.

Estimate the date of birth (EDB)

- To determine the estimation of EDB:

Certain LMP	Add 9 months and 7 days (280days) to first day of LMP If cycle shorter or longer than 28 days, subtract or add that number of days from the EDB as required
Uncertain LMP	Arrange US scan. The earliest scan after 6 weeks gestation is the most accurate for dating
IVF pregnancy	Use the EDB provided by the fertility centre

- Only change menstrually determined dates if USS:
  - <14 weeks – if 5 days difference
  - 14-20 weeks – if 10 days difference
  - >20 weeks – if 14 days difference
  - Dates should not be changed by a third trimester ultrasound scan.
- Inform the woman that the hospital may slightly alter the EDB.

Screening tests for chromosomal abnormalities

- Women should be counselled and offered the following screening tests
- Offer either:

A First trimester Screen (NT+) at 11-13 weeks gestation
or
Non-invasive prenatal testing (NIPT) from 10 weeks gestation with an early fetal anatomy scan at 12-14 weeks gestation

- The increased risks of aneuploidy for women over 35 years should be considered.

  Women with a history of genetic conditions should be referred for genetic counselling. eReferral is HealthLink. To discuss referrals:
  - Urgently – phone (02) 9311-1111 and ask for the Clinical geneticist.
  - Routinely - phone (02) 9113-3635.
  - If unsure where to direct a request, consider phoning the Genetics Counsellor via the Genetics department (02) 9113-3635 (business hours).

Arrange initial pathology screening investigations

- Ensure a copy of ALL results are sent to the antenatal clinic
  - SGH – Forward to SESLHD-ANCResults@health.nsw.gov.au
  - TSH – Forward to seslhd-seslhd-tsh-gpsc@health.nsw.gov.au

Routine investigations (all women)	Comments
FBC	Perform each pregnancy
Blood group and antibody screen	Perform each pregnancy

Rubella IgG	Perform each pregnancy
Syphilis serology	Perform each pregnancy
Hep B surface antigen	Perform each pregnancy
Hep C and HIV	Perform each pregnancy, ensure counselling
MSU for M/C/S	Perform each pregnancy
Vitamin D	Perform each pregnancy
Varicella IgG	Do not repeat if known IgG status positive

Targeted investigations (per clinical circumstance)	Comments
Chlamydia PCR (urine)	if < 25 years or risk factors present
CMV IgG	If high risk
TSH	If clinically indicated
HbEPG	If at risk of thalassaemia e.g. MCV<86 Always perform with iron studies (ferritin is sufficient)
HbA1c	If high risk. If ≥ 6.5% diagnose Overt Diabetes in Pregnancy. If ≥ 6.0-6.4% recommend OGTT. Manage as per NSW Health Gestational diabetes- screening, diagnosis and classification GDM Screening
75gGTT	For women with previous GDM or HbA1c ≥ 6.0-6.4% From 13 weeks gestation onwards. Avoid with history of bariatric surgery. Manage as per NSW Health Gestational diabetes- screening, diagnosis and classification GDM Screening.
Cervical screening test	If > 25 years and due; safe at any time during pregnancy; click here for clinical guidelines.
Ferritin	If risk factors for Fe deficiency, or low Hb and MCV Ferritin is preferred over full iron studies as it is more cost effective, unless the woman is acutely unwell.
Reproductive Carrier Screening	Offer to all women unless previously tested. If positive result contact Clinical Genetics. See HealthPathways

Notes:

Generally, electrolyte**s, liver function and ESR do not** need to be routinely tested for **low risk women.**

Refer to local hospital

SGH:

- GP's are to complete an eReferral via Healthlink
- Women may phone the Antenatal clinic 9113 2162 Monday to Thursday 8:30am to 3:30pm and Fridays 8:30am to 12pm for appointment enquiries.

TSH

- GP's are to complete an eReferral via Healthlink
- Women may phone the Antenatal clinic on 9540 7240 for appointment enquiries.

Discuss options of care available to women

- **GPSC –** Pregnancy care for low-risk women is shared between an accredited GP and midwives/doctors from the Antenatal Clinic. Labour and postnatal care is attended by Birth Unit and Postnatal Midwives.
- **Antenatal Clinic –** Mixed risk pregnancy care is provided by midwives and obstetric doctors in antenatal clinics. Staff work collaboratively to provide care to best meet the individual needs of each woman and her family. Antenatal clinics for women with low-risk pregnancies at SGH may also operate in the community at Hurstville, Kingsgrove and Wolli Creek Child and Family Health Centres.
- **Midwifery Group Practice (MGP) -** a mixed risk model in which continuity of care is provided to women throughout pregnancy, birth and the postpartum period by a small group of known midwives. These midwives are on call to care for the women booked into MGP. They work in collaboration with the obstetric team and clinical review is conducted by a lead obstetrician. Women attend the Birth Unit for intrapartum care. Early referrals are recommended to ensure access to this model.
- **Midwifery Antenatal Postnatal Service (MAPS) –** a known midwife provides antenatal and early postnatal care.
- **Centering (SGH) -** Antenatal care and group education are provided by a small team of known midwives and crosscultural workers or interpreters as relevant. The two-hour sessions include an individual antenatal check-up as required, plus group information about pregnancy and birth, breastfeeding, newborn care and community supports.
- **Djurali Naba (formally New Directions) -** Families who identify as Aboriginal or Torres Strait Islanders can receive their pregnancy care through this continuity of care model. Known midwives and an Indigenous health worker conduct visits in the Antenatal Clinic at both hospitals and postnatal care is provided for up to 14 days. After this time, ongoing care for indigenous families is transferred to the Narrangy–Booris service and continues until the child is 5 years old.
- **Active Birth Team (ABT - SGH) -** A small team of midwives provide care for women with low risk pregnancies. There is a focus on alternative / non-invasive pain relief during labour including use of baths for pain relief and water birth. Midwives provide all antenatal, intrapartum and postnatal care for up to 14 days post birth.
- **High Risk medical clinics (SGH)**
    - Risk Associated Pregnancy (RAP) - The RAP clinic is a specialised antenatal clinic for women with high risk pregnancy. Obstetricians and midwives provide multidisciplinary care.
    - Obstetric Medicine Clinic (OMC) - This clinic is for women with pre-existing renal or hypertensive disorders, or previous pregnancy related hypertensive disease. Women are reviewed by renal physicians who work in partnership with the RAP Obstetric team
    - Fetal Medicine Clinic - A fetal medicine clinic is available at SGH and a referral pathway to Royal Hospital for Women as required. Specialist ultrasound services and amniocentesis is available through the clinic. Genetic counselling services are also available via referral.
    - NBAC – A clinic for women who are having their Next Birth After a previous Caesarean Section. Counselling is provided by obstetric staff about mode of birth options.
    - Twins Clinic - This specialist clinic is for dichorionic diamniotic (DCDA) and monochorionic diamniotic (MCDA) twin pregnancies only. Pregnancy care is conducted by doctors and midwives, with referral to services such as lactation consultant or social work available as required. Additional investigations and scans are arranged, and the obstetric staff specialist performs ultrasounds at their discretion.

Subsequent antenatal visits and investigations

Antenatal history and examination

- Antenatal visits must include the following as a minimum

Maternal Assessment	Fetal Assessment
Blood pressure and signs/symptoms of pre-eclampsia	Fetal movements*
Urinalysis (where indicated)	Fetal heart rate (after 16 weeks)
Signs and symptoms of pulmonary embolus	Symphysis-fundal height (after 20 weeks)
Vaginal bleeding and or discharge	Fetal presentation (after 26 weeks)
Psychosocial screening - Mood and emotional wellbeing, Domestic and family violence	Engagement of fetal head (after 37 weeks)
Weight (if indicated)	
Presence of uterine activity	

* Clinicians should remind women at each scheduled and unscheduled antenatal visit after 28 weeks' gestation of the importance of maternal awareness of fetal movements and to report concerns of a decrease in strength and/or frequency or a non-diurnal pattern of movements. Refer to the Safer Baby Bundle Resources

Any maternal concern of decreased fetal movements, change or absence in movement patterns overrides any definition based on numbers

Gestation specific investigations and immunizations

Timing	Recommended investigations / appointment requirements
Any time	• Flu vaccine (optional - as per season)
10-16 weeks	• Early GTT (if indicated)
20 weeks	• Morphology ultrasound incl. measurement of cervical length • Boostrix for women at high risk of premature birth
28 weeks	• Antibody Screen • FBC • Syphilis screening • 75g GTT (if GDM not already present) • Vitamin D (if low at booking) • Ferritin (if iron deficiency suspected or low at booking)
28-32 weeks	• Boostrix (optimal timing) • RSV Vaccine
36 weeks	• Low vaginal swab for Group B Streptococcus culture (unless urine positive in pregnancy) • FBC/Ferritin (if previously low)

Criteria for Immediate referral to the hospital

GP shared care is a program for low-risk women. Where any complications arise in pregnancy and where immediate assessment may be required, **contact the obstetric registrar**. Women **must** be referred back to the hospital for ongoing care.

Concerns requiring IMMEDIATE assessment (<20 weeks to Emergency Department, ≥20 weeks to Birth Unit) if:

- Uterine activity is noted or reported i.e. threatened preterm labour
- Preterm rupture of membranes
- Abdominal pain
- Antepartum haemorrhage
- Abdominal trauma
- Severe hypertension (refer to health pathways)
- Decreased or concerns regarding fetal movements
- Headaches or visual disturbances
- Seizures or "faints" in which seizure activity may have occurred
- Symptoms or signs of pre-eclampsia
- Dyspnoea on mild-moderate exertion, orthopnoea or nocturnal dyspnoea.
- Symptoms or signs suggestive of deep vein thrombosis
- Pyelonephritis
- Intractable vomiting with dehydration and ketosis

***Note this list is non exhaustive and clinical judgement must be used**

Criteria for referral back to first available AN clinic appt

GP shared care is a program for low-risk women. Where any complications arise in pregnancy, call the registrar and ensure women is referred to the hospital for ongoing care.

Concerns requiring next available appointment at the hospital:

- Hypertension (refer to health pathways)
- Concern regarding fetal growth (i.e. Small for gestational age or fetal growth restriction))
- Ultrasound concerns including placenta previa, fetal abnormality, mal-presentation after 36 weeks, shortened cervix etc.
- Gestational diabetes requiring oral medication or insulin or further complications.
- Concern for intrahepatic obstetric cholestasis of pregnancy
- Infections such as syphilis, HIV or CMV
- Rhesus D alloimmunisation.
- Necessity for support services such as Mental health support, Social Worker or Drug and Alcohol Services.
- Any other problem which represents a significant departure from a normal antenatal course and which will require attention before a routine clinic.

***Note this list is non exhaustive and clinical judgement must be used**

Resources for GP's

GP's should familiarise themselves with the following resources:

- Safer Baby Bundle - The Safer Baby Bundle is a national initiative with five evidence-based elements to address key areas where improved practice can reduce the number of stillborn babies.
- Australian Breastfeeding Association
- MotherSafe - The MotherSafe service provides a comprehensive counselling service for women and their healthcare providers concerned about exposures during pregnancy and breastfeeding.
- National Antenatal Care Guidelines NSW Health has produced number of publications that provide pregnant women with advice on all aspects of pregnancy.
- Pregnancy Birth and Baby – a government website with pregnancy, birth and newborn information
- Multicultural Health Communication Service - Pregnancy Resources Pregnancy and Parenting resources available in other languages
- National Midwifery Guidelines for Consultation and Referral
- https://aci.health.nsw.gov.au/networks/maternity-and-neonatal/resources/hypertension-pregnancy Includes use of aspirin in pregnancy fact sheet
- GDM Screening NSW Health Gestational diabetes- screening, diagnosis and classification