Guidelines for Consultation with Obstetric and Related Medical Services (*Referral Guidelines*)

Aratohu Kimi Āwhina ki Te Ratonga Whakawhānau Pēpi, Ratonga Rata (Ngā Aratohu Tuku Atu)

The *Referral Guidelines* are to be used in conjunction with the Primary Maternity Services Notice 2021 (https://www.health.govt.nz/publication/primary-maternity-services-notice-2021) and relevant funded maternity service specifications (link https://nsfl.health.govt.nz/service-specifications/current-service-specifications/maternity-service-specifications).

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Process to update the 2012 *Referral Guidelines*

The Ministry of Health has contracted *Allen + Clarke* to undertake an update of the 2012 *Referral Guidelines*.

Our project team (Anna Gribble, Professor Frank Bloomfield, Dr Michelle Wise, and Norma Campbell) is grateful for the advice received to date from maternity sector stakeholders in response to a survey conducted in April 2021. This advice informed the draft updated *Referral Guidelines* presented in this paper. We received many comments about individual conditions and categories. Each of the proposed amendments was considered by the Maternity Guidelines Review Steering Group.

Our project team is grateful to the Steering Group for its advice on evidence review, the *Referral Guidelines* document and flowcharts, and for building consensus opinion on the range of conditions and categories. A summary of the Steering Group's considerations (which have included targeted literature reviews where relevant) are included in *Table 2*.

The Maternity Guidelines Review Steering Group includes:

- Dr Angela Beard (co-Chair, He Hono Wahine)
- Sue Bree (co-Chair, Midwifery Leaders Group)
- Claire MacDonald (New Zealand College of Midwives)
- Dr Karaponi Okesene Gafa (Royal Australian and New Zealand College of Obstetricians + Gynaecologists)
- Dr Lesley Dixon (New Zealand College of Midwives)
- Liz Lewis-Hills (New Zealand Society for the Study of Diabetes)
- Dr Mariam Buksh (Royal Australasian College of Physicians)
- Dr Matthew Drake (Australian and New Zealand College of Anaesthetists)
- Dr Rachael McConnell (Royal Australian and New Zealand College of Obstetricians + Gynaecologists)
- Dr Rosemary Hall (New Zealand Society for the Study of Diabetes)
- Dr Sue Belgrave (Royal Australian and New Zealand College of Obstetricians + Gynaecologists)
- Dr Trevor Lloyd (Royal New Zealand College of General Practitioners).

Acknowledgement of gender

Not all people who become pregnant identify with the female gender. Terms specific to female identity are used in this document for ease of understanding, while acknowledging that this is a cis and heteronormative approach. We do not intend to exclude people of diverse gender identity, gender expression or sex characteristics where the words wahine/woman/women/her/she are used. Pregnant people should advise their Lead Maternity Carer (LMC) and the other health professionals involved in their care of their preferred pronouns so that these are used correctly and documented in their records.

Feedback questions

Proposed updates to the *Referral Guidelines* are based on advice from the maternity sector received via a survey conducted in April 2021, consensus discussions within the Maternity Guidelines Review Steering Group, targeted literature reviews and general review. The revisions include:

- recognition of *Ngā Paerewa Health and Disability Services Standards*
- sections on Te Tiriti o Waitangi
- amendments to the guiding principles
- wording amendments to recognise that a wide range of health practitioners may be involved in delivering care to pregnant and birthing women, and women and their babies: the *Referral Guidelines* are relevant to all health practitioners involved in caring for pregnant women and their babies
- the addition of a flowchart to guide practice when a woman declines care and amendments to other flowcharts to recognise current practice or to harmonise wording
- specific updates the table of conditions and referral categories (*Table 2*)
- other wording amendments to align to the Primary Maternity Service Notice 2021.

Thank you for considering this draft updated *Referral Guidelines*. We appreciate your thoughts and comments in relation to the following questions.

1. Do you have any feedback on the **proposed guiding principles**?
2. There is currently a **Primary** referral category. Is this category still required as a separate category, or could it be included in the consultation category?
3. Do you have any feedback on the **process maps**?
4. Do you have any feedback on the **proposed** changes to the condition definitions or the referral categories (please see *Table 2*)?
5. Do you have views on whether the unique codes used in *Table 2* of the *Referral Guidelines* should be replaced with the **SNOMED CT identifier** (as set out in HISO 10050.2:2020 Maternity Care Summary Standard)?
6. For some (but not all) conditions, a **timeframe** for consultation or transfer of clinical responsibility for care has been proposed. Do you have any feedback on this suggestion in general, or the specific timeframes proposed (please see *Table 2*)?
7. Do you have any other views about the referral category for - 3003 Previous caesarean section (currently consultation)?

Please send your feedback to agribble@allenandclarke.co.nz by **29 October 2021.**

1 Purpose

The *Referral Guidelines* are intended to:

- improve maternity care safety and quality
- improve the consistency of consultation, transfer of clinical responsibility for care and transport processes
- give confidence to women, whānau, and health practitioners if a primary health care or specialist consultation, or a transfer of clinical responsibility for care is required
- promote and support coordination of care across providers.

The *Referral Guidelines* are based on best practice and are informed by available evidence, expert opinion and maternity service delivery in Aotearoa New Zealand. The *Referral Guidelines* sit alongside other relevant clinical guidelines. They should be read in conjunction with the *Ngā paerewa Health and disability services standard 8134:2021* (*Ngā paerewa*) and the corresponding *Sector Guidance for Birthing Units* and *DHB In-patient/private hospital services*. *Ngā paerewa*, alongside the sector guidance and the *Referral Guidelines*, provide a suite of information about best practice maternity service provision.

The *Referral Guidelines* relate to medical care. Socio-economic determinants also have an impact on health, but these are out of the scope for the *Referral Guidelines*.

A note about the phrases 'LMC' and 'maternity care provider'

The terms 'LMC' and 'maternity care provider' are used throughout the *Referral Guidelines*.

The Primary Maternity Services Notice 2021 describes an LMC as a midwife, an obstetrician or a general practitioner (GP) with a Diploma in Obstetrics and Medical Gynaecology (or equivalent as determined by the New Zealand College of General Practitioners) AND is either a maternity care provider in their own right or is an employee of or contractor to a maternity care provider AND has been selected by the woman to provide her lead maternity care.

The LMC is based in the community and is responsible for coordinating the woman's maternity care, or a baby's postnatal care. Not every woman will have a named LMC due to her specific care requirements or circumstances. Women may receive maternity care from an employed case-loading midwife or midwifery team. These maternity care providers along with other health care providers (such as a nurse practitioner, GP, obstetrician or family planning practitioner) may also need to refer the women for specialist services.

For the purposes of this document the term 'maternity care provider' is used, throughout the *Referral Guidelines* to encompass these other health practitioners that may provide health care at the time an offer of consultation or transfer of clinical responsibility for care becomes relevant.

In order to support clarity of responsibility and ongoing care provision, if the woman has an LMC (including a named community midwife/midwifery team), referrals should be made by this maternity practitioner because they are responsible for co-ordinating care and they should be the main point of contact for communication and planning. Any other health practitioner providing care for a pregnant or postpartum woman or her baby who considers that a referral is warranted, should contact the LMC to discuss in the first instance.

The term 'maternity care provider' encompasses all health practitioners who may provide maternity care at the time an offer of consultation or transfer of clinical responsibility for care becomes relevant. A maternity care provider may be a GP, midwife, obstetrician, nurse practitioner, or family planning practitioner.

If the woman does not yet have an LMC, a GP, nurse practitioner or family planning provider should prioritise linking the woman with an LMC over referral to specialist services (where referral is for a non-urgent issue). Other health practitioners would be expected to make a referral in acute or time critical situations where the woman has not yet registered for maternity care, or the woman stated they have attempted to contact and unable to contact their usual carer or the hospital. The LMC should be notified that such a referral has occurred.

2 Users of the *Referral Guidelines*

The *Referral Guidelines* are relevant to all health practitioners involved in caring for pregnant and birthing women and women and their babies in Aotearoa New Zealand. Regardless of their place of work, maternity care providers should use the *Referral Guidelines* to support their clinical judgement, knowledge and expertise and provide for a timely, consistent and effective approach to the woman's maternity care. Women and whānau can use the *Referral Guidelines* to understand how access to health services can be facilitated during pregnancy, birth and in the postpartum period.

3 Te Tiriti o Waitangi

Giving effect to Te Tiriti can be demonstrated through the practical application of the principles as articulated by the courts and the Waitangi Tribunal.[1] Applying the principles to maternity services is vital to enabling Māori to express their mana,[2] and ensures Māori receive high-quality, culturally safe and equitable health outcomes. Using the principles to work effectively and respectfully with Māori requires maternity services and maternity care providers to demonstrate the principles of Te Tiriti in their day-to-day practice with Māori.

The principles of Te Tiriti provide the framework for maternity services and maternity care providers. How these principles apply to maternity services is supported by *Ngā paerewa*, and in particular, 1.1 Pae ora healthy futures.

The Waitangi Tribunal concluded that persistent health inequities experienced by Māori were the consequence of the failure to apply the principles of Te Tiriti at structural, organisational and health practitioner levels of the health and disability sector. Giving effect to Te Tiriti requires maternity care providers to know the principles of Te Tiriti and be able to capably apply these in partnership with Māori in their day-to-day maternity clinical practice.

For the health and disability sector, the principles of Te Tiriti are as follows:

- **Tino rangatiratanga**: Maternity services and maternity care providers support the right of Māori to receive effective maternity care, conceptualising the woman's decisions as a continuation of a much older, Māori collective-endorsed practice of self-determining one's own health and wellbeing and that of the whānau.
- **Equity**: Maternity services and maternity care providers can contribute to equitable obstetric and neonatal health outcomes for Māori by ensuring that, at a minimum, these outcomes match those of other New Zealanders. Equitable maternity outcomes will be achieved when the *Referral Guidelines* are implemented in ways that give effect to the principles of Te Tiriti, relevant professional competencies, and *Ngā paerewa*.
- **Active protection**: Maternity services and maternity care providers share evidence-based information about obstetric and neonatal outcomes so that Māori can make decisions and prepare themselves to uphold their tikanga or cultural practice (i.e., karakia, rongoa, support people, etc.). Maternity care providers actively support Māori to make decisions that are best for them.
- **Options**: Maternity services and maternity care providers ensure that Māori have maternity care that enables them to uphold their tikanga or cultural practice regardless of where birth takes place. Processes must complement wahine Māori mana or inherent authority and dignity, support their tikanga or cultural practice, and be culturally safe as defined by Māori.
- **Partnership**: Maternity services and maternity care providers work in partnership with Māori, including a wahine Māori whānau, if requested. A partnered approach to the process and decision-making ensures wahine Māori can enact their rangatiratanga or self-determine their futures while exercising mana motuhake or authority over their bodies and reproductive health.

[1] In Hauora Report, Waitangi Tribunal, 2019: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

[2] See Ministry of Health Te Tiriti o Waitangi Framework for the Ministry's four goals, each expressed in terms of mana: https://www.health.govt.nz/system/files/documents/pages/whakamaua-tiriti-o-waitangi-framework-a3-aug20.pdf

4 Guiding principles

The following principles underpin the *Referral Guidelines*.

- The woman, her baby and whānau (as defined by the woman) are at the centre of all processes and discussions.
- The woman should have continuity of maternity care through a single point of contact, regardless of how her care is provided (eg, through a community-based approach or through a secondary or tertiary maternity service).
- The woman has the right to receive full, accurate, unbiased information about her options, the risks and benefits of these options, and the likely outcomes of her decisions. The woman has a right to make informed decisions on all aspects of her care, including the right to decline care and to decline referral for specialist consultation or a transfer of clinical responsibility for care.
- Health practitioners should be aware that different cultures and religions conceptualise anatomy, pregnancy, birth and the postpartum period in different ways and should adapt their language and approach accordingly.
- Health practitioners are responsible for their clinical decisions and actions, and for acting within their competency and scope of practice.
- Communication between all maternity care providers involved with the woman will include her, and will be open, clear, timely and appropriately documented.
- Transfer of clinical responsibility for care is a negotiated process involving the woman, the LMC (if not the referrer) and the health practitioner to whom clinical responsibility is to be transferred.
- Health practitioners are responsible for appropriately documenting decisions, including any variation from the *Referral Guidelines* or other guidelines, and the circumstances of any such variation. Documentation of all steps by all health practitioners involved is necessary, particularly where there is transfer of clinical responsibility for care from one health practitioner to another.
- Maternity services should monitor maternal and neonatal outcomes by ethnicity so that progress towards equity can be monitored, and variations in outcome and areas for quality improvement identified and implemented based on this analysis.
- Women should have access to an evidence-based and consistently high standard of care, regardless of where they live. The approach to referral for consultation, transfer of clinical responsibility for care and emergency transport is nationally consistent with equitable access to services regardless of location, with some allowance for local needs and conditions. The ways that this standard of care is achieved may differ depending on local situations.

5 Categories of referral

Table 1: Categories of referral

Referral category	Consequent action
Primary	The LMC discusses with the woman that a consultation may be warranted with a GP, midwife or other relevant primary health provider (eg, physiotherapist, lactation consultant, smoking cessation services, drug and alcohol service, maternal mental health service) as her pregnancy, labour, birth or puerperium (or the baby) is, or may be, affected by a condition that would be better managed by, or in conjunction with, another primary provider. Where a referral occurs, the decision regarding ongoing clinical roles and responsibilities must involve a three-way conversation between the woman, the primary care provider and the LMC (if not the referrer). Where there is no LMC, communication must include the referrer. This should include discussion of any ongoing management of the condition by the primary care provider. Clinical responsibility for the woman's maternity care remains with the LMC. A referral to a primary care provider may result in a referral for consultation or a transfer of clinical responsibility for care. In this event, the provider must notify the LMC (or the referrer if no LMC) of any referral or transfer.
Consultation	The LMC must recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing care and advice on management and any recommendation to subsequently transfer care must involve a three-way conversation between the woman, the specialist and the LMC (if not the referrer). Where there is no LMC, communication must include the referrer. This should include discussion of any need for and timing of specialist review. Advice on the timing of the referral is provided for some of the listed conditions, but timing is generally indicated by the severity of the condition, the experience and scope of practice of the referrer, the availability of services and the woman's access to them. A specialist will not automatically assume responsibility for ongoing care following a consultation. This responsibility will vary with the clinical situation and the wishes of the woman. A consultation with a specialist may result in a transfer of clinical responsibility for care. In this event, the consulting specialist formally notifies the referrer (or the LMC or maternity care provider if the woman is not registered with an LMC, if different from the referrer) of the transfer and documents it in the woman's records.
Transfer	The LMC must recommend to the woman (or parent(s) in the case of the baby) that the responsibility for her care be transferred to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The decision regarding ongoing clinical roles/responsibilities must involve a three-way conversation between the woman, the specialist and the LMC (if not the referrer). Where there is no LMC, communication must include the referrer. The specialist will assume ongoing clinical responsibility and the role of the LMC from that point on will be agreed between those involved. This should include discussion about timing of transfer of clinical responsibility back to the LMC when the condition improves. Discussions about the timing of transfer of clinical responsibility back to the LMC must involve the woman, the relevant specialist and

	the LMC. Where there is no LMC, communication must include the referrer. Decisions on transfer of clinical responsibility for care should be documented in the woman's records.
Emergency	An emergency necessitates the immediate transfer of clinical responsibility for care to the most appropriate health practitioner available. Responding to an emergency may include providing emergency transport by road or air to a secondary or tertiary maternity facility able to provide the necessary level of care (see *Process Map 5*). In such circumstances the clinical roles and responsibilities are dictated by the immediate needs of the woman and/or baby and the skills and capabilities of health practitioners available including those involved in providing emergency transport if it is required. The LMC is likely to have an ongoing role throughout the emergency, with the nature of that role, depending on the other health practitioners present.

6 Processes for referral for consultation and/or transfer of clinical responsibility for care

The following process maps set out referral processes.

This guidance is for all health practitioners involved in the woman or baby's care during pregnancy and birth, including those involved in referral for consultation, transfer of clinical responsibility for care and emergency situations. There is guidance on what to do if a woman declines any of these options.

The aim is a consistent level of service, delivered according to local needs and conditions.

6.1 Timing

The decision to refer and the timeliness of being seen will depend on factors such as the severity of the condition, the experience and scope of practice of the referrer, the availability of services and the woman's access to them. All health practitioners are responsible for their clinical decisions, including the timing of referral.

For these reasons, the revised *Referral Guidelines* do not generally include timing recommendations for each condition; however, there are some conditions for which a specific timing for referral for consultation or transfer of clinical responsibility for care is recommended to ensure that certain actions can occur in appropriately.

There may be situations when services required for a woman are not available in the area, or not available at the time she needs them (eg, the woman cannot be seen in outpatient clinic in a timely manner). In this situation, the referrer should make the referral and document it in the woman's records. Where appropriate, the referrer should contact the service and advise it of the situation. The referrer should, where necessary, discuss other options for care with the woman.

6.2 Process maps

The process maps that follow show the steps that referrers should take.

- A **Primary condition** in the referral criteria refers to a condition for which the referrer will discuss with the woman that referral to another primary care provider may be warranted.
- A **Consultation condition** in the referral criteria refers to a condition for which the referrer must recommend to the woman that a consultation with a specialist is warranted.
- A **Transfer condition** in the referral criteria refers to a condition for which the referrer must recommend to the woman that there is a transfer of clinical responsibility for care to a specialist.
- An **Emergency condition** in the referral criteria refers to a condition that requires immediate transfer of clinical responsibility for care from the referrer to the most appropriate available practitioner (where possible).

The maps are designed to show the critical steps that should be taken in each instance. Flexibility is important if the *Referral Guidelines* are to be used effectively. Local situations

vary in geography, demographics, workloads and workforce. Situations can change rapidly, especially in emergencies. The process should provide a framework for, but not override, local protocols that have been developed involving a multidisciplinary approach to achieve the same outcome in ways that work for local needs and circumstances.

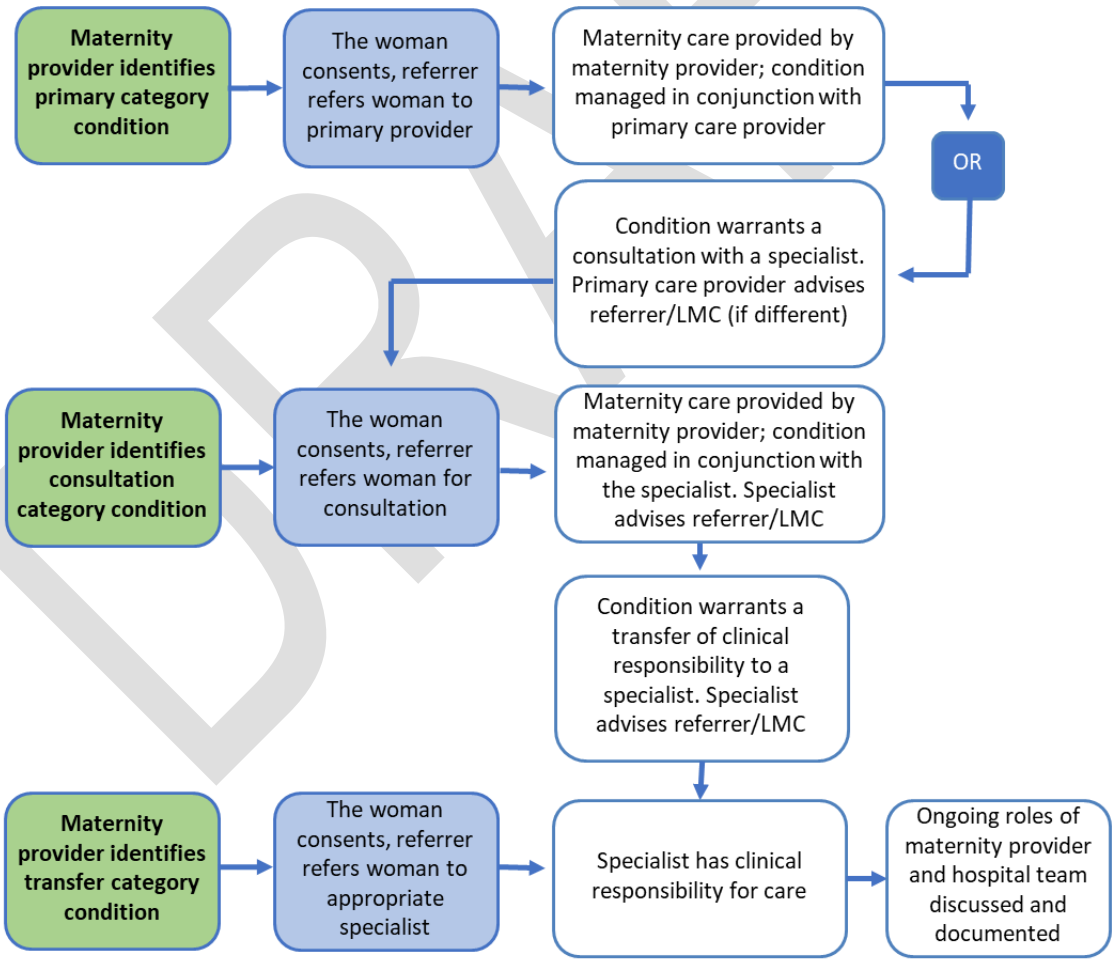
Where clinical responsibility for care is transferred to a specialist, the LMC (if not the referrer) can continue to provide care within their scope of practice and competence, and with the support of the specialist team and with the woman's agreement.

The process maps are a continuum: a referral may result in a specialist consultation or a transfer of clinical responsibility for care if that is found to be necessary.

Each of the six process maps must be used with reference to the process notes.

Referrers should not rely on the process maps alone for guidance

Referral for consultation or transfer: process maps as a continuum



*The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care

6.2.1 Process of referral to a primary care provider

If a maternity care provider finds (on booking or at any time) that a woman has a condition in the **Primary** referral category, the maternity care provider discusses with the woman that a consultation may be warranted with a primary care provider (eg, GP, another midwife, nurse practitioner, physiotherapist, lactation consultant, nutrition services, smoking cessation services, drug and alcohol services, or maternal mental health services).

There are many health-related conditions that may affect pregnant women and babies. The list of referral criteria does not attempt to cover all of these, but instead includes those of relevance during pregnancy and in the earliest days postpartum. It may be appropriate for a maternity care provider to recommend that a woman consult her GP or other primary care provider regarding a condition that is not listed.

Most women in Aotearoa New Zealand are enrolled with a general practice or primary health care clinic which holds their medical records and provides care for ongoing medical needs. Many women attend their general practice to confirm pregnancy and receive initial advice.

General practice and maternity care are separately funded. Maternity care provided by a midwife, a GP or a hospital team is free of charge to all eligible women; if a woman chooses a private specialist obstetrician, she pays a charge in addition to the government subsidy. General practice care is partially subsidised, and normally incurs a part charge even when it is provided to women who are pregnant. Charges are set by each practice. The referrer must advise the woman that there may be a charge to her for her consultation with a GP or other primary care provider.

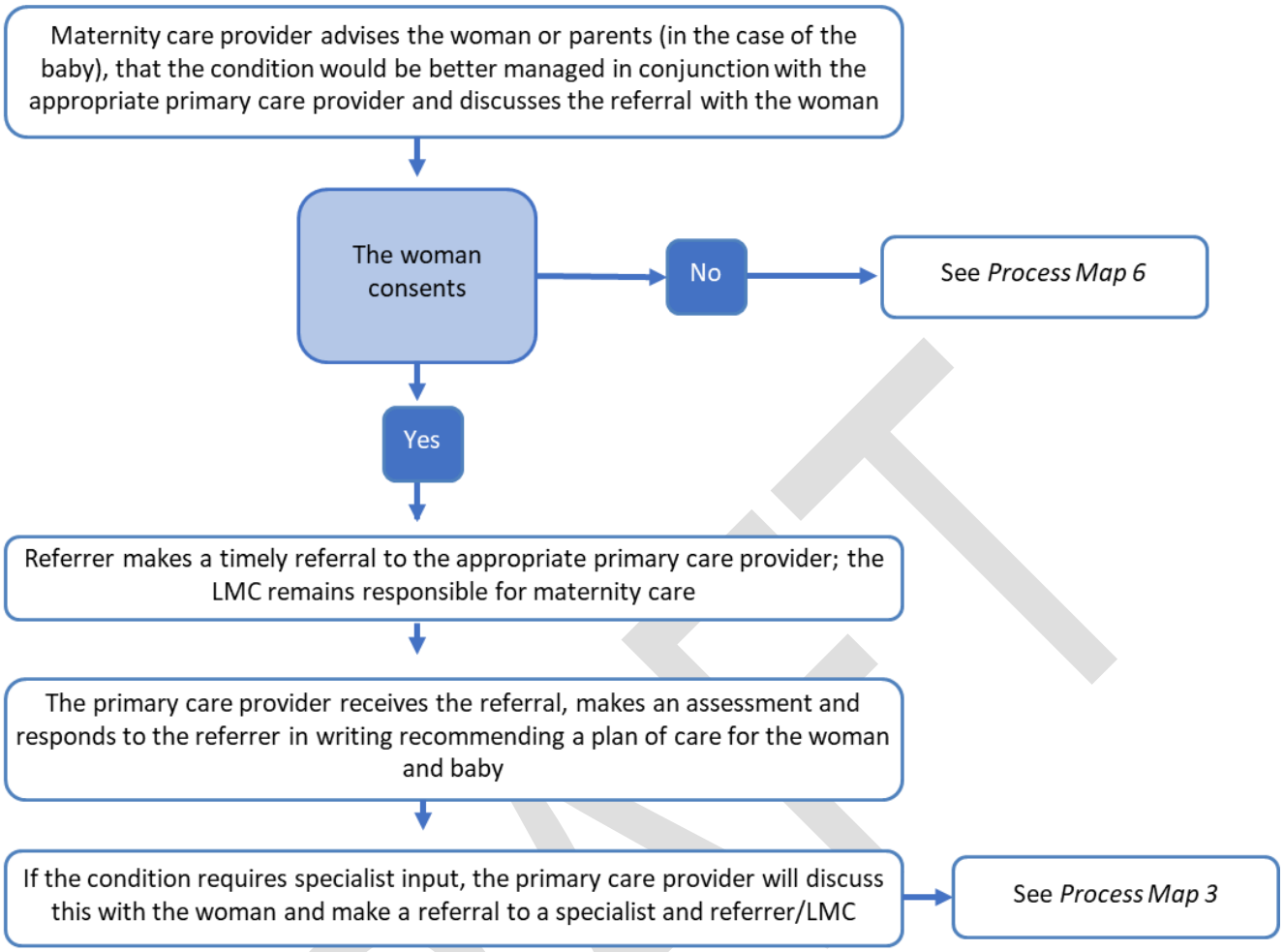
Roles and responsibilities

When a woman is referred to a primary care service, the primary care provider may provide advice or ongoing management for the condition while the LMC retains the clinical responsibility for care for maternity care. The referral may result in a recommendation that the condition requires the offer of a referral for specialist consultation or a transfer of clinical responsibility for care (covered by the consultation or transfer process maps). In all cases, there is a professional responsibility to maintain communication, collaboration and documentation and to inform the referrer (and the LMC if they are not the referrer), in writing, of the outcome of the referral.

Communication

Referral to another primary care provider requires the referrer to send adequate information to that provider, including any relevant clinical notes, test results, histories, etc. It also requires that the primary care provider notify the referrer (and the LMC if they are not the referrer) of any subsequent referrals, any recommendations for ongoing management of the woman and/or baby by the LMC, changes in medication or management of the condition itself, test results or any other relevant information. Communication and information sharing by all parties must be timely, appropriate and complete.

Process Map 1: Referral to a primary care provider



*The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care

6.2.2 Process notes for referral to a specialist for consultation

Conditions listed in the **Consultation** referral category are those for which the referrer must recommend to the woman that she has a consultation with a specialist about that condition. Consultation can be in the form of a discussion between the referrer and the specialist on the phone or videoconference or via email. The consultation may result in the specialist seeing the woman in person. The specialist consultation may be done by an individual health practitioner and may include review by a secondary services team. The LMC should be consulted on the need for referral and ongoing responsibilities if they are not the referrer.

If a woman sees a maternity care provider before she has registered with an LMC and the maternity care provider identifies a condition that requires a specialist consultation, the maternity care provider can refer as per *Process Map 2*. Once the woman has registered with an LMC, the maternity care provider should provide the LMC with all the relevant information.

The specialist to whom the woman is referred may be an obstetrician, radiologist, anaesthetist, physician, psychiatrist, surgeon or paediatrician.

Roles and responsibilities

At the time of the consultation, the clinical responsibility for care remains with the LMC (or maternity care provider if the woman is not registered with an LMC). The specialist should advise the LMC/maternity care provider of recommended monitoring and provide a documented care plan which has been agreed between the woman, the specialist and the LMC/maternity care provider. The specialist may become responsible for management of the specific condition if that is appropriate and warranted, and if the woman agrees.

Communication

This process assumes that the decisions about a woman's care are based on a three-way conversation between the woman, the LMC (if not the referrer), and the specialist. Where there is no LMC, communication must include the referrer.

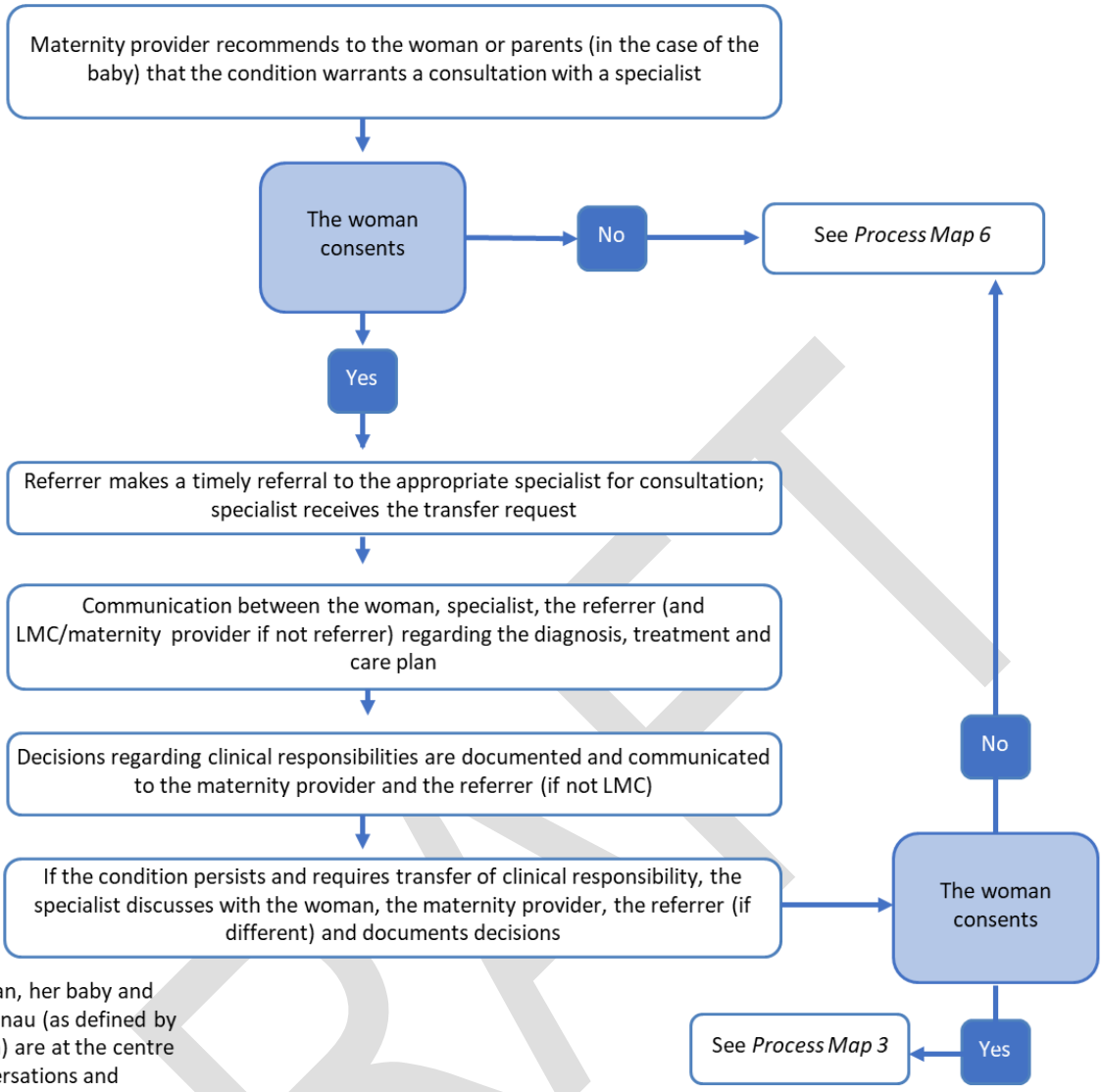
The referrer should provide all necessary clinical notes and information to the specialist along with the referral. The specialist is responsible for informing the LMC of decisions, recommendations and advice as part of the documented plan of care following the consultation. Where there is no LMC, communication must include the referrer.

Meeting local conditions

The process will need to take account of:

- capacity of local/regional secondary care services to see referred women in a timely manner
- access to the required specialist services in the area (eg, genetic services are not readily available in all areas of Aotearoa New Zealand)
- distances, time and cost for the woman to reach a hospital if she needs to be seen in person by a hospital-based specialist.

Process Map 2: Referral to a specialist for consultation



*The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care

6.2.3 Process for transfer of clinical responsibility for care

Roles and responsibilities

Conditions listed as **Transfer** are those for which the LMC/maternity service provider must recommend transfer of clinical responsibility for care to a specialist. Once clinical responsibility for care is transferred, clinical decisions and decisions on the roles and responsibilities of all other health practitioners involved with the woman's care rest with the specialist, considering the needs and wishes of the woman.

There is potential for LMCs to retain a role in the provision of care for the woman, especially where the LMC is a midwife. Continuity of care should be preserved wherever possible. For example, a woman who is pregnant with twins requires specialist oversight but can continue to receive midwifery care from her LMC midwife. The specialist has clinical responsibility and a clear, written care plan including roles and responsibilities is documented.

An LMC may decline ongoing involvement with a woman's care if the clinical situation becomes outside their scope of practice or experience or unreasonably impacts on their workload.

Communications

It is critical to document the point at which responsibility for coordination and provision of maternity care is formally transferred to the specialist. This requires:

- a three-way conversation between the woman, the LMC, and the specialist to determine that the transfer of clinical responsibility for care is appropriate and acceptable (where there is no LMC, communication must include the referrer)
- the LMC to provide all relevant information, including any relevant clinical notes, test results, and histories, to the specialist
- a discussion and documented decision about the nature of the ongoing role of the LMC or whether all care, including midwifery care, is transferred to the specialist and the hospital midwifery team.

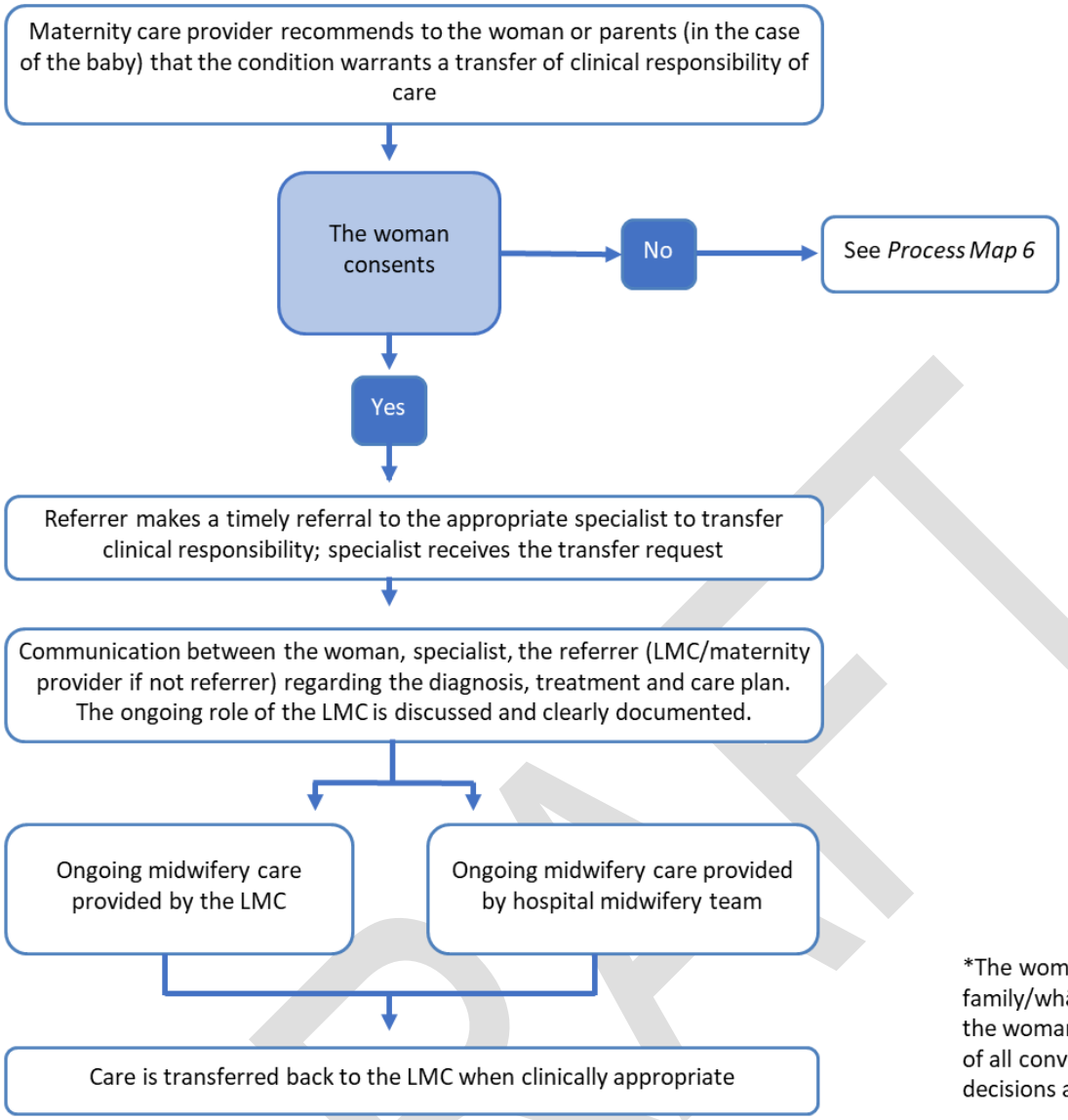
Transfer of clinical responsibility for care requires timely and full communication between the LMC and the specialist. All other health practitioners involved in the process (eg, GP or other primary care provider) should be informed of the decisions made (including referrers if they are not the LMC).

Meeting local conditions

The detail of transfer of clinical responsibility for care processes will differ depending on the scope of practice and experience of the LMC and others involved in the woman's care (including LMC care). It will also vary according to geographical considerations. Transfer of clinical responsibility for care in some cases may be to the care of a specialist in the nearest main centre.

The steps in *Process Map 3* should be reflected in local processes or protocols.

Process Map 3: Transfer of clinical responsibility for care



*The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care

6.2.4 Process for emergency transfer of clinical responsibility for care

Conditions listed as **Emergency** are those that require immediate attention by the most appropriate health practitioner available. The type of health practitioner will depend on the specific condition and whether the emergency is taking place within a hospital, in the community or at a primary maternity facility. The most appropriate health practitioner may include (but is not limited to):

- the woman's LMC
- other midwives
- the nearest GP or rural hospital doctor
- obstetricians, either in person or by telephone if no obstetrician is on site or the emergency is taking place in the community or at a primary maternity facility
- an obstetric registrar on site at a tertiary maternity service
- an anaesthetist, paediatrician or other relevant specialist.

Roles and responsibilities

The roles and responsibilities during the emergency will be defined by clinical need. Generally, the most experienced and relevant health practitioner will take the lead and advise others of what actions they should take. The LMC has the lead until such time as they transfer the clinical responsibility for care to the most appropriate health practitioner (where this is possible). An obstetric or neonatal emergency often but not always involves a transfer of clinical responsibility from an LMC if it requires transport to or occurs within a secondary or tertiary maternity facility.

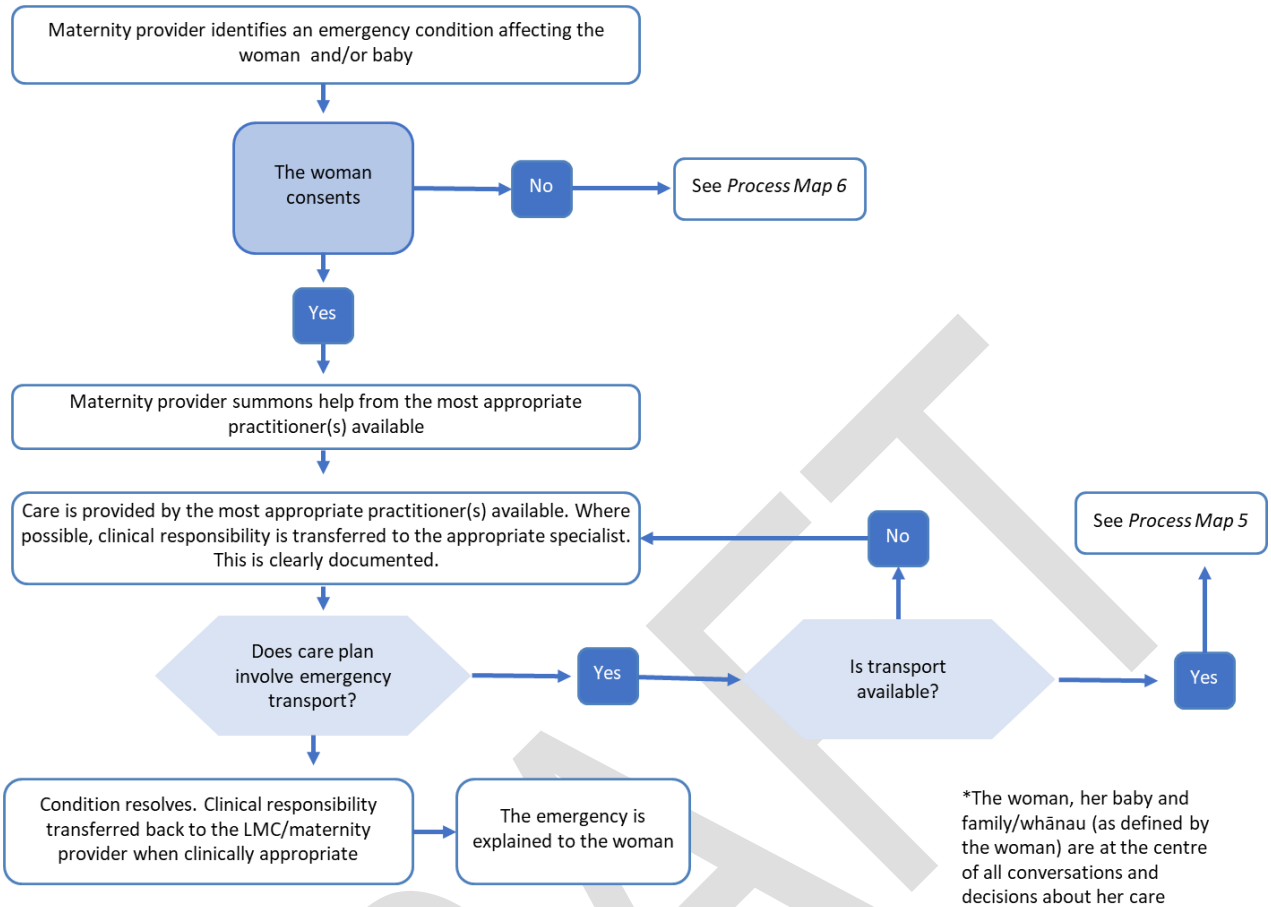
The transfer of clinical responsibility for care must be clearly established and documented at the time or as soon as practicable once the situation has stabilised.

Communications

Effective communication with the woman and her whānau (as defined by the woman) is essential in an emergency. As much information as possible should be provided to the woman and her whānau, and to others responding to the emergency. It is expected that the LMC will have discussed the management of obstetric or neonatal emergencies with the woman prior to the occurrence of such an emergency.

Communication with the woman may be difficult in some cases due to the nature of the emergency. Although the woman retains the right to decline treatment or transport and the right to receive complete information, the situation may mean that a comprehensive discussion of benefits, risks and options is not possible. The woman may not be legally competent to make decisions due to the nature of the emergency. Under the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Regulations 1996, when a woman is not competent to make an informed choice, the provider may provide services in the best interests of the consumer.

Process Map 4: Emergency transfer of clinical responsibility for care



6.2.5 Process for emergency transport

Emergency transport refers to transport used in situations in which the woman must be moved from the community to a secondary or tertiary maternity facility, or between secondary and tertiary facilities. During this period, the LMC may be consulting and working with other health practitioners as shown in *Process Map 4*. Transfer of clinical responsibility for care may have occurred before transport.

Clinical responsibility for care during transport

Until care is formally transferred to a specialist, the LMC retains clinical responsibility for care. This means that paramedics or ambulance crew must take clinical direction from the LMC when they are responding to an obstetric or neonatal emergency.

If the LMC cannot provide a clinical escort during transport, clinical responsibility is transferred to the crew for the period of transport only. This clinical responsibility will normally be considered to have been transferred when the woman arrives at the secondary or tertiary maternity facility.

Transport between maternity facilities

Health services have specific process for requesting emergency transport from one facility to another. LMCs should ensure they are aware of the processes in their local area. For the purposes of the *Referral Guidelines*, maternity facilities include primary maternity facilities, base hospitals and other facilities from which women may need to be transferred in the event of an obstetric or neonatal emergency.

If the agreed emergency transport process is not practical in the situation or is not working (eg, due to communication difficulties), LMCs should follow the procedure detailed in *Process Map 5* for transport from the community to a secondary or tertiary facility.

Emergency transport resulting from a telephone consultation with a specialist

If an LMC consults with a specialist and a decision is made for emergency transport, the specialist decides on the most appropriate mode of transport in consultation with the emergency services and the LMC. The secondary or tertiary facility must inform the LMC of what transport to expect. The process is the same regardless of mode of transport (i.e., air or road). If the woman is being transported in a private car, the LMC must explain this to the hospital team.

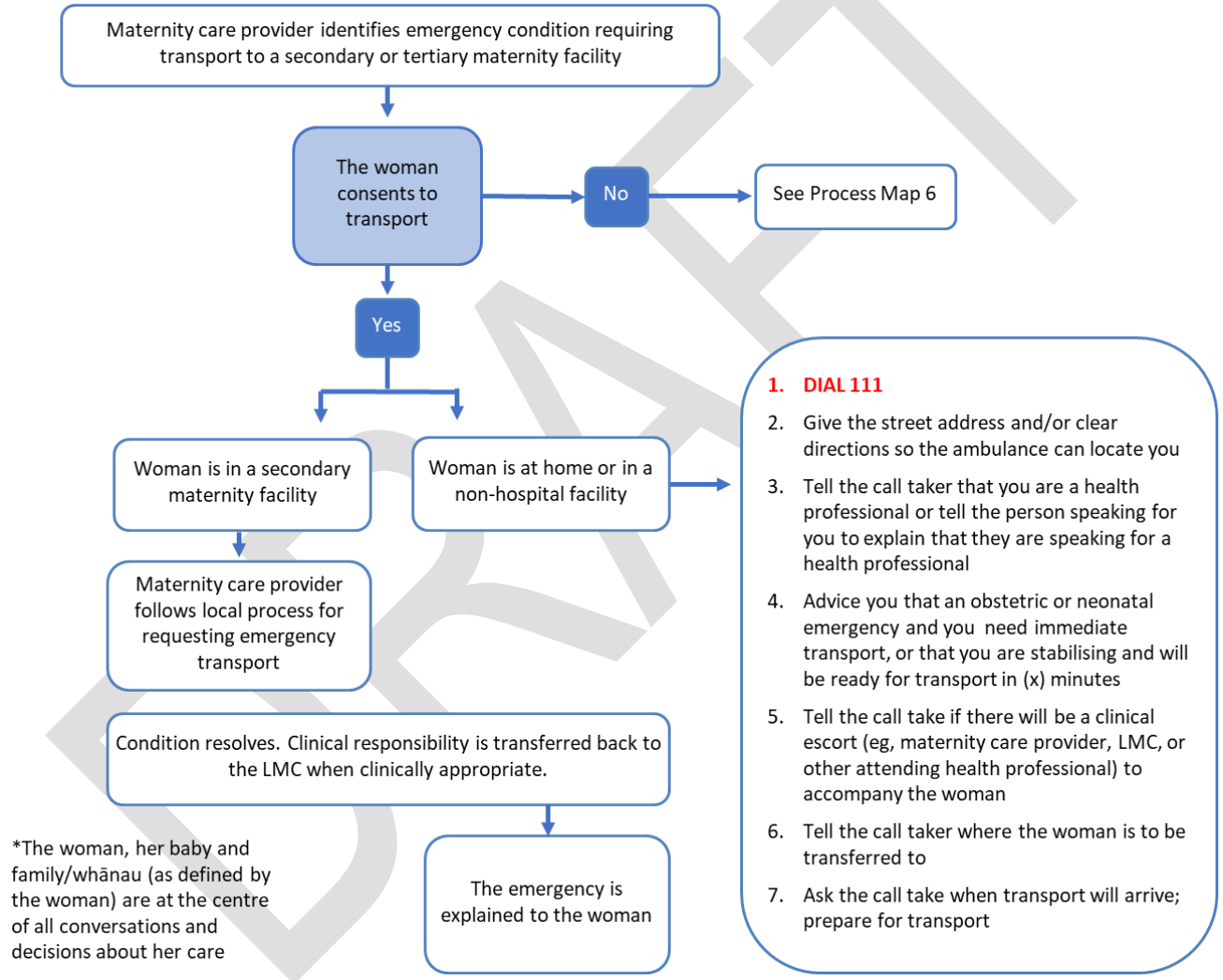
If the hospital team decides to use a retrieval team, the LMC must be informed that the team is coming and when it can be expected. Specific instructions should be provided to the LMC to maintain clinical safety until the team arrives.

LMC responsibilities prior to and during the transfer process

In preparation, all LMCs should[3]:

- be familiar with the process of arranging an emergency transfer in their locality
- provide care until transport arrives
- ensure the woman and her support people understand the need for transfer and have provided consent (NB if the woman does not consent, please refer to *Section 5*)
- provide up-to-date clinical records and necessary administrative data to facilitate transport and transfer.

Process Map 5: Emergency transfer



[3] New Zealand College of Midwives. 2008. *Transfer Guidelines*.

6.3 When a woman declines a referral, consultation, transfer of clinical responsibility for care, emergency treatment or emergency transport

The right to informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in Aotearoa New Zealand. This means that a woman can choose to decline treatment, referral to another health practitioner, or transfer of clinical responsibility for care.

If a woman chooses not to be referred or not to consult with a specialist, the maternity care provider may be left operating outside their experience or scope of practice, and/or may feel that they cannot provide the level of care the woman needs for her safety and the safety of her baby.

If a woman declines a referral, consultation or transfer of clinical responsibility for care, the maternity care provider should:

- **clarify** with the woman when it may be appropriate to revisit this decision (eg, a change in the clinical circumstances)
- **explain** to the woman that the maternity care provider needs to consider discussing her case with at least one of the following (ensuring that the woman's right to privacy is always maintained):
    - another midwife or GP
    - an appropriate specialist
    - an experienced colleague/mentor
- **share** the outcomes of any discussion that the maternity care provider has had and any resulting advice with the woman
- **document** in the care plan the process, the discussions, recommendations given, and decisions made, and the woman's response.

If, after this process, care arrangements that are satisfactory to the maternity care provider and the woman has not been reached, the maternity care provider must decide whether to continue or to discontinue care.

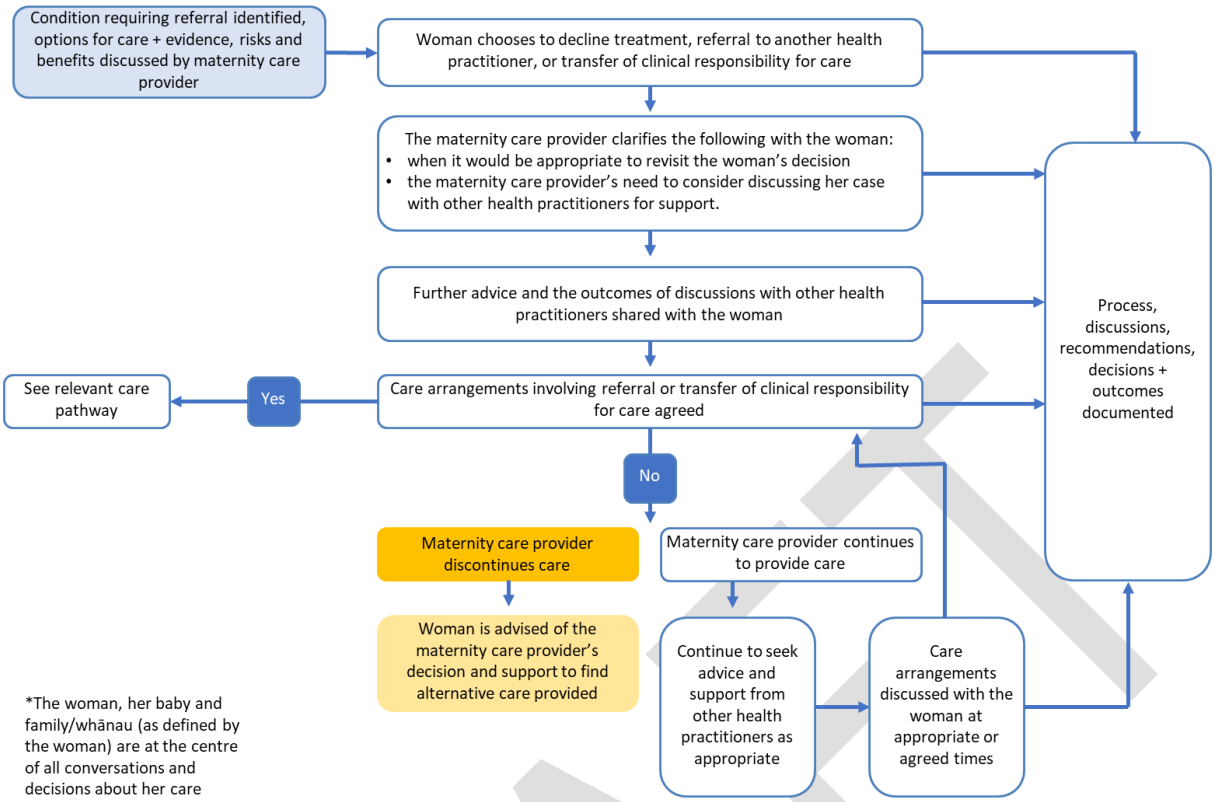
If the maternity care provider decides to continue care, they should:

- **continue** making recommendations to the woman for safe maternity care, including further attempts at referral
- **engage** other practitioners as appropriate for professional support (eg, secondary obstetric or neonatal service, other midwives, etc.)
- **continue** to document all discussions and decisions.

If the maternity care provider decides to discontinue care, they should:

- clearly communicate the decision and the reasons for it to the woman
- assist the woman to find alternative care within a reasonable timeframe.

Process Map 6: Woman (or parents) declines treatment for herself or a baby



6.3.1 Obstetric or neonatal emergency

In an obstetric or neonatal emergency, the maternity care provider cannot refuse to attend the woman. If the woman declines emergency transport or transfer of clinical responsibility for care while in active labour, the maternity care provider should remain in attendance. This may result in the maternity care provider being called on to deal with a situation that is not within their scope of practice. It may be outside their experience or ability to deal with safely or may require treatment that they cannot perform. In these situations, the maternity care provider should:

- provide care within professional standards
- provide care to the best of their ability
- attempt to access appropriate resources and/or personnel to provide any needed care (dependent on the woman's consent)
- clearly document all discussions and actions
- debrief with clinical colleagues after the event with appropriate support.

6.3.2 When the woman/parents decline care for their baby

Parents can decline care for their baby, but they cannot unreasonably withhold care for emergency treatment without which there is a risk of serious harm or death. If parents decline consent for treatment of the baby, maternity care providers should discuss the baby's needs and treatment options with the parents, and document all advice given and actions taken.

7 Conditions and referral categories

Table 2 (overleaf) provides a list of conditions for which a maternity care provider should advise or recommend to the woman that a referral, consultation or transfer of clinical responsibility for care takes place.

The referral categories are detailed in *Section 5* and the processes that should be used are detailed in *Section 6*.

Health practitioners must use clinical judgement in deciding when and to whom to refer a woman. For example, a condition that is normally a cause for a referral to a primary care practitioner may be severe enough on presentation to warrant a specialist consultation.

The referral categories may form part of a continuum. Placing a condition in the Consultation category does not preclude a subsequent transfer of clinical responsibility for care if that is indicated by the results of the consultation, or if the condition persists or worsens.

All decisions concerning a woman and/or baby's care, including recommendations for referrals, consultations and/or transfer of clinical responsibility for care, must be made in discussion with the woman, and with all health practitioners involved in the care.

If a woman wishes to have a consultation with a specialist or wishes clinical responsibility for care to be transferred when there is no clinical indication, she should discuss her request with her LMC.

Table 2 (overleaf) proposes a range of changes to the conditions and referral categories.

The proposed changes reflect sector suggestions provided to the project team in April 2021, discussions with the Maternity Guidelines Review Steering Group, evidence review and review of other guidelines currently in use in Aotearoa New Zealand.

Some suggestions previously made by stakeholders have not been recommended. A short rationale for each change is provided, where needed.

To support consistent recording of information and ease of use, it is proposed that the unique codes contained in the current iteration of the *Referral Guidelines* be replaced with the SNOMED CT identifiers (as set out in HISO 10050.2:2020 Maternity Care Summary Standard). As this is a proposal, the codes have not yet been altered (but would be if sector feedback supports this).

Table 2: Conditions and referral categories

Code	Condition	Description	Referral category	Proposed change
1000–2000 Pre-existing and/or co-existing medical conditions				
Anaesthetics				
1001	Anaesthetic difficulties	Previous failure or complication (eg, difficult intubation, failed epidural, severe needle phobia)	Consultation	No change
1002	Malignant hyperthermia or neuromuscular disease		Consultation	No change
Autoimmune/rheumatology				
1003	SLE/connective tissue disorder	Active, major organ involvement, on medication	Transfer	No change
1004		Inactive, no renal involvement, no hypertension, or only skin/joint problems	Consultation	No change
1005	Thrombophilia including antiphospholipid syndrome	On warfarin, previous obstetric complications or maternal thrombosis	Transfer	No change
1006		No previous obstetric complications or maternal thrombosis	Consultation	No change
Cardiac				
1007	Arrhythmia, palpitations, murmurs	Recurrent, persistent or associated with other symptoms NB Respiratory sinus arrhythmia does not require referral	Primary	Description amendment to clarify when primary care is not required
1008	Cardiac valve disease	Mitral/aortic regurgitation	Consultation	No change
1009		Mitral/aortic stenosis	Transfer	No change
1011	Cardiac valve replacement		Transfer	No change
1012	Cardiomyopathy		Transfer	No change
1013	Congenital cardiac disease		Consultation	No change
1014	Hypertension	Hypertension confirmed pre-conception or prior to 20 weeks gestation with or without a known cause, measured on two or more occasions at least four hours apart or on antihypertensive medication	Consultation before 16 weeks' gestation	Description amendment to align to *Hypertension and pre-eclampsia guidelines* and timing recommendation
1015		Diastolic BP >110 mmHg or systolic BP >160 mmHg	Transfer as soon as possible	Description amendment to align to *Hypertension and pre-eclampsia guidelines* and timing recommendation
1016	Ischaemic heart disease		Transfer	No change
1017	Pulmonary hypertension		Transfer	No change

Code	Condition	Description	Referral category	Proposed change
Endocrine				
1019	Diabetes	Gestational, well controlled on diet or metformin	Consultation	Description amendment to be clearer about definition of control No change: shared care is provided for
1020		Pre-existing (Type 1, Type 2, MODY)	Transfer	Description amendment to be clearer No change: shared care is provided for
1021		Gestational, requiring insulin	Consultation	Category change (from transfer)
1022	Thyroid disease	Hypothyroidism	Primary	No change
		Hyperthyroidism	Consultation	No change: there are times when consultation is needed (i.e., women with TSH receptor antibodies)
1023	Hypopituitarism		Consultation	No change
1024	Prolactinoma		Consultation	No change
	Other known endocrine disorder significant in pregnancy	Eg, Addison's disease, Cushing's disease	Consultation	No change
Gastroenterology				
1025	Cholecystitis	Presenting as acute abdominal pain	Consultation – as soon as possible	Condition title change, description amendment, category change to ensure appropriate consultation (from primary) and timing recommendation
1026	Cholestasis of pregnancy		Transfer	No change
	Previous fatty liver in pregnancy		Consultation	No change
1027	Inflammatory bowel disease	Active or on medication	Consultation	No change
1028		Inactive	Primary	No change
1029	Hepatitis	Acute	Consultation	No change
1030		Chronic active	Consultation	No change
1081		Active chronic on immunosuppressants	Transfer	No change
1031	Oesophageal varices		Transfer	No change
NEW	Bariatric surgery		Consultation in the second trimester	New condition/category
Genetic				
1032	Any known genetic condition significant in pregnancy		Transfer	No change
1033	Marfan's syndrome		Transfer	No change

Code	Condition	Description	Referral category	Proposed change
Haematological				
1034	Anaemia	Hb < 90 g/L, not responding to treatment	Consultation	No change
1035	Haemolytic anaemia		Transfer	No change
1036	Bleeding disorders	Including Von Willebrand disease	Consultation	No change
1037	Thalassaemia		Consultation	No change
1038	Thrombocytopaenia		Consultation	No change
1039	Sickle cell disease		Transfer	No change
1040	Thromboembolism	Previous deep vein thrombosis, pulmonary embolism	Consultation	Description amendment to clarify it is previous thromboembolism, category change (from transfer)
1041	Thrombophilia		Consultation	No change
Infectious diseases				
1042	CMV/toxoplasmosis	Acute	Transfer	No change
1044	HIV positive		Transfer	No change
1045	Listeriosis	Acute	Transfer	No change
1046	Rubella		Consultation	No change
1047	Syphilis		Consultation	No change
1048	Tuberculosis	Active	Transfer	No change
		Contact	Primary	No change
1049	Varicella	Acute	Transfer	No change
Neurological				
1050	Arteriovenous malformation, cerebrovascular accident, transient ischaemic attacks		Consultation	No change
1051	Epilepsy	Controlled	Consultation	Category change (from primary), timing recommendation and a new category to align with PMMRC advice
1052		Poor control or multiple medications	Transfer in first trimester	
NEW		New diagnosis	Transfer as soon as possible	
1053	Multiple sclerosis		Consultation	No change
1054	Myasthenia gravis		Transfer	No change
1055	Spinal cord lesion		Transfer	No change
1056	Muscular dystrophy or myotonic dystrophy		Transfer	No change
Mental health				

Code	Condition	Description	Referral category	Proposed change
1058	Current alcohol or drug misuse/ dependency		Primary	No change: primary care is an appropriate entry point for mental health
NEW	Depression and anxiety disorders		Primary	New condition to separate depression and anxiety from AOD issues
1059	Other mental health condition	Stable and/or on medication eg, bipolar disorder	Consultation	No change
		Complex mental health needs	Consultation	New condition/category
		Acute unstable psychosis	Transfer	No change
Renal disease				
1061	Glomerulonephritis		Transfer	No change
1062	Proteinuria	Chronic	Consultation	No change
1063	Pyleonephritis		Consultation	No change
1064	Renal failure		Transfer	No change
1065	Renal abnormality or vesico-ureteric reflux		Consultation	No change
Respiratory disease				
1066/ 1067	Asthma	Moderate (using reliever more than twice per week)	Primary	Description amendment to clarify when primary care is needed (moderate, not mild)
1068		Severe (continuous or near continuous oral steroids or hospitalisation)	Consultation	Description amendment to clarify severe No change to category as consultation is appropriate
1069	Acute respiratory condition		Primary	No change but COPD added as a new condition
1070	Cystic fibrosis		Transfer	No change
NEW	COPD		Consultation	New condition/category
Transplant				
1080	Organ transplant		Transfer	No change
2000–3000 Previous gynaecological conditions or surgery				
2001	Cervical surgery including cone biopsy, laser excision or large loop excision of the transformation zone (LLETZ)	One LLETZ procedure with known depth excision ≥10 mm without subsequent term vaginal birth Note: previous spontaneous preterm birth requires consultation	Consultation in first trimester	Description amendment to clarify LLETZ risks and timing recommendation
2003	Congenital abnormalities of the uterus	Without previous normal term pregnancy outcome	Consultation in first trimester	Description amendment to clarify risk if no previous normal term outcome and timing recommendation
2007	Previous uterine surgery	Myomectomy	Consultation	No change

Code	Condition	Description	Referral category	Proposed change
2008		Previous uterine perforation	Consultation	No change: ERPOC is already included
2009	Prolapse	Previous surgery	Consultation	No change
2010	Vaginal abnormality	Eg, septum	Consultation	No change
2011	Female genital mutilation		Consultation	No change
3000–4000 Previous maternity history				
3001	Previous placental abruption		Consultation	No change
3002	Alloimmune thrombocytopaenia	As risk to fetus of thrombocytopaenia	Transfer	No change
3003	Caesarean section		Consultation	**There has been a suggestion to reconsider the situations when women require obstetric consultation. What are your views?**
3004	Cervical insufficiency		Transfer in first trimester	Change in condition title to reflect current use and timing recommendation
3005	Trophoblastic disease	Hydatidiform mole or vesicular mole, within last 12 months	Consultation	No change
3008	Hypertensive disease	Gestational hypertension, pre-eclampsia with significant fetal growth restriction (FGR) or requiring delivery < 34 weeks	Consultation before 16 weeks' gestation	Description amendment to align to *Hypertension and pre-eclampsia guidelines* and timing recommendation to enable aspirin prophylaxis
		Previous eclampsia or HELLP	Consultation before 16 weeks' gestation	Timing recommendation to enable aspirin prophylaxis
3010	Fetal growth restriction	Birthweight <5th percentile on population growth chart or <10th percentile if a customised growth chart is used	Consultation before 16 weeks' gestation	No change currently BUT condition definition may change to align with new guidelines on fetal growth when agreed
3011	Manual removal	With adherent placenta, consider previous management of third stage	Consultation	No change
3012	Perinatal death		Consultation	No change
3013	Postpartum haemorrhage	> 1000 mL	Consultation	No change: primary care is not appropriate for PPH; consultation for > 1000 mL blood loss is consistent with *PPH consensus guidelines*
3014	Preterm birth	< 35 weeks	Consultation	No change
3015	Recurrent miscarriage	Three or more	Consultation in the first trimester	Timing recommendation to enable potential complications to be identified early

Code	Condition	Description	Referral category	Proposed change
3016	Shoulder dystocia		Consultation	No change
3017	Termination of pregnancy	Previous complications of termination and or three or more surgical terminations	Consultation in the first trimester	Timing recommendation to enable potential complications to be identified early
3018	SUDI (Sudden unexplained death of an infant)		Primary	No change: SUDI is in the midwifery scope of practice
3019	Fetal congenital abnormality		Consultation	No change
3020	Obstetric anal sphincter injury	3a, 3b and 4th degree tearing with incontinence or flatus	Consultation	Change in condition title to reflect current use, description amendment to better reflect obstetric needs Evidence does not support routine episiotomy
4000–5000 Current pregnancy				
4001	Acute abdominal pain		Consultation as soon as possible	Timing recommendation added
4002	Abdominal trauma		Consultation as soon as possible	Timing recommendation added
4003	Abnormal CTG		Consultation as soon as possible	Timing recommendation added
4004	Antepartum haemorrhage		Consultation as soon as possible	Timing recommendation added No change to category as APH is a spectrum: consultation is appropriate
4005	Blood group antibodies		Consultation	No change
4006	Eclampsia		Emergency	No change: adding HELLP does not add clarity
4007	Fetal abnormality		Consultation	No change: specifying MFM specialist is not consistent as no specific advice on 'who' is used
4008	Gestational proteinuria	2+ protein on random dipstick testing Protein creatinine ratio > 0.3		Description amendment because 24 h proteinuria is no longer used
4009	Gestational hypertension	New onset hypertension after 20 weeks' gestation without signs of pre-eclampsia; systolic BP >140 mmHg or diastolic BP >90 mmHg measured on two or more occasions at least four hours apart	Consultation	Description amendment to align to *Hypertension and pre-eclampsia guidelines* and timing recommendation
4010	Intrauterine death		Transfer	Category change (from consultation)
4011	IUGR/small for gestational age	EFW 10th percentile on customised growth chart, or AC <5th percentile on ultrasound or	Consultation	No change currently BUT condition definition may change to align with new

Code	Condition	Description	Referral category	Proposed change
		discordancy of AC with other growth parameters, normal liquor		guidelines on fetal growth when agreed
4012		EFW < 10th percentile on customised growth chart, or AC < 5th percentile on ultrasound, OR discordancy of AC with other growth parameters, reduced liquor or abnormal umbilical doppler	Transfer	No change currently BUT condition definition may change to align with new guidelines on fetal growth when agreed
4013	Infant large for gestational age	EFW on a customised growth chart >90th percentile, with gestational diabetes	Consultation	Description amendment but should this be 95th percentile?
4015	Malignancy		Transfer	No change
4016	Malpresentation	> 36 weeks; breech, transverse, oblique or unstable lie	Consultation before 36 weeks' gestation	Timing recommendation added No description change as already well covered
4017	Class III obesity	Body mass index (BMI) > 40; may include an anaesthetic consultation	Transfer	Change in condition title to reflect current use No change in description: evidence supports consultation and transfer at these BMI thresholds because of potential risk associated with obesity (eg, pre-eclampsia, gestational diabetes, low Apgar, caesarean birth, etc.)
	Class II obesity	BMI 35-40; may include an anaesthetic consultation	Consultation	
4018	Multiple pregnancy	Twins and higher order multiples	Transfer	No change: LMCs can provide shared care
4019	Oligohydramnios	No pool depth equal or greater than 2 cm	Consultation	Description amended to remove AFI (radiology use). No change in category as consultation is appropriate
4020	Placenta praevia; vasa praevia	At or > 32 weeks	Transfer	No change
4021	Polyhydramnios	Mild (deepest pocket measurement 9-11 cm)	Consultation	Description amended for to provide for milder conditions and category change (from transfer for mild polyhydramnios)
		Moderate (deepest pocket measurement 12-15 cm) or severe (deepest pocket measurement >16 cm)	Transfer	
4022	Pre-eclampsia	New onset hypertension after 20 weeks' gestation (systolic BP >140 mmHg or diastolic BP >90 mmHg measured on two or more occasions at least four hours apart) with one or more of the following: proteinuria > 30 mg/mmol or 2+ protein on dipstick testing confirmed by a	Transfer – as soon as possible	Description amendment to align to *Hypertension and pre-eclampsia guidelines* and timing recommendation

Code	Condition	Description	Referral category	Proposed change
		protein creatinine ratio test, other maternal organ dysfunction (renal, liver, neurological, haematological), or IUGR		
4023	Preterm rupture of membranes	< 37 weeks and not in labour	Transfer	Category change (from consultation)
4024	Prolonged pregnancy	Refer in a timely manner for planned induction by 42 weeks	Consultation	No change
4025	Premature labour	34 – < 37 weeks	Consultation	No change: shared care is provided for
4026		< 34 weeks	Transfer	No change
4027	Pre-labour rupture of membranes at term	Consult before 24 hours	Consultation	No change
4028	Confirmed reduced fetal movements	Following normal cardiotocograph but still concern – may require liquor assessment/ growth assessment	Consultation	No change: shared care is provided for
4029	Herpes genitalis	Active lesions	Consultation	No change
4031	Uterine fibroids	Cervical fibroids, retroplacental fibroids, submucosal or intramural fibroids >5 cm, multiple fibroids	Consultation	Description amendment to clarify which fibroids need obstetric review
4032	Urinary tract infection (UTI)	Recurrent	Consultation	No change
4033	Influenza-like illness		Primary	No change
NEW	Contraceptive device in-situ	Includes both intrauterine devices/systems and implants	Consultation in first trimester	New condition/category
NEW	Quarantinable infectious diseases	See Schedule 1 of the Health Act 1956, includes COVID-19	Primary	New condition/category
NEW	Parvovirus B19 infection		Consultation	New condition/category
NEW	Polycystic kidneys	Maternal not fetal finding	Consultation	New condition/category
NEW	Velamentous cord insertion		Consultation	New condition/category
NEW	Thromboembolism	Deep vein thrombosis, pulmonary embolism	Emergency	New condition/category
5000–6000 Labour and birth – first and second stage				
5001	Amniotic fluid embolism		Emergency	No change
5002	Anhydramnios		Transfer	No change
5003	Cerebral anoxia/cardiac arrest		Emergency	No change
5004	Complications of anaesthetic		Consultation	No change
5005	Complications of other analgesia		Consultation	No change
5006	Malpresentation	Compound presentation	Transfer	No change: malposition is covered in 5008/5021

Code	Condition	Description	Referral category	Proposed change
		Breech diagnosed in labour	Consultation	No change
5007	Cord prolapse or presentation		Emergency	No change
5008	Deep transverse arrest		Transfer	No change
5009	Epidural		Consultation	No change: does not need transfer of clinical responsibility
5010	Instrumental vaginal delivery		Transfer	Title change to reflect that instrumental birth is transferred
5011	Fetal heart rate abnormalities		Consultation	No change: advice on non-reassuring FHR is provided in other guidance
5012	Hypertonic uterus		Consultation	No change
5013	Induction of labour		Consultation	No change
5016	Intrapartum haemorrhage		Transfer	No change
5017	Maternal tachycardia	Sustained	Consultation	No change
5018	Meconium liquor	Moderate or thick	Consultation	No change: meconium is a flag to assess fetal wellbeing not for transfer
5019	Obstetric shock		Emergency	No change
5020	Obstructed labour		Transfer	No change
5021	Prolonged first stage of labour	< 2 cm in 4 hours for nullipara. Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions.	Consultation	Description amendment to improve clarity
5023	Prolonged active second stage of labour	> 2 hours of active pushing with no progress for nullipara or > 1 hour of active pushing with no progress for multipara	Consultation	No change: prolonged second state of labour can signal issues
5024	Pyrexia in labour	> 38 degrees with or without fetal tachycardia	Consultation	No change: 38^0 aligns to HQSC guidance on sepsis
5025	Shoulder dystocia		Emergency	No change
5026	Uterine inversion		Emergency	No change
5027	Labour requiring oxytocin augmentation		Consultation	No change: clinical guidance, not practice issues Change in condition title to non-brand drug
6000–7000 Labour and birth – third stage				
6001	3rd and 4th degree lacerations		Transfer	No change
6002	Cervical laceration		Transfer	No change

Code	Condition	Description	Referral category	Proposed change
6003	Postpartum haemorrhage (PPH)	> 500 mL of blood loss with ongoing losses	Consultation	No change: >500mL blood loss is consistent with *PPH consensus guidelines*
		Ongoing uncontrolled bleeding	Emergency	Description and category amended
6004	Retained placenta		Transfer	No change
6005	Shock		Emergency	No change
6006	Vaginal laceration	Complex	Consultation	No change
6007	Vulval and perineal haematoma		Transfer	No change
7000–8000 Services following birth – woman				
7001	Breast infection	Suspected abscess or not settling with antibiotics	Consultation	No change: within midwifery scope of practice
7002	Neonatal death	Discussion and plan	Consultation	No change
7003	Post-birth neurological deficit	For example, neuropraxia	Consultation	No change
7004	Postnatal depression		Primary	No change: mental health issues are addressed in primary care
7005	Postnatal psychiatric event	Including bipolar, psychosis	Transfer	Change in condition title to clarify that this is for acute presentation, category change (from consultation)
7006	Sepsis		Transfer	Change in condition title to reflect current use No change to category as transfer is appropriate
7007	Pyrexia of unknown origin		Consultation	No change to category: consultation is appropriate Description amended as can be pyrexic without rigours
7008	Secondary PPH		Consultation – as soon as possible	Timing recommendation added
NEW	Vaginal or perianal prolapse		Consultation	New condition/category
8000–9000 Services following birth – baby				
General				
8001	Abnormal neonatal examination	Minor abnormalities not specified elsewhere	Primary	No change: primary care is appropriate
8002	Fetal ultrasound abnormality	Any	Consultation	No change
8003	Congenital anomaly	Conditions that may require early treatment	Consultation	No change
NEW	Abnormal red eye reflex		Consultation	New condition/category
Cardiovascular				

Code	Condition	Description	Referral category	Proposed change
8004	Heart murmur, no symptoms		Consultation	No change
8005	Heart murmur with symptoms		Transfer	No change
8006	Persistent or recurrent cyanosis		Transfer	No change
CNS				
8007	Microcephaly	Occipitofrontal head circumference < 3rd percentile	Consultation	Clarification to align to *Newborn Network Clinical Guidelines*
8008	Convulsions or unresponsiveness		Emergency	No change
8009	Excessive irritability		Consultation	No change: consultation is appropriate
8010	Limpness, hypotonic	With abnormal vital signs or other abnormality	Emergency	Description amended and category changed to better focus on babies needing emergency care
8011	Severe infant depression at birth	eg, Apgar score of 6 or less at one minute with little improvement by 10 minutes	Emergency	No change but definition (<7) more clearly worded.
Growth and feeding				
8013	Sustained feeding difficulties in a newborn not related to gestational age		Consultation	No change
8014	Dehydration or > 10 - 12.5% weight loss since birth		Consultation	Description amended to align with *NZ Newborn Clinical Network* guidance
8015	Persistent vomiting without blood or bile		Consultation	No change: consultation is appropriate
8016	Fetal growth restriction	Birthweight < 5th percentile	Consultation	Change in condition title and definition to reflect current use
8017	Low birthweight	Birthweight 2000–2500 g	Consultation	No change
8018		Birthweight < 2000 g	Transfer	No change
8019	Poor weight gain	Birthweight not regained by 14 days	Consultation	No change: babies should regain birth weight by day 14
8021	Preterm	Gestation >35 – <37 weeks	Consultation	No change
8022		Gestation < 35 weeks	Transfer	No change
Gastrointestinal				
8023	Suspected oesophageal atresia	Unable to pass a gastric tube in a mucousy baby	Transfer	No change
8024	Abdominal distension or mass		Consultation	No change
8025	Persistent or bile-stained vomiting or persistent fresh blood in stools		Consultation – as soon as possible	Timing recommendation added
8026	No passage of meconium by 36 hours		Consultation	No change

Code	Condition	Description	Referral category	Proposed change
8027	Inguinal hernia		Consultation	No change
Genitourinary				
8028	Failure to pass urine in the first 36-hour period		Consultation	No change
8029	Hypospadias or foreskin abnormality		Consultation	No change: consultation is appropriate
8030	Undescended testes		Primary	No change: primary is appropriate
NEW	Antenatal genitorenal renal dilation	Anterior-posterior renal pelvic diameter (AP RPD) < 15 mm with no peripheral dilatation or additional findings	Primary	New condition/category
		AP RPD ≥15 mm or with no peripheral dilatation or additional findings OR AP RPD <15 mm with peripheral dilatation	Consultation	
		AP RPD ≥15 mm with peripheral dilatation or additional findings or any AR RPD with additional findings	Transfer	
NEW	Ambiguous genitalia		Transfer	New condition/category
Haematology				
8031	Evidence of a bleeding tendency	Haematemesis, melaena, haematuria, purpura, generalised petechiae	Transfer	No change
8032	Haemorrhage from cord or other site		Transfer	No change
8033	Maternal isoimmunisation	Rhesus or other antibodies. Refer prior to delivery	Transfer	No change
8034	Maternal thrombocytopaenia		Consultation	No change
NEW	Neonatal subgaleal haemorrhage		Transfer	New condition/category
Infection				
8036	Suspected chorio-amnionitis	Fetal tachycardia, maternal pyrexia, offensive liquor	Consultation – as soon as possible	Timing recommendation added
8037	Temperature instability	Temp < 36.5°C or > 37.5°C confirmed within one hour following appropriate management	Consultation – as soon as possible	Timing recommendation added
Jaundice				
8038	Any in first 24 hours		Transfer	No change: transcutaneous measurements are not used for screening not diagnostic purposes
8039	Bilirubin > 250 mmol/L in first 48 hours		Consultation	
8040	Bilirubin > 300 mmol/L at any time		Consultation	
8041	Prolonged jaundice: visible or > 150 mmol/L from 2 weeks in term infant and 3 weeks in preterm infant		Consultation	Change in condition title to reflect current use

Code	Condition	Description	Referral category	Proposed change
8042	Significant jaundice in previous infant		Consultation	No changes: confirmed red cell antibodies are not needed to consult
Maternal factors				
8043	Infant of a woman with history of substance or alcohol misuse/ dependence in this pregnancy	Eg, methadone, marijuana, alcohol, codeine, valium, methamphetamines	Consultation	No change
8044	Infant of woman with diabetes	Hypoglycaemia	Transfer	Description amended
8045		Apparently normal infant or with abnormal findings other than hypoglycaemia	Consultation	Description amended
8046	Intrauterine infection	Toxoplasmosis, rubella, cytomegalovirus (CMV), other. Referral before delivery often appropriate	Consultation	No change
8048	Maternal medication with risk to baby	Eg, carbimazole, antipsychotics, antidepressants, anticonvulsants	Primary	No change: few medications are contraindicated for breast-feeding
8049	Maternal/family history with risk factors for baby	Eg, vesico-ureteric reflux, bleeding disorder, congenital heart disease, deafness, Graves' disease, syphilis, severe handicap in parent, bipolar disease, schizophrenia, other psychiatric condition	Consultation	No change
Orthopaedics				
8051	Congenital hip problem	Unstable hips, breech delivery, family history of dislocated hips	Consultation	No change
8052	Congenital foot problem	Talipes equinovarus or significant positional foot deformity	Consultation	No change
Respiratory				
8053	Respiratory distress	Any cyanosis, persistent grunting, pallor	Transfer	No change: transfer is sufficient
8054	Apnoea	Baby has stopped breathing and does not start again spontaneously	Emergency	Description amended and category changed (from transfer)
8055	Persistent tachypnoea	With respiratory rate greater than 60/min for greater than 1 hour from birth	Consultation – as soon as possible	Timing recommendation added
8056	Stridor, nasal obstruction, or respiratory symptoms not specified elsewhere		Consultation – as soon as possible	Timing recommendation added
8057	Birth injury		Consultation	No change
8058	Absent femoral pulses		Emergency	New condition/category

Definitions

Consultation	The process by which, in communication with the woman, the referrer seeks an assessment, opinion and advice about the woman and/or her baby from a secondary/tertiary care specialist, by way of a referral. A consultation may or may not result in transfer of clinical responsibility for care. Consultations may involve the woman and/or baby being seen by the other health practitioner; however, a discussion between health practitioners is often appropriate on its own. Consultation can take place in person, by telephone, videoconference, email or by other means as appropriate in the situation.
Emergency transport	The physical transport of a woman and/or baby by air or road ambulance in an emergency.
Family planning practitioner	A health practitioner who is registered with the Medical Council of New Zealand (established by the Health Practitioners Competence Assurance Act 2003) in the vocational scope of practice of family planning and reproductive health and holds an annual practising certificate.
Hospital team	The hospital team includes midwives, obstetricians, neonatologists, anaesthetists, and others. These secondary or tertiary maternity team members work collaboratively together, and with the LMC, to achieve the best health outcome for the woman and her baby.
Lead Maternity Carer (LMC)	A person who is a midwife, obstetrician or a GP with a Diploma in Obstetrics, a Diploma in Obstetrics and Medical Gynaecology (or equivalent, as determined by the New Zealand College of General Practitioners), and who is either a maternity care provider or is an employee of or contractor to a maternity care provider, and who has been selected by the woman to provide her lead maternity care.
Maternity care provider	Maternity care provider is the term used to encompasses all health practitioners who provide maternity care at the time an offer of consultation or transfer of clinical responsibility for are becomes relevant. For example, a maternity care provider may be a GP, employed community midwife, obstetrician, or family planning practitioner.
Primary maternity facility	A community-based birthing unit, usually staffed by midwives. Primary maternity services provide access for women assessed as being at low risk of complications for labour and birth care. They do not provide specialist services.
Primary care provider	A health care provider who works in the community and who is not a specialist for the purposes of the *Referral Guidelines*. This provider may be a GP, nurse practitioner, midwife, physiotherapist or lactation consultant, or a smoking cessation service, drug and alcohol service, nutrition service, or maternal mental health service.
Referral	The process by which one health practitioner (usually the LMC) seeks consultation with or transfer of clinical responsibility for care to another appropriate health practitioner, for a condition affecting the woman and/or the baby.
Specialist	A medical practitioner who is registered with a vocational scope of practice in the register of medical practitioners maintained by the Medical Council of New Zealand and who holds a current annual practising certificate. For the purposes of the *Referral Guidelines*, the definition of 'specialist' excludes GPs because GPs are covered by the primary referral process. The term ‘specialist’ refers to a person or their delegate, not a service or a team.

Secondary maternity service	A secondary maternity service provides the services specified in the service specification for secondary and tertiary maternity services available from the National Service Framework Library (click link).
Tertiary maternity service	A tertiary maternity service provides the services specified in the service specification for secondary and tertiary maternity services available from the National Service Framework Library (click link).
Transfer of clinical responsibility for care	The transfer of clinical responsibility for care from the LMC to a specialist. Responsibility for care may be transferred back to the LMC if appropriate. In obstetric emergencies, transfer of clinical responsibility will be to the most appropriate available practitioner.

Further advice on Te Tiriti

Health practitioners may find support from their professional association to be helpful in terms of giving effect to the principles of Te Tiriti. This may include the following:

- Medical Council of New Zealand: Statement on cultural safety
- Medical Council of New Zealand: He Ara Hauora Māori: A Pathway to Māori Health Equity
- Midwifery Council of New Zealand: Statement on Cultural Competence for Midwives
- Turanga Kaupapa: principles that give life and meaning to the midwifery profession's recognition of Māori as Tangata Whenua and the profession's obligations under Te Tiriti. See Midwives' Handbook for Practice
- The Royal Australasian College of Physicians: Guideline commentary on consulting with Māori and their whānau.

Health practitioners may also value familiarisation with the following:

- Māuri Ora Associates: Best health outcomes for Māori: Practice implications
- New Zealand Medical Association: Improving Māori health through clinical assessment: Waikare o te Waka o Meihana
- University of Otago MIHI 501 Health Professionals Course: Application of Hui Process and Meihana Model to Clinical Practice.

Cultural safety

Practicing in a culturally safe way is important and a requirement of Te Tiriti, particularly the principles of *Active Protection*, *Options*, and *Partnership*. It is important that health practitioners know that tikanga or correct protocols and practices are often specific to whānau, hapū and iwi. Tikanga is not a 'one size fits all'. Similarly, mātauranga Māori (Māori knowledge) is not a single entity; rather there is traditional and contemporary mātauranga Māori, and mātauranga Māori that is specific to hapū and iwi environments that include land, seas, waterways, weather systems, the stars, flora and fauna, and things seen and unseen. Older forms of mātauranga Māori have been somewhat protected from colonisation by virtue of having been composed or narrated in te reo Māori.

Rangatiratanga or self-determining rights over tikanga and mātauranga Māori is crucial to its safety and survival. For this reason, health practitioners should be very careful not impose their understanding of tikanga or mātauranga Māori onto Māori through maternity care. Nor should they assume that all Māori are familiar with terms such as tikanga, mātauranga and Te Tiriti. Unfamiliarity with such terms can be experienced by Māori as a diminishment of their mana[4] as expressed by Te Tiriti; an outcome that is antithetical to Te Tiriti, the *Referral Guidelines*, and the Standards: Ngā Paerewa.

[4] Ministry of Health (2020). *Whakamaua: Tiriti o Waitangi framework*. Wellington: Ministry of Health