

Scottish Perinatal Network Transport Group

Pathway for Urgent Unscheduled Transfers from Community Maternity Units to a Consultant Led Unit

DOCUMENT CONTROL SHEET

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1.0	Feb 2026	Original version	

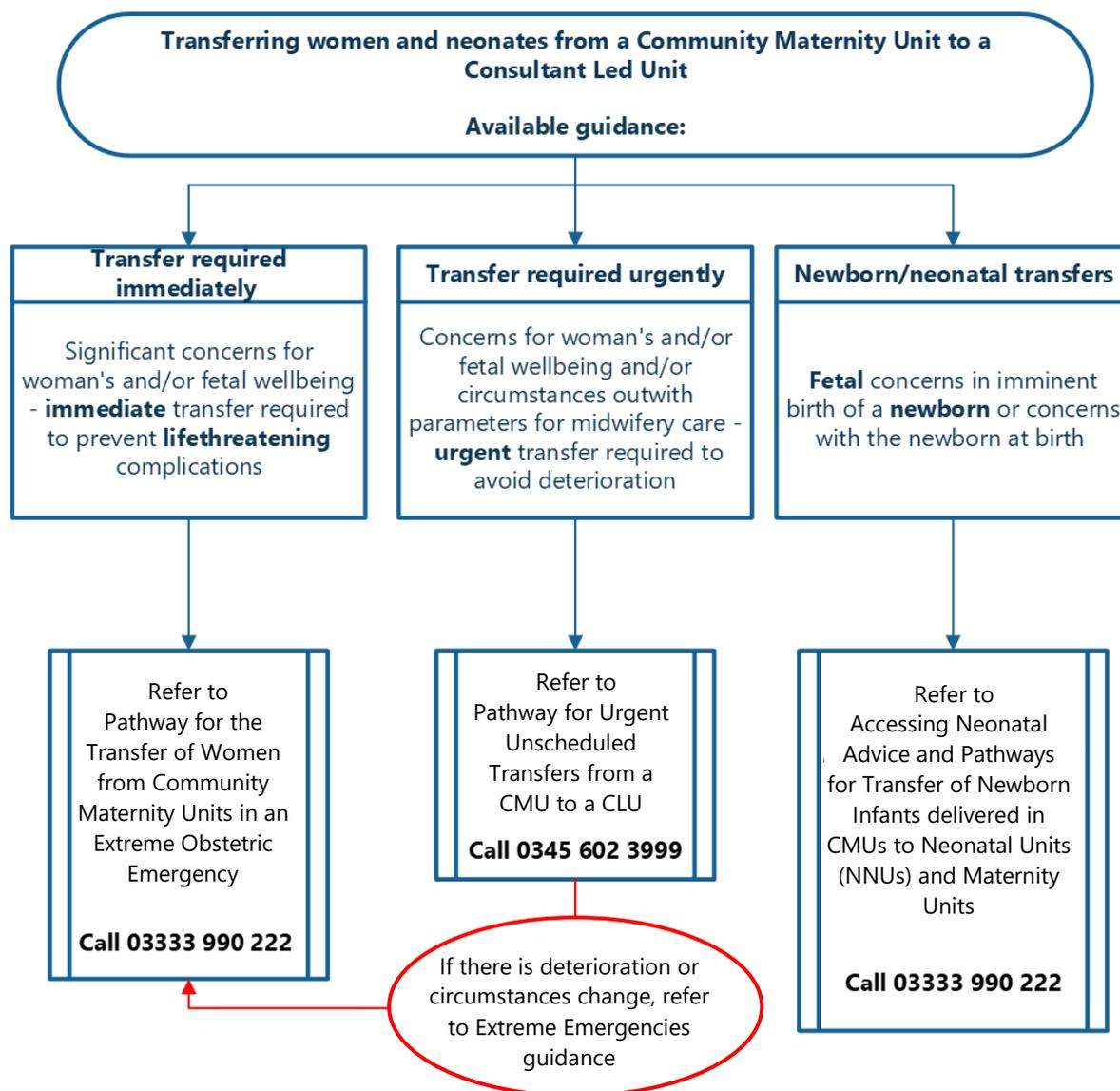
Disclaimer

The recommendations in this guideline represent the view of the National Neonatal Network Transport Group, arrived at after careful consideration of the evidence available. When exercising their clinical judgement, healthcare professionals are expected to take this guidance fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to follow the guideline recommendations and it remains the responsibility of the healthcare professional to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

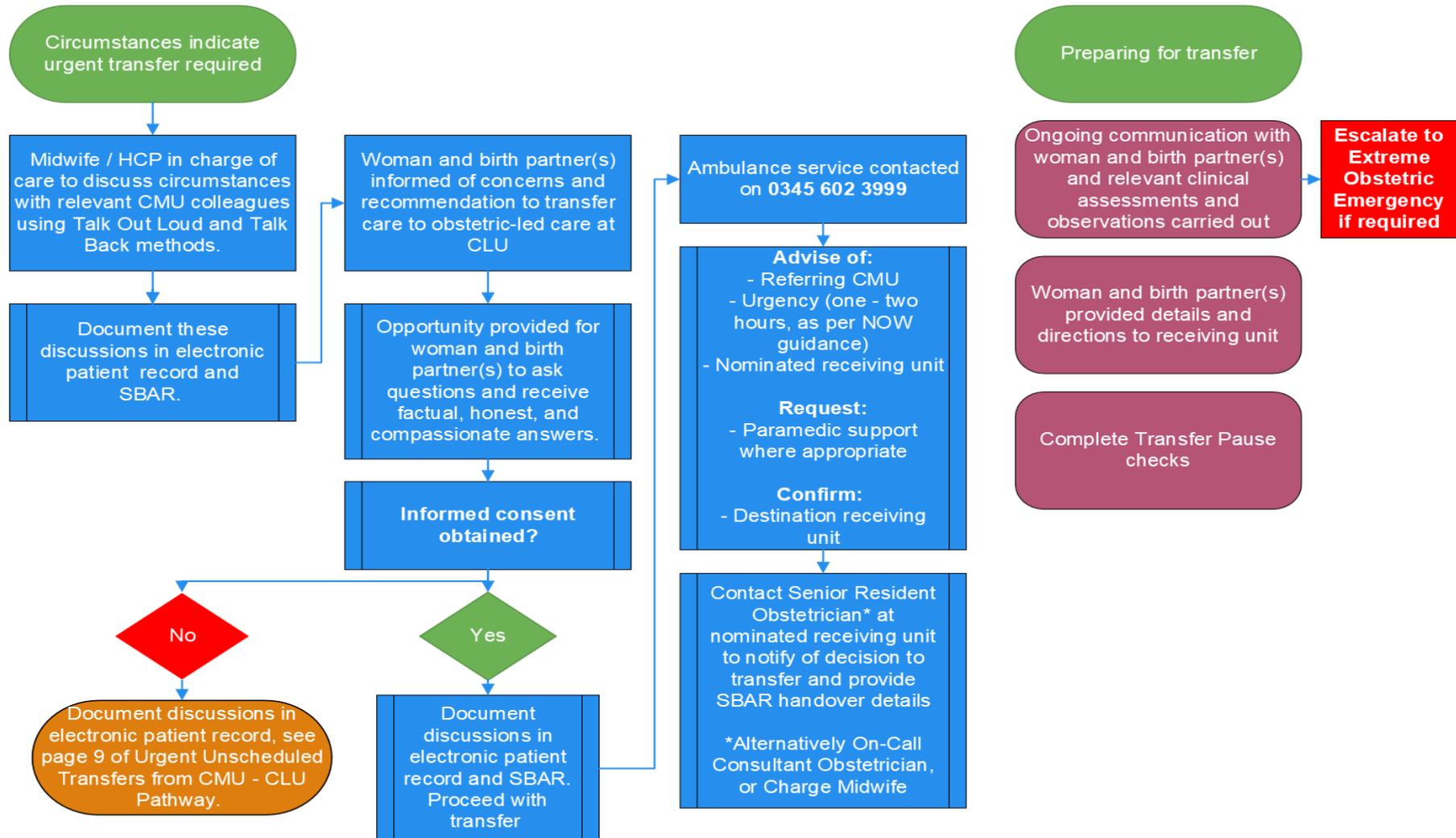
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CHOOSING THE CORRECT GUIDANCE



PROCESS MAP



PURPOSE

Safe, timely and urgent transfer from a Community Midwifery Unit (CMU) to obstetric care requires effective interdisciplinary working and communication within and between the units. NICE guidance on Intrapartum Care indicates that transfer of care of women in labour should be carried out "as soon as possible after the decision to transfer has been made" and recommends categorising the transfer as either "life-threatening emergency" or "urgent".

The purpose of this document is to provide an easy-to-use pathway for the care of women where **urgent** transfer to a CLU is indicated, antenatally, in labour, or postnatally. The pathway relies on a full ongoing clinical assessment of maternal and fetal status by healthcare professionals (HCPs) in the referring unit (including vaginal examination and cervical assessment if necessary and will add important information to the decision-making process).

CLINICAL SITUATIONS NOT IN SCOPE OF THIS PATHWAY

- Transfers from a home birth to a CLU
- Transfer for perinatal mental health concerns
- Transfer for life-threatening concerns, or concerns specifically relating to a neonate, please refer to the "Choosing the Correct Guidance" flowchart above.

CLINICAL SITUATIONS IN SCOPE OF THIS PATHWAY

Examples of when urgent transfer from a CMU to a CLU may become indicated are listed below. This is **not an exhaustive or exclusive list**. Other medical conditions or issues the midwife assesses as requiring urgent obstetric review, or where the required care exceeds what the CMU can provide (e.g. maternal request for analgesia or clinical recommendation following postnatal trauma) can also factor in the decision-making process.

- Preterm rupture of membranes
- Any concern with fetal heart rate on IA that requires CEFM
- Suspected malpresentation in labour
- Delayed progress in 1st stage of labour
- Abnormal maternal observations (including pyrexia, tachycardia and hypertension) during any stage (antenatal, intrapartum, postnatal)
- Antepartum haemorrhage with normal maternal and fetal observations and no active or continuing bleeding
- Any meconium-stained liquor
- Retained placenta
- Postpartum haemorrhage <1500mls with no ongoing bleeding and normal maternal observations

- Third-or-fourth-degree perineal tear with no ongoing, significant bleeding

CLINICAL PATHWAYS OF CARE FOR WOMEN DEVELOPING COMPLICATIONS IN MIDWIFE-LED SETTINGS

Transfer of care refers to the transfer between midwifery-led care and obstetric-led care. Urgency will depend on the **context** and **situation**. As part of full clinical assessment, the CMU midwife/HCP should:

- Consider situational factors such as
 - Distance to the receiving unit
 - Likely journey time
 - Weather conditions
 - Available transport options
 - CMU facilities (e.g., staff, skills, equipment) to manage deterioration
- Use appropriate guidance and clinical judgement to assess and decide
 - Whether to transfer care (may involve discussion with receiving unit)
 - Whether the transfer of care should involve the Scottish Ambulance Service (SAS) or be by private vehicle
 - Level of urgency
- Provide care, advice and support while transfer arrangements are made.
- Commence MEWS while awaiting transfer if the woman is no longer suitable for midwifery led care
- Do not delay transfer to undertake CTG

The clinical assessment and decision of the midwife/HCP in the CMU should be respected and ultimately overrides the opinion of all other professionals/agencies and all other assessment tools.

CMU MIDWIFE/HCP COMMUNICATION WITH THE WOMAN AND HER BIRTH PARTNER:

This is a continuation of discussions earlier in pregnancy about the need to present early with any concerns and to consider possible logistics should changes to the birth plan be required.

- Women and their birth partner(s) should be informed as soon as any concerns arise.

- Women and their birth partner(s) should be given appropriate information, advice, and time to discuss the identified development of a complication.
- Opportunity should be given for women and their birth partner(s) to ask questions and receive factual, honest and compassionate answers.
- Discuss and obtain informed consent as appropriate

Birth Partners should be given:

- Clear directions to the receiving unit(s) and appropriate department(s)- postcodes should be provided for Sat Nav
- Details of car parking and visiting arrangements
- If birth partner(s) intend to follow the ambulance, clear instruction should be given to drive in adherence with speed limit and road conditions, and not to attempt to keep pace with the ambulance. Birth partner(s) could consider asking someone to drive them if they are not in a condition to drive themselves

CMU MIDWIFE/HCP COMMUNICATION WITHIN THE CMU

- Talk Out Loud: As soon as a concern has been identified the midwife in charge of care should discuss with a midwife colleague on shift or on-call and document the discussion and decision on the electronic record
- SBAR: The midwife should complete in full a SBAR note prior to discussing transfer with obstetric colleagues at the receiving unit
- Talk back: To ensure the clinical situation has been understood correctly (by colleague) This should be documented in the electronic record along with the outcome of the discussion

CMU MIDWIFE/HCP TELEPHONE CALLS WITH:

- Ambulance service on 0345 602 3999: giving details of where the woman is to be transferred to (ensuring the correct Consultant Led Unit is repeated). Where appropriate an ambulance with paramedic support should be requested
- Senior Resident Obstetrician: advising of the decision to transfer and giving SBAR handover details. If Senior Resident Obstetrician is not available, the on-call Consultant Obstetrician should be contacted
- Charge Midwife: If it is not possible to speak to the Senior Resident Obstetrician or the on-call Consultant Obstetrician, advise the Charge Midwife of the decision to transfer and give full SBAR handover details. The transfer process should continue as planned and should not be delayed waiting for a call back from an obstetrician as this can take place en route

The Senior Resident Obstetrician / On-call Consultant Obstetrician / Charge Midwife receiving handover details from this call should alert other relevant healthcare professionals (e.g. anaesthetic and neonatal) at the receiving unit of the incoming transfer as required.

CMU MIDWIFE/HCP DOCUMENTATION:

- Complete documentation on the electronic system including:
 - SBAR handover note discussion with Obstetric Registrar or Charge Midwife
 - Fluid balance, PVC bundle and MEWS
 - Information given to the woman
 - Any updates to the woman's recorded preferences/care requests and/or concerns relating to the new circumstances. This will help ensure her choices and decisions are respected and supported through transfer and handover of care

MIDWIFE ESCORT

Women transferred while in established labour or immediately following birth (including for perineal repair) should be escorted by the CMU Midwife/HCP who has provided her care where possible and appropriate, **unless this would exceed safe working hours**.

COMPLETE THE TRANSFER PAUSE PRIOR TO DEPARTURE

The purpose of the transfer pause is a brief final check to ensure all are agreed of purpose, roles and responsibilities and safe to go. See appendix 1.

During transfer the Midwife Escort should:

- Ensure their own safety by remaining seated and wearing a seat belt when the ambulance is moving.
- Alert Senior Resident Obstetrician if there is any noted deterioration en route.
- Judge whether spontaneous birth is imminent and if so:
 - Request that the ambulance stops in a safe place
 - Prepare the woman for birth
 - Prepare a paramedic to assist with the resuscitation of the baby
 - Continue the journey as soon as the mother and baby are stable
 - Alert Obstetric registrar and / or Charge Midwife in the receiving unit

In the case of air ambulance transfers, where a stop during the journey is not possible, both the midwife escort and the aircrew should be adequately prepared to deal with an emergency in flight. A thorough risk assessment involving maternity and air ambulance staff needs to be undertaken prior to any air transfer.

On arrival at the receiving unit, once the ambulance is stationary, the Midwife Escort should:

- Introduce the woman to receiving midwife and orient to the new unit as appropriate
- Review SBAR/transfer pause and relevant documentation and handover care to receiving midwife in the presence of and with contribution from the woman (and partner if present)
- Fully review birth preferences with receiving midwife and woman, explain and discuss any changes and agree a revised plan of care
- Ensure SBAR handover note is signed by referring and receiving team/staff

FOLLOW-UP

All women transferred intrapartum or postnatally from a CMU to a CLU should be offered an opportunity to review events with their primary midwife, who can signpost and refer to further support or services as required, e.g. perinatal mental health, Birth Reflections Clinic, in line with local systems and processes.

CARE OF WOMEN WITH COMPLICATIONS WHO DECLINE TRANSFER TO AN OBSTETRIC UNIT

Although this guidance recommends that women with complications should be transferred to an obstetric unit to receive appropriate care from the wider multidisciplinary team, some women may decline the transfer against clinical advice.

Where women make competent and informed choices not to transfer, they have a right to do so and should not be judged. Midwives must continue to:

- Provide the best care possible in partnership with the woman
- Clearly document any discussions with the woman in the electronic record
- Maintain contact with the Senior Resident Obstetrician at referral unit regarding the ongoing plan of care
- Agree and document an appropriate plan for care with the woman, including strategies for managing any further complications that may arise during birth
- Make the woman aware she can consent to transfer to an obstetric unit at any time

APPENDIX 1 – TRANSFER PAUSE

Affix Patient Label Here

Referring Unit:
Date of Transfer:
Receiving Unit & Ward:

Transfer Pause - to be completed prior to escorting the woman to the ambulance for transfer to ensure woman, ambulance staff and midwife all in agreement re: plan		Circle / document answer
Transfer of woman still required and agreed by Midwife, transport professionals and woman		<input type="checkbox"/>
Pre-transfer clinical assessment completed		<input type="checkbox"/>
Has clinical assessment changed?		<input type="checkbox"/>
Response level agreed still appropriate?		Yes / No
	"NOW" (for extreme obstetric emergency)	<input type="checkbox"/>
	"NOW" – One – 2 Hours (for urgent unscheduled transfer)	<input type="checkbox"/>
	"NOW" - Within 4 Hours	<input type="checkbox"/>
Receiving unit informed & SBAR note commenced		Time:
Summarise Woman's Clinical Status		Stable / Unstable
Woman dressed appropriately, wrist band on, sufficiently covered for transfer		<input type="checkbox"/>
Woman has her bag / belongings		<input type="checkbox"/>
Mode of transfer to ambulance agreed:		
	Walking	<input type="checkbox"/>
	Wheelchair	<input type="checkbox"/>
	Trolley	<input type="checkbox"/>
Have you verbalised and confirmed current SBAR to the woman & partner, ambulance crew and agreed.		Time:
Equipment / extras checklist:		
	Documentation	<input type="checkbox"/>
	Bloods (if required)	<input type="checkbox"/>
	M/W Transfer Bag & drugs	<input type="checkbox"/>
	Bottled water	<input type="checkbox"/>
	Midwife mode of transfer home arranged/considered	<input type="checkbox"/>
HCP and ambulance crew agree roles and responsibilities during transfer		Yes / No
Agree safe positioning of midwife during transfer		<input type="checkbox"/>
Agree plan for assessment and monitoring en route		
Receiving unit informed of change in circumstances en route (if applicable)		Time:
Time of departure		Time:
Time of arrival & handover		Time:

APPENDIX 2 – NOMINATED RECEIVING UNITS

Each CMU in Scotland will have a nominated receiving unit.

For pre-term births (usually $\geq 22+0$ and < 27 weeks for single, and $\geq 22+0$ and < 28 weeks for multiple, pregnancies), transferring the woman to a maternity unit with co-located neonatal intensive care unit (NICU) facilities should be considered, rather than the nominated receiving unit, provided transport there does not compromise maternal life and health.

CMU	Nominated Receiving Unit:	Nominated Receiving Unit for pre-term births:
Barra Benbecula Campbeltown Dunoon Inverclyde Islay Jura Lochgilphead Oban Rothesay (Isle of Bute) Smaller West Coast Islands Tiree Vale of Leven Western Isles	Paisley Maternity Unit – Royal Alexandra Hospital (PA2 9PN) <i>Note: In some circumstances, Western Isles Hospital, Stornoway, could receive transfers from Barra or Benbecula if time does not allow transfer to a mainland centre.</i>	Queen Elizabeth University Hospital (G51 4TF)
Arran	Ayrshire Maternity Unit – University Hospital Crosshouse (KA2 0BE)	Queen Elizabeth University Hospital (G51 4TF)
Inverurie Orkney Peterhead Shetland	Aberdeen Maternity Hospital (AB25 2ZL)	Aberdeen Maternity Hospital (AB25 2ZL)
Arbroath Perth	Ninewells Hospital (DD21UB)	Ninewells Hospital (DD21UB)
Fort William Skye Wick Elgin	Raigmore Hospital (IV2 3UJ)	Aberdeen Maternity Hospital (AB25 2ZL) or Queen Elizabeth University Hospital (G51 4TF)

DEVELOPMENT GROUP MEMBERSHIP

Name	Role/Title	Health board
Lynsey Callaghan	Professional Lead for Midwifery and Child Health	NHS Highland
Hilary Conetta	Consultant Neonatologist	NHS GGC
Sharon Copland	Senior Charge Midwife for Integrated Care	NHS Ayrshire & Arran
Diane Cunningham	Community Midwife	NHS Ayrshire & Arran
Catriona Davis	General Practitioner	NHS Highland
Tara Fairley	Consultant Obstetrician	NHS Grampian
Victoria Flanagan	Consultant Obstetrician, Clyde	NHS GGC
Lauren Flett	Midwife Sonographer	NHS Orkney
Laura Flynn	Lead Midwife, Clyde	NHS GGC
Adam Gordon	Consultant Obstetrician	NHS Orkney
Sharon Graham	Staff Midwife	NHS Highland
Nicola Harper	Clinical Midwifery Manager	NHS Dumfries & Galloway
Jane Henderson	Senior Charge Midwife	NHS Ayrshire & Arran
Allan Jackson	Consultant Neonatologist	NHS GGC / CL ScotSTAR
Jaki Lambert, Chair	Director for Scotland	Royal College of Midwives
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Lesley McArthur	Senior Charge Midwife	NHS Highland
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Laura Menzies	Lead Midwife	NHS Highland
Andrew Moir	Head of Service, Air Ambulance Division	Scottish Ambulance Service
Charlotte Morbey	Clinical Risk Midwife	NHS Highland
Shuhbro Mullick	Consultant Paediatrician	NHS Western Isles
Julie Murphy	Consultant	NHS GGC
Rebecca Northridge	Consultant Obstetrician	NHS Tayside
Jane Raitt	Midwife	NHS Grampian
Asha Shetty	Consultant Obstetrician	NHS Grampian
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Kirstin Silf	Consultant Obstetrician	NHS Ayrshire & Arran
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Darren Thomas	Consultant Obstetrician	NHS Highland
Gillian Valentine	Associate Director of Midwifery	NHS Highland

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