Joint RCOG & RCM Statement - Planning for Winter 2020/21: reducing the impact of COVID-19 on maternity services in the UK

Key principles for ongoing service planning

- It is essential that maternity service staff, including midwives, maternity support workers, students, trainees and junior medical staff, are not redeployed to other areas of the hospital outside of maternity care in the event of further peak(s) in infection rates. This is required to maintain the safe provision of care to women and their babies throughout the winter.
- Health service leads should recognise the impact of current challenges and pressures on staff in maternity services and provide appropriate ongoing support for wellbeing.
- The NICE-recommended schedules of antenatal[1] and postnatal[2] care should be offered in full wherever possible. These appointments should be offered in-person as far as possible, with particular attention to those from BAME communities or those living with medical, social or psychological conditions that make them higher risk.
- Screening for diabetes in pregnancy should continue to be provided following NICE guidelines,[3] where safe and possible to do so. Alternative screening methods (as recommend by RCOG COVID-19 guidance on modifications to maternal medicine services) should only be offered where locally high prevalence of COVID-19 means that this strategy is safer for women, considering that this may result in reduced detection of the most mild cases of GDM.[4–6]
- Open access for pregnant women to day assessment and triage services should be maintained. Maternity staff should actively encourage women to call for advice if they have concerns about their or their baby's wellbeing and attend if advised to do so.
- Continuity of carer should be maintained where possible, particularly where this is offered to women from vulnerable groups who may also be at greater risk from COVID-19.
- All places of birth, including midwifery-led units and support for birth at home, should be maintained as far as possible in the context of local staffing and service capacity.
- The involvement of a birth partner or other supportive adult should be encouraged where possible in the antenatal and postnatal period; this may vary from unit to unit, dependent on local context including staffing and the local coronavirus alert level. Women should be able to have a chosen birth partner accompany them throughout labour and birth.
- Maternity services should continue to participate in studies and programmes that provide immediate and urgent feedback, including MBRRACE and UKOSS.
- Maternity services should work in partnership with local service user voice groups such as Maternity Voices Partnerships/Maternity Services Liaison Committees when planning service provision during the pandemic.

1. Introduction

In the first wave of the COVID-19 pandemic maternity services and staff, including midwives, obstetricians, maternity support workers, student midwives and trainees, neonatal teams, theatre teams, anaesthetists, sonographers, receptionists, cleaners, clinical and support colleagues and service user groups worked together to ensure the safe ongoing provision of maternity care while reducing transmission to women, their babies and families and maternity staff. This was a huge effort, including the rapid adoption of many changes to the way maternity services work.

To facilitate this the RCOG and RCM, together with partners from the NHS, other Royal Colleges, and service user and professional stakeholders, produced a suite of guidance and other documents which detailed modifications to maternity care to be considered by NHS Trusts and Health Boards during the pandemic.

These modifications were intended to reduce transmission risk and adapt to significant pressures placed on maternity services including staff shortages. Modifications included temporary reduction of in-person appointments, the increased adoption of virtual appointments, and consideration of a reduction in birthplace options; these were widely adopted.[7,8]

We now know more about both COVID-19 and its impact on pregnant women, and the way in which maternity services function during a pandemic. While most current research indicates that pregnant women appear to be at no greater risk of severe illness from COVID-19 than non-pregnant women, there may be an increased risk of pregnant women requiring admission to intensive care. As with non-pregnant individuals, women from Black, Asian and minority ethnic groups, those who have a raised body mass index, or those who have pre-existing health conditions are at an increased risk of hospital admission and death.[9–12]

Changes to service provision, COVID-19 pressures and fear of transmission appear likely to have led to a reduction in the quantity of care that women and their families have been able to and have chosen to access.[8] The recent MBRRACE rapid report highlights instances of significant barriers to accessing care or in-person review due to the pandemic.[9] While we do not yet understand the impact of these changes to the overall quality of care provided, a unit in London has reported an increase in stillbirth.[13]

It is now clear that COVID-19 will be with us for some time to come, and that services should continue to build on the resilience and team working that has been demonstrated throughout the first wave to continue to provide safe and personalised care and up to date information to women and families. This document is intended to support clinical leaders in maternity to make these decisions in partnership with local service user voice groups, and to continue to plan service provision during these challenging times.

2. Context of maternity care

High quality, accessible maternity care is essential for the safety of women and their babies. Every day, around 2,000 babies are born in the UK, almost all with the assistance of the NHS. Maternity care covers care that is provided both in hospitals and the community, with the majority of antenatal and postnatal care provided in the community, and some in women's

homes. Inpatient maternity services are essential, open access services and provide care that is almost entirely unscheduled or urgent (occurring within two weeks of scheduling) with workloads difficult to anticipate in advance.

Maternity staff cannot be replaced by other staff groups due to their specialist skill set and protecting this workforce from unnecessary risk is therefore crucial to ensure that maternity care can be sustained. Therefore, the organisation and staffing of maternity care provision should be considered separately from planning other services by Trusts and Boards, with the safety and protection of the maternity workforce a key priority in service planning.

3. Ongoing impact of the pandemic

There remain significant challenges to maternity services, including increased national restrictions and local lockdowns. The need to wear adequate PPE creates barriers to communication and rapid provision of care in emergencies. As the first wave of the pandemic eased, some Trust/Board representatives reported it has been difficult to restore the full range of birthplaces and attendance of birth partners at appointments, scans and during early labour. This has led to distress for some women, birth partners and their families, while maintaining increased pressure on already overstretched maternity units.

In many areas, other services supporting pregnant women and new families in the community are currently operating a reduced service. The pandemic has created new anxieties for pregnant women and their families and reduced social support in local communities as well as from other family members. This has increased the need for support from community maternity services to fill the gap, particularly in relation to perinatal mental health and early parenting, including infant feeding. In some areas, due to the pandemic, community maternity services are still not able to access the facilities and locations (for example in children's centres) where they would normally provide clinics.

Maternity staffing levels remain significantly impacted by the virus – with some staff still unable to provide in-person care. This is exacerbated by issues in the wider system including delays in obtaining tests and receiving results for symptomatic staff or family members and the provision of childcare for children self-isolating due to outbreaks in schools or early years' settings.

4. Planning for winter 2020/21

It is likely that services will be required to consider some modifications in their provision over the coming weeks and months, particularly if local prevalence is high (necessitating local lockdowns or other restrictive measures) or staffing is severely impacted by illness or self-isolation.

4.1 Evaluating previous response and current service status

Maternity services should, wherever possible, unless they have already done so, conduct an exercise to evaluate their own response to the first wave of the pandemic and the impact this has had on care provided to women and families as well as staff. Where possible, this should be informed by local data on pregnancy and birth outcomes, and incorporate the perspectives of clinical leadership, junior staff, local women and service user groups and cover both hospital and community services. This should be used to inform a local evaluation of previous

service changes and plan for implementation when faced with any significant future increase in case numbers, or reduction in staff availability.

4.2 Reviewing current evidence and recommendations

Services should review the following evidence and recommendations as a matter of priority, and encompass them into their planning:

1. The findings and recommendations of the MBRRACE rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK
2. Recommendations from NHS England on
    a. Delivering midwifery intrapartum care where escalation protocols require to be enacted
    b. Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic
    c. Framework to assist NHS Trusts to reintroduce access for partners, visitors and other supporters of pregnant women in English maternity services

    Recommendations from Scottish Government, Welsh and Northern Irish Assemblies and NHS England on recovery of services
3. Recommendations from the RCOG and RCM guidance on Coronavirus infection and pregnancy.
4. Guidance from the RCM and RCOG on antenatal and postnatal care, and midwife led services. Updated versions of these guidance documents are in progress and will be published in the coming weeks.

References

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3. NICE. NICE Guideline 3: Diabetes in pregnancy: management from preconception to the postnatal period. nice.org.uk/guidance/ng3

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