AIMS Response to the Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic, version 1, published 9/4/20

1. AIMS welcomes this clear guidance to support Trusts to manage and maintain safe Maternity Services at this time. AIMS feels that it provides a good reflection of what women are telling us they need at this difficult time, and should provide a useful guide for Trust Boards across the country, as they consider how best to continue to meet the needs of women and babies in the face of the impact of Covid19 on maternity services.

2. AIMS looks forward to seeing an assessment of the impact of this guidance, and contributing to further versions of this guidance, it is updated it and as comments are taken on board from a wider range of stakeholders. We assume that there is no set timescale for updates, but we would welcome the inclusion of a note in the guidance to make clear the route for submitting comments.

3. Going forward, AIMS believes that this guidance, and the assessment of its impact, will provide an important contribution to the necessary evaluation of the maternity services' response to the pandemic at a national level, an evaluation which we would expect to be transparent and inclusive of a wide-range of stakeholders.

4. The Government has, of course, been helpfully clear about its commitment to transparency at this time: "In fast moving situations, transparency should be at the heart of what the government does." AIMS welcomes this document, as a key contribution to this commitment. (https://www.gov.uk/government/news/coronavirus-covid-19-scientific-evidence-supporting-the-uk-government-response)

5. AIMS welcomes the new governance and communication arrangements set out in this guidance. At a local level, we welcome the guidance to Trusts to explain their current maternity service provision on their website, in a form readily accessible to service users. We look forward to this coming on line over the next few days. We would suggest that this website information is clearly labelled by date of issue and that each version is numbered. Each update should be sent to all members of the local MVP.

6. AIMS also welcomes the guidance to Trusts to put in place written escalation plans to ensure that changes to services are properly considered, authorised, documented and communicated. We are unsure, however, about the transparency of this process and would like to suggest some additional arrangements for local reporting and the sharing of these plans. We suggest that this could take the form of publicly available Board papers, sharing (a) the escalation plans agreed; (b) detailing all Board-level safety champion agreements to changes in service (as notified to the regional level). In

addition, these plans, and changes, as they are agreed, should be sent to all members of the local MVP for their review and comment. We would also like some clarification about the role of the regional Chief Midwives in monitoring and publicising what is happening across their region, and how this fits with the national monitoring planned. (As an appendix to this document, it would also be useful to include a list of the regional Chief Midwives.)

7. AIMS welcomes the intention of the co-production mechanism with the local MVP. We agree that MVP Chairs can be an effective and efficient channel of communication, but we note that discussions with MVP Chair alone do not constitute consultation with a wide-range of local service users. MVP chairs do not hold all the knowledge and wisdom of the wider service user representative group. Conversations between the MVP Chair and the wider group will therefore be necessary to ensure effective input into local decisions. It would be helpful if the guidance could reflect this.

8. To ensure that local decisions can be made most effectively, AIMS welcomes the recognition of the importance of regional modelling, to ensure that the organisation of maternity services across the country reflects well how the virus is spreading, and is likely to spread. We are keen that this modelling be made publicly accessible as it develops, to ensure that services are organising maternity care in a way that both mitigates the spread of the virus and minimises the risk of spread, not only to mothers and babies, but also to midwives and doctors and the wider maternity service workforce.

9. AIMS would like to see put in place a transparent national mechanism for sharing innovative thinking and practical solutions that are working well, and to encourage other Trusts to consider adopting these models.

10. AIMS welcomes the call for Trusts not to suspend any services unless they have considered “alternative options, such as deploying returning retirees and independent midwives”, to keep “as many options available for as long as possible” and to “ consider maintaining at least one midwifery care option.” This will be an important element of the escalation plans, which must be open to scrutiny (see point 6 above).

11. AIMS welcomes the call “to develop a clear standard operating procedure with their regional ambulance service. This could include local alternative transport pathways for women where a timely response is likely to be delayed.” On a point of detail, we are concerned that the current text implies that transfers always require an ambulance service response to maintain safety. We would suggest that it is made clearer in the text that every transfer decision should include an assessment of whether the transfer could be made by transport other than ambulance, to reduce the pressure on this service.

12. Linked to this, we were surprised to note the absence of any reference to the role of CCGs in this guidance. We wonder what is envisaged on that, and suggest that CCGs and Local Authorities could play a hugely helpful role in supporting the maternity services at this time. For example, partnership working could support Trusts to come up with and deliver innovative solutions to some of the non-clinical resource shortfalls that might otherwise work to restrict services. eg transport and other facilities for maternity services. We note that there is some good innovation in the UK in terms of the

commissioning of new off-hospital site locations e.g. scans taking place in new locations. From other countries, we have seen innovation around pop-up birth centres.

13. AIMS welcomes the recognition of the need to prevent “avoidable perinatal mortality and morbidity (including issues relating to mental health and wellbeing)” and continuing “to provide a personalised risk assessment for all women and agree with them a package of care”. The personalisation of care must remain a priority during this period. We suggest that Trusts should be advised to consider individual requests for support to birth at home, for example, on a case-by-case basis, bearing in mind the needs of the woman (including her mental health needs) as well as what can be done to mitigate staffing constraints. We feel it should be considered unacceptable to have a blanket Trust-wide suspension of support for births at home, and that this guidance should be clear about this.

14. Regarding the resourcing requirements related to supporting births at home, AIMS suggests that it might be necessary to review current practice in this area, and come up with innovative solutions. For example, Trusts might consider that - since there is no legal requirement for two midwives to attend a birth - they might consider sending just one midwife (when they do not have sufficient staff to provide two), possibly with the support of another suitable person. This could be a maternity care assistant, another healthcare professional or a student, in order to increase the availability of midwives to attend births in all settings.

15. AIMS is pleased to see the statement “Trusts should also consider how they will respond to more women choosing to stay at home as long as possible and subsequently experiencing an unplanned home birth (babies ‘born before arrival’) during this time”. In addition, we feel that it is crucial to include in the guidance the issue of how Trusts will support women who are forced to decide between birthing at home without midwifery support or going to hospital, and make the decision to birth at home.

16. AIMS welcomes the intention behind the words “Trusts may also consider how they can offer the same style of care in the obstetric unit, perhaps by moving equipment such as birthing pools.” We are concerned, however, that this underestimates the difference in ethos between a birth centre and an obstetric unit. Trusts would need to ensure that Birth Centre protocols continued to apply to low risk women birthing in the OU, rather than standard OU protocols, as well as providing appropriate equipment to support physiological birth. On a point of detail, we question how practical it would be to move birthpools to another location, as some of these will be plumbed in. This guidance needs to suggest to Trusts that additional portable birthpools be ordered, if pools are not able to be moved, to quickly facilitate this.

17. AIMS would also appreciate some consideration of who is best-placed to support low-risk women birthing in consultant-led delivery suites. We would like the guidance to suggest that staffing should be organised wherever feasible so that midwives skilled and experienced in supporting straightforward births outside of the acute hospital setting are allocated to supporting such women in the delivery suite environment.

18. AIMS is pleased to see it acknowledged that “During the COVID-19 pandemic freestanding units and home births have the advantage of helping to keep women out of

hospital, reducing the pressure on hospital services". We suggest that the guidance be explicit about encouraging Trusts to manage staff shortages in a system-wide way. For example, addressing midwifery shortages by limiting out of hospital options will likely have an impact on the number of women requiring otherwise avoidable interventions if they birth in a consultant-led setting. Thus such a change may place increased demands on obstetricians, anaesthetists and midwives working within the hospital setting. Trusts might be encouraged to consider, therefore, whether it is more beneficial to increase, rather than limit, access to out of hospital births.

19. AIMS welcomes the guidance that indications for induction of labour may need to be reviewed and limited to women who have a "clear clinical indication". We suggest the guidance proposes that consideration is also given to whether the clinical indication is strong enough to justify the risk and resource implications in the current circumstances, and reminds Trusts that all elective procedures and other interventions require the woman's informed consent. This means that they must be given clear information on the risks and limitations on support and services relating to Covid-19 as well as the usual risks and benefits.

20. AIMS is pleased to see the reaffirmation of the importance of women being accompanied by birth partners. We understand that some Trusts are limiting this to a birth partner who is part of the birthing woman's household. It would be helpful if the guidance made clear that other birth partners are permitted, for example where a woman does not have a chosen birth partner who shares her home, she should be able to nominate another trusted person as her birth partner. We are also concerned that the current guidance talks of women having a single birth partner. A second birth partner may be critical to some women's mental well-being or other needs e.g. due to disability, or being non-English speakers. Again, we would recommend that the guidance reflects this, and encourages Trusts to consider such needs on a case-by-case basis. Another concern is that this guidance makes it acceptable for hospitals to restrict access for a birthing partner during the early stages of induction when women are not yet in established labour/on the labour ward. We would prefer guidance that encourages local Trusts to explore options to enable birth partners to be present throughout an induction. Trusts should also be asked to document the rationale for any such restriction in their escalation policy.

21. Finally, we would appreciate it if further versions of this guidance include numbered paragraphs and bullet points for ease of commenting, as well as details of the authorship and where the document is located online.

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