

Specialty guides for patient management during the coronavirus pandemic

# Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic

9 April Version 1

The COVID-19 pandemic has presented a significant challenge for the NHS: the provision of high quality care for those experiencing serious symptoms of the virus needs to be balanced with the safe delivery of core non-elective services, such as maternity, a service strongly focused on safety and with very limited opportunities to reduce demand. This challenge will inevitably mean that some clinical staff are deployed to areas of hospitals they do not usually work in. At the same time, many midwives, obstetricians, anaesthetists and support staff are in self-isolation, temporarily reducing the available maternity workforce, with varying and sometimes significant impacts felt locally.

In such circumstances, it is right that NHS trusts, working together as part of local maternity systems (LMS), consider how best to maintain intrapartum services through a phased approach, to ensure that staff are deployed in the best way and women and babies continue to experience safe care.

This document sets out how safe services should be maintained and how decisions about reorganisation of services should be taken. The appendix provides a template for communicating changes in the services to local women and their families.

It has been produced in consultation with the Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Anaesthetists, the Obstetric Anaesthetists Association and maternity service user representatives.

Separate guidance is available from RCOG and RCM on [ante- and postnatal care](#) and on [antenatal screening](#).

## Maintaining safe services

Maternity care, especially intrapartum care, is a core non-elective service that needs adequate staffing and access to facilities. The principle must be to maintain the safety and wellbeing of women and their babies. This means preventing avoidable perinatal mortality and morbidity (including issues relating to mental health and wellbeing). At the same time, services should aim to maximise choices for women within the constraints of the available staffing and facilities. They should continue to provide a personalised risk assessment for all women and agree with them a package of care.

Providing safe services also means balancing the response to COVID-19 with the continuing need to manage obstetric risk. Some trusts report that they are redeploying their maternity workforce, facilities and equipment (eg ventilators from obstetric theatres) to other parts of the hospital to help with the COVID-19 response. The board level safety champion is well positioned to work with the hospital's senior management team and maternity services to ensure an appropriate balance.

RCOG guidance provides [staffing options for obstetrics and gynaecology services during the COVID-19 pandemic](#). At the very least a maternity service must be able to respond to emergencies; as a rough guide this means having a workforce similar to that generally seen at weekends. An additional multidisciplinary team will be required during the day to ensure the continued provision of elective caesarean sections. Trusts may consider seconding staff from other areas of the hospital, such as gynaecologists, to maintain the maternity service, with appropriate refresher training. In the event of critical staff shortages trusts' major incident teams should consider testing staff who are self-isolating, as well as relevant family members, for COVID-19, to expedite their return to work.

Trusts should consider the availability of all the professions that impact on their ability to provide a complete, safe maternity service:

- **Midwives** and **maternity support workers** are required to care for pregnant women and their babies and should only be redeployed within maternity care.
- **Obstetricians** should not be redeployed beyond the point where doing so would put the operation of an emergency service at risk, eg inability to maintain the emergency caesarean section and operative vaginal delivery service. Access to clinically indicated elective caesarean section also needs to be maintained to avoid further increases in emergency work.
- [NHS England and NHS Improvement guidance](#) advises trusts to ensure that services supported by **anaesthetists** that cannot decrease clinical activity (eg emergency surgery, obstetrics) are safely staffed. Again, this means not beyond the

point where doing so would put the operation of an emergency service at risk, including inability to maintain an epidural service for women in labour.

- **Neonatal** services may be reorganised locally in line with the national neonatal critical care surge guidance.

Many trusts have reported imposing restrictions on visitors. While it may be necessary to restrict numbers for reasons of infection control, women should have access to one birth partner during labour (from the point of admission to labour ward or birth centre) and birth in line with [World Health Organization advice](#). The birth partner will often be able to support midwives in caring for the woman and her baby, as well as being important for the wellbeing of the woman in labour. Birth partners must be asymptomatic; if they are not, the woman must be asked to nominate another person.

## Suspending services

Faced with a shortage of clinical staff, the safest option may be to consolidate care in fewer places by closing specific services temporarily. Such decisions must be influenced by a risk assessment and only made after considering:

- alternative options, such as deploying returning retirees and independent midwives
- a progressive approach, thereby keeping as many options available for as long as possible – suspending certain options, particularly place of birth, will have a significant impact on some women and should be avoided unless absolutely necessary to ensure a safe service.

All the following conditions must be met before trusts suspend intrapartum care options:

- The available workforce must be either too small or of insufficient skill mix to ensure the safety of women and their babies with services in their current configuration.
- Women must still be able to make decisions about the care they receive in line with the principles of informed consent.
- The withdrawal of services must be temporary and must be clearly communicated to women and their families.
- The extent of the withdrawal of options must be proportionate and tailored to the specific workforce constraints.
- The withdrawal of options must be identified in an escalation plan, which has been agreed by the board-level safety champion, cleared through the organisation's internal governance processes and notified to the NHS England and NHS Improvement regional chief midwife and relevant regional director of nursing as appropriate.

- Other organisations within the LMS and maternity clinical network, including the local ambulance service and the local neonatal operational delivery network, must have been consulted on the escalation plan to ensure that the impact on them is manageable and sufficient capacity remains available in the local area to meet demand.
- The local Maternity Voices Partnership (MVP) service user chair, representing local women and families, must have been involved in the decision-making process.

## Escalation plans

Trusts must put together a maternity-specific escalation plan setting out the extent of the current staff shortage and detailing the service changes to fill the gap, alongside any other mitigations that have already been made, such as use of students and employing retirees and independent midwives. Trusts that are not currently facing an acute staff shortage should nevertheless now consider developing a stepped escalation plan which can be enacted if numbers of available staff fall substantially.

Trusts must work together as LMS or more widely through maternity clinical networks to ensure that decisions made in one place do not have a disproportionately negative impact on another, and that services can be co-ordinated across a wider footprint, enabling better management of capacity and demand.

Recovery plans are essential and should bear in mind the regional modelling of how the virus is likely to spread and, as testing becomes more widely available, the return to work of staff who have had COVID-19.

## Place of birth choices in midwifery services

Alongside hospital midwifery units, freestanding midwifery units and home birth teams provide a safe option for many women as set out in National Institute for Health and Care Excellence (NICE) guidance. A decision on whether to maintain, limit or withdraw these services should not be taken lightly and will involve careful balancing of a number of considerations:

- 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.<sup>1</sup> Some trusts report increasing requests for home births from pregnant women concerned about the potential risk of infection from giving birth in a hospital or with fear of birth in a hospital environment.

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<sup>1</sup> [NICE CG190](#) highlights that for low-risk multiparous women, planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit or in an obstetric unit.

- Midwifery units and home birth services tend to operate with a smaller pool of midwifery staff. High staff absence in community midwifery services can reduce staffing ratios to an unsustainable level if staff numbers cannot be supported through deployment of student midwives, maternity support workers, and retired or non-clinical midwives.
- A proportion of women need to transfer from home or a freestanding unit to the obstetric unit. This usually requires a response from an ambulance service, which may also currently be stretched. This means transfers from home to hospital may not be sufficiently quick to ensure the safety of mother and baby.

Where a home birth service is in operation, trusts or LMS may need 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. Women should always be given information that reflects locally agreed pathways for transfer to enable informed decision-making.

If a trust decides to suspend a freestanding midwifery unit, home birth service or redeploy an alongside midwifery unit (eg for use by women with COVID-19 symptoms) to guarantee safety, it should consider maintaining at least one midwifery care option. 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. Work as a LMS may help to keep options open, either by sharing staff or by making transfers of care available. Consideration may be given to limiting rather than suspending some services: for example, to low risk women who have had a baby before and are at much lower risk of requiring intrapartum transfer than primiparous women.<sup>2</sup>

Understanding the impacts and potential risks relating to women's mental health and wellbeing during this period is vital, and a personalised care approach can support this. This needs to cover a range of issues, including:

- acknowledging the pandemic is likely to increase anxiety among pregnant women, given it brings further uncertainty
- understanding the impact of changes in service provision and therefore birthing choices for women with a history of birth trauma, tokophobia, etc and the risks to their mental health; as well as the risks to women without such a history
- the importance of robust plans for women identified as at risk of, or experiencing, complex/severe mental health problems in the intrapartum period and beyond. The 'red flags' identified through MBRRACE reports need to be understood and addressed, to ensure that women experiencing mental ill health at this time can still

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<sup>2</sup> [Birthplace study](#), transfer rate 2% versus 40%.

access specialised mental health care if required. Maternal mental illness remains one of the leading causes of maternal death.

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.

### **Suspending obstetric units**

Occasionally busy obstetric services close temporarily to manage demand. Such a decision must be taken in line with existing processes, in conjunction with other trusts in an LMS or maternity clinical network, as they are likely to be experiencing similar pressures.

In the most challenging circumstances it may be better for hospitals with a particularly high demand for intensive care due to COVID-19 infections, working in conjunction with their LMS, to temporarily close a maternity unit and move care to another nearby hospital. This potentially allows:

- redeployment of some clinical staff within the hospital (such as anaesthetists and junior medical staff)
- other key maternity workers to move to support a nearby unit
- a better standard of maternity care for women and their babies at the nearby unit.

An alternative might be to support the stretched unit by redeploying staff temporarily from elsewhere.

If temporary closure is required, the staff should be redeployed to support other local trusts. NHS England and NHS Improvement have produced an [enabling staff movement toolkit](#) to help with this.

It is more important than ever that women who are expected to give birth at less than 27 weeks' gestation can do so in a maternity unit with appropriate on-site neonatal care, to avoid unnecessary transfers of care, although neonatal services may be reorganised locally in line with the national neonatal critical care surge guidance.

Many trusts have established pathways for women with specific needs. As these address specific risks, including safeguarding, trusts will need to consider how to manage these risks as service models change.

### **Suspending access to certain interventions**

A shortage of obstetricians or anaesthetists may mean there is insufficient capacity to meet demand. In extreme circumstances, there may be no option other than to temporarily suspend

access to elective procedures. Trusts should make every effort to avoid this situation and, in particular, should work as a LMS or maternity clinical network to keep options open, either by pooling staff or by making transfers of care available to women.

Women who are being induced can require long periods of admission and have higher levels of subsequent interventions during labour. Indications for induction of labour may need to be reviewed and limited to women who have a clear clinical indication. It may be possible to improve outpatient provision of induction of labour, depending on the availability of transport to hospital, in line with RCOG/RCM guidance.<sup>3</sup>

### **Engaging with service users and their families**

Trusts or LMS must work with their MVP service user chair to develop their plans. This does not need to be a long process – one of the benefits of standing MVPs is the ability to mobilise input quickly. They will understand the pressures services are currently under and may be able to suggest improvements to proposals that make relatively little operational difference but have a big impact on service user experience or outcomes. Where decisions have already been made, the MVP must be involved in regular reviews.

Trusts or LMS must communicate temporary changes to service provision clearly and transparently, including on a public-facing website, so that women can make informed decisions about the care they receive. There is considerable public understanding about the pressures the NHS is currently under, but the link between COVID-19 and maternity service capacity may not be well understood by all. At the same time, women are understandably concerned about the risk of transmission of the virus and the possible restrictions around birth on them and their baby. The appendix gives an example statement. Local communications should be co-produced with the local MVP service user chair.

Trusts should consider establishing telephone or video call helplines for women with concerns or requiring advice about accessing the services they need (as already exist in Hampshire and Surrey Heartlands and as established in Cornwall and Stockport in response to COVID-19, for example). This may also help with demand management. Midwives who are self-isolating may be able to staff these helplines.

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<sup>3</sup> [Coronavirus \(COVID-19\) Infection in Pregnancy: Information for healthcare professionals](#) (version 5), section 3.4.

## Appendix: Communicating with women and their families

Please co-produce all communications to women and their families with your MVP service user chair to ensure the language is easy to understand and that you have covered all the key points. You can use this template as a basis and adapt it as appropriate to your local circumstances.

It is helpful to communicate with local women and families now and as your service may change over the coming days. Communicating in a number of different ways, for example using written text and by making a short, informal film can be beneficial. Please refer to the [guidance from the Royal College of Obstetricians and Gynaecologists](#) for co-produced, up-to-date information for women and their families.

### Template statement

We want to make sure you and your baby are well during the coronavirus pandemic and we are committed to providing safe and personal maternity care. It is important that you have all the information you need to help you to make informed decisions about your maternity care.

We might have fewer maternity staff available. This means we have had to think about how we will care for you and your family during your labour and birth.

Women who have coronavirus or coronavirus symptoms will be cared for in a separate part of the maternity unit to women who do not have symptoms. This is to keep everybody who uses our services as safe as possible.

We have already... [detail what you have done to mitigate against low staffing levels, such as bringing independent midwives into the team, etc].

However, we have had to make some changes to ensure we keep you and your baby safe. These are ... [add in the temporary changes you have made]. These changes have been made with our Maternity Voices Partnership (MVP) user chair. You can find out about the MVP's role here [add hyperlink to webpage/social media page].

These choices of place of birth that are still be available are [delete as necessary]:

- homebirth
- alongside midwifery-led unit
- freestanding midwifery-led unit
- obstetric unit.

You will still be treated with respect and dignity.



You will still be able to have a birth partner of your choice during your labour and birth, as long as they do not have symptoms of coronavirus.

You can still expect us to communicate clearly with you.

You will still be able to have access to pain relief options, including gas and air and an epidural.

You will still be able to be mobile, use a birthing ball and birth in a position of your choice.

Your midwife or obstetrician will support you at this time as you plan for your labour and birth. This might include changing your plan for your birth or transferring your care to a different maternity service. Your midwife or obstetrician can help you with this.

In the meantime, if you have any questions please contact [midwife, COVID-19 helpline, etc.].