AIMS For a better birth...

Conference Report: Pandemic recovery of maternity & child services September 2022

AIMS Journal, 2023, Vol 35, No1

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By Nadia Higson

This conference, organised by the Royal Society of Medicine's Maternity and the Newborn forum, provided a platform for research findings from PIVOT-AL (Parent-Infant coVid OrganisaTional Academic Learning collaborative[1]) looking at various aspects of the impact of Covid-19 on maternity and child services and how this can inform services as they rebuild. The PIVOT-AL collaboration is a network of researchers who came together during the pandemic to carry out a wide range of rapid-funded projects, with an emphasis on sharing and open access.

Professor Soo Downe opened the day by reminding us that the challenge is to identify "How are we going to stop doing what we've always done" which will require radical change at the system level. If changes are only made on the basis of 'what goes wrong' they can have unintended consequences for what usually goes right. What is needed is a move towards the concept of 'Safety II' (drawn from resilience engineering [2] [3]) which includes a focus on *maintaining* safety.

There were too many individual presentations to cover in detail in this short article, but a number of important themes emerged.

Many presentations provided evidence for what AIMS Helpline volunteers observed about the damaging impact of service restrictions on women and their partners, and the unhelpful nature of blanket policies [4]

. As Dr Pat O'Brien from the Royal College of Obstetricians and Gynaecologists (RCOG) said in a panel discussion, in many cases "common sense went out of the window."

Research showed that service users were angered by the changes in maternity services, by lack of information about the changes, and lack of birth options, and felt unable to plan due to constant changes in policy. Often, they tried to regain a measure of control by making decisions that would give them some degree of certainty. That might be to plan for a homebirth or freebirth, for induction or for a planned caesarean. Many had a sense that hospital was unsafe due to Covid.

Several speakers reflected on the clash between infection control demands and relational, human caring, which led to holistic well-being being deprioritised. As one speaker commented "True safety is not just 'not dying.'" This impacted on staff as well as service users, with the conflict between public health ethics and clinical ethics making them unable to offer person-centred care, resulting in "burn-out, demoralisation and 'moral injury.'"

A number of presentations focused on the impact of the pandemic and the resulting maternity services restrictions on the mental and emotional wellbeing of mothers and families. Despite evidence that the pandemic increased the incidence of domestic violence, the rate of reporting was low and referrals to secondary mental health[5] decreased by 78%. The rate of people scoring positive for depression increased by 40% but there was no change in referrals. It is likely that the lack of in-person appointments meant that problems were not identified.

Based on a national online study, during the first lockdown there was a 43% prevalence of PND and 61% prevalence of anxiety - substantially higher than the rates normally reported. A qualitative study identified the high level of distress caused by being left to navigate pregnancy and birth alone. Another study found that younger women and LGBTQ+ parents scored higher on postpartum anxiety than other groups.

There were also concerns about the impact on babies. Although lockdowns meant that babies had more interactions with their parents, the effect of seeing fewer people seems to have led to lower ability to attend to sensory input and sensitivity to social stimuli, which may lead to future problems with socialisation.

The day finished with a summary of:

- What novel care practices developed during the pandemic should be retained
- What pre-pandemic practices need to be reinstated
- What pandemic practices should be stopped

The guiding themes for this were recognising:

- the importance of partner support ("If this ever happens again, we can't take partners away")
- the importance of relationships between service users and carers, in the community as well as in hospital

- the *equal* importance of physical, mental and moral health[6]
- the need for clear, concise and consistent communication across all services
- the need to allow creativity and the search for innovative ways to offer care to continue

Work is underway to support 'build back better[7]' by synthesising the findings of the PIVOT-AL studies to draw robust conclusions on which to base policy. Roadshows are planned to discuss the findings and plan the way forward, including listening events in all four nations. We can only hope that despite the current crisis in the NHS, Trust Boards and maternity services management will make the time to listen and act on these findings with the urgency they deserve. However, it's been concerning to see that the knee-jerk response to the recent ambulance strikes has, in many Trusts, been to place blanket bans on support for homebirths and birth centre births regardless of individual needs.

If you are an MVP user representative or other birth activist, why not challenge your local maternity service to explain how they are 'building back better' in the light of this research - or are they simply "doing what {they've} always done?"

Author Bio: Nadia Higson is an AIMS Trustee, volunteer AIMS Coordinator, and a member of the Campaigns Team, in which capacity she led AIMS campaigning on pandemic-related maternity service restrictions. She is also a local MVP user rep and an NCT antenatal practitioner. She was the principal author of the AIMS Guide to Induction of Labour and has written several of the Birth Information pages on the AIMS website, including "Coronavirus and your maternity care".

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[1] PIVOT-AL - twitter.com/PIVOTAL_Collab

[2] "Safety management through centralized control, labelled by Hollnagel as 'Safety-I', aims to align and control the organization and its people through the central determination of what is safe. Safety management through guided adaptability, or 'Safety-II', aims to enable the organization and its people to safely adapt to emergent situations and conditions."
www.sciencedirect.com/science/article/pii/S0951832018309864

[3] "Safety management should therefore move from ensuring that 'as few things as possible go wrong' to ensuring that 'as many things as possible go right'. We call this perspective Safety-II."
www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf

Editor's note: Safety 1 equates with pathogenesis, Safety 2, with salutogenesis.
www.aims.org.uk/journal/item/editorial-salutogenesis

[4] AIMS comment: Applying blanket policies without taking account of individual needs may have contravened the Equality Act 2010.

www.gov.uk/guidance/equality-act-2010-guidance

[5] Editor's note: 'Secondary mental health' is the term used for referrals from the first or primary health practitioner consulted (for example, a midwife or GP) to more specialist mental health care.

[6] Editor's note: I take the term 'moral health' to mean the state where one's behaviours are congruent with one's personal values of what is right or wrong. Moral injury is when one feels forced to do something believed to be wrong - or forced *not* to do something believed to be right. (Examples might include: leaving your partner when she is in labour and wants you there; or, as a midwife, not inviting the partner to stay, even though you knew separation would add to the mother's distress and affect the course of her labour.)

[7] Department of Health & Social Care (2022) *'Build Back Better: Our Plan for Health and Social Care'* https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/build-back-better-our-plan-for-health-and-social-care#our-plan-for-healthcare