AIMS For a better birth...

Running maternity services during the coronavirus pandemic: keep calm and don't forget the woman!



By Natalie Carter, Consultant Midwife, Chelsea and Westminster NHS Foundation Trust

Hello, my name is Natalie. I am immensely proud to work in a service that maintained most services for women giving birth during the COVID-19 pandemic. I would like to share with you how we did it, the challenges of doing it, and the recovery from it!

It begins and continues with leadership, with a Director of Midwifery who puts the woman at the centre of every decision, asking the difficult questions that examine every possibility before saying either we can't or we can or we just need to do it differently! Long before COVID-19 the mission for the provision of high-quality maternity care at this Trust has included continuity, choice, equality, and respect for the birthing rights of women. I believe it is fundamentally this drive and belief in what is possible and expected within our service and in those that provide it that enables us to say we can, and we will.

Sitting alongside this leadership is an enormous team effort. Before lockdown took effect a daily morning COVID-19 call was established between the cross-site key stakeholders from midwifery, obstetrics,

gynaecology, anaesthetics, and included one of the co-chairs from the Maternity Voices Partnership (MVP) once a week. This was and still is a group of around 25 people, which enabled the service to be immediately responsive to the pace of change as these are the key decision makers. One of the first challenges was creating the identified 'spaces' where separate pathways would exist to keep those with COVID and those without apart. On both hospital sites the alongside birth centres were discussed as the areas that could become COVID positive zones and they have remained a potential space for this in the escalation plan if there was an increased need for capacity but we have not needed to use these spaces so far. It would have been easy to see this space as ideal due to its contained nature, but we made a strong argument for enabling women with straightforward pregnancies to access a space that would facilitate birth with the best chance of keeping intervention rates low and as such prompt discharge home from the hospital setting, especially given we may face a situation with reduced anaesthetic support for epidurals for pain relief in women unaffected by COVID. At all times we tried to keep in mind helping women be in the hospital for as short a time as possible minimizing their exposure risk while also still respecting their choices.

It also didn't make sense for our obstetric and anaesthetic colleagues to have to cover a greater area of oversight with the existing obstetric areas and then the birth centre space as a positive COVID area as well. Far safer and easier for staff to locate the COVID positive zones as close to the obstetric labour ward as possible, including temporary theatres. Temporary partitions and doors enabled areas to be closed off but accessible to staff and alternative entrances used for women to keep pathways separate. Fortunately, we did not reach a position where capacity was breached within these spaces and we did not have to escalate into the birth centre areas and effectively close them as midwifery-led areas. They remained open for the duration, only experiencing a small drop in numbers of births which can be explained by the increase in home births.

Another significant challenge was the continued provision of a safe home birth service. Firstly, from a staffing point of view where we did encounter gaps due to sickness and midwives shielding. The community workforce were incredible at supporting each other, covering on-call gaps, working additional hours, and positively embracing every new woman who suddenly wanted to birth at home, including several who had complexities where guidelines recommended the birth took place in hospital. Staff who were part time and able to increase their hours did, many cancelled annual leave, and pausing all mandatory training and study leave helped maintain staffing levels. The senior midwifery on-call team found themselves covering as second midwives which helped support women with more complex needs who were choosing to birth at home. We were also able to ask our local independent midwifery colleagues for help and support during this time because of the existing relationship we have built with them over the last few years. These independent midwives have a bank contract with us which enables them to provide midwifery care to their clients in the midwifery-led areas at our hospital sites.

The second challenge around the home birth service was the announcement from the London Ambulance Service (LAS) that they could no longer guarantee safe response times. This was met head on by our Director of Midwifery in terms of finding a solution. Again, reminding ourselves that supporting women

to remain out of the hospital was perhaps one of the most important safety considerations underpinned the importance of finding this solution. Speaking with our colleagues in the LAS and neighbouring ambulance services led us to contract a private ambulance and a crew to be available for both our community sites for several months, 24 hours a day 7 days a week. The local private transport provider (HATS) is experienced in providing health service related travel and a Standard Operating Procedure (SOP) was developed with all parties to support the use of this service. The LAS remained the first call for category 1 transfers with the HATS ambulance responding if LAS were unable and for all other category transfers. The HATS service was required three times during the contract period with them. This was a fantastic experience of collaboration to ensure the safety of women and valuing the importance of this service provision. Support for this also came from the Trust Chief Nurse and executive team in terms of sign-off for the cost of this contract.

Pressure also came to stop the provision of water births. The consultant midwife network across the country was extremely valuable for sharing everyone's thoughts, research, and conversations regarding this. There was a surprising difference of opinion amongst our microbiology consultants about the potential risks of infection to babies and staff through water, indicative I think of the amount we did not and still do not know about this virus. A mantra our Director of Midwifery kept repeating to us was 'Is this proportionate?'. It was helpful to keep us steady throughout all the adrenalin, stress, and fear. Was our response proportionate to what we knew, did not know and in relation to different groups of women: those who were unwell or suspected of being unwell, or those who to the best of our knowledge were well and not affected. For the latter we did not stop access to water as we did not have any evidence that this would cause a greater transmission risk. We did however ensure our staff had full provision of PPE to alleviate any concern they had about the possibility of a greater risk, should she be carrying the virus unbeknownst to us. We also created guidance that if the pool water became contaminated with faeces, the woman be asked to exit, shower and the water replaced, or she consider getting out to birth in order to reduce any risk to her baby or the staff giving care.

Although partners were restricted, at no time were they unable to be present once a woman was in established labour. This was defined not on the basis of a vaginal examination, but by the labour she was experiencing and the support she needed. Under no circumstances were women to be alone during labour and agreements for an additional second person in labour due to exceptional circumstances were made on occasion for women with significant physical or mental health concerns. We got innovative with certain services where it was safe, to enable women to be at home with their partners as much as possible. For example, we extended outpatient induction with the mechanical balloon to include the majority of women undergoing induction which meant they could spend the first part of induction at home with their partner while partners were restricted from the ward areas. Women then waited at home until the labour ward was ready to accept them for an ARM, which is when the membranes are broken to release the waters.

We have always had a good working relationship with our MVP and none more so than during this time. Our co-chairs on the MVP have been invaluable in supporting us to communicate with women. They have

hosted us on social media for live weekly Facebook Q&As, helped us create the messaging for regular updates and leaflets to explain changes to services. They have spent hours posting photos of staff in their PPE to provide reassurance to women prior to coming into the hospital sites and managing daily message queries from women. We also had a lot of fun getting a videographer to come and help us put our antenatal education online. This now includes a variety of videos for women to engage with, as well as weekly Zoom Q&As with our amazing antenatal education and infant feeding teams.

The Maternity Transformation Programme, which has Continuity of Carer as one of the main quality improvements, was put on hold during the pandemic. Up until that point we had achieved 30% of women booked onto a Continuity of Carer pathway. We have caseload teams caring for specific groups of women such as those with straightforward pregnancies, a home birth team, caseload for women with previous gestational diabetes and teams located in geographical areas of high deprivation. We have also created hybrid teams that provide shift-based continuity rather than on-call continuity. To date these teams are working as part of the birth centres and the obstetric medicine service. All these teams were sustained throughout the pandemic and we are predominantly sustaining our current continuity achievements. Where some teams have had staff needing to shield there has been a small drop in numbers of women able to be booked but this should shortly resolve itself. The target of 51% of women booked onto continuity teams by March 2021 is likely to be put back to a later date once the programme resumes. However, we have continued to plan the next stage of our implementation and intend to maintain momentum wherever possible.

While the staff have been amazing, it is important to note that maintaining these services has not come without a degree of stress and concern for staff. Reassurance and good communication have been important but have not always been as good as we would intend, with the pace at which guidance and decisions were made. WhatsApp and Facebook groups helped but of course this can also lead to work infiltrating home life. And with the lack of any recent annual leave having been taken, this 'recovery' period now is really important to process and take stock of what we achieved but also what we have all experienced and how it has made us feel. The Trust has provided well-being support throughout this time and continues to do so, and the incredible donations from local business have been overwhelming and very gratefully received. Staff are being encouraged to take annual leave now for rest and recuperation while we slowly reintroduce things like mandatory training, albeit in a 'new normal' format.

Women have of course experienced restrictions, ones which we would never have thought we would have to make. For example, partners have not always been able to attend care in some situations such as scans and appointments. We are part way through reinstating visiting and thankfully partners are now attending scans. We are proud to have maintained the majority of services that support women to give birth to their babies in the way that they have chosen and dreamed of, while also balancing the protection and needs of our staff and all women and their babies.

AIMS comment

We reached out to the midwives at Chelsea and Westminster NHS Foundation Trust when we heard that they were not following many other NHS Trusts in shutting down services that women were telling AIMS were more, not less, crucial, for them during the pandemic. We would be very interested to hear from women who have received care from Chelsea and Westminster NHS Foundation Trust since March 2020, and how well they feel their needs have been met.