



Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers

Version 1, 14 December 2020

Executive summary

1. Pregnant women value the support from a partner, relative, friend or other person through pregnancy and childbirth as it facilitates emotional wellbeing and is a key component of safe and personalised maternity care. It is therefore our aim, further to a risk assessment, that a woman should have access to support from a person of her choosing at all stages of her maternity journey and that all trusts should facilitate this as quickly as possible. At the same time it is our priority to prevent and control COVID-19 infection and keep women and staff safe. Many trusts have already found creative solutions to overcome remaining challenges and they have maximised the support that pregnant women can receive throughout their pregnancy. It is important now that all trusts do this.
2. We are asking all trust boards to urgently complete any further action needed so that partners can accompany women to all appointments and throughout birth, by following three steps:
 - i. Undertake a risk assessment in each part of their maternity service to identify precisely whether and if so where there is an elevated risk of COVID-19 transmission if support people are present (eg if space prevents social distancing)
 - ii. Make changes to the configuration of space used to provide care and/or how the available space is used to address the issues highlighted in the risk assessment, alongside provision of other appropriate infection prevention and control measures, including training and PPE

- iii. Use your available testing capacity (eg PCR, rapid PCR testing, or lateral flow testing) to test women and their support people to help mitigate infection risks, in particular for scan appointments, for fetal medicine appointments, at birth, and for parents whose babies require neonatal care. Treat support people who test negative as part of the team supporting the woman.

Introduction

3. Maternity services across England have sought, throughout the pandemic, to ensure that women have a single asymptomatic birth partner with them during labour, birth and the immediate postnatal period. Services have been working towards further opening of maternity settings to support people since the end of the first lockdown. This document sets out three key actions which NHS trusts should take to enable women to receive support from a partner, relative, friend or other person when receiving maternity care during the COVID-19 pandemic. It will also be of interest to women using NHS maternity services and their families, the public and stakeholder organisations. It replaces *Framework to assist NHS trusts to reintroduce access for partners, visitors and other supporters of pregnant women in English maternity services*, published on 8 September 2020, and builds on trusts' work to implement that.
4. Pregnant women value the support from a partner, relative, friend or other person through pregnancy and childbirth as it facilitates emotional wellbeing and is a key component of safe and personalised maternity care. **Women should therefore have access to support at all times during their maternity journey and trusts should facilitate this**, while keeping the risk of transmission of the virus within NHS maternity services (including to pregnant women, other service users and staff) as low as possible. This means welcoming the woman and her support person, regarding them as an integral part of both the woman and baby's care throughout and not as a visitor. It includes making sure that women can safely take a support person to:
 - the early pregnancy unit
 - all antenatal scans
 - other antenatal appointments where the woman considers it important to have support
 - labour and birth from the point of attendance at the hospital or midwifery unit.
5. Women should also have access to support people while admitted for early pregnancy loss or on the antenatal or postnatal ward in line with pre-COVID trust policies.
6. Parents of babies in neonatal critical care also need to be involved in their baby's care as much as possible. Integral to this is ensuring parents have access to their baby, while

complying with legislation and government guidance on managing transmission risks. Parents are partners in care and should not be considered to be visitors. NHS England, as commissioners of specialised services, is asking neonatal critical care providers to adopt the same three action points to maximise opportunities for parents to be with their babies and to identify how to facilitate parental presence at all times of day. This is in line with [guidance from the Royal College of Paediatrics and Child Health](#).

The terminology used in this document

7. This document covers the following:

- an essential supporter – an individual required by a woman with specific communication or physical or mental health care needs, eg an interpreter or carer
- a birth partner – the primary (non-clinical) person chosen by a woman to support her during labour and birth
- other supporters – these may be invited by the woman to support her at times other than during labour, eg during an antenatal appointment
- parent of a baby in neonatal critical care
- support people – these include anyone in any of the categories above and is used for brevity.

8. The support person may be the baby's father or co-parent, but it does not need to be; what is important is that the support person is chosen by the woman.

9. Support people are not 'visitors' because they carry out a support role. This distinction is important. Trust policies for visitors should comply with [Visiting healthcare inpatient settings during the COVID-19 pandemic: principles](#), published on 13 October 2020.

Maintaining COVID-safe maternity services during the pandemic

10. NHS trusts in England have maintained safe and personalised maternity care during the pandemic, which we need to continue. This includes keeping virus transmission low.

11. The government's strategy for keeping virus transmission low centres on good hand hygiene, face coverings, and maintaining social distancing ("hands, face, space"). Hospitals and other healthcare facilities have been asked to observe a universal 2-metre rule wherever possible. The size and layout of rooms used for healthcare varies between and within hospitals/healthcare settings. Some maternity units benefit from antenatal and postnatal wards largely with single rooms and have dedicated waiting areas for clinics and scans. But many others have a limited footprint, sometimes sharing waiting areas, and women staying in four or six-bedded bays for antenatal or postnatal care.

12. These challenges mean that some trusts will need to make changes to the way they use their facilities to enable support people to accompany women to maternity care safely. While we recognise that these challenges exist, it is important that trusts should find creative solutions to overcome them while ensuring the safety of their staff and that they can access support and advice to do so.

Three key actions

13. We are asking all trust boards to urgently complete any further action needed so that partners can accompany women to all appointments and throughout birth, by following three steps:
- i. Undertake a risk assessment in each part of their maternity service to identify precisely whether and if so where there is an elevated risk of COVID-19 transmission if support people are present (eg if space prevents social distancing)
 - ii. Make changes to the configuration of space used to provide care and/or how the available space is used to address the issues highlighted in the risk assessment, alongside provision of other appropriate infection prevention and control measures, including training and PPE
 - iii. Use your available testing capacity (eg PCR, rapid PCR testing, or lateral flow testing) to test women and their support people to help mitigate infection risks, in particular for scan appointments, for fetal medicine appointments, at birth, and for parents whose babies require neonatal care. Treat support people who test negative as part of the team supporting the woman.

Principles underpinning the three key actions

14. Trusts should work with the local Maternity Voices Partnership (MVP) and representatives from all staff groups in undertaking these actions and communicating the outcomes.
15. Communications plans should be clear about the timescale for these actions, and information should be readily accessible to women, support people and their families, digitally and in accessible formats. The agreed information should also be provided to all relevant staff groups.

16. At the same time trusts should continue to emphasise the importance of staff, service users and support people complying with measures to keep virus transmission low:
- good hand hygiene – trusts can encourage this by clearly signposting hand-washing stations or alcohol gel
 - good respiratory hygiene through the “Catch it, bin it, kill it” approach (eg using a tissue to catch coughs or sneezes and immediately disposing of this in a bin)
 - complying with 2-metre social distancing
 - all staff, women in outpatient settings and support people wearing face coverings as recommended
 - staff and support people using personal protective equipment (PPE), as directed by [national guidance](#).
17. Support people should be asked to follow these measures. They should be advised that non-compliance will result in them being asked to leave, unless they are exempt for medical reasons.
18. Trusts should especially prioritise the need for continuous support for women with particular needs, such as those with a disability, significant communication challenges or complex medical, mental health or social factors. They should ensure their approach does not have a disproportionate impact on women with protected characteristics as described in the Equality Act 2010. An equality impact assessment can help with this. Trusts should specifically consider women from a black or Asian background, or with hypertension, diabetes or raised BMI, in line with the known additional risks to these women, as identified by MBRRACE-UK.
19. Trusts’ should comply with legislation and government guidance on managing the risks of transmission of the virus. This includes:
- [legislation](#) on mandatory isolation for individuals who are COVID-19 positive or are required to isolate due to exposure to COVID-19 – there is no exemption for birth partners
 - rules on [national/local](#) COVID-19 restrictions in place.

Undertaking the risk assessment

20. The risk assessment will need to involve the people in the trust with relevant expertise: for example, the lead for infection prevention and control, the director/head of midwifery, the clinical director for obstetrics and clinical leaders from other relevant services, such as radiography and neonatology, safety champions and local staff representatives.

21. Trusts should assess:

- the physical space in the maternity service and other areas being traversed, including any communal areas, eg in waiting areas and clinic rooms
- the number of women expected to attend a clinic or an ultrasound scan, and the use of any communal areas including waiting areas shared with other services
- the number of women expected in an inpatient maternity unit, eg a postnatal ward
- the staffing of the maternity clinic/unit, including how many are in more vulnerable categories for COVID-19.

22. The risk assessment should consider each area of the hospital or healthcare facility separately, as the impact of access to support people will differ according to space available and clinical risks in each area. For ultrasound scan clinics in particular, trusts should take account of the case mix of people using the scan facilities, which could include patients with other conditions which mean they are at increased risk from COVID-19.

Making changes

23. The individual who is responsible for estates within the trust will need to be involved in the preparation of the action plan, alongside clinical and managerial leadership for maternity and radiography and infection control.

24. Many trusts have already made such changes, for example:

- moving care to larger rooms where social distancing can more easily be maintained
- minimising the movement of service users and support people around the premises
- introducing one-way systems where feasible and proactively managing the risk of queues and pinch points that may compromise social distancing
- encouraging women and support people to attend their appointment on time and to wait outside the hospital if they arrive early.

25. Waiting areas were not designed with social distancing in mind. Many trusts have developed creative solutions: for example, considering whether it is practical for support people to wait outside the hospital/clinic (or in their car). They could be called into the clinical area when the clinician is ready to begin the appointment.

26. Trusts may need to tailor their approach in different areas if one section of the service (eg the postnatal ward) has ample physical space and ventilation but others (eg scan facilities) do not.

27. Trusts will not have direct control over the estate in some care settings, particularly community settings, including GP surgeries. In such circumstances Trusts should work with leads for these settings to ensure the three key actions have been undertaken in order to enable women and their partners to attend appointments safely.

Testing

28. Where women and their support people in neonatal care test negative for COVID-19 and both staff and support people follow IPC guidelines, including use of PPE, the additional risk of COVID-19 transmission is likely to be small. It should therefore be possible to treat support people as part of the team supporting the woman and her baby, and allow other measures to mitigate some of the risks from reduction in the application of the 2-metre social distancing. Women should not be refused access to asymptomatic partners without recent possible exposure to COVID-19 infection, while test results are pending and where appropriate infection control can be maintained through other means. The same applies to the parents of babies in neonatal care.

Antenatal care

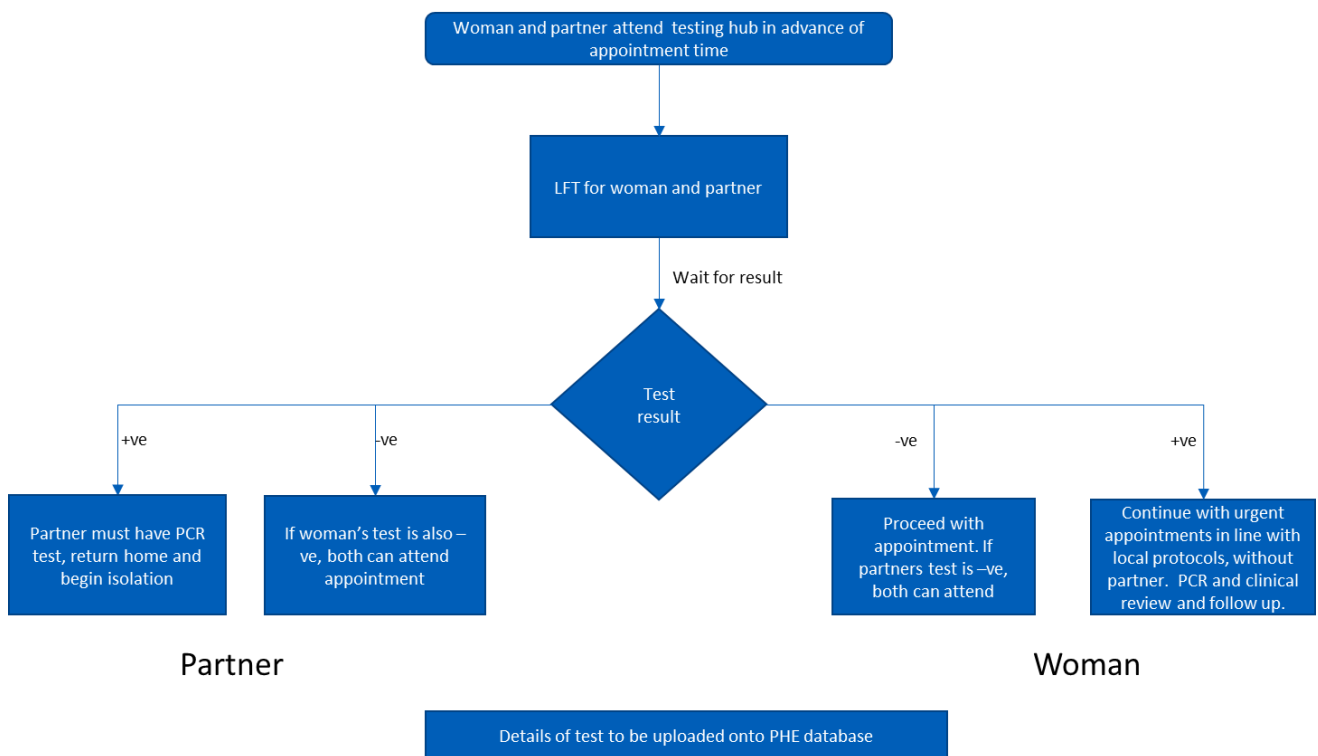
29. Women have not been routinely offered testing ahead of attendance at antenatal appointments. We are now asking trusts to offer all women and their support people lateral flow testing ahead of specifically 12 and 20 week scans and fetal medicine appointments so as to facilitate attendance and ensure support is in place.

30. Lateral flow testing capacity is now being made available to NHS trusts. A proportion of these should be made available to test women and their support people where necessary as set out above. Each trust has sufficient tests available for use in maternity as well as for other nationally agreed use cases, such as staff testing.

31. Trusts should plan the deployment of this lateral flow testing carefully. For example, a temporary testing hub may need to be established in the external grounds of each trust, so as to avoid crowding in the maternity unit, however for smaller clinics, testing at the entrance by an appropriate staff member will be possible. Women and partners will need to be asked to attend for testing, leaving sufficient time in advance of their appointment for the results to be obtained. Once results are communicated to the patient and her support partner, they should be recorded as per statutory requirements

32. Where a woman and her support person both test negative for COVID-19 they will be invited to proceed to the maternity unit or scan suite and asked to present their test result to trust clinical staff prior to entering the relevant area. Infection prevention and control measures remain important in women and support partners with a negative test result, due to the sensitivity of the test.

33. Trusts should put plans in place for when a support person tests positive for COVID-19. In such circumstances the trust will need to explain what the positive result means, including the requirement to self-isolate, how to obtain care if they need it, and that they will not be able to accompany the woman to that appointment. They will also need to have a confirmatory PCR test. Antenatal appointments are important for the safety and wellbeing of the woman and her baby, so the woman should be advised to proceed with her appointment, although she may choose to rebook her appointment for another time so she can be accompanied by an alternative support person who has not tested positive for COVID-19.
34. Where a woman herself tests positive for COVID-19 in advance of an antenatal appointment, this is likely to be of greater concern than normal to both the woman and her support partner because of the woman's pregnancy. Trained personnel should explain what the positive result means, including the requirement to self-isolate. She will also need a confirmatory PCR test. The maternity team should follow local protocols so that women who test positive with COVID-19 can continue with urgent or time-dependent appointments, with appropriate IPC measures in place. In line with current legislation, pending review by government, where a woman tests positive for COVID-19 her support person is under an obligation to self-isolate and will not be able to accompany her to her appointment.
35. The woman will need additional advice and reassurance on the implications of her diagnosis for her pregnancy. Advice should be provided as part of a clinical review and a plan for follow up, taking into consideration whether the woman meets the criteria for enhanced surveillance during her pregnancy. All maternity units have been asked to put in place increased support for at-risk pregnant women, such as having a lower threshold to review, admit and consider multidisciplinary escalation in women from a black, Asian or minority ethnic background. This discussion and plan should be documented by the maternity team.



Labour and birth

36. Trusts routinely test women for COVID-19 on admission and should always offer a test to birth partners at the same time, making use of rapid testing when available locally in line with local testing protocols. If Lateral Flow Devices are used, trained personnel will need to administer the test and to record the details of every test electronically to be uploaded onto the Public Health England (PHE) database.
37. Trusts should put plans in place for when a support person tests positive for COVID-19. In such circumstances the trust will need to explain what the positive result means, including the requirement to self-isolate and how to obtain care if they need it, and require the partner to leave. The woman can select an alternative support person who has not tested positive for COVID-19. Midwives and obstetricians should discuss this with each woman and, where possible, her support person in the antenatal period, so that contingency arrangements can be made.
38. Trusts should also have clear plans in place for when a pregnant woman herself tests positive for COVID-19. In line with current legislation, pending review by government, where a woman tests positive for COVID-19 her support person must return home to self-isolate. The implications of the current legislation for COVID-positive pregnant women are being explored by the government to identify legal safeguards to ensure that all women are able to be supported by their support person.

Neonatal services

39. Trusts should put in place processes routinely to test parents for COVID-19 on their baby's admission to a neonatal unit, making use of rapid testing when available locally. These tests should be carried out at regular intervals in line with local protocols for the duration of their baby's stay. If lateral flow devices are used, trained personnel will need to administer the test and to record the details of every test electronically to be uploaded onto Public Health England (PHE) database.
40. Trusts should put plans in place for when a parent tests positive for COVID-19. In such circumstances the trust will need to explain what the positive result means, including the requirement to self-isolate and how to obtain care if they need it. Parents should be offered video access to their baby for the duration of their self-isolation.