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

Version 2, 15 April 2021

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.

    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 any available testing capacity (including the national rollout of lateral flow testing) to test women and their support people to help mitigate infection risks, in particular for scan appointments, for foetal 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. Put communications in place to advise women of this.

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, published on 16 March 2021.

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 2-metre rule, unless providing clinical or personal care and wearing appropriate PPE. 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 or put in place other mitigations, such as appropriate PPE and testing, 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 any available testing capacity (including national rollout of lateral flow testing) to test women and their support people to help mitigate infection risks, in particular for scan appointments, for foetal 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. Put communications in place to advise women of this.

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 distancing unless providing clinical or personal care and wearing appropriate PPE
    - 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. There is an exemption to allow COVID-19 positive women to have support, although support people who are themselves COVID-19 positive will need to isolate and the woman will need to nominate an alternative

    - rules on national and/or 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
    - the role PPE can play in reducing the risk of virus transmission.

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 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. The Government has announced that twice weekly rapid (lateral flow) testing is available to everybody from 9 April 2021 and that tests can be ordered online. Women and their support people should order tests via this route, and carry out tests at home on the day of their appointment, reporting their results online immediately. This will generate an email and a text message confirmation of the result. They should bring proof of a recent negative test with them to each appointment. Women and/or their support people who have access to lateral flow tests via a different route, eg their employer or a school bubble, should bring proof of their latest regular test. NHS trusts will need to put in place communications to advise women and their support people of this requirement. They will also need to put in place a mechanism to check and record results of women and their support people who have tested at home when they attend for their appointment. Frequently asked questions providing further detail of how this can be operationalised have been published.

30. NHS trusts will need to put in place alternative arrangements for women who have difficulties with home testing, including when a woman may need to attend a maternity unit at short notice. Lateral flow testing capacity has been made available to NHS trusts and these can be made available to test women and their support people where

necessary. Each trust has sufficient tests available for use in maternity as well as for other nationally agreed use cases, such as staff testing.

31. If the support person tests positive, they should isolate as set out in government guidance. The woman can then select an alternative support person who has not tested positive to COVID-19. If the support person gets a positive test result through a lateral flow test, a confirmatory PCR test will be required. 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.

32. 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. The woman should be advised to contact her maternity services prior to attending an appointment if she has tested positive and that she will 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.

33. 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

34. Trusts routinely test women for COVID-19 on admission and may either offer a test to birth partners at the same time, or seek proof of a negative home rapid (lateral flow) test as set out for antenatal care above.

35. Trusts should also have clear plans in place for when a pregnant woman herself tests positive for COVID-19 to provide her with safe personalised and COVID-secure care. 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, if they are on site, 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.

Neonatal services

36. Many trusts have put in place processes to routinely test parents for COVID-19 on their baby's admission to a neonatal unit, making use of rapid testing when available locally. Trusts may either continue to use these established processes or seek proof of a negative home rapid (lateral flow) test as set out for antenatal care above. NHS trusts will need to put in place communications to advise parents of this requirement. These tests should be carried out at regular intervals in line with local protocols or twice weekly in line with the national testing scheme for the duration of their baby's stay.

37. 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.