Title: Standard Operating Procedure for Maternity Antenatal and Postnatal Visiting (inc Community & Homebirth)
Department: Women's Directorate - Maternity
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Approved by: W&C Covid 19 Huddle
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Target Organisation: Worcestershire Acute Hospitals NHS Trust
Target Departments: Antenatal Clinics, DAU & Community Services
Target Staff Categories: Midwives, Maternity Support Workers, Sonographers & Consultant Anaesthetists, Consultant Obstetricians & Gynaecologists.

SOP Purpose
To ensure the correct and proper procedure is followed in the antenatal and postnatal services to support women during the Covid 19 pandemic.

Date	Amendment	By Whom
01.04.2020	• Update to reflect recommendations in recent RCOG guidance • Updated to reflect changes in PPE	Justine Jeffery
03.07.2020	• Return to face to face primary PN visiting • Return to the full schedule of antenatal contacts in line with NICE • Use of home monitoring of blood pressure for non face to face appointments • Acknowledgement of increase risk for women from a BAME community and the requirements to meet the recommendations from NHSE	Justine Jeffery
6.11.2020	• Updated with need to wear FRSM in all settings incl women • New triage questions included as per PHE guidance.	Justine Jeffery

1.0 Introduction

This guidance has been prepared to support antenatal and postnatal services during the evolving coronavirus pandemic. This document intends to outline which elements of routine antenatal and postnatal care are essential and which could be modified, given national recommendations for social distancing of pregnant women and escalation during severe staffing shortages. Additional information is also outlined to protect women from BAME communities to provide greater protection during Covid 19.

2.0 Providing a safe and responsive antenatal and postnatal care service

General guidance for services is provided in the RCOG's coronavirus guideline.

2.1 Provision of advice for women about antenatal and postnatal care

All changes to maternity services will be shared with women via the Trust's website, Community Midwifery Service, the MVP social media pages and by letter if appointments have been rescheduled.

2.2 Providing face to face consultations safely

Where women require a face to face consultation due to the need for physical examination and/or screening all staff in attendance and the woman **must** wear a FRSM- masks will be provided by the midwife for homes and GP surgeries. The teams must ensure that prior to the commencement of the consultation the following Triage questions are considered:

Question	Yes	No
1. Do you or any member of your household/family have a confirmed diagnosis of COVID-19? If yes, wait for the agreed period of time depending on date of onset (10-14 days) before treatment or if urgent care is required, refer to MBC for ongoing treatment.		
2. Are you or any member of your household/family waiting for a COVID-19 test result? If yes, ascertain if treatment can be delayed until results are known. If urgent care is required refer to MBC for ongoing treatment.		
3. Have you travelled internationally in the last 14 days? If yes confirm where and if this is a country that has been agreed as safe for travel by the government. If this is not on the list then 14 days quarantine will apply. If regent care is required refer to MBC for ongoing care.		
4. Have you had contact with someone with a confirmed diagnosis of COVID-19, or been in isolation with a suspected case in the last 14 days? If yes, wait for the agreed period of time depending on what date of the isolation period the woman is at (ideally 14 days) before treatment or if urgent refer to MBC for ongoing care.		
5. Do you have any of the following symptoms? High temperature or fever New continuous cough A loss or alteration to taste or smell If yes provide advice on who to contact (GP/111) or if unwell and admission required refer to MBC for ongoing care for to MBC for ongoing care.		

This may be a telephone call prior to the appointment or an assessment at entry to the maternity setting, primary care setting or both.

If a woman attends an antenatal appointment but describes symptoms, she should be advised to return home immediately. A member of clinical staff will then make contact with the woman to risk assess whether an urgent home antenatal appointment is required, or whether the scheduled appointment can be delayed for a period of up to 14 days.

3.0 Key principles for the provision of antenatal care through the evolving coronavirus (COVID-19) pandemic

3.1 Maintaining essential monitoring

Many elements of antenatal care require in-person assessment, in particular blood pressure and urine checks, measurement of fetal growth, and blood tests. Routine antenatal care is essential to detecting common complications of pregnancy such as pre-eclampsia, gestational diabetes, and asymptomatic urine infection.

Current WHO guidance recommends a minimum of eight antenatal contacts for low risk women.

1. *A minimum of six face to face antenatal consultations is therefore advised.*
2. *There is no appropriate evidence about replacing this minimal antenatal care with remote assessment*
3. *There is a shortage of evidence about rationalising visit numbers, but evidence from lower and middle income countries suggests that attendance at five visits or less is associated with an increased risk of perinatal mortality (RR 1.15; 95% CI 1.01 to 1.32, three trials)*

CO Monitoring

CO monitoring will cease and guidance will be issued on when to recommence this programme.

Midwives and doctors should still ask about and document smoking status at booking and 36 weeks, provide very brief advice and refer women who smoke to specialist stop-smoking support on an opt-out basis.

Advise women that they are much more likely to stop smoking with support (be aware that this local provision may also have had to change recently – eg from face-to-face support to telephone consultations).

Continue to provide or recommend women use nicotine replacement as part of their quit attempt: eg a patch as well as a faster-acting product, such as inhalator, gum or spray. Women may wish to consider purchasing this while awaiting their stop-smoking appointment.

This situation should be regularly reviewed and plans put in place to reinstate CO monitoring as soon as it is considered safe to do so.

Women should be asked if other people in the household smoke, advised about the risks of exposure to second hand smoke and informed of support available for partners or family members to quit, for instance local telephone support or the national smoking helpline (0300 123 1044).

3.2 Remote care support capacity (telephone or video consultations)

The most recent guidance supports the return to face to face consultations for the majority of antenatal care.

In some cases clinics can be run effectively using telephone or video consultations instead of face to face encounters for example were home monitoring is available. All remote consultations should be recorded on Badgernet. Remote appointments will be appropriate for a range of consultations, including:

- Supporting women at risk of or currently experiencing mental health problems

- Maintaining contact with families living with a range of vulnerabilities or where there are safeguarding concerns

- Discussion of plans for birth

- Provision of breastfeeding support and early parenting advice and guidance

- Maternity staff who are identified as vulnerable or currently self - isolating and are well, can provide this remote support.

3.3 Homebirth

There is no national guidance that suggests that the homebirth service should not continue and where possible (in support of social distancing of pregnant women) the service will continue unless:

1. WMAS are unable to provide a timely response to homebirth calls and transfer to hospital
2. The on-call rota cannot be maintained due to availability of staff

Homebirth information will be collected as per current local guidance. For those women who request homebirth which is outside national guidance the Matron for Community & Divisional Director of Midwifery will work with the midwifery team and the named Consultant to ensure that there is a clear plan for staff to follow and there is supporting documentation evidence that the woman has made an informed choice following a benefits and risks conversation.

Women who are suspected or confirmed Covid-19 should be advised to birth in hospital as continuous electronic fetal monitoring is recommended. Women who are well should be supported to plan and prepare for Homebirth as per current local guidance.

3.4 Use of home appointments

- Home visits may be preferable, provided the woman and everyone in her household is well.

- Staff attending homes should be mindful of exposure to COVID-19 in a home visit and should adhere to strict infection control procedures when entering and leaving homes. It has been shown that the coronavirus can survive on surfaces for up to 17 days.

- Maternity staff should be provided with appropriate personal protection equipment as per PHE guidelines when providing care for women with suspected infection or when entering homes where other members of the household have symptoms.

The following four recommendations can be made for women to help reduce the risk to staff

1. Declare if anyone in the house has had a recent COVID infection or symptoms
2. Women should be asked to be the only person in the room when the midwife is visiting to reduce exposure to family members
3. Wearing of a FRSM
4. Well ventilated room

3.5 Capacity

We will experience difficulties with our capacity to provide all services throughout the pandemic. We have a daily huddle with senior team members to review the antenatal service, service provision and available staff. Where required, the appointments highlighted in ***Table 1*** as being in-person appointments should be prioritised and if staffing levels support a full schedule of antenatal visiting as outlined in the NICE guidance should be followed.

When there are acute staff shortages, existing systems for recruiting additional staff will be used. Maternity support workers, midwifery students, and obstetric team members can be used to support core service delivery.

4.0 Antenatal appointments modified schedules

4.1 Low risk women

- All continuity teams will continue and women should receive care from their continuity team and primary midwife.
- Women should, where possible, be offered a virtual booking appointment or a one-stop clinic appointment that includes booking and scan together.
- Women should then have a minimum of six antenatal contacts in total.
- Wherever possible, scans and antenatal appointments and other investigations should be provided within a single visit, involving as few staff as possible.
- Suggested modifications to the existing schedule of antenatal care for low risk women (in times of severe staffing shortages), including where face-to-face appointments can be replaced with remote assessments are detailed below in the ***Table 1.***
- At all remote appointments, women should be asked about wellbeing and, if in third trimester, fetal movements.
- Consider scheduling the post-dates appointment on a day where induction of labour can be commenced (after 41+0, in line with NICE guidance).

- Consider using outpatient induction of labour for low risk women.

4.2 Modifications to NICE Schedule of Antenatal Care for Low Risk women

- The antenatal appointment schedule will need to evolve in light of the impact of the pandemic on staffing levels.

- In areas where the spread of the pandemic is in earlier stages and staffing allows, all of the appointments below (green, amber and red) should be maintained for all women for as long as possible.

- As staffing shortages increase during the course of the pandemic, services will need to consider reducing appointments. The appointments shown below in green should be maintained.

4.3 Women at increased risk of complications

Some women have a condition or complication that necessitates additional appointments or multi-disciplinary care during pregnancy. Those appointments that do not require measurement of fundal height, blood or urine tests, or scans, should be provided remotely via video or teleconferencing.

Triaging obstetric clinics to reduce duplication of hospital or healthcare worker contacts In order to rationalise appointments, obstetric antenatal referrals can be triaged locally by a consultant with a telephone appointment to discuss a proposed plan of care with the woman. This means that women in general follow their schedule of care with the midwives and see obstetricians in a targeted way.

It is recognised that women from a BAME community are at increased risk of developing severe or life threatening Covid -19. Coupled with the extensive evidence that BAME women have a poorer experience and poorer outcomes during pregnancy it is necessary to greater protection during the pandemic.

It is proposed that:

1. *Face to face home visits for all antenatal and postnatal visits*
2. *Have discussions at booking re vitamins/dietary requirements*
3. *Direct access to hospital e.g. walk in to Triage without the requirement to call the service before if the woman and/or her family are worried*
4. *Referral to the specialist midwife for vulnerable women if there are high social risks*
5. *Ensure that the midwifery and obstetric team have a lower threshold to investigate clinical concerns*

Table 1-Revised schedule of visits

	Visit	Who	What	Modifications
1	Booking visit	All women	Full history, initial screening for medical, psychological and social risk factors.	Virtual booking where possible, or one-stop visit, with dating scan and all testing in maternity unit
1+	Dating scan	All women	Combined antenatal screening, all blood tests, BP and urine testing to be taken at dating scan appointment.	
	16 weeks	All women	Review results of screening review, discuss and record the results of all screening tests. Reassess planned pattern of care for the pregnancy and identify women who need additional care. Give information about ongoing care.	Virtual appointment or omit as necessary
2	18-20 weeks	All women	Routine anomaly scan Check BP and Urine at this visit instead of 16 week appointment.	Maternity unit or community unit with ultrasound facilities
	25 weeks	Nulliparous women	Measure fundal height, BP and urine; review scan results.	Omit unless staffing allows or additional concerns
3	28 weeks	All women	Discuss current health. Enquire about fetal movements. Discuss mental wellbeing, and offer advice and sources of further support and information. Follow up any safeguarding concerns. Discuss plans for antenatal classes (remote access). Measure fundal height, BP and test urine; repeat blood tests to screen for anaemia and RBC allo-antibodies; anti-D prophylaxis for Rh negative women.	Maintain appointment
	31 weeks	Nulliparous women	Omit – replaced with 32/40 for all.	
4	32 weeks	All women	Measure fundal height, BP and test urine; discuss results of investigations at 28 weeks; discuss plans for birth. Discuss wellbeing, fetal movements. Follow up safeguarding issues.	Maintain appointments. If need to reschedule due to illness/quarantine, see or contact all women within 3 weeks of previous contact.
5	36 weeks	All women	Measure fundal height, BP and test urine; discuss fetal movements and wellbeing, discuss plans for birth and all usual care.	
	38 weeks	Nulliparous women only	Measure fundal height, BP and test urine and all usual care	
6	40 weeks	All women	Measure fundal height, BP and test urine; give information about options for prolonged pregnancy	
	Post dates from 41+0 (Locally agreed protocol)[6]	All women	Measure fundal height, BP and test urine; discuss fetal movements and wellbeing	Appointment to be followed immediately by outpatient / inpatient IOL to avoid a further attendance

5.0 Postnatal care

Postnatal care should be individualised according to the woman and new-born's needs. The minimum recommended number of contacts is three: at day 1, day 5 and day 10. Day 1 & 5 will require face to face however day 10 can be completed via telephone.

• Prioritise face to face visiting for women:

- From a BAME community
- Known psycho-social vulnerabilities
- Operative birth
- Premature/low birthweight baby
- Other medical or neonatal complexities

Continuity models should continue and women should continue to receive care from their continuity team and primary midwife. Aim to ensure continuity of midwife providing any remote postnatal care. Home visits may be preferable to community clinic visits to comply with social distancing, but staff safety must also be maintained.

It may be necessary to consider further amendments to postnatal care if ther is further escalation of the pande4mic:

- Provision of care by senior student midwives and maternity support workers
- Reduction of face to face visits, particularly for healthy term multiparous women and their babies
- It is important to coordinate postnatal care with local health visitors to ensure smooth transfer of care. HV have withdrawn face to face contact unless socially indicated.
- Remote support by third sector organisations will be invaluable to provide support for breastfeeding, mental health and early parenting advice.

6.0 PPE

Please follow PHE guidance for all appointments in clinics, GP surgery and Children's clinic and follow the RCM guidance for completing a home visit (information given to women on discharge). Care workers should use personal protective equipment (PPE) for activities that bring them into close personal contact, such as contact with bodily fluids.

- Aprons, gloves and fluid repellent surgical masks should be used in these situations. If there is a risk of splashing, then eye protection will minimize risk.
- Gowns should be worn for 2 & 3rd stage of labour.
- New personal protective equipment must be used for each episode of care. It is essential that personal protective equipment is stored securely within disposable rubbish bags
- These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside (in the home) for at least 72 hours before being put in the usual household waste bin.

7.0 Visiting Hospital

Please refer to NHSE guidance re current visiting guidance. At the time of writing this document the current guidance agreed locally is:

- Women attend outpatient appointments alone (unless require a carer to support or have significant MH concerns)
- 1 birth partner can be present for the entirety of labour and birth (inc elective CS)
- Ward visiting as agreed locally

8.0 Further advice for women

Any woman contacting their community midwife for advice should be offered advice as outlined in

https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

We would advise you to follow the most recent Royal College of Obstetricians and Gynaecologists (RCOG) guidance

https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/