Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic

Information for healthcare professionals

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Table of changes

1.1	17.4.20	**1.1:** Added the following elements into data to be considered at each stage: independent midwives, staff requirements to maintain essential antenatal and postnatal care, consideration of local geography and demographics.
1.1	17.4.20	**3:** Reference made to NHS England guidance on the reconfiguration of intrapartum care services. Recommended co-production of local plans with service user groups.
1.1	17.4.20	**Throughout:** Revised throughout to ensure compatible with NHS England guidance on reconfiguration of intrapartum care services.

1. Introduction and background

Childbearing women and newborn infants continue to require safe person-centred care during the current COVID-19 pandemic and they represent a unique population. The majority are healthy, experiencing a life event that may bring clinical, emotional, psychological, and social needs. Women and newborn infants therefore require access to quality midwifery care, multidisciplinary services and additional care for complications including emergencies, if needed.

When staff and services are under extreme stress there is a real risk of increasing avoidable harm, including an increased risk of infection, morbidity and mortality, and reductions in the overall quality of care. Safety, quality and preventing avoidable harm must be key priorities in decision making. Continuation of as near normal care for women should be supported, as it is recognised to prevent poor outcomes.

1.1 Provision of midwife-led birth settings

With reference to the current COVID-19 pandemic, the International Confederation of Midwives (ICM) recommends that in countries where the health systems can support homebirth, healthy women experiencing a low-risk pregnancy may benefit from giving birth at home or in midwife-led units rather than in a hospital where there may be many COVID-19 patients, if there is the ability to provide appropriate midwifery support and appropriate emergency equipment and transfer.[1]

This guidance has been developed to support maternity service leads in decision making about midwife-led birth settings in the evolving coronavirus pandemic, and it was informed by a rapid review conducted by the RCM Professorial Advisory Group.[2]

This guidance recommends a **staged approach** in responding to emerging issues with staff shortages and other service pressures during the pandemic. Decisions about when to implement each stage will need to be made at a local level based on current local data:

- Bed occupancy in the maternity unit(s)
- Community workload
- Sickness rate among midwifery staff (midwives, maternity support workers and senior student midwives)

- Available midwifery staffing (including additional midwives from the NMC emergency register, independent midwives, those previously in non-clinical roles or year-3 student midwives)
- Skill mix of available midwifery staffing – including level of seniority and experience in provision of community-based care
- Availability of ambulances and trained paramedic staff, to provide emergency transfer

1.2 Benefits and safety of midwife-led birth settings

The positive impact of midwife-led birth settings is well documented, including reductions in the need for a range of medical interventions.[3,4,5] These positive impacts remain of significant importance to prevent avoidable harm, and availability of midwife-led care settings for birth should therefore be continued as far as is possible during the pandemic.

There is considerable evidence to support the safety of homebirth for healthy women when supported by qualified midwives practising within a supportive network. Findings from the Birthplace study confirm that, for women having their first baby, the likelihood of requiring transfer from home to the obstetric unit in labour or immediately after birth is 45% and from a midwife-led unit is 36-40%. The transfer rate is much lower at 10% for women having their second (or third or fourth) baby.[4] Transfers reported in the study were mostly for non-emergency reasons such as slow progress in labour and maternal request for pain relief.[4] No increased risks of perinatal or neonatal adverse outcomes for planned homebirths were identified in the largest meta-analysis of 500,000 mother-baby dyads.[6]

2. Principles for equitable, safe, effective, quality maternal and newborn care in a pandemic

The following principles are critical during the COVID-19 pandemic. They were developed by the RCM's COVID-19 Professorial Advisory Group, drawing on evidence of essential components of quality care and incorporating the latest information from the World Health Organization (WHO) and the ICM on COVID-19. These principles should underpin maternity care for every woman and baby, every time.

Care providers must:[2]

- Continue to provide evidence-based, equitable, safe, compassionate and respectful care for physical and mental health, wherever and whenever care takes place, by remote access if necessary
- Protect the human rights of women and newborn infants, as far as possible
- Ensure strict hygiene measures and social distancing when possible
- Follow national guidance on use of personal protective equipment (PPE)
- Ensure birth companionship
- Prevent unnecessary interventions
- Not separate a woman from her newborn infant(s) unless absolutely necessary
- Promote and support breastfeeding
- Protect and support staff, including their mental health needs.

3. Midwifery services reorganisation during the COVID-19 pandemic

Service leads will wish to make decisions about reorganisation of their services, including the need to centralise due to staffing and other service pressures, on the best available evidence.

There is very little evidence available to support changes in configuration of services, and particularly changes to more centralised services, during the COVID-19 pandemic. Emerging evidence from European settings supports continuing to strengthen community services in order to enable social distancing and minimise spread in healthcare settings.[7] The importance of deployment of outreach services, community clinics and home care rather than the centralisation of services has been identified.[7,8,9] It may be of benefit for midwifery services to keep community midwifery staffing as separate as possible from hospital midwifery staffing for as long as this is feasible to reduce the risk of transmission between staff.[8,9]

The ICM has based their current recommendations for maternity care during COVID-19 on supporting community birth for healthy women and newborn infants as a means of reducing spread of infection.[1] NHS England clinical guidance[10] on temporary reorganisation of intrapartum care during the pandemic states that freestanding midwifery units and homebirths help to keep women out of hospital and reduce the pressure on hospital services.

However, it is recognised that safety in birth remote from hospital settings requires the availability of appropriate midwifery staffing and ambulance transfer facilities. Where these are not available, it may be necessary to modify available services, seeking at all times to maximise the provision of a safe and positive birth experience to all women.

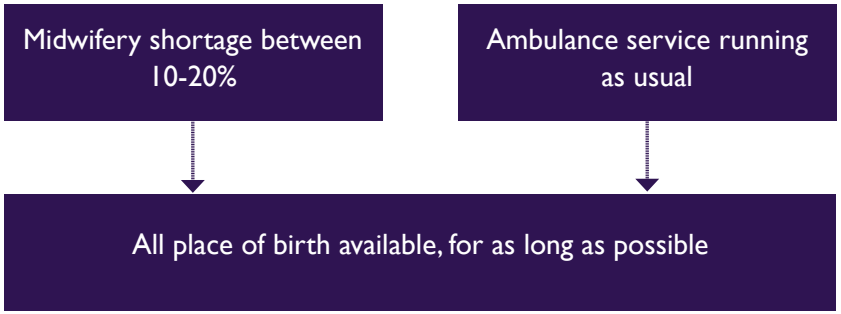
The phased approach described below identifies the need to have a flexible approach to service provision – stepping up into a more centralised service as the impact of the pandemic on staffing and ambulance services reaches its peak, while seeking to maintain or step back down the provision of midwifery led and community based care settings when staffing and ambulance provision allows. Decisions about offering birth place options for women in a particular area are best made in a way that demonstrates recognition that any reduction in birthplace options is temporary and will be continually reassessed throughout the timeline of the pandemic.

It is important to work and communicate effectively with service users and their families. Input into planning and changes to services should be sought from local user groups, including Maternity Voices Partnerships (MVPs) and Maternity Services Liaison Committees (MSLCs). The presence of existing relationships will enable this to be done rapidly; where possible, plans and communications should be co-produced.

3.1 Phase one: preparation

In the preparation phase, midwifery care should be provided as normal, with all birth settings including home, freestanding and alongside midwife-led units (FMUs and AMUs), and obstetric units running as usual, for as long as possible. Birth in midwife-led settings is recommended for low-risk women, as per NICE guidance on place of birth.[5]

The percentages set out below are aimed to provide a helpful rule of thumb, to be contextualised for local need.



Women should be advised, through local trust or board websites, other official communications and online forums, including local service user forums, that the provision of care may need to be adapted as the situation changes, with communications co-produced with local MVPs/MSLCs.

Prior to triggering phase two, the following should be considered:

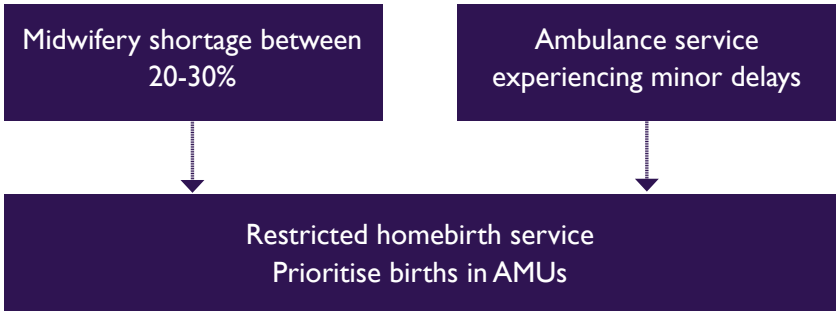
- Review the number of midwives routinely sent to homebirths. Current policy in most areas across the UK is for two midwives to attend all homebirths. Consideration may be given to adaptation of these policies to include senior student midwives, returning registered non-clinical midwives, returning recently retired midwives or appropriately prepared maternity support workers to attend as the second member of the team for low-risk home births.

- Community midwifery teams and freestanding midwifery units within the same trust/health board should plan to integrate their systems with all-inclusive rotas so as to maximise the spread of resources and maintain the full range of maternity settings for as long as sustainable staffing allows.

3.2 Phase two

The second phase is triggered if the midwifery shortage is exacerbated by the pandemic and is above 20%. The impact of the percentage of staff shortages will vary according to the location of the care; a smaller shortage may have a greater impact in a very rural area, for example.

Local geography and demographics should therefore also shape decision making when moving from one phase to another.



Midwives practising in the community should have their workload reviewed and where possible the provision of antenatal and postnatal care rationalised, in line with RCM/RCOG guidance.[11] This will include increasing the provision of virtual rather than face to face appointments where appropriate.

In some NHS trusts/health boards there are multiple midwife-led units. To ensure viability it may be necessary to reduce the number of freestanding midwife-led units providing care, and to prioritise alongside over freestanding midwife-led units to reduce the workload of the ambulance service, especially if delays in response time start to be experienced.

Consider the following points to enable decision making about rationalising place of birth options for women:

- Scale-up the number of rooms on AMUs, or set up midwifery-led rooms on obstetric-led units to ensure women who prefer, or are eligible for, midwifery-led care can receive it.
- Utilise midwifery staff more flexibly between different areas, to support women's choice of place of birth, while maintaining a safe level of antenatal and postnatal care.[11]
- Provide virtual midwifery support and assessment to enable longer stays at home in early labour, where this is appropriate.
- Offer homebirth only to low-risk multiparous women and offer low-risk primiparous women option of alongside midwife-led unit birth, to reduce need for intrapartum transfers.
- Encourage early discharge from midwife-led units to free up intrapartum capacity.

- Ensure communication with ambulance service is in place and category 1 calls only are requested of them.

- Use dedicated services for emergency transfer (including private or army ambulances) and dedicated private taxi for non-emergency transfer.

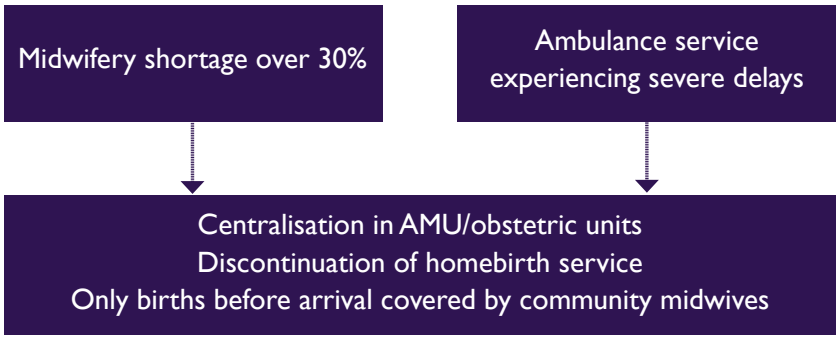
During phase two, women should be made aware of plans for centralisation if phase three is triggered, through individual contact with women booked for birth at home or in a midwife-led setting; trust and board websites; other official communications and online forums, including local service user forums. Communications should be co-produced with local MVPs/MSLCs.

3.3 Phase three

Phase three is triggered once the midwifery shortage is over 30% or once the ambulance service is unable to support category 1 emergency calls without severe delays. If the safety of homebirth cannot be assured and midwifery staffing does not allow safe staffing of all places of birth, centralisation is recommended.

Anticipation is recommended so local trusts/health boards should have protocols and standard operating procedures in place and be able to trigger phase three smoothly and safely.

Alongside midwife-led units will be the only midwife-led settings available to women, as well as allocated midwife-led rooms on obstetric units in those NHS trusts/health boards lacking an alongside midwife-led unit.



3.4 Phase four: de-escalation

It is essential that the changes recommended by this guidance are reviewed daily and de-escalated according to the availability of midwifery staff and safe transfer.

3.4.1 Table: process for de-escalation

Midwifery shortage over 30%	Midwifery shortage between 20 and 30%	Midwifery shortage between 10% and 20%
Centralisation in alongside midwife-led and obstetric units	• Reinstate restricted homebirth service • Reinstate freestanding midwifery-led units • All-inclusive rota for community and midwifery-led unit midwives	• Reinstate homebirth service for all women • Reinstate all options for place of birth

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Authors

Lia Brigante, RCM Quality & Standards Advisor

Mervi Jokinen, RCM Professional Advisor

Mary Ross-Davie, RCM Director

Birte Harlev-Lam, RCM Executive Director

Eddie Morris, RCOG

Pat O'Brien, RCOG/UCLH

Jennifer Jardine, RCOG

Sophie Relph, RCOG

Anita Powell, RCOG

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Royal College of Obstetricians & Gynaecologists

Royal College of Obstetricians and Gynaecologists, 10-18 Union Street, London, SE1 1SZ

T: +44 (0) 20 7772 6200 E: covid-19@rcog.org.uk W: rcog.org.uk Registered Charity No. 213280