Guidance for Antenatal and Postnatal Services in the evolving Coronavirus (COVID-19) pandemic

Information for healthcare professionals

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Table of updates

A summary of previous updates can be found on pages 14–15.

Version	Date	Summary of changes
3	21.10.20	**Throughout:** Replaced 'face-to-face' with 'in-person' to clarify that video consultations are not a direct replacement for in-person review.
3	21.10.20	**Throughout:** Rewording for clarity; document reviewed as current with reference to current (as of 1.10.2020) public health guidance in UK nations.
3	21.10.20	**Throughout:** The overall recommendation is that NICE - recommended schedules of antenatal and postnatal care should be provided wherever possible. This is emphasised throughout the document, with areas for use of virtual appointments if necessary highlighted.
3	21.10.20	**0 Introductory note:** Added for autumn 2020
3	21.10.20	**2:** Modification to advice "When reorganising services, maternity services should be cognisant of evidence that black, Asian and minority ethnic group (BAME) individuals, women living in areas of multiple deprivation, and women with pre-existing comorbidities are at particular risk of developing severe and life-threatening COVID-19."
3	21.10.20	**2.2:** Providing in-person consultations safely: Updated to refer to current isolation guidelines for either 10 or 14 days.
3	21.10.20	**3.6:** Recommendation added: 'Antenatal education Services, where they have not already done so, should seek to provide remote antenatal education classes. Remote antenatal classes may continue as in-person classes are re-introduced, as they may be more accessible and acceptable for some women.'
3	21.10.20	**4.1:** Reference made to further information about safely providing virtual consultations, which can be found in the RCM's briefing and the accompanying poster.
3	21.10.20	**4.1:** Recommendations modified and added: • The NICE Schedule of Antenatal Care should be maintained in its entirety. • If modifications to the pre-pandemic antenatal schedule are unavoidable, suggested modifications to the existing schedule of antenatal care for low risk women, including where in-person appointments might be replaced with remote assessments are detailed in the table in 4.1. • In line with recommendations made in RCOG/RCM guidance 'Coronavirus infection and pregnancy', all women should be asked about their mental wellbeing at every appointment. Where a woman identifies that she is experiencing psychological distress including high levels of anxiety or depression, additional appropriate support should be instigated as rapidly as possible.

3	21.10.20	**4.1.1:** Table in section 4.1.1 modified to identify appointments for low risk women suitable to be provided virtually.
3	21.10.20	**3.1.1:** Additional section added: 'Supporting the development of trusting relationships'.
3	21.10.20	**5 Postnatal care:** Recommendations modified • Postnatal care should be individualised according to the woman and newborn's needs and should follow the NICE guidance for postnatal care as far as possible • Visits on day 1 at home, and day 5 for the newborn blood spot should be prioritised as in-person visits

Introductory note: Autumn 2020

As the pandemic situation evolves, those charged with leading maternity services will once more be reflecting on antenatal and postnatal service provision. The challenges are, as in the spring, increases in local infection prevalence and the risk of nosocomial transmission, increases in staff absence and self-isolation and resulting service pressures.

It is now clear that for the 700 000 women who have or will give birth in the UK between March 2020 and March 2021, the majority or all of their care will occur under some form of coronavirus-induced restriction. To these women, this is not a temporary change, but their whole pregnancy and birth experience. It is, therefore, essential that we do everything we can to optimise the physical and mental wellbeing of pregnant women and new parents, while maintaining adherence to social distancing and reducing as far as possible the potential for nosocomial transmission.

The document below continues to provide guidance on using a flexible approach to modifications to antenatal and postnatal services. Recommendations should be interpreted in the context of local infection rates and service pressures.

1. Introduction

This guidance is for antenatal and postnatal services to support them 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 to reduce transmission between women, their families and maternity staff.

2. Providing a safe and responsive antenatal and postnatal care service

General guidance for services is provided in the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) document Coronavirus (COVID-19) infection in pregnancy.[1]

When planning services, maternity services should be cognisant of evidence that black, Asian and minority ethnic group (BAME) individuals, women living in areas of multiple deprivation, women with a higher BMI and those with pre-existing comorbidities are at particular risk of developing severe and life-threatening COVID-19.[2,3] Particular consideration should be given to the experience of women of BAME background and women living with deprivation when evaluating the potential or actual impact of any service change.

2.1 Provision of advice for women about antenatal and postnatal care

Maternity services should provide clear signposting for pregnant and postnatal women about changes to antenatal and postnatal services and their reasoning on their trust or health board websites through their social media accounts or through electronic notes.

Such information should be co-produced and disseminated in partnership with Maternity Voices Partnerships (MVPs) and Maternity Services Liaison Committees (MSLCs). It should be available in community languages other than English, and in visual or easy to understand formats as far as possible. Where such translation services are not available, consideration should be given to providing local community online groups and radio stations with information about any service changes, to enable them to share key information with the local communities.

2.2 Providing in-person consultations safely

Where women require an in-person consultation because of the need for physical examination and/or screening, a system should be in place for evaluating whether they have symptoms that are suggestive of COVID-19, or if they meet current 'stay at home' guidance (criteria for England, Wales and Northern Ireland and in Scotland). This may be a telephone call prior to the appointment or an assessment at entry to the maternity setting, or both.

If a woman attends an antenatal appointment but describes COVID-19 symptoms, she should be advised to return home immediately, unless she requires immediate emergency care. A member of clinical staff should then make contact with the woman to risk assess whether an urgent home antenatal appointment is required, whether the scheduled appointment can be conducted remotely or if it can be delayed for a period of 10–14 days.

3. 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 may require in person assessment, specifically blood pressure and urine checks, measurement of fetal growth and blood tests. Some areas have implemented the provision of home monitoring equipment to enable fewer in-person appointments in some circumstances. Routine antenatal care is essential in detecting common complications of pregnancy such as pre-eclampsia, gestational diabetes and asymptomatic urine infection.

The NICE Schedule of Antenatal Care[4] should be maintained in its entirety. Women should continue to receive the minimum of eight antenatal consultations, of these at least six contacts should be in-person. Further detail is in section 4.1.

Current World Health Organization (WHO) guidance recommends a minimum of eight antenatal contacts for low risk women.[5] Evidence from lower and middle income countries suggests that attendance at five in-person visits or less is associated with an increased risk of perinatal mortality (RR 1.15; 95% CI 1.01–1.32, three trials).[6]

A minimum of six in-person antenatal consultations is therefore advised. There is no appropriate evidence to replace this minimum antenatal care with remote assessment.

3.1.1 Supporting the development of trusting relationships

As always, consideration should be given to enabling women and maternity staff to build rapport and a trusting relationship during pregnancy when organising or modifying in-person and virtual maternity care. This relationship encourages engagement in antenatal care and enhances the ability of maternity staff to notice changes in the woman's health, and to support her to talk openly about concerns and problems.

In-person appointments should be prioritised for women at increased risk of complications because of COVID-19, including women from BAME groups. This is likely to be most easily facilitated by providing in-person appointments whenever possible and particularly at the start of the pregnancy. Telephone and text communication can form one element of antenatal contact, but they are unlikely to be as effective and lead to a relationship of trust without initial in-person contact.

Video consultation can also be used to support more personal interaction, and should aid the professional to understand the woman and her context more fully than telephone only communication. However, when offering video consultation, midwives and obstetricians should be aware of the limitations of the speed of data connections and costs involved in the use of mobile data. Women should not be disadvantaged if they are unable to access adequate data for video consultations. Further information about safely providing virtual consultations can be found in the RCM briefing[7] and the accompanying poster, and from the NHS in Scotland.

3.2 Building remote care support capacity

Maternity services should aim to maximise the use of remote means to provide additional antenatal consultations. Remote consulting enables greater compliance, with social distancing measures recommended for pregnant women and maternity staff, while enabling a pregnant woman to have a partner, family member or friend join the appointment for support.

Remote appointments will be appropriate for a range of consultations, including:

- Some routine or specialist antenatal and postnatal appointments (see table in section 4.1.1).
- Consultations with the obstetric or anaesthetic team that do not require physical examination or blood tests.
- Where additional support is required for 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.

- Monitoring of the health and wellbeing of women and their babies, when women are self-isolating because of COVID-19 symptoms or they/a household member have received a positive COVID-19 test result.

- Provision of breastfeeding support, early parenting advice and guidance, and health support after birth (such as pelvic floor exercises).

Maternity staff should be provided with the technology and training to be able to offer remote antenatal and postnatal consultations. Consideration should be given to enabling staff who are identified as vulnerable or currently self-isolating but well, to provide this remote support. Some areas have created schemes to help address digital poverty, through the targeted provision of IT hardware for those without so that they are able to access care through virtual means.

3.3 Use of home appointments

Home visits may be preferable to attendance at a hospital, provided the woman and everyone in their household is well.

Maternity 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 SARS-CoV-2 can survive on surfaces for several days.[8] Maternity staff should wear a face covering and be provided with appropriate personal protection equipment (PPE) when caring for women with suspected infection or when entering homes where other members of the household have symptoms. The RCM has provided **guidance for staff** [9] and accompanying information for **women** on preparing for home visits.

3.4 Capacity

Maternity units will have differing capacity issues throughout the autumn and winter. A daily discussion should be scheduled with senior team members with oversight of the antenatal service, to review service provision and available staff. Where required, the appointments highlighted in section 4.1.1 as being in-person appointments should be prioritised.

3.5 Staffing Numbers

Where there is acute staff absence, existing systems for recruiting additional staff should be used. Maternity support workers, midwifery students, independent midwives and obstetric team members can be used to support core service provision.

3.6 Antenatal education

Services, where they have not already done so, should seek to provide remote antenatal education classes. As in-person classes are re-introduced, remote antenatal classes may be maintained as they may be more accessible and acceptable for some women.

4. Antenatal appointments modified schedules

4.1 Low risk women

Where continuity models of care are in place and these are able to continue, women should receive care from their continuity team and primary midwife.

- Women should, where possible, be offered an in-person booking appointment or a one-stop clinic appointment that includes booking and scan together.
    - In general, women should have a **minimum of six in-person 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.
- If modifications to the pre-pandemic antenatal schedule are unavoidable, suggested modifications to the existing schedule of antenatal care for low risk women, including replacing in-person appointments with remote assessments are detailed in the table below.
- At all remote appointments, women should be asked about their wellbeing and, if in their third trimester, fetal movements. If a woman is concerned about fetal movements or her wellbeing physical attendance should be advised at a designated site.
- Consider offering outpatient induction of labour for low risk women.[10,11]

4.1.1 Suggested modifications to NICE Schedule of Antenatal Care for low risk women

- The NICE Schedule of Antenatal Care should be maintained in its entirety. Women should continue to receive the minimum of eight antenatal consultations, of these at least six contacts should be in-person.
- Services should regularly review the ongoing impact of any changes to the schedule of appointments, through local governance procedures.
- Where there is significant staff isolation or sickness, services will need to consider reducing the provision of in-person appointments. The appointments shown below in green should be maintained in-person.
- As early as possible when staffing allows, services should work towards reinstating all appointments to return to pre-pandemic appointment schedules.
- In line with recommendations made in RCOG/RCM guidance Coronavirus (COVID-19) infection in pregnancy, all women should be asked about their mental

wellbeing at every maternity appointment. Where a woman identifies that she is experiencing psychological distress including high levels of anxiety or depression, additional appropriate support should be instigated as rapidly as possible.

- Services should consider the needs of vulnerable women, including those who are more likely to develop severe complications from COVID-19, when reorganising services.

	Visit	Who	What	Modifications
1	Booking visit	All women	Full history, initial screening for medical, psychological and social risk factors.	Combine appointments where possible
1+	Dating scan	All women	Combined antenatal screening, all blood tests, blood pressure (BP) and urine testing.	
	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.	Potential virtual appointment
2	18-20 weeks	All women	Routine anomaly scan. Check BP and urine at this visit.	
	25 weeks	Nulliparous women	Measure fundal height, BP and urine; review scan results.	Potential virtual appointment

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 red blood cell alloantibodies; anti-D prophylaxis for Rhesus negative women.	Maintain appointment.
	31 weeks	Nulliparous women	Measure fundal height, BP and test urine.	Potential virtual appointment
4	34 weeks	All women	Measure fundal height, BP and test urine; discuss results of investigations at 28 weeks; discuss birth choices. Discuss wellbeing, fetal movements. Follow up safeguarding issues	Maintain in-person appointments. If need to reschedule because of self-isolation, 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	All women	Measure fundal height, BP and test urine; discuss fetal movements and wellbeing, discuss plans for birth and all usual care.	
6	40 weeks	Nulliparous women	Measure fundal height, BP and test urine; give information about options for prolonged pregnancy	
	Post dates from 41+0[12] (Locally agreed protocol)	All women who have not given birth	Measure fundal height, BP and test urine; discuss fetal movements and wellbeing	Consider co-scheduling appointment with offered outpatient / inpatient IOL to avoid a further attendance[a]

[a] If, following informed discussion, a woman declines induction for prolonged pregnancy, remote consultation with a senior obstetrician or consultant midwife should be offered to discuss further steps.

4.2 Women at increased risk of complications

Where continuity models of care are in place and these are able to continue, women should receive care from their continuity team and primary midwife, in addition to specialist services. Continuity of carer is likely to be of particular importance for women at higher risk of complications from COVID-19, mental health problems, obstetric problems and living with multiple deprivation.

Some women (as many as 50%) have a medical or obstetric condition or complication that necessitates additional appointments or multidisciplinary care during pregnancy. Those appointments that do not require measurement of fundal height, blood or urine tests, or scans, may be provided remotely via video or teleconferencing.

BAME women have been identified as being at higher risk of developing severe illness if they contract COVID-19. They should be advised of their higher risk of complications at the start of their pregnancy, and the importance of avoiding contracting the virus through careful infection control practices and social distancing. Women who are over 35 years, with a BMI of over 30 kg/m^2, or who have underlying medical conditions also have an elevated risk of becoming unwell with COVID-19.

Services should ensure that these higher risk women who test positive for COVID-19 or who describe symptoms, should be provided with appropriate follow-up care to monitor the severity of their illness, which can be through regular remote contact.

4.2.1 Triaging obstetric antenatal clinics to streamline services and 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, in general, women will follow their schedule of care with the midwives and have care with obstetricians in a targeted way.

5. Postnatal care

Postnatal care should be individualised according to the woman and newborn's needs and should follow the NICE guidance for postnatal care as far as possible.[13]

- The minimum recommended number of contacts is three as per NICE recommendations: at day 1 following birth (if at home) or discharge from maternity unit (if admitted); day 5; and day 10. The visits on day 1 at home and day 5 (for the newborn blood spot) should be prioritised as in-person appointments.

- Maternity services should offer a combination of in-person and remote postnatal follow-up, according to the woman and baby's needs. Prioritise in-person visiting for women with:

- known psychosocial vulnerabilities,
- operative birth,
- premature/low birthweight baby,
- other medical or neonatal complexities.

- Where continuity models of care are in place and these are able to continue, women should continue to receive care from their continuity team and primary midwife. Aim to ensure continuity of midwife for remote postnatal care.
- Home visits may be preferable to community clinic visits to comply with social distancing, but maternity staff safety must also be maintained.
- It may be necessary because of staff shortages to consider further amendments to postnatal care:
  - Provision of care by senior student midwives and maternity support workers.
  - Reduction of in-person 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.
- Remote support by third sector organisations is invaluable to provide support for breastfeeding, mental health and early parenting advice.

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Summary of previous changes

Version	Date	Summary of changes
1.1	17.4.20	**3.1:** Clarification added that face-to-face contacts are in person, physical appointments.
1.1	17.4.20	**3.2:** Clarification added that remote appointments enable a partner or supporter to join the appointment.
1.1	17.4.20	**3.5:** Clarified that independent midwives may be used to support service delivery.
1.1	17.4.20	**4.1.1:** Highlighted recommendation from RCOG/RCM coronavirus guidance to ask about mental wellbeing at each appointment.
1.1	17.4.20	**4.1.1:** Modification to post-dates appointment to clarify that women should be offered immediate induction of labour if practical and acceptable.
1.1	17.4.20	**5:** Highlighted recommendation from RCOG/RCM coronavirus guidance to offer face-to-face and remote postnatal follow-up.
1.2	24.4.20	**Appendix - Patient information:** Removed Appendix, will be published separately in due course.
2	22.5.20	**2:** Statement added: 'When reorganising services, maternity services should be particularly cognisant of emerging evidence that black, Asian and minority ethnic group (BAME) individuals are at particular risk of developing severe and life-threatening COVID-19. There is already extensive evidence on the inequality of experience and outcomes for BAME women during pregnancy and birth in the UK. Particular consideration should be given to the experience of women of BAME background and women living with multiple deprivation when evaluating the potential or actual impact of any service change.'
2	22.5.20	**2.1:** Statement added: 'Such information should be available in community languages other than English and in visual or easy-to-understand formats as far as possible. Where such translation services are not available, consideration should be given to providing local community online groups and radio stations with information about any service changes, to enable them to share key information with the local communities about service change.'
2	22.5.20	**3.1:** Inserted statement: 'Some areas are implementing the provision of home monitoring equipment which may enable fewer face-to-face appointments in some circumstances.'
2	22.5.20	**3.1.1:** Additional section added: 'Supporting the development of trusting relationships'.
2	22.5.20	**3.2:** Added note that remote appointments may be particularly suitable for women with suspected or confirmed COVID-19.
2	22.5.20	**3.3:** Statement added: 'The RCM has provided guidance for staff and women in preparing for home visits.'

2	22.5.20	**4.1.1:** Recommendations added: • Where services can support it, the NICE Schedule of Antenatal Care should be maintained in its entirety. • Services should review the ongoing impact of any changes to the schedule of appointments, through local governance procedures. • As early as possible when staffing allows, services should work towards reinstating all appointments to return to pre-pandemic appointment schedules. • Services should consider the needs of vulnerable women, including those who are more likely to develop severe complications from COVID-19, when reorganising services.
2	22.5.20	**4.1.1:** Small edits made to associated table to emphasise that 'amber' appointments should be maintained if staffing allows or additional concerns.
2	22.5.20	**4.2:** Added further recommendations about continuity of carer and care for women at increased risk of severe illness if they contract COVID-19, including BAME women, women who are overweight or obese and those with underlying medical conditions.
2	22.5.20	**5:** Clarification added that the minimum recommended number of postnatal contacts is three: at day 1 following birth (if at home) or discharge from maternity unit (if admitted), day 5 and day 10.
2.1	19.6.20	**5.1:** Clarification added that the first visit after birth should be prioritised as a face-to-face visit.
2.2	10.7.20	**0:** Added a note on the implementation of this guidance to clarify that the guidance was intended for the peak of the pandemic and that services should return to normal practice as soon as the local risk of transmission and prevalence allows.

References

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2. Allotey J, Stallings E, Bonet M, Yap M, Chatterjee S, Kew T, et al. Clinical manifestations, risk factors, and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis. BMJ 2020;370:m3320.

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6. Dowswell T, Carroli G, Duley L, Gates S, Gülmezoglu AM, Khan-Neelofur D, et al. Alternative versus standard packages of antenatal care for low-risk pregnancy. Cochrane Database Syst Rev 2015;(7):CD000934.

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10. National Institute of Health and Care Excellence. Inducing Labour. NICE Quality Standard 60; 2014.

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12. National Institute of Health and Care Excellence. Inducing Labour. NICE Clinical Guideline 70; 2008.

13. National Institute of Health and Care Excellence. Postnatal care up to 8 weeks after birth. NICE Clinical Guideline 37; 2015.

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