



Royal College of
Obstetricians &
Gynaecologists

Guidance for antenatal and postnatal services in the evolving coronavirus (COVID-19) pandemic

Information for healthcare professionals

Version 1: Published Monday 30 March 2020

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 of pregnant women.

2. 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

Maternity services should provide clear signposting for pregnant and postnatal women about changes to antenatal and postnatal services on their Trust or Health Board websites, through their social media accounts, or through electronic notes. Key information for inclusion is detailed in appendix 1.

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, a system should be in place for evaluating whether she has [symptoms that are suggestive of COVID-19, or if they meet current 'stay at home' guidance](#) (criteria for [England, Wales and Northern Ireland](#)/ 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 symptoms, she should be advised to return home immediately. A member of clinical staff should 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 7 or 14 days.

Further information about processes for managing delayed appointments and local failsafes are available in the [RCOG's coronavirus guidance](#).

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, 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 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).² **A minimum of six face to face antenatal consultations is therefore advised.** There is no appropriate evidence about replacing this minimal antenatal care with remote assessment.

3.2 Building remote care support capacity

Maternity services should, however, 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.

Clinics can be run effectively using telephone or video consultations instead of face to face encounters. Remote appointments will be appropriate for a range of consultations, including:

- Some routine or specialist antenatal and postnatal appointments
- 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 should be provided with the technology and training to provide 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.

3.3 Use of home appointments

Home visits may be preferable, provided the woman and everyone in her 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 the coronavirus can survive on surfaces for up to 17 days.³ 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.

3.4 Capacity

Maternity units will have differing capacity issues as the pandemic evolves. 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 table 4.1.1 as being in-person appointments should be prioritised.

3.5 Staffing numbers

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

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 a virtual booking appointment or a one-stop clinic appointment that includes booking and scan together.
 - In general, 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, including where face-to-face appointments can be replaced with remote assessments are detailed in the table in 4.1.1
- At all remote appointments, women should be asked about wellbeing and, if in third trimester, fetal movements. If a woman is concerned about fetal movements or her physical wellbeing, physical attendance should be advised at a designated site.
- 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.^{4,5}

4.1.1 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.

	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

4.2 Women at increased risk of complications

Some women (as many as 50%) 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.

4.2.1 Triageing 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 women in general follow their schedule of care with the midwives and see obstetricians in a targeted way.

5. Postnatal care

Postnatal care should be individualised according to the woman and newborn's needs.⁷

- The minimum recommended number of contacts is three: at day 1, day 5 and day 10.
- Prioritise face to face visiting for women with:
 - Known psycho-social 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 providing any 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, as the pandemic progresses, to consider further amendments to postnatal care:
 - 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.
- Remote support by third sector organisations will be invaluable to provide support for breastfeeding, mental health and early parenting advice.

References

1. WHO Reproductive Healthcare. WHO recommendation on antenatal care contact schedules. (2016). Available from: <https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-antenatal-care-contact-schedules>
2. Dowswell, T. et al. Alternative versus standard packages of antenatal care for low-risk pregnancy. *Cochrane Db Syst Rev* (2015) doi:10.1002/14651858.cd000934.pub3
3. Moriarty LF, Plucinski MM, Marston BJ, et al. Public Health Responses to COVID-19 Outbreaks on Cruise Ships — Worldwide, February–March 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:347-352. doi:10.15585/mmwr.mm6912e3
4. National Institute for Care Excellence (NICE). Quality Standard 60: Inducing Labour. (2014).
5. RCM Midwifery Blue-Top Clinical Guidance 2: Midwifery Care for Induction of Labour. (2019).
6. National Institute for Care Excellence (NICE). Clinical Guideline 70: Inducing Labour. (2008).
7. National Institute for Care Excellence (NICE). Clinical Guideline 37: Postnatal care up to 8 weeks after birth. (2015).

Appendix: Patient information

Coronavirus (COVID-19) infection and pregnancy: Information for you

About this information

This information is for you if you are expecting a baby or have recently given birth. It may also be helpful if you are a partner, relative or friend of someone who is in this situation.

This information is provided to help you understand how to make contact with maternity services about your health and scheduled or required appointments in relation to your pregnancy during the unprecedented times of the coronavirus outbreak.

If you have been allocated a local health continuity team or a named community midwife

You should continue to contact your continuity team or community midwife by telephone to discuss any questions or concerns you might have and to check on arrangements for all scheduled and future appointments.

If you have not been allocated a local health continuity team or a named community midwife

You should contact your local maternity unit in order to be connected to an appropriate continuity team or named community midwife so that you can discuss any questions or concerns you might have and to check on arrangements for all scheduled and future appointments.

Can I still attend my antenatal/postnatal care appointments?

Your antenatal and postnatal care remains an important part of your pregnancy to provide checks on the health of you and your baby.

Your local maternity team may reduce routine appointments, provide more home visits or deliver more appointments over the phone or video to reduce the number of times you need to travel. You will be informed of any changes to your care in advance.

Further information for you

You can find all the latest guidance and information on how to protect you and your family during COVID-19 at the following organisation websites:

- [Joint guidance](#) from the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives Royal College of Paediatrics and Child Health, Public Health England and Health Protection Scotland.
- [UK Government guidance](#) explaining social distancing and self-isolation.
- [NHS 111 website](#)
- [NHS Inform in Scotland](#)
- [Public Health England](#)
- [Health Protection Scotland](#)
- [Mental Health Support](#)

Authors

Mary Ross-Davie, RCM Director

Jaki Lambert, Midwifery Advisor, Scottish Government

Lia Brigante, RCM Quality and Standards Advisor

Clare Livingstone, RCM Policy advisor

Susanna Crowe, RCOG Each Baby Counts Learn and Support/Royal London
Hospital

Pran Pandya, PHE/UCLH

Eddie Morris, RCOG

Pat O'Brien, RCOG

Jennifer Jardine, RCOG Obstetric Fellow

Sophie Relph, RCOG Obstetric Fellow

Gemma Goodyear, RCOG Obstetric Fellow

DISCLAIMER: The Royal College of Obstetricians and Gynaecologists (RCOG) has produced this guidance as an aid to good clinical practice and clinical decision-making. This guidance is based on the best evidence available at the time of writing, and the guidance will be kept under regular review as new evidence emerges. This guidance is not intended to replace clinical diagnostics, procedures or treatment plans made by a clinician or other healthcare professional and RCOG accepts no liability for the use of its guidance in a clinical setting. Please be aware that the evidence base for COVID-19 and its impact on pregnancy and related healthcare services is developing rapidly and the latest data or best practice may not yet be incorporated into the current version of this document. RCOG recommends that any departures from local clinical protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

 @RCObsGyn  @rcobsgyn  @RCObsGyn



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