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

Information for healthcare professionals

Version 1.2: Published Friday 24 April 2020

Table of 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.

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/RCM 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/RCM 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 (physical) 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, while enabling a pregnant woman to have a partner, family member or friend join the appointment for support.

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, independent midwives 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 face-to-face 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[6] 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.

- In line with recommendations made in RCOG/RCM guidance 'Coronavirus infection in pregnancy', all women should be asked about their mental wellbeing at every appointment.

	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 co-scheduled with offered outpatient / inpatient IOL to avoid a further attendance[T]

[T] - If, following careful discussion, a woman declines induction for prolonged pregnancy, remote consultation with a senior obstetrician should be offered to discuss further steps.

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 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 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.[8]

- The minimum recommended number of contacts is three: at day 1, day 5 and day 10.
- Maternity services should offer a combination of face-to-face and remote postnatal follow-up, according to the woman and baby's needs. 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

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