Royal College of Obstetricians & Gynaecologists

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

Information for healthcare professionals

Version 2.1: Published Friday 19 June 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.
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.

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 and RCM coronavirus guideline, section 2.

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. Further detail on the supporting evidence for this is available in the RCOG guidance on coronavirus in pregnancy.

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.

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.

2.2 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' criteria from guidance for households with possible coronavirus infection (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, 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, 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 fail-safes are available in the RCOG's COVID-19 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. Some areas are implementing the provision of home monitoring equipment which may enable fewer face-to-face appointments in some circumstances. 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 fewer is associated with an increased risk of perinatal mortality (RR

1.15; 95% CI 1.01–1.32; 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.

3.1.1 Supporting the development of trusting relationships

As always, consideration should be given to enabling women and those who care for them to build rapport and a trusting relationship during pregnancy. This 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 feel more able to talk openly about concerns and problems.

Face-to-face appointments should be prioritised for women at increased risk of complications due to COVID-19, including women from BAME groups and women living with multiple deprivation.

This is likely to be most easily facilitated by providing face-to-face appointments whenever possible and particularly at the start of the pregnancy. Telephone and text communication can form one element of antenatal contact, but is unlikely to be as effective without first building trust and a relationship through face-to-face contact first.

Video consultation can also be used to support more personal interaction and the ability of 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.

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, though this relies on the woman having access to appropriate telephone or IT resources. 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.
- Discussing plans for birth.
- Providing monitoring of the wellbeing of women who are self-isolating because of COVID-19 symptoms or with a positive COVID-19 test result.
- 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 several 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. The RCM has provided guidance for **staff** and **women** in preparing for home visits.

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 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 delivery.

4. Modified schedules for antenatal appointments

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, 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 this section.

- At all remote appointments, women should be asked about wellbeing and, if in the 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 discussed and commenced if the woman provides consent to induction (after 41+0, in line with NICE guidance).

- Consider offering outpatient induction of labour for low-risk women.[4,5]

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

- Where services can support it, the NICE Schedule of Antenatal Care should be maintained in its entirety. [6]

- Services should review the ongoing impact of any changes to the schedule of appointments, through local governance procedures.

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

- Where there is significant staff absence, services will need to consider reducing appointments. The appointments shown below in green should be maintained.

- 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 and pregnancy', all women should be asked about their mental wellbeing at every appointment.

- 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
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.
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 unless attendance required for additional testing or other concerns
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.	Maintain if staffing allows or additional concerns.
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.
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 as far as possible. If need to reschedule due to illness/quarantine, see or contact all women within 3 weeks of previous contact.
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.	
40 weeks	All women	Measure fundal height, BP and test urine; give information about options for prolonged pregnancy.	
Post dates from 41+0[7] (Locally agreed protocol)	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

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. Continuation of continuity of carer

is likely to be of particular importance for women at higher risk of complications from COVID-19, those with mental health or obstetric problems, or those living with multiple deprivation

Some women (as many as 50%) have a medical or obstetric 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, 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 that they are at higher risk of complications at the start of pregnancy and of the importance of avoiding contracting the virus through careful infection control practices and social distancing.

Women who are older than 35 years, overweight or obese or who have underlying medical conditions may 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 follow up 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 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 following birth (if at home) or discharge from maternity unit (if admitted), 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. The first visit at home (day 1 after discharge or birth) should be prioritised as face-to-face visit. After the first visit, face-to-face visiting should be prioritised 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 62: Antenatal Care for uncomplicated pregnancies.

7. National Institute for Care Excellence (NICE). Clinical Guideline 70: Inducing Labour. (2008).

8. National Institute for Care Excellence (NICE). Clinical Guideline 37: Postnatal care up to 8 weeks after birth. (2015).

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

THE ROYAL COLLEGE OF MIDWIVES

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