



Royal College of  
Obstetricians &  
Gynaecologists

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

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Information for healthcare professionals

**Version 2:** Published Wednesday 21 October 2020

# Table of changes

A summary of previous updates can be found on page 12.

Version	Date	Summary of changes
<b>2</b>	21.10.20	<b>0:</b> Introductory Note: Autumn 2020. Added to reflect current situation.
<b>2</b>	21.10.20	<b>Throughout:</b> Editorial modifications, and language updated to reflect current situation as of 30 September 2020.
<b>2</b>	21.10.20	<b>1.1:</b> Added an additional local consideration: Availability and provision of personal protective equipment
<b>2</b>	21.10.20	<b>0:</b> Added statement based on learning from first wave “In some areas, it has proved challenging to fully restore homebirth services after the initial temporary pause period, even though staffing and ambulance services have returned to more normal levels. The potential difficulty of restoration should be taken into account when making decisions about the necessity to pause any services.”

# Introductory note - Autumn 2020

Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG) guidance on suggested maternity service modifications during the COVID-19 pandemic were developed to support services in decision making about service provision in the first wave of the pandemic in spring 2020.

During the summer, when levels of SARS-CoV-2 infection fell, maternity services were advised to reflect on their local risk and return to providing clinical care as recommended by pre-existing local and national guidance (e.g. NICE antenatal care schedule, restoration of homebirth and midwife-led care settings for birth) as soon as it was safe to do so.

As the UK moves into a second wave of the pandemic, with increases in local infection prevalence and staff absence and the resultant pressure on services, those charged with leading maternity services will once more be reflecting on the feasibility of being able to provide women with all birthplace options.

The document below provides guidance on using a flexible approach to these decisions, taking into account local and national considerations.

## I. Introduction and background

Pregnant women and newborn babies continue to require safe and personalised care during the COVID-19 pandemic.

When reorganising services, units should be cognisant of evidence that some women are at specific risk of developing severe and life-threatening COVID-19 including: individuals from black, Asian and minority ethnic groups, women living in areas of higher deprivation, women with a higher BMI and those with pre-existing comorbidities. Particular consideration should be given to the experience of these groups of women, when evaluating the potential or actual impact of any service change.

### I.1 Provision of midwife-led birth settings

With reference to the 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.<sup>1</sup>

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

This guidance recommends a **staged approach** in responding to emerging issues with staff absence 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 up-to-date local data:

- Sickness rate among midwifery staff (midwives, maternity support workers and senior student midwives).
- Number of midwives needing to self-isolate or who are unable to undertake in-person duties, who are able to provide virtual or remote care.
- Available additional temporary midwifery staffing (including independent midwives, additional midwives from the Nursing and Midwifery Council's emergency register, those previously in non-clinical roles or year three 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.
- Consideration of staff requirements to ensure continued provision of essential antenatal and postnatal care.
- Consideration of local geography and demographics that may impact on the ability to continue a full range of services.
- Availability and provision of personal protective equipment (PPE).

## 1.2 Benefits and safety of midwife-led birth settings

The positive impacts of midwife-led birth settings are well-documented, including reductions in the need for a range of medical interventions.<sup>3-5</sup> These 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 assisted by skilled midwives practicing 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 (OU) 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 (third or fourth) baby.<sup>4</sup> Transfers reported in the study were mostly for non-emergency reasons such as prolonged labour and maternal request for pain relief.<sup>4</sup> 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.<sup>6</sup>

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

The following principles are critical during the COVID-19 pandemic. They were developed by the RCM Professorial Advisory Group, drawing on evidence of essential components of quality care and incorporating the latest information from the World Health Organisation (WHO)

and the ICM on COVID-19. These principles should underpin maternity care for every woman and baby each and every time.

Care providers must:<sup>2</sup>

- 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 babies.
- Ensure strict hygiene measures and social distancing when possible.
- Follow national guidance on use of PPE.
- Ensure birth companionship.
- Prevent unnecessary interventions.
- Not separate a woman from her newborn baby (or babies) 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 redeploy staff, and to address other service pressures based on the best available evidence.

There is very little evidence available to support changes in configuration of services, and specifically changes to centralise 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. The importance of deployment of outreach services, community clinics, and home care rather than the centralisation of services has been identified.<sup>7-9</sup> It may be of benefit for midwifery services to keep community midwifery staffing as separate as possible from hospital midwifery staffing to reduce the risk of transmission between staff.<sup>8,9</sup> The ICM has based their recommendations for maternity care during COVID-19 on supporting community birth for healthy women and newborn babies to reduce spread of infection.<sup>1</sup> [NHS England clinical guidance<sup>10</sup> on temporary reorganisation of intrapartum care during the pandemic](#) states that freestanding midwifery units (FMUs) 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 skilled midwifery staffing and paramedic ambulance transfer facilities. Where

these are not available it may be necessary to modify services, seeking at all times to maximise the provision of a safe and positive birth experience of their choosing to all women.

The phased approach described below identifies the need for flexibility in 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 return to the full provision of midwifery-led and community-based care settings when staffing and ambulance provision allows. Decisions about offering birthplace options for women in a specific area are best made in a way that demonstrates recognition that any reduction in birthplace options is temporary and will be continually reassessed.

The decision to suspend homebirth services in some parts of the UK during the pandemic has created significant levels of concern and anxiety for some women planning to give birth at home, and has led to some challenge.<sup>11</sup> In some areas, it has proved difficult to fully restore homebirth services after the initial temporary pause period, even though staffing and ambulance services have returned to more normal levels. This potential difficulty should be taken into account when making decisions about the necessity to pause any services.

Midwifery service leads will need to use judgement and guidance to seek to provide safe, high quality maternity services during the pandemic for the women in their care and this will, on occasion, require making difficult decisions about what services can be safely provided. The rights of women to choose their preferred place of birth will need to be balanced against the rights of all women to receive a safe level of midwifery care.<sup>12</sup>

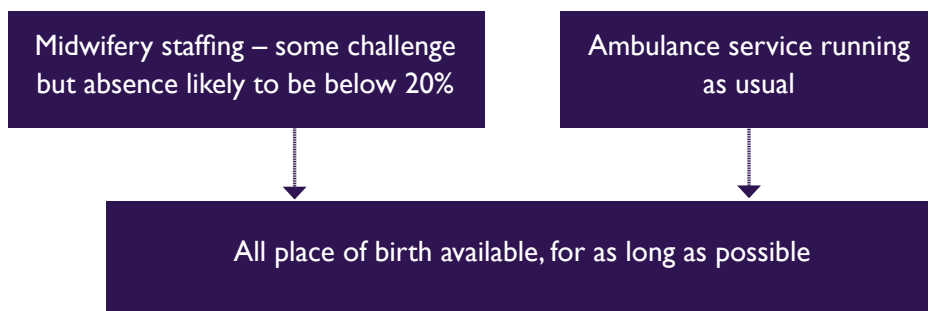
Where a service lead is making a decision about temporary suspension of some services including homebirth as a result of the pandemic, they should inform their Trust Board or NHS Board and commissioner and seek advice from their local legal department. Principle 6 of the NHS Constitution identifies that the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. As the NHS is funded by public money, this principle highlights the importance of using this funding fairly in a way that benefits everyone the NHS serves. The NHS seeks to maximise benefits within the constraints of limited resources. In Scotland, a similar sentiment is expressed in the section on 'Health needs and preferences' in the Patients' Charter.

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. Maternity service leads should ensure that clear information is provided to all women booked to give birth about current service configuration, which is updated regularly through the service website, social media and through MSLCs and MVPs.

### **3.1 Phase one: preparation and restoration**

In the preparation and restoration phase, midwifery care should be provided as normal as far as possible, with all birth settings including home, FMUs and alongside midwife-led units (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.<sup>5</sup>

The percentages set out below are aimed to provide a helpful rule of thumb rather than a definitive rule, to be contextualised for local need. The impact of staffing absence will vary according to the size of the team and other key factors such as rurality.



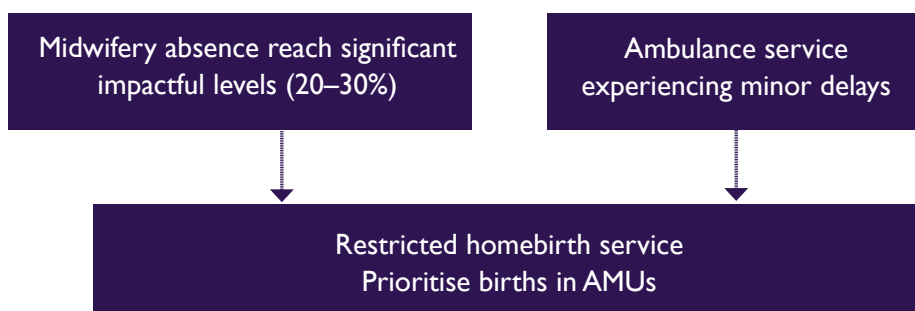
Women should be advised through local trust or board websites, other official communications and online forums, including local service user forums, that the provision of care may need to be adapted as the situation changes, with communications co-produced with local MVPs/MSLCs.

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

- Review the number of midwives routinely sent to homebirths. 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 FMUs within the same trust/health board should plan to integrate their systems with all-inclusive rotas so 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 absence is exacerbated by the pandemic. This may be above 20% or if a reduction in skill mix creates a shortage of experienced midwives. The impact of the percentage of staff absence will vary according to the location of the care; a smaller proportion of midwifery absence 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 in-person antenatal and postnatal care adapted, in line with RCM/RCOG guidance.<sup>13</sup> Virtual appointments may be provided by midwives required to self-isolate or those who are recommended by occupational health to work remotely, if appropriate home working technology is provided.

In some NHS trusts/health boards there are multiple midwife-led units. To ensure viability it may be necessary to reduce the number of FMUs providing care, and to prioritise AMUs over FMUs 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 pausing place of birth options for women:

- Scale-up the number of midwife-led rooms in the maternity unit 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](#).<sup>13</sup>
- 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 an AMU birth, to reduce need for intrapartum transfers.
- Promote early discharge from midwife-led units to free up intrapartum capacity.
- Ensure communication with ambulance service is in place and category I calls only are requested of them.
- Use dedicated services for non-emergency transfers (including private or army ambulances or dedicated private taxi).

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.

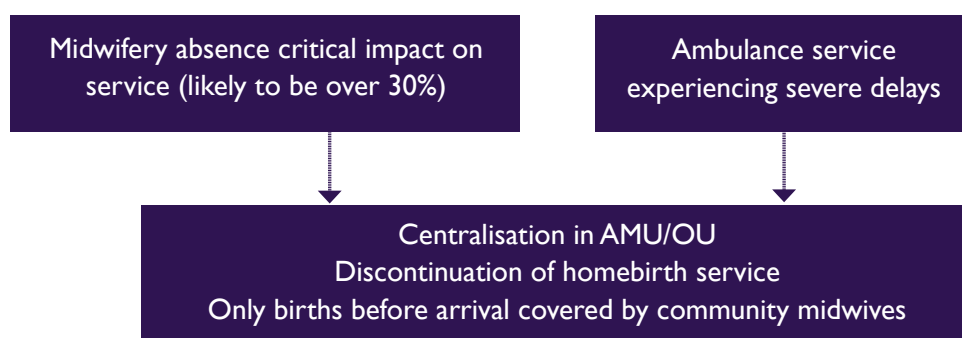
### 3.3 Phase three

Phase three should be triggered once the midwifery absence reaches a critical point (likely to be over 30%) or once the ambulance service is unable to support category I 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.



AMUs 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 AMU.



### 3.4 Phase four: de-escalation or restoration

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

#### 3.4.1 Process for de-escalation or restoration

Midwifery absence critical (e.g. > 30%)	Midwifery absence significant (e.g. 20–30%)	Midwifery absence nearing normal levels (e.g. < 20%)
<ul style="list-style-type: none"> <li>Centralisation in AMUs and obstetric units</li> </ul>	<ul style="list-style-type: none"> <li>Reinstate restricted homebirth service</li> <li>Reinstate FMUs</li> <li>All-inclusive rota for community and midwife-led unit midwives</li> </ul>	<ul style="list-style-type: none"> <li>Reinstate homebirth service for all women</li> <li>Reinstate all options for place of birth</li> </ul>

## 4. References

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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

## Summary of previous changes

Version	Date	Summary of changes
<b>1.1</b>	17.4.20	<b>1.1:</b> 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.
<b>1.1</b>	17.4.20	<b>3:</b> Reference made to NHS England guidance on the reconfiguration of intrapartum care services. Recommended co-production of local plans with service user groups
<b>1.1</b>	17.4.20	<b>Throughout:</b> Revised throughout to ensure compatible with NHS England guidance on reconfiguration of intrapartum care services
<b>1.2</b>	22.5.20	<b>1:</b> Statement added: 'When reorganising services, units 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 extensive evidence on the inequality of experience and outcomes for BAME women during pregnancy 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.'
<b>1.2</b>	17.4.20	<b>1.1:</b> Inclusion of 'Number of midwives needing to self-isolate or who are 'shielded' but who are able to provide virtual or non-patient-facing care' among the staff groups.
<b>1.2</b>	17.4.20	<b>3:</b> Further detail added on the basis for making decisions around closing some birth settings.
<b>1.2</b>	17.4.20	<b>Throughout:</b> Small changes to clarify document.
<b>1.3</b>	17.4.20	<b>1:</b> 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.

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.

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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](mailto:covid-19@rcog.org.uk)

W: [rcog.org.uk](http://rcog.org.uk)

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