Oxford Academic Health Science Network

What can we learn from our initial response to COVID-19?

A survey response from staff in maternity and neonatal services in six trusts in the Oxford AHSN region

November 2020

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Abstract

Background & Objectives

This report seeks to present the rapid learning in response to the first phase of the COVID-19 pandemic experienced by maternity and neonatal healthcare staff from all six Trusts in the Oxford Academic Health Science Network (Oxford AHSN) region.

It will present staff perceptions of changes that appeared to work well in response to the pandemic, changes felt to be less successful and changes which require further consideration. The report will highlight key findings based on staff perception which may enable regional shared learning for a cohesive and collaborative approach when planning for a subsequent wave of COVID-19 or for recovery.

Methods

A questionnaire was designed by a regionally established, multidisciplinary task and finish group. The survey was conducted across six NHS hospitals within the Oxford AHSN region and one neighbouring hospital during the period between July 23 and August 17, 2020. The survey was open to all maternity and neonatal staff including domestic and portering staff groups.

Results

A total of 868 respondents completed the questionnaire with responses returned from all staff groups. We have identified nine areas of focus, including visiting, remote consultations, and communications. Staff groups experiencing higher levels of unease include community midwifery teams and non-clinical frontline staff.

Conclusions

This report highlights that although each Trust responded to the pandemic in different ways, the feedback from the staff on areas where improvement is needed appears to be uniform. This presents an opportunity for individual Trusts to work collaboratively as a network when planning for either a subsequent wave of COVID-19 or for recovery.

Acknowledgements

We would like to take the opportunity to thank all members of the task and finish group for their time in this work, and the staff who took the time to complete the survey and report. Your unwavering dedication and commitment to the care of mothers and babies is clear in your responses. We thank you. The analysis was undertaken by Dr Lauren Morgan (Morgan Human Systems) who compiled the report with support of the task and finish group.

Key messages

Visiting

A consistent region wide approach to visiting will ensure parity for women and families and likely be more acceptable to all when faced with restrictions. Partners provide a key support role for women during their maternity and neonatal journey and should not be considered visitors of their partners or new born babies.

Impact of virtual working, training, and meetings

Remote working, training and virtual consultations have been welcomed by all. However, women from high risk or vulnerable groups should be appropriately assessed (face-to-face) since clinical records, mental health and interpreting services are not always remotely available. Ensure staff consulting remotely, have access to all the relevant multidisciplinary health care records to provide the safest clinical care.

COVID-19 risk assessments and Personal Protective Equipment (PPE) availability

Staff should be supported regarding the continued impact of wearing PPE. This includes regular training and update sessions on PPE etiquette, fit testing, and infection control procedures. Particular consideration should be given to those who are suffering psychological and cognitive strain and those groups who are "at-risk" and require additional risk assessment.

Changes to staffing

Decisions regarding redeployment should be open, inclusive, and fair. Redeployed staff may need additional support in their new role. Recognition of the strain on mental health for all staff roles, clinical, managerial, and administrative and for service users and families should continue to be a priority and sign posting to relevant services and support should be prioritised.

Communication strategies

A network wide approach with key enablers to increase engagement and inclusivity in decision making should be created. This should involve co-production, supporting diversity and equality and ensuring representation of staff in clinical and non-clinical roles. BAME staff and patients should be represented effectively to address current inequities. The role of the highly valuable Maternity Voices Partnership (MVP) should be streamlined regionally and consideration be given to ensure the role is sustainable in the future.

Community teams

Some community teams are anxious because of the many changes made to the work format and workload. Ongoing open and inclusive dialogue is required with these teams to support the retention of staff who are happy and feel well supported to deliver high quality personalised women-centred care.

Pausing of service provision

Sharing intelligence at a network/regional level to inform workforce planning for the management of key services such as continuity of carer midwifery teams and home birth teams during a second wave is critical. Feedback from staff, women and families should be used to inform decision making as appropriate.

Innovations to delivery of monitoring and care

Region-wide shared learning of outcomes of innovation within individual Trusts should occur. Existing networks should be used to evaluate and look to reduce regional variation in innovation pathways.

Ease of making change during COVID-19

We should look to identify the key enablers and agile working styles which have resulted in being able to design and delivery innovation swiftly and safely, to be able to inform future practice.

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Introduction

The objective of this regional survey was to capture the learning from the first wave of the COVID-19 pandemic from the maternity and neonatal staff working within one of six Trusts represented in the Oxford AHSN region. By collecting and collating the survey responses the intention was to use the information gained to inform decision makers on what was perceived to go well and what could be improved for a second wave or for recovery planning. Other aims were to reduce variation in practices across the region where appropriate and to facilitate shared learning for a more streamlined, consistent approach.

Trusts included in the review are:

- Oxford University Hospitals NHS Foundation Trust (OUH)
- Buckinghamshire Healthcare NHS Trust (Bucks)
- Frimley Health NHS Foundation Trust
- Milton Keynes University Hospital NHS Foundation Trust (MKUH)
- Royal Berkshire NHS Foundation Trust (RBH)
- Great Western Hospitals NHS Foundation Trust (GWH)

The report was commissioned by Oxford AHSN and Oxford Patient Safety Collaborative (PSC), with members of the Oxford PSC Perinatal Governance Group and the Oxford PSC Maternity and Neonatal Network as part of their response to COVID-19. A multidisciplinary task and finish group was formed in June 2020 (with obstetric, midwifery and neonatal representation) from the six NHS Acute Trusts in the Oxford AHSN region and a Lay Partner from Oxford AHSN. Members of the service users' group, the Oxfordshire MVP provided feedback on the survey design.

This report collates the subjective observations and perceptions of staff on the impact of changes which occurred during the first wave of the COVID-19 pandemic and how that influenced them in caring for mothers, partners, babies and families. The teams who worked during the lockdown period experienced multiple rapid changes in their daily working lives. This report reveals how the staff perceived those changes, which changes appeared to work well, and which appeared less successful. This report makes suggestions based on the findings, which may aid future improvement work.

Context

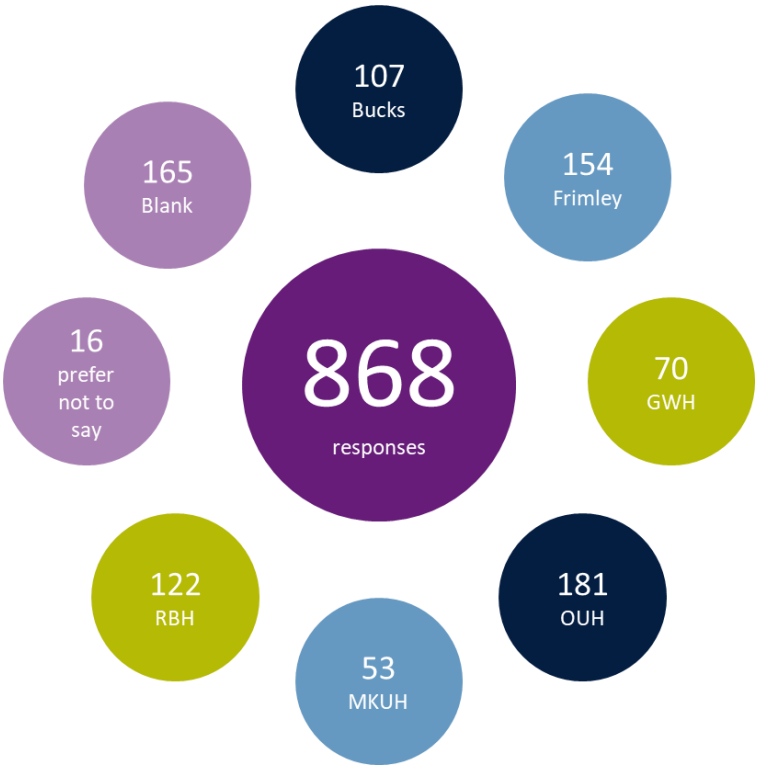
The initial phase of the COVID-19 pandemic was an unprecedented, rapidly evolving situation unlike anything that the NHS had ever previously experienced in its history. Trusts had mounting pressure on them to implement multiple, complex changes swiftly, in line with, at times, what appeared to be contradictory national guidance. Senior team members were having to adopt a "command and control" style of leadership to promptly respond to and facilitate national and trust-wide emergency-agendas. The rapidity of the changes undoubtedly impacted on service delivery, staff morale and wellbeing. Staff were expected to work under extreme pressure and intensity. This survey of staff was taken towards the middle of the first wave of the pandemic. The responses from staff reflect their perception at the time. Since the time of this survey national guidance has further developed and the trusts involved in this piece of work have been as responsive and proactive to developing care pathways as possible. Trusts have also considered feedback from staff and patients and implemented modified processes to maintain both safety and quality priorities.

"Functioning as one single unit or a network is critical to improving safety and reducing variation regionally. The regional meetings encourage dialogue, build relationships, and have a multidisciplinary membership so seek to hear from as varied a group of staff as possible. What was interesting about the first wave of COVID-19 is that each of the Trusts took on a silo approach and when the perinatal governance team got together in June we were all wondering why we did not reach out to each other as we would have done normally? I hope these report findings inspire a spirit of working collectively as a region to deliver the best care for women, babies, families and staff during the challenging months which are ahead of us all."

Comment by a member of the task and finish group

The Survey

During July and August 2020, a survey was circulated to all maternity and neonatal staff in six NHS Trusts within the Oxford AHSN region, with questions that focussed on what could be learnt collectively from individual Trust responses to the COVID-19 pandemic. Staff were able to complete an online (SurveyMonkey) or a paper-based version. The survey had a mix of fixed response (strongly agree to strongly disagree) and open-ended questions. Efforts were made to ensure all staff groups had an opportunity to respond. A small incentive of amazon vouchers for five randomly selected respondents was offered.



We have collated the survey responses and analysed the results. There appears to be significant homogeneity (similarity) in the data across the Trusts. We are therefore presenting the data regionally so as to enable a broader insight to staff views, and this will enable us to use the data more effectively to inform future planning. The rapid nature of this investigation is to facilitate the use of the data to build and refine our response to this pandemic.

Responses

Staff from across maternity and neonatal areas responded. The largest group to respond was midwives (385), followed by obstetricians (72), midwifery support workers (58), neonatal nurses (48), ward clerks (19), anaesthetists (18), managers (15), paediatricians/neonatologists (9), nursery nurses (7), housekeepers (4), another role within maternity services (62) and a number didn't provide an answer to the question. This reflects a response rate of up to 50% in some categories.

Analysis

The report contains analysis of the quantitative data, and thematic analysis of the qualitative data. All quotes are illustrative of a response group and are anonymised and unedited to preserve fidelity. Clarification is added in square brackets where appropriate.

It was evident in the survey analysis that many staff took the time to comment on how well they felt their colleagues had coped during this period of rapid change. We recognise the significant effect the COVID-19 pandemic has had and continues to have on all of us.

"The COVID-19 pandemic brought a sudden change in the work pattern and this was the first time NHS/ any unit faced a global emergency and it was amazing to see how people worked together to deliver best care to their patients."

The survey results have helped us to gain a subjective understanding of the impact of the pandemic on changes to patterns of working and the training experience for staff, the impact of redeployment, effects on staff and patient wellbeing and mental health. We encourage you to read and share this report widely and consider how your service might begin to embed the short and longer term solutions that are the result of the analysis of the regional response to this survey.

Survey Results

The data is presented as individual themes, where qualitative and quantitative data relating to that theme are presented. Nine areas of focus were identified within the responses and are presented within distinct chapters in the report.

"For very anxious women who have a history of previous loss not being able to have their partner with them in scans was emotionally very difficult"

1. Visiting

"Parents are not visitors"

Modifications to the format of visiting was and continues to be one of the most challenging and contentious changes occurring as part of the response to the COVID-19 pandemic. Trust policies on permitting access to services for women's partners, other supporters and visitors underwent frequent changes in the early days of the pandemic, and there was considerable variation between Trusts on visiting practices.

This data reflects staff's thoughts on the visiting policies within their Trusts. Data on mothers and family's thoughts and experiences is currently being collected elsewhere and should be considered together with this survey's responses when making future decisions.

One of the potentially negative unintended consequences of vital efforts to control the spread of COVID-19 and keep services safe for mothers, babies and families was that partners and birth supporters were treated as visitors and therefore there were restrictions on their presence in the hospital.

Maternity and Neonatal services have reflected on and learnt from this and current efforts to reintroduce visiting (whilst still challenging) are reflective of the awareness and understanding of the importance of support for the family unit, even more so, during this difficult pandemic time.

The findings from the staff survey regarding staff perception of the visiting restrictions are interesting. 63% of staff who responded to the survey strongly agreed/ agreed that fewer visitors and restrictions on partner/family presence during appointments was a potentially positive change for mothers and babies. 90% agreed/strongly agreed that it was a positive change for staff.

Conversely, some staff (59) commented they did not specifically observe that the reduced partner presence was a positive change.

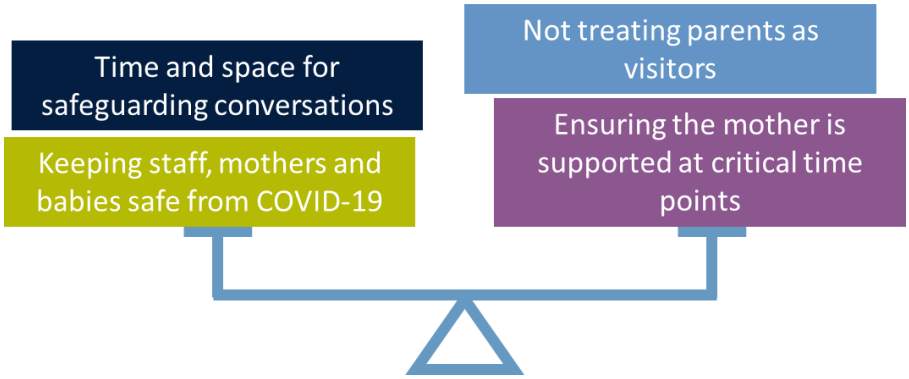
Feedback included concerns about lack of support at scan visits *"Not allowing women to be accompanied or supported during scans and appointments has been very damaging".*

Feedback also included concerns about neonatal visiting and the impact on neonatal care *"Treating parents as visitors rather than integral to the baby's care and restricting access. Huge stress on staff and families especially as mothers often could not drive in and there was nowhere for the 'other' parent to be or to even go the toilet. Also, inability to allow parents to stay overnight on site when their baby was unwell."* Illustrates the hugely challenging nature of this subject. The decisions made clearly had wide reaching negative impact.

> *"[in my Trust] No adjustments to policies were allowed for those at high risk of mental health issues. Women transferred care to other hospitals as a result"*

A few staff (9) commented that the lack of partner presence presented the opportunity for more sensitive safeguarding conversations, and that in non-COVID circumstances the absence of facilities to allow partners to stay comfortably e.g. beds and toilets cause issues for staff which may add to their workload. *"Even though for some women having appointments without any partners was a negative experience. For some women it was positive as it allowed them to be completely honest with us, they were asking their own questions and we were able to get a more efficient assessment of their mental health and just how they are feeling at the moment. Especially with domestic issues [safeguarding]".*

Partners have a valid role and should be included in the whole picture. There is a clear need to further explore how to achieve the fine balance of creating a personalised safe space for those mothers who require it whilst supporting them to have partners present.



Maintaining the balance between the sometimes-conflicting requirements for visiting remains a huge challenge for units.

Staff also provided their thoughts on the impact of changes to the wider visiting policy i.e. open visiting. Issues observed in the wider visiting scenario included challenges in remaining consistent with the rest of hospital. Concern was also expressed that on occasions sick mothers could not have visitors *"sick (non COVID-19) women not being allowed to have visitors"*. Some staff believe (29 comments) that the modifications to the wider visiting policies may have improved care by allowing women to focus on their babies and staff to focus on providing care for the women. *"Having less visitors has made a big difference to staff answering doors and having disagreements with visitors trying to gain access… Phoning fathers in community to check how they are coping has been a really positive change that hopefully will continue"*

> *"In the beginning sourcing PPE was difficult as the procedure was changed, but no one (in our office at least) was made aware of the new procedure"*

Despite differences in the visiting policy between individual Trusts the qualitative survey data showed overall consistency in the themes of staff perceptions.

A considered and consistent regional approach may be beneficial to ensure parity for women and their families and an apparent unified approach which may appear to be more equitable than is the case at present.

Key points:

- Partners provide a key support role for women in maternity and should not be considered visitors of their newborn babies
- Visiting rules could be more nuanced to consider the separate role of parents in supporting pregnant women and other visitors
- The lack of facilities (in some settings) to support the presence of partners in maternity units needs to be considered when changes to policy are being discussed
- Space for safeguarding conversations needs to be protected within the care pathway in the presence of partners and other visitors
- A consistent regional approach to visiting would ensure parity for women, babies, and families, where possible and perhaps be more acceptable to women and their families when faced with restrictions

2. Impact of virtual working, training, and meetings

Virtual MDT clinical meetings were a positive change for staff. 69% of staff agreed/strongly agreed that this was the case. Allowing greater network access, supporting working from home, and allowing virtual teaching were all seen as positives. "*More input from the network via teams/zoom meetings was useful".*

However, the reduction in face to face contact has been less positive for both staff and mothers and babies. Staff reported that the reduced contact has increased risk for some women *"The reduced antenatal care schedule. Women have reported they felt like they hadn't seen their midwife until their third trimester, it created more work for the midwives, that was more awkward, and there have been things such as slow or static growth picked up later due to missed appointments".*

Staff have commented on the need for better IT support to ensure safe remote working practices i.e. so the full clinical picture is available during virtual consultations "*As a doctor working in antenatal clinic we were provided with little information about the patient (just the booking summary sheet and investigation results available on ICE) and so any additional information had to be gleaned from the patient (for example, we did not have access to the patient's scans). This resulted in time-consuming telephone consultations and the risk of missing important information about the patient which might impact on the antenatal plan made. Seeing the patient face-to-face and having access to their maternity notes I feel is safer particularly for high-risk antenatal patients".*

Staff have commented on what changes they would like to see for future models of working with COVID-19 restrictions in place.

- "*More online training sessions"*
- *"Would like to have found a way to continue mandatory training and opportunities in order to support my learning and completion of my course sooner"*
- *"The telephone triage midwife to be able to work from home when taking and triaging telephone calls. The vulnerable groups would be able to work from home throughout regardless of personal circumstance and this is a tremendous help to the unit."*
- *"Remote follow up is heavily reliant on entries in EPR [electronic patient record]. This could be streamlined if we had the administrative capacity to scan in paper records to the electronic patient record - this would facilitate safer remote working for clinicians were a second wave to occur"*

> *"some of the virtual/phone appointments do not work for all women especially when language barriers exist"*

Technology is perceived as an enabler, but access, experience and capability can also present challenges. Many staff reported issues in the continuity of care, technology functioning and the potential for increased risk for high risk women. It is important to note the perceived increased risk

for a population where we know risk is already increased (language barriers). With regards to training and meetings there is evidence that the increased use of technology encouraged networking which suggests there is an appetite for further learning and sharing online.

Key points:

- Remote/virtual consultations may further increase the risk for high risk/ vulnerable groups for example, in situations where clinical records and /or interpreting services are not readily available
- The delivery of remote care felt disjointed, opportunities to 'catch' potential problems may be missed, or identified "too late"
- Ensuring those conducting remote consultations have all relevant information about the woman and her pregnancy available to them
- Regional networks may wish to develop regional pathways that support remote/virtual consultations with patients and families to standardise care
- Continue to offer opportunities for training and learning online where possible – staff say they welcome this flexibility and accessibility
- Supporting working from home where appropriate has been a positive change, many would like to see this option continue and further developed

3. COVID-19 risk assessments and Personal Protective Equipment (PPE) availability

Nationally optimising PPE supplies to ensure availability for healthcare staff has been concerning with supplies either running low or in some cases absent particularly in the first surge of the pandemic. Training healthcare staff in correct use of PPE and ensuring staff were competent in donning and doffing PPE has been both challenging and time consuming. Rapid changes in the advice to staff regarding the type of PPE required for different clinical scenarios throughout the lockdown period has made it difficult for hospitals to maintain consistent messaging and for staff to remain engaged. The pandemic unearthed some poor practices in infection control processes and highlighted the need for organisations to ensure that staff have regular training in Fit testing.

The availability of testing for clinical staff has been a concern, as has the provision of the 'correct' PPE (33 comments regarding concerns about PPE and testing).

Units appear to have improved training and awareness and availability of the correct PPE as the pandemic evolved, including Fit testing, which has reduced stress (21 comments). *"Once established, the rapid availability for staff testing and paid COVID-19 leave took away some anxiety".*
Some pathways were introduced to support the care of COVID-19 patients, which respondents felt have worked well. These are listed below.

- Early introduction of pathways for care of COVID-19 positive patients on wards
- New pathways for managing elective caesarean section for patients who were COVID -19 positive and for managing emergencies in the 'labour' room. We developed joint guidelines with paediatrics, anaesthetics, and obstetrics
- Swab testing for inpatients, flexible appointment schedule to accommodate results and shielding
- The negative pressure room use and the set-up of a COVID-19 room on our unit.

There were some pathways introduced to support the care of COVID-19 patients that respondents felt did not work as well. These are listed below.

- Initially isolated COVID-19 areas were set up but there was less demand than expected so these were often empty while non COVID-19 areas were squeezed into a smaller space
- The swapping of hot and cold areas was at times a little confusing and we did not know where we would be working next and how things had changed
- Staffing in hot zones was not sufficient, walkie talkies not effective to communicate with one another.

When staff were asked what they would do differently, they commented on:

- Considering the impact of wearing PPE: "Allow staff in all clinical departments to wear scrubs as on a hot day, formal uniform plus PPE is horrendous to wear for a 12-hour shift"
- "Adjust shift patterns to 7.5 hours, to reduce exhaustion due to extra PPE and to have more staff available for 2 hours per day to ensure all staff received a break. Adjust shift pattern to reduce the night duty to 10 hours so staff could benefit from a shorter shift."

- Protect all staff: “Make sure PPE for receptionists (masks/screens) were distributed earlier rather than after the COVID-19 peak” “I would have been more organised with fit testing of masks. Ensuring night shifts were covered as well as day”
- Prioritise the department appropriately: “Make obstetric theatres a priority for the provision of fluid resistant PPE”
- Protect specialist skills: “Group individuals with subspecialist skills into separate groups to avoid mass illness and an inability to continue to provide that service if all individuals with same skill set were to be off unwell or isolating simultaneously e.g. a micro team of obstetric physician and maternal medicine obstetrician OR e.g. interventional fetal medicine consultant and second fetal medicine specialist which would each run opposite another team of the same skillset. Team A could work in house while team B worked remotely and then swap over to minimise same exposure to COVID-19.”

The COVID-19 pandemic was experienced as a rapidly changing environment with sometimes unclear communication experienced by staff at all levels. In general, the advice from national bodies, when it came, was helpful and gave confidence to those in senior positions that they were making decisions to keep patients and staff as safe as possible while maintaining essential services.

Key points:

- Ensure there is a framework to support regular training in the use of PPE and Fit testing for all staff
- Senior leadership teams should consider how they ensure that domestic, catering and portering staff are included in this framework
- Education on infection control procedures should be an ongoing priority for all organisation members – using different forms of communication to be universally accessible and as relevant as possible
- Consider shift pattern changes, additional staffing, and dedicated rest areas where possible to support staff who suffer psychological and cognitive strain due to the impact of continued PPE wearing
- Ensure risk assessments are in place for at-risk staff groups and for those returning to work to mitigate the risk of COVID-19 for vulnerable staff

4. Changes to staffing

> *"Proper midwifery staffing at start of COVID-19 (first time in my midwifery career). This meant no delays in IOL [induction of labour]/Augmentation, helped early discharge etc. from delivery suite"*

The positive responses to changes to staffing included the increase in the numbers of staff working clinically.

63% of staff agreed/strongly agreed that the redeployment of those staff who were shielding to other roles was a positive change for staff.

Changes that were less well received related to staff who were redeployed and who found the experience stressful and situations where staff felt less supported (e.g. no management presence on the ward /unit).

"Specialist roles all redeployed to clinical. This was necessary at the start of lockdown as all hands needed on clinical roles to cover increase in staff sickness/staff shielding. In hindsight the specialist roles would have benefited from still being covered to some degree, even if it had only been a few days each week. Vital care input was lacking at an already vulnerable time for new families"

38% of staff disagreed or strongly disagreed that redeployment of some staff to areas outside maternity/neonatal units was a positive change for staff.

Staff commented that they felt there could be improved parity in the staffing changes, including maintaining a sense of equity and fairness in a way that visibly recognised the vital roles played by administrative staff alongside the importance of the role of clinical staff.

Survey responses reflected the appreciation staff felt with reference to increased staffing levels having a positive impact on the workload, reducing delays in procedures for women and providing additional support for staff. Redeployment of staff to unfamiliar areas and choosing not to redeploy certain teams was felt by some to be a good change. Several positive comments relate to the importance of increased support, a timely reminder (if needed) that teamwork and providing emotional support to our colleagues can make such a difference. Equally respondents articulated that redeployment of staff, especially to areas where they may not have had experience for some time can be incredibly stressful, and support for those staff is important.

Key points:

- Redeployment can be challenging for staff who are required to work in unfamiliar settings and those staff may need additional support in their new role
- Openness and fairness in decisions about staffing levels and redeployment as a response to the pandemic is important and should include an open consultation with the staff groups who are affected
- Creative lateral thinking on how best to use staff who are shielding is important and support the provision of excellent care
- Recognition of the strain on mental health for all staff roles, clinical, managerial, and administrative and for service users and families should continue to be a priority and sign posting to relevant services and support should continue

5. Communication strategies

Keeping information up to date and accurate is a recognised challenge, and many appreciate the different ways Trusts did this *"I was made aware of the policy changes by daily and then weekly maternity governance updates sent via e-mail. I think that the team did an amazing job in updating us every day and good communication skills have been shown from everyone."*

"Excellent communication and updates from Chief Executive via Facebook"

Ensuring all groups are included when considering communication channels and supporting staff to feel involved in decision making is key. *"As it was, it was all very exclusive which didn't feel very helpful with regards to team building & morale"*

Staff agreed/strongly agreed that the increased involvement of the MVP in communicating changes to women, birthing women and their families was a positive change for mothers and babies (71%), and staff (66%). Staff have commented that the weekly facetime live with MVP, midwives and women has been particularly beneficial. The MVP were able to provide maternity services with insight into what information women and families needed and were concerned about at the time.

"I was mindful in all the decision making around pathways and all the discussion around staff wellbeing that we were almost exclusively talking about midwives, support workers, doctors, sonographers. It took some time for us to listen to concerns from other staff groups; administration/reception staff and I never really felt we were inclusive enough for other team members (housekeeping/ cleaning /portering staff) without whom the place falls apart. Maybe there were conversations happening, but I think it would have been good to have been much more inclusive from the outset- actively seeking out those groups who rarely get acknowledged for the work they do, let alone asked about how they feel or if there are issues in their work areas that need to be addressed. So important given the preponderance of adverse outcomes from COVID-19 amongst BAME (who make up the majority of the non-medical/clinical/admin roles)"

Key points:

- A network wide approach could be considered to support work on a framework/SOP that outlines key enablers to increase engagement and inclusivity in decision making. This could highlight the need for consultation and co-production, supporting diversity and equality and ensuring representation of staff groups who are in both clinical and non-clinical roles
- The pandemic has highlighted inequity in services for BAME staff and patients and offers a real opportunity for focussed work in this area
- The role of the MVP is recognised by maternity services as valuable as it provides links to the voices of women and families. There is variation in how the service is funded across the region and consideration is required to reducing the variation and perhaps considering streamlining the process region-wide.

6. Community teams

One of the earliest and most rapid changes which impacted community midwifery teams was a disbanding of the continuity of carer pathway in some areas. As part of a national response prior to the pandemic, community midwifery teams were embedding a novel model of working whereby they were delivering continuity of care by way of working as teams of clinicians who provided care to a certain cohort of women. This was implemented with the intention of providing maternity care to improve experience for women (Implementing Better Births; Continuity of carer model, NHSE, 2017).

The use of community hubs for the provision of care to pregnant and post-natal women had mixed reviews, some commented on the improved team-working, but specific issues have been identified with:

- Technology including Wi-Fi, lack of printing facilities for essential items e.g. addressograph labels
- Collection of samples e.g. blood/urine
- Physical space, including lack of examination couches, available space for safeguarding conversations
- Stocking up on equipment e.g. gloves, facemasks, aprons
- Providing antenatal and postnatal care
- Removal of sharps boxes and clinical waste

Many staff believe there have been increased admissions of babies, possibly due to reduced follow-up appointments, or due to babies not been seen in the community until day 5/6.

The process of allocating the community team to attend if there is a woman that is symptomatic of COVID-19 at home presents a risk to the team and is stressful for the midwife and her family.

""I'm not sure pulling midwives out of GP surgeries benefitted anyone and the lack of permanence of the 'hubs' provided has led to so many changes and insecurity for the staff and the women"."

Key points:

- Community teams have undergone many changes which have had considerable impact on how teams plan their workloads and provide care for women and families. There are high levels of anxiety among some of those midwives.
- It is clear from this survey that ongoing consultation with community midwifery teams is paramount if maternity services are to retain community staff who are happy and feel supported to deliver high quality personalised women-centred care
- Facilities available in the community to support the provision of high-quality care are variable, and consideration of the issues identified with teams working from 'hubs' for example, the lack of facilities for the staff to perform their roles safely, are important

7. Pausing of service provision

"I would have kept the birth centre open, closed the homebirth team and brought them into the birth centre"

There were several areas where staff felt that pausing service provision did not work well.

Service stopped	Comments
Homebirth	Suspension of the homebirth service
Stretch & sweep	Stopping services such a stretch and sweeps and postdates clinic
Diagnostic provision	Implications of not carrying out laparoscopic procedures for patients. Huge difference having to go through a sometimes "diagnostic" laparotomy
Birth centre	Having birth centre closed so less choice for women
Scan provision	Reduction in capacity for serial growth scans or scans for suspected SGA (small for gestational age) babies. This has caused a great deal of anxiety amongst women and staff and I do not feel there has been adequate justification for the changes. Removal of the routine 36-week scan
Saving babies lives pathway	Two growth scans does not feel enough to reassure that fetal growth is normal
Clinical governance	Maintain robust pathway for multidisciplinary review of root cause analysis/action plans prior to sign-off by Trust risk team.

The unprecedented changes required to protect staff, mothers and babies and the wider community from COVID-19 meant that some services were reduced, suspended, or stopped entirely. On reflection it is possible to see where some services could continue to run, should there be future waves of the pandemic.

Key points:

- Sharing intelligence at a network/regional level to inform workforce planning for the management of key services such as continuity of carer midwifery teams and home birth teams during a second wave is critical
- Quality and safety agendas should continue to be a priority as should ensuring provision of choice
- Feedback from staff, women and families should be used to inform decision making as appropriate

8. Innovations to delivery of monitoring and care

During the pandemic, several novel outpatient approaches including delivery of care, surveillance and ongoing monitoring for pregnant women and post-natal women commenced e.g. blood sugar monitoring and blood pressure monitoring. In addition, changes to the location of care provision and the team providing that care were made. Some trusts introduced or expanded the provision for the outpatient induction of labour process to prevent women from being separated from their partners and families in the early stages of the induction of labour pathway. The impact of the pandemic gave a certain freedom to decision making and an opportunity for rapid cycles of innovation and change such that if a change was put in place and didn't work or had unintended consequences it was possible to either stop it or try a different change with speed.

For example, the implementation of a pathway to dispense postpartum contraception in hospital has eliminated the need for women to go to the GP for this reason in some Trusts. In others having to don and doff PPE before entering a labour room to review the electronic fetal monitoring recording (fresh eyes approach) meant this usual routine was impractical and where remote fetal monitoring observation screens were available this was used as a second person reviewing the fetal monitoring tracing. Positives were fewer interruptions for the woman and her partner and a feeling of *'real collaborative decision making with the midwife in charge of the shift'.*

Some of the changes to the pathways may have already been in place in some settings but not others (e.g. outpatient induction of labour), and we can be somewhat reassured of their success based on other unit's data. However, some changes to care (e.g. change in screening test for gestational diabetes), will require robust analysis before adopting them as routine practice into maternity care.

For some changes, e.g. outpatient neonatal intravenous antibiotics, the evaluation will need to consider the outcomes for the mothers, and the possible economic benefits of reduced length of stay, alongside the clinical outcomes.

"No home visits by community midwives presents a huge problem in a safeguarding scenario"

The list of changes is provided below.

Service	Type of service
Home monitoring	Self-monitoring at home for women with raised blood pressure and gestational diabetes mellitus
Home Birth Service	Continued provision of home birth service
Intravenous Antibiotics (outpatient)	Outpatient intravenous antibiotics program for neonates although the number of allocated places needs to be increased
Intravenous Antibiotics (inpatient)	Administering intravenous antibiotics for neonates on the postnatal ward, reducing separation of mum and baby
CTG monitoring	Fresh eyes review occurred in the main hand over room not in the labour room.
Triage phone line	Dedicated staff member for triage phone working in a private room (non-clinical environment)
Discharge	Advanced postnatal discharge pathway
Postpartum contraception	Contraception being available on the postnatal wards and delivery suite
NIPEs completed in hospital	The availability of trained staff to support the Newborn Infant Physical Examination (NIPE) to be completed on labour ward as part of a holistic care bundle to women and their families.
Day 5 weight	Combined Day 5 weight and newborn blood spot screening
GDM screening change	Change in screening test for GDM [Gestational Diabetes monitoring] is much easier. From oral glucose tolerance testing (OGTT) to HbA1c (blood test) – reducing numbers of individuals diagnosed
Equipment purchasing	Ability to purchase necessary equipment with less authorisation being required.

Key points:

- Consider sharing the outcomes of individual Trusts audits of service changes and identify what and where we can learn from other sites
- Use the existing networks to evaluate where there is variation regionally in the innovation pathways described and consider where there is opportunity for reducing variation in practice
- Provide a platform for all staff to hear from women and families on their experiences during the pandemic, for example the impact of service changes, access to midwifery staff and their confidence in innovations rolled out during this timeframe.

9. Ease of making change during COVID-19 period

73% of respondents agreed/strongly agreed that making change was easier during the COVID-19 pandemic. Staff commented on the enablers which they identified as key to making changes easier. These have been categorised and displayed below, along with the number of staff who identified that reason. The primary reason given, perhaps unsurprisingly, was the national focus and priority behind the changes.

Key points:

- Staff supported a working model which gave more local ownership to decision making where it was relevant to that clinical area
- Many of the factors that made making change easier should be possible in the absence of a pandemic, services could consider where it is possible to safely keep the enablers to swift and effective innovation and improvement practices
- The pandemic resulted in more agile ways of working and reflected the ability of organisations/services to be innovative and creative, it is vital to harness that energy in future planning for digital services
- What can our maternity and neonatal services learn from the feeling of 'one team working together' expressed during the survey that will be a positive change to behaviour and culture in healthcare teams and improve safety for women, babies and their families?

Appendix A: Report Authors (incl. Task & Finish Group members)

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Jayne Poole	Buckinghamshire Healthcare	Governance Lead for Women's & Children's
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