December 2020 Update: Delivering Maternity and Neonatal Services During the Covid-19 Pandemic

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Scottish Government
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During the unprecedented situation created by Covid-19, NHS services have had to adapt, altering service provision and introducing measures to reduce spread of the virus to women, families and staff.

From the outset of the pandemic maternity and neonatal care has been recognised as an essential acute, integrated and community service, providing both scheduled and unscheduled care. **Midwives, obstetricians and the wider maternity and neonatal workforce are required to continue to care for pregnant women, babies and families and therefore should not be redeployed outwith this setting.**

The Royal College for Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) have produced UK wide guidance to support organisations, staff and women and their families throughout the pandemic. This guidance underpinned that issued by The Scottish Government, including: Maternity Covid-19 Planned Care/Service Standards; Guidance for Workforce Planning for Midwifery during Covid-19 (which included a calculator to support local workforce planning and outlined service provision in line with midwifery workforce considerations); and the Maternity Critical Care Guidance.

As an essential service, Neonatal Care continued with modifications described within guidance as set out in Royal College of Paediatrics and Child Health (RCPCH) , RCOG and the British Association of Perinatal Medicine (BAPM) Guidance.

Purpose

This document provides guidance for NHS Boards for the management of maternity and neonatal services in Scotland in response to levels of Covid-19 infection locally, to aid Boards with local service planning. It aims to collate guidance relevant to the essential provision of maternity and neonatal care and, additionally, interpret how that should be applied to meet the needs of women and families.

It should be read within the context of Covid-19-Scotland's Strategic Framework which sets out how the Scottish Government's strategic approach to suppress the virus to the lowest possible level. The Framework includes a system of 5 protection levels (ranging from 0-4). Ministers, with expert advice, will apply these levels, which can be applied locally or nationally, guided by evidence on the state of the epidemic, and only for as long as necessary. Protection Levels will be regularly reviewed, to check a local protection level a postcode checker can be found at https://www.gov.scot/check-local-covid-level/.

This document should be considered within this particular context of planning work underway within Boards, including those for winter preparedness. Local remobilisation plans should continue to be informed by the clinical prioritisation of services and national guidance/policy frameworks, including those relating to Test and Protect and Infection Prevention and Control (IPC), which are so critical to safeguarding both staff and patients alike.

This document will be updated to contextualise relevant Scottish Government and clinical guidance produced by key stakeholders including RCOG, RCM, RCPCH and BAPM. **This should be read alongside [Visiting Guidance in Maternity and Neonatal Settings during COVID 19](#) (updated version published 2 Dec).**

This document has been written in partnership with healthcare professionals who care for pregnant women and babies and covers the key areas of: antenatal, intrapartum, postnatal and neonatal care, bereavement, staffing, training and national reporting, setting out minimum standards of care within each level. The Scottish Government continues to engage with service user representatives to ensure that the voice of women in the development of guidance for maternity and neonatal services, is heard.

The Scottish Government is working with Public Health Scotland, the University of Aberdeen and the Maternal and Infant Health Research Unit at the University of Dundee to undertake research which aims to look at women's experiences of maternity services during the current pandemic, how maternity care has changed during this period and the acceptability and accessibility of changes. This will provide an understanding of what interventions should be promoted and developed after the pandemic, which should be adapted or which should be discontinued.

It should be noted that this document supersedes the Maternity Covid-19 Planned Care/Service Standards (v2 circulated 19 May).

Testing

In accordance with the letter from the Chief Nursing Officer and National Clinical Director on 27 November, asymptomatic testing of emergency admissions is being introduced from early December, including admissions to maternity units. At the time of publication, all patients who are asymptomatic at the point of admission should be tested using PCR tests. This will support the continued implementation of Infection Prevention and Control (IPC) Guidance. National clinical pathways have been developed for maternity and neonatal settings, and have been issued to Boards through Chief Executives.

Remobilisation

Scotland has moved forward with the Remobilisation of services in line with the principles from [Re-mobilise, Recover, Re-design: the framework for NHS Scotland](#). These principles should be applied to maternity and neonatal services so that services at each stage are:

SAFE: Creating the safest environment and conditions for maternity services to best meet the needs of the population while putting the safety and wellbeing of the maternity and neonatal workforce on a par with the rest of the population.

Integrated: In recognising the crucial interdependencies between the different parts of the health and social care system and with other parts of society, planning approaches should identify the important connections between services and systems and take account of partners including local government, staff and service users. This will highlight the interdependencies and put in place processes to ensure

resources are allocated where they are most needed to ensure the whole system operates effectively and efficiently.

Quality: As services are remobilised the highest standards of care will be maintained that prioritises shared decision making with women and families. Safe sustainable high quality maternity care rooted in individual and staff wellbeing.

Close to home: Services close to people's homes. While the pandemic has valued technology this is within the context of personal connection that listens to what matters to women and their families. Going forward there is a need to minimise unnecessary travel by providing care within the community and closer to home. We will evaluate and develop the role of virtual consultations within a person centred approach, ensuring that all care is proportionate to need.

Prevention: We will increase our work on prevention focusing on the public health role of maternity and neonatal services in improving the future health of population.

Equality: This pandemic has exposed and exacerbated deep rooted health and social inequalities. Maternity and neonatal services will act to mitigate against these by ensuring that services are provided in way that is proportionate to need. Services will focus on how to support those who are most vulnerable (clinically and socially).

Sustainability: Maternity and Neonatal Services need to ensure financial sustainability, while reducing inequalities and improve health and wellbeing.

The Best Start

The majority of maternity services continued to implement Best Start throughout the first wave of the pandemic, and in some cases continuing to roll out parts of the programme. Teams have introduced innovations at pace in response to the pandemic, such as the use of technology, home monitoring and new ways of delivering care which support Best Start aims of bringing care closer to home, keeping mother and baby together and individualising care for pregnant women, new mothers and babies. With Boards again focused on the rising incidence of COVID in many areas, which must be the priority, maternity and neonatal teams are encouraged to maintain the progress they have made and to take forward innovation where they are able to do so. The Best Start team are ready to work with and support Boards where as required. Recognising that capacity will vary across the country, Scottish Government will not be requesting implementation plans or monitoring progress at this stage.

Living with Covid-19 (Levels 0-1 low incidence of the virus with isolated clusters, and low community transmission)	Protective Measures depending on local virus prevalence (Levels 2-3 increased incidence of the virus, with multiple clusters and increased community transmission)	Restricted Measures (Level 4 very high or rapidly increasing incidence, and widespread community transmission which may pose a threat to the NHS to cope)
Restoring Clinical Pathways and Improving the Quality of Care: Antenatal Care		
✓ Where services can support it, they should deliver the full pathway of antenatal maternity care, with appropriate IPC measures in place to protect women and staff: • Person centred care delivered for all women. • Routine schedule of antenatal visits for all women as per QIS Pathways for Care. including 8 – 10 in person antenatal appointments. • Provide additional tailored care for women with additional medical, social and psychological needs. • Provide care for critically ill women in line with Maternity Critical Care Guidance. • Coronavirus (COVID-19): outpatient and primary care consultations outlines principles for reducing potential transmission within outpatient and primary care settings.	As Levels 0 – 1, plus: ✓ As an **essential service**, maternity care continues with potential modifications described within: • Guidance for Workforce Planning for Midwifery Services During COVID-19 (issued 8 May, attached at Annex A). ✓ Where there is significant staff absence and services can no longer sustain in person antenatal care in line with QIS Pathways for Care, antenatal appointments can be reduced as per the RCM/RCOG schedule, to a minimum of 8 appointments (6 face to face). This should be returned to the routine schedule of visits as soon as possible. ✓ Appointments that do not require hands on maternal and/or fetal assessment can be held using Near	As levels 2 – 3.

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• Follow RCM Antenatal and Postnatal Services Guidance in the Evolving Covid-19 Pandemic
 	
✓ Maintain increased vigilance when caring for women with Covid risk factors for deterioration and hospital admission:
  • Black, Asian and other minority ethnic groups.
  • Maternal age 35 years and over.
  • Being overweight or obese.
  • Respiratory and cardiac comorbidities.
  • Pre-existing med conditions such as Type 1 or 2 Diabetes or Hypertension *.
  • Living in areas or households of increased socioeconomic deprivation.
 	
✓ Maintain increased vigilance for vulnerable women who are more susceptible to poor outcomes.
  • All women should be asked about their mental wellbeing at every
	Me, these are outlined in RCOG/RCM as 16 and 25 week appointments.
	
	✓ For planned home visits, the expectation is that no one outside the household or extended household should be in the home.
	
	✓ Travel across local authority borders in different levels can continue for essential antenatal, intrapartum and postnatal care provision if they are not available in your local area. Maximise use of Near Me and remote monitoring to reduce unnecessary travel.
	
	✓ Travel restrictions provide exemptions for travel across levels to accompany a pregnant woman or child for scheduled or unscheduled care, or to visit a person in hospital.	

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appointment and referred for additional support as required. • All women should be asked about money concerns and referred for additional support as required. ✓ Continue providing information for pregnant women on NHS Inform and badgernet, with local information also available via badgernet and local internet/social media platforms. ✓ Continue to develop use of Near Me and remote blood pressure monitoring to supplement and enhance the routine schedule of care and to increase access/deliver person centred care - subject to individual risk assessment. ✓ Continue Baby Box registration between 18 – 20 or 28 week appointment. ✓ For antenatal home visits, where anyone in the family does not live in the same household (unless part of		

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the extended household), the expectation is that they should observe indoor physical distancing and not be Covid positive, self-isolating or showing any symptoms of coronavirus as per national guidance.		

Parent Education , Birth Preparation and Peer Support		
✓ Continue to promote access to 'understanding your pregnancy, labour, birth and your baby', online antenatal education package. ✓ Antenatal and postnatal group sessions continue, virtually or in person subject to risk assessment and appropriate physical distancing. • Midwifery Teams can engage their local TEC support for advice on the recommended platforms to use where virtual sessions are used. ✓ Breastfeeding support to continue in person or virtually, subject to risk assessment and appropriate physical distancing.	As Levels 0 – 1, plus; ✓ Travel across local authority borders in different levels can continue for essential antenatal and postnatal education provision and parenting support. Maximise use of Near Me and remote monitoring to reduce unnecessary travel.	As Levels 2- 3, plus: ✓ Pause in person breastfeeding support. Pause in person antenatal and postnatal group sessions, but continue virtual and online antenatal and postnatal education and breastfeeding support.

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Restoring Clinical Pathways and Improving the Quality of Care: Intrapartum Care		
✓ Where services can support it, they should deliver the full pathway of intrapartum maternity care, with appropriate IPC measures in place to protect women and staff: • Provide full range of birth options including care in AMU/FMU, obstetric unit and homebirth. • Provide care for critically ill women in line with Maternity Critical Care Guidance. • Optimise physiological birth. • Continue delayed cord clamping. • If no other risk factors and induction of labour indicated, offer outpatient home induction. • For homebirths, where anyone in the family does not live in the same household (unless part of the extended household), the expectation is that they should observe indoor physical distancing and not be Covid positive, self-isolating or showing any symptoms of coronavirus as per national guidance.	As Levels 0 - 1, plus: ✓ As an **essential service**, maternity care continued with potential modifications described within: • Guidance for Workforce Planning for Midwifery Services During COVID-19 (issued 8 May, attached at Annex A). ✓ Consider scaled approach to full service provision and maintaining birthplace options based on workforce and transport pressures, as per RCOG/RCM Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic. ✓ For planned home births no one outside the household or extended household should be in the home, the expectation is that birth partners should observe indoor physical distancing and not be Covid positive, self- isolating or showing any	As Levels 2 – 3.

Living with Covid-19 (Levels 0-1 low incidence of the virus with isolated clusters, and low community transmission)	Protective Measures depending on local virus prevalence (Levels 2-3 increased incidence of the virus, with multiple clusters and increased community transmission)	Restricted Measures (Level 4 very high or rapidly increasing incidence, and widespread community transmission which may pose a threat to the NHS to cope)
• Hospital birth is recommended for a Covid positive or symptomatic mother.	symptoms of coronavirus as per national guidance.	
Restoring Clinical Pathways and Improving the Quality of Care: Postnatal Care		

✓ Where services can support it they should deliver the full pathway of postnatal care, with appropriate IPC measures in place to protect women and staff:
  • Provide routine schedule of postnatal care including in person visits as per QIS Pathways for Care.
  • Provide additional Tailored care for women and families with additional medical, social and psychological needs
  • Provide care for critically ill women in line with Maternity Critical Care Guidance.
  • Coronavirus (COVID-19): outpatient and primary care consultations outlines some principles for reducing potential transmission within outpatient and primary care settings.
	As Levels 0 - 1, plus:
	
	✓ As an **essential service**, Maternity care continued with potential modifications described within:
	  • Guidance for Workforce Planning for Midwifery Services During COVID-19 (issued 8 May, attached at Annex A).
	
	✓ Where there is significant staff absence and services can no longer sustain in person postnatal care in line with QIS Pathways for Care, prioritise home visits when hands on assessment required and for BAME or vulnerable women more at risk of poor outcomes.
	
	✓ Travel restrictions provide exemptions for travel across levels to accompany a woman or child for scheduled or
		As levels 2 – 3.

Living with Covid-19 (Levels 0-1 low incidence of the virus with isolated clusters, and low community transmission)	Protective Measures depending on local virus prevalence (Levels 2-3 increased incidence of the virus, with multiple clusters and increased community transmission)	Restricted Measures (Level 4 very high or rapidly increasing incidence, and widespread community transmission which may pose a threat to the NHS to cope)
✓ Follow RCOG/RCM Guidance on Infection in Pregnancy ✓ Maintain increased vigilance when caring for women with Covid risk factors for deterioration and hospital admission • Black, Asian and other minority ethnic groups • Maternal age 35 years and over • Being Overweight or Obese • Respiratory and cardiac comorbidities • Pre-existing med conditions such as Type 1 or 2 Diabetes or Hypertension * • Living in areas or households of increased socioeconomic deprivation. ✓ Maintain increased vigilance for vulnerable women who are more susceptible to poor outcomes. • All women should be asked about their mental wellbeing at every visit and referred for additional support as required.	unscheduled care, or to visit a person in hospital. ✓ National Bereavement Care Pathways (NBCP) early adopter boards to continue with the pilot as far as capacity allows. ✓ All aspects of normal bereavement care to be provided for both parents and access to bereavement space to continue.	

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• All women should be asked about money concerns and referred for additional support as required. ✓ Continue providing information for pregnant women on NHS Inform and badgernet, with local information also available via badgernet and local internet/social media platforms. ✓ Continued to develop use of Near Me and remote monitoring to supplement and enhance the routine schedule of care and to increase access/deliver person centred care - subject to individual risk assessment. ✓ For postnatal home visits, where anyone in the family home does not live in the same household (unless part of the extended household), the expectation is that they should observe indoor physical distancing and not be Covid positive, self-isolating or showing any symptoms of coronavirus as per national guidance.		

Living with Covid-19 (Levels 0-1 low incidence of the virus with isolated clusters, and low community transmission)	Protective Measures depending on local virus prevalence (Levels 2-3 increased incidence of the virus, with multiple clusters and increased community transmission)	Restricted Measures (Level 4 very high or rapidly increasing incidence, and widespread community transmission which may pose a threat to the NHS to cope)
✓ National Bereavement Care Pathway (NCBP) early adopter Boards to continue with the pilot across all five pathways in all sites. ✓ All aspects of normal bereavement care to be provided for both parents and access to bereavement space to continue.		
Neonatal Care		
✓ Keeping Families Together: • Both parents able to attend neonatal wards to provide essential care for their baby as per guidance issued by BAPM and Bliss, provided they are not covid positive, self-isolating or showing any symptoms of the virus, as per national guidance. • Parents should be offered opportunities to remove face masks when it is safe to do so, to encourage bonding. • Skin to skin and kangaroo care to continue.	As Levels 0 - 1, plus: ✓ As an **essential service**, neonatal care continued with modifications described within guidance issued by the Perinatal Network on 20 March, and as set out in RCPCH, RCOG and BAPM Guidance. ✓ Parents are permitted to Travel across local authority borders in different levels to be with their baby in hospital or attend appointments. ✓ Parents who do not have access to a private car, can claim reimbursement for one return taxi journey between	As Levels 2 -3.

Living with Covid-19 (Levels 0-1 low incidence of the virus with isolated clusters, and low community transmission)	Protective Measures depending on local virus prevalence (Levels 2-3 increased incidence of the virus, with multiple clusters and increased community transmission)	Restricted Measures (Level 4 very high or rapidly increasing incidence, and widespread community transmission which may pose a threat to the NHS to cope)
Resume Bliss Baby Charter process where possible. ✓ Continue providing information for new parents on NHS Inform and badgernet, with local information also available via badgernet and local internet/social media platforms. ✓ Continue use of Near Me and Vcreate to supplement and enhance the routine schedule of care and to increase access/deliver person centred care - subject to individual risk assessment. ✓ National Bereavement Care Pathway (NCBP) early adopter Boards to continue with the pilot across all five pathways in all sites. ✓ All aspects of normal bereavement care to be provided for both parents and access to bereavement space to continue.	their home and hospital, each day, in levels two to four, through the Neonatal Expenses Fund. ✓ National Bereavement Care Pathways (NBCP) early adopter boards to continue with the pilot as far as capacity allows. ✓ All aspects of normal bereavement care to be provided for both parents and access to bereavement space to continue.	
Training		
As Levels 0 -1, plus:	As Levels 2-3.	

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✓ Postgraduate training: In person/or blended training to be resumed where paused, including Core Mandatory Training and CPD.	✓ Postgraduate training: In person/or blended training to be continued where staffing levels allow, in particular core mandatory and essential training for safety should be continued where possible.	

Policy Implementation and input to Audits

- ✓ Collect and submit required data for all women admitted to hospital who have tested positive for covid-19 though the UKOSS study.
- ✓ Collect and submit required data for all babies admitted to hospital who have tested positive for covid-19 through the BPSU study.
- ✓ Best Start: local implementation of the redesign of maternity and neonatal services as set out in The Best Start can continue commensurate with capacity, staffing levels and virus management. No requirement to submit data or plans, however the Best Start team are ready to work with any Boards that have capacity to take forward Best Start improvement work.
- ✓ Best Start: Resume Baby Bliss Charter Accreditation Process where there is capacity to do so.
- ✓ Continue local improvement and reporting for MCQIC,
- ✓ All national clinical audit and confidential enquiries data submission to resume (where paused).

At all levels, this guidance is underpinned by key detailed guidance, as follows:

- Scottish Government Information and Support on Covid-19.
- Scottish Government Guidance on use of face masks in hospitals is available at https://www.gov.scot/publications/coronavirus-covid-19-interim-guidance-on-the-extended-use-of-face-masks-in-hospitals-and-care-homes/.
- HPS Four Nation Guidance on use of PPE is available at https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/infection-prevention-and-control-ipc-guidance-in-healthcare-settings/ with addendum for Scotland: National Infection Prevention and Control Manual: Scottish COVID-19 Infection Prevention and Control Addendum for Acute Settings: http://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-infection-prevention-and-control-addendum-for-acute-settings/
- BAPM Guidance on the classification of mothers and newborns for care pathways.
- Technology Enabled Care Guidance: Continued use of Near Me Technology All Boards have a TEC lead and Maternity Teams should speak with them for support in using appropriate technology to deliver care and education.
- Family Support Directory for parent information in one place, including Baby Box's, Ready Stead Baby, bereavement support etc.
- The National Bereavement Care Pathways COVID -19 webpage provides information on support organisations for both staff and patients can be found here https://www.nbcpscotland.org.uk/covid-19/ .

Annex A

Guidance for Workforce planning for midwifery services during COVID -19

This guidance applies during Covid-19 emergency and should not be used when the emergency is over

Aim

To provide clinical guidance to support decision making using a nationally developed professional judgment decisions making template for midwifery staffing requirements in maternity services during the extreme circumstances of the COVID -19 pandemic.

Driver

During the COVID-19 pandemic it is anticipated that changes will be required in service delivery or clinical models as a result of a number of factors that will vary according to speciality. These include increasing demand, reduction in staff availability due to absence, requirement to implement social distancing measures and the protection of shielded pregnant women and staff. It is therefore highly likely that current staffing models and in particular skill mix may no longer be achievable or appropriate. A planned approach to changing staffing models and skill mix is required to ensure that associated risks can be mitigated in a consistent way and that the best possible care can be provided.

Maternity is an essential acute and community service with no anticipated reduction in need throughout the course of the pandemic. Midwives and the wider maternity workforce will be required to continue care for pregnant women, babies and families and should not be redeployed outwith maternity services.

This clinical guidance has been developed to support clinicians identify where changes may be required to service and clinical models, and the risk mitigating factors which should be considered ring the different phases of the pandemic, taking account of the local context in which the modelling is taking place.

The professional judgement staff modelling template has been developed to provide a consistent approach for clinical and workforce managers to quickly calculate the whole time equivalent (wte) staffing requirement based on the professional judgement of the user in line with the clinical guidance, whilst recognising variation in clinical settings and models of care. The balance must seek to prioritise safe person-centred care that considers the physical and mental wellbeing of women and families within a service where the ability to reduce demand is minimal.

Clinical Guidance for maternity and neonatal care during COVID-19 pandemic.

The Scottish Government has issued guidance to Boards related to maternity care during the pandemic. In addition, the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) joint guidance

outlines specific advice related to adaptations to services for both midwifery and obstetric care provision.[1,2]

Midwifery Staffing During COVID 19

Midwifery staffing requirements are normally determined using the Healthcare Staffing Programme workload planning tool as part of the common staffing method. This is accompanied by professional guidance regarding one to one care in labour and a caseload size as outlined in the 'Best Start Forward Plan for Maternity and Neonatal Services' (2017). Full implementation of The Best Start was not in place in all Boards prior to the pandemic.

As the coronavirus pandemic is unprecedented, it is recognised to be highly likely that availability of midwifery staff who usually work in specific clinical areas will reduce due to staff absence. Midwifery staffing will therefore require to be altered to ensure staff with relevant experience are utilised in the most effective way. During peak periods it is envisaged that returner midwives, final six month student midwives, year 2 students and redeployed staff will be required to support the delivery midwifery care under the direct or indirect supervision of substantive midwives.

In considering available staff those midwives who are self-isolating or shielding due to Covid-19 that are able to provide care via telehealth or other remote means should also be included in this context.

A flexible pragmatic and staged approach with an emphasis on team-working rather than a ratio approach will need to be considered in order to utilise maternity skilled staff effectively and ensure the most effective care to woman and babies.

Consideration should also be given to the possibility of utilising staff with midwifery registration from other clinical specialties should this be required to sustain maternity services. When considering deployment of staff from other areas a comprehensive risk assessment must be made to ensure that there is a whole system approach to risk assessment and that movement of staff does not have the unintended consequence of disabling other services. In order to ensure a whole systems approach it will be necessary to prioritise access to different staff groups dependent on pressures being experienced across the system whilst ensuring the most effective use of transferrable skills in different clinical settings.

Examples of the type of staff who may be made available are:

- Health visiting or family nurse practitioners for their skills with safeguarding and infant feeding.
- Health visiting or family nurse practitioners who have recent experience of midwifery care.
- Nursery nurses, maternity care assistants and clinical support workers with previous experience in maternity and neonatal care.

Purpose

The professional judgement decision making template will assist Boards to scenario plan and will support a consistent approach as the pandemic progresses. It will provide the operator with the function of calculating the number of staff required on each shift whilst considering the optimum skill mix within the context in which the service is operating at the time. Skill mix will need to alter dependent on availability of staff and changes to workload as a result of changing clinical models as the pandemic progresses. The template will enable to user to alter absence to reflect total absence being experienced at the time or to model based on different assumptions about absence.

How: Recognising the interdependencies of the different aspect of maternity care. The template will allow the user to enter the staffing number required per shift and to identify the minimum number of substantive midwives per shift, the number of registrants who have returned to the NHS during the pandemic and student midwives in the final six months of training and then to identify the number of support staff required. This will allow for scenario planning as the skill mix alters.

Scenario Planning

A phased approach should be taken to introducing skill mix and new staff groups to the relevant clinical environment. Some scenarios are provided below for antenatal, postnatal, labour ward and high dependency categories which are intended to provide guidance on the phasing of implementation for planning purposes. When staffing in each stage is no longer sustainable movement to the next stage is advised The moving through each phase will be dependent on local availability of staff and should be applied taking account of the local context in which the service is delivered. Boards should revert to the previous stage as soon as local context allows, with the ultimate aim of returning to stage one (pre COVID). Boards may be at different stages for antenatal, intrapartum and postnatal care simultaneously at times. It is also essential when considering staffing requirements using these scenarios to consider the clinical leadership required to support staff working out with their normal scope of practice and those who are supervising and delegating to them.

Antenatal Care Boards should revert to the previous stage as soon as local context allows, with the ultimate aim of returning to stage one (pre COVID)	
Stage **Service**	**Staffing**
One (pre COVID): • Full range antenatal services.	• Preparation: escalation plans developed, all services still in place, no pressure on transport identified, training and upskilling commenced • Maintain numbers and skill mix of registered to unregistered staff • Care by midwife • Students supernumerary

Two:	
• Minimum 6 face to face appointments • Consider alternative care delivery methods • Consider joining up appointments • Stop antenatal group sessions	• Returner midwife or final 6 month student support midwife with antenatal care, considering continuity of carer • Through risk assessment and decision making processes allocate women to returner midwife or final 6 month student matching skills to women's need • Increase capacity by releasing midwives from stepped down or consolidated services • Returner midwife has support of midwifery team dependant on need • Student midwife has direct or indirect supervision dependant on need
Three:	
• Minimum 6 face to face appointments • Consider alternative care delivery methods • Consider joining up appointments • Stop antenatal group sessions	• Returner midwife, final 6 month or year 2 students support midwife with antenatal care, considering continuity of carer • Through risk assessment and decision making processes allocate women to returner midwife or student matching skills to women's need • Returner midwife has support of midwifery team dependant on need • Student midwife has direct or indirect supervision dependant on need and level • This stage carries risk in ensuring appropriate supervision of students
Four:	
• Minimum 6 face to face appointments • Consider alternative care delivery methods • Consider joining up appointments • Stop antenatal group sessions	• Returner midwife, student midwife or redeployed staff support midwife with antenatal care, considering continuity of carer • Through risk assessment and decision making processes allocate women to returner midwife, student or redeployed staff matching skills to women's need • Returner midwife has support of midwifery team dependant on need • Student midwife or redeployed staff has direct or indirect supervision dependant on need and level • This stage carries risk in ensuring appropriate supervision of students or redeployed staff

Note: students, other than final 6 months, should have normal experience alongside
a midwife

Intrapartum Care Boards should revert to the previous stage as soon as local context allows, with the ultimate aim of returning to stage one (pre COVID). Women will have 1:1 care at all times, however provision may not be by a midwife dependant on the service stage	
Stage **Service**	**Staffing**
One (pre COVID): • Full range of intrapartum options available	• Preparation: escalation plans developed, all services still in place, no pressure on transport identified, training and upskilling commenced • Maintain numbers and skill mix of registered to unregistered staff • 1:1 care by midwife • Students supernumerary
Two: • Consider reducing care options ensuring mix of midwifery and obstetric led care	• Midwife or returner midwife • Through risk assessment and decision making processes allocate women to returner midwife matching skills to women's need • Increase capacity by releasing midwives from stepped down or consolidated services • Returner midwife has support of midwifery team dependant on need
Three: • Unable to sustain full range birth options. centralise to AMU/OU • BBA covered by community	• One midwife oversees the care of 2 women, the other woman cared for by final 6 month or year 2 student midwife • Through risk assessment and decision making processes allocate women to returner midwife or student matching skills to women's need • Returner midwife has support of midwifery team dependant on need • Student midwife has direct or indirect supervision dependant on need • This stage carries risk in ensuring appropriate supervision of students
Four: • Unable to sustain level 3 restricted birth options without deployment of staff from other clinical specialities	• One midwife oversees the care of 3 women, the other 2 women cared for by final 6 month or year 2 student midwife or staff redeployed from other specialties • Through risk assessment and decision making processes allocate women to returner midwife, student or redeployed staff matching skills to women's need • Returner midwife has support of midwifery team dependant on need • Student midwife and redeployed staff has direct or indirect supervision dependant on need • This stage carries risk in ensuring appropriate supervision of students or redeployed staff
Existing HDU • Maintain services	• Maintain numbers and skill mix of registered to unregistered staff
Additional HDU	• Maintain numbers and skill mix of registered to unregistered staff

• Plan for surge capacity as required	• Through risk assessment and decision processes upskill proportionate number of staff to ensure skilled staff on every shift

Note: students, other than final 6 months, should have normal experience alongside a midwife

Postnatal Care Boards should revert to the previous stage as soon as local context allows, with the ultimate aim of returning to stage one (pre COVID).	
Stage **Service**	**Staffing**
One (pre COVID): • Full range of postnatal services.	• Preparation: escalation plans developed, all services still in place no pressure on transport identified, training and upskilling commenced • Maintain numbers and skill mix of registered to unregistered staff • Care by midwife, • Students supernumerary
Two: • Home visiting based on need • Minimum contacts day 1,5,10 • Prioritise face to face contact based on need • Consider other care delivery methods • Stop postnatal group sessions	• Returner midwife or final 6 month student support midwife with postnatal care, considering continuity of carer • Through risk assessment and decision making processes allocate women to returner midwife or final 6 month student matching skills to women's need • Increase capacity by releasing midwives from stepped down or consolidated services • Returner midwife has support of midwifery team dependant on need • Student midwife has direct or indirect supervision dependant on need
Three: • Home visiting based on need • Minimum contacts day 1,5,10 • Prioritise face to face contact based on need • Consider other care delivery methods • Stop postnatal group sessions	• Returner midwife, final 6 month or year 2 students support midwife with postnatal care, considering continuity of carer • Through risk assessment and decision making processes allocate women to returner midwife or student matching skills to women's need • Returner midwife has support of midwifery team dependant on need • Student midwife has direct or indirect supervision dependant on need and level • This stage carries risk in ensuring appropriate supervision of students
Four: • Home visiting based on need • Minimum contacts day 1,5,10 • Prioritise face to face contact based on need • Consider other care delivery methods • Stop postnatal group sessions	• Returner midwife, student midwife or redeployed staff support midwife with postnatal care, considering continuity of carer • Through risk assessment and decision making processes allocate women to returner midwife, student or redeployed staff matching skills to women's need • Returner midwife has support of midwifery team dependant on need • Student midwife or redeployed staff has direct or indirect supervision dependant on need and level • This stage carries risk in ensuring appropriate supervision of students or redeployed staff

Note: students, other than final 6 months, should have normal experience alongside a midwife

Clinical Supervision and leadership

At a time of significant pressure it is essential that roles, responsibilities and accountability is clear. Clinical supervision will be particularly important at this time for all staff to support their health and wellbeing.

All registered midwives can delegate tasks to others in accordance with the NMC code. Further support for decision making in relation to delegation can also be found in the decision support framework produced by the Northern Ireland Practice and Education Council which has been adopted for use in the 4 countries of the UK. This may be helpful to midwives when delegating or supervising staff who have been deployed to maternity services as a result of Covid-19.

https://nipec.hscni.net/download/projects/current_work/provide_adviceguidanceinformation/delegation_in_nursing_and_midwifery/documents/NIPEC-Delegation-Decision-Framework-Jan-2019.pdf

https://learn.nes.nhs.scot/28973/coronavirus-covid-19/delegation

Applying scenarios to professional judgement decision making template

The template requires local information on numbers of patients or beds, the length of shifts, the percentage absence and the skill mix required per shift. Using professional judgement, this enables the user to calculate the minimum number of locally experienced NHS substantive staff to ensure a midwife with local knowledge and expertise per shift. This also allows for variation to the skill mix dependent on availability of staff. The ultimate aim is to clearly identify the number of staff required to provide care whilst giving consideration to a significantly altered skill mix and associated risks as the pandemic progresses.

Within the template there is step by step guidance and definitions of key terms. There are pop-up explanatory notes throughout the template. The output will highlight if there is a shortfall in the current wte which indicates that more staff may be required or alternatively if there is capacity for staff to be deployed to another area.

It should be noted that the calculation does not include time for clinical leadership and management.

The professional judgement decision making template and associated guidance for use is attached as a separate supporting document.

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