Delivering Maternity and Neonatal Services Through the COVID-19 Pandemic: Beyond Level Zero

September 2021

Scottish Government
Riaghaltas na h-Alba
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Delivering Maternity and Neonatal Services: Beyond Level Zero

Introduction

At the time of publication and as of 19th July the whole of Scotland is in level 0.

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 its continued response to COVID-19 and 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. Scotland has now moved beyond the Protection Levels system. The COVID-19 pandemic, however, is not over and we must continue to focus on suppressing the virus to a level consistent with alleviating its harms while we recover Coronavirus in Scotland - gov.scot (www.gov.scot).

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) and vaccination 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 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 based on Boards risk assessments. 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 could be promoted and developed after the pandemic, which could be adapted, or which could be discontinued.

Testing

In accordance with the letter from the Chief Nursing Officer and National Clinical Director on 27 November 2020, asymptomatic testing of emergency admissions was introduced from early December 2020, 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.

Vaccination

COVID-19 vaccines are now **recommended** in pregnancy. Vaccination is the best way to protect against the known risks of COVID-19 in pregnancy for both women and babies, including admission of the woman to intensive care and premature birth of the baby. Women may wish to discuss the benefits and risks of having the vaccine with their healthcare professional and reach a joint decision based on individual circumstances. However, alongside the non-pregnant population, pregnant women can receive a COVID-19 vaccine even if they have not had a discussion with a healthcare professional. Further guidance for professionals on vaccination in pregnancy has been produced by RCOG and RCM.

Self-Isolation for Maternity and Neonatal Staff

In accordance with the letter from the Chief Nursing Officer, Chief Medical Officer and Director for Health Workforce issued to Health Boards on 27 August 2021, from 9 August people (including health and care workers) identified as close contacts of someone who has tested positive for COVID19 are no longer required to automatically self-isolate if they are double vaccinated with the 2nd dose of COVID-19 vaccine at least two weeks prior to exposure to the case, have no COVID-19 cardinal symptoms

(i.e: a new continuous cough or high temperature of 37.8 or above or a loss of, or change in, normal sense of taste or smell (anosmia)) and return a negative PCR test taken after exposure to the case. These circumstances are set out in the Policy Framework which is available on the SHOW website.

As a cohort, pregnant women and neonatal babies are not considered to be in the high clinical risk category in the context of staff exemption from self-isolation, unless they have another condition that puts them into that high-risk category (for example are on chemotherapy, immune-suppressants such as pre/immediately post-transplant, or those who have profound immune-deficiency). Whilst pregnant women in the third trimester at more risk if they catch COVID-19, and pregnant women are largely unvaccinated, the staff who are caring for them will have taken PCR and lateral flow tests and will be wearing PPE, so the risks of any transmission will be very small. Babies (even those in neonatal care) will only suffer mild symptoms of COVID-19 and so are at low risk. Boards can take decisions locally about categories of patients that are considered high risk, but for clarity, this need not include pregnant women and neonates as a whole cohort, whilst recognising that there may be a small number of pregnant women and babies who will need to be protected as they have specific additional co-morbidity that make them high risk.

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. 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 remaining on an emergency footing and focused on the rising incidence of COVID-19 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 required. Recognising that capacity will vary across the country, Scottish Government will not be requesting implementation plans or monitoring progress at this stage. An extension to the program in recognition of the importance of the forward plan and the impact of the pandemic on implementation has been agreed.

Antenatal Care

Normal Service Provision	Moderate to High Workforce Pressures Managed Locally with Contingencies in Place
✓ Where services can support it, they should deliver the full pathway of antenatal maternity care, with appropriate IPC measures in place toprotect 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 forwomen with additional medical, social and psychological needs. • Face to face CO_2 monitoring provision to be re-instated subject to risk assessment. • Provide care for critically ill womenin 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. • 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 hospitaladmission: • Black, Asian and other minorityethnic groups. • Maternal age 35 years and over. • Being overweight or obese. • Respiratory and cardiaccomorbidities. • Pre-existing med conditions such	✓ As an **essential service**, maternity care continues with potential modifications described within: • Guidance for Workforce Planning for Midwifery Services During COVID-19 (issued August 2021, 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 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 can continue for essential antenatal, intrapartum and postnatal care provision if they are notavailable in your local area. Maximise use of Technology Enabled Care and remote monitoring to reduce unnecessary travel.

as Type 1 or 2 Diabetes or Hypertension • Living in areas or households ofincreased socioeconomic deprivation. ✓ Maintain increased vigilance and ensure culturally appropriate care for vulnerable women and have a reduced threshold for face-to-face care, investigation and referral. • All women should be asked about their mental wellbeing at every 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 alsoavailable via Badgernet and local internet/social media platforms. ✓ Continue to develop use of Technology Enabled Care 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. ✓ 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 the extended household), the expectation is that they should observe indoor physical distancing and not be COVID-19 positive, self- isolating or showing any symptoms of coronavirus as per national guidance.	

Parent Education, Breastfeeding and Peer Support

Normal Service Provision	Moderate to high Workforce Pressures Managed Locally with Contingencies in Place
✓ 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 usewhere virtual sessions are used. ✓ Breastfeeding support to continue in person or virtually, subject to risk assessment and appropriate physical distancing.	✓ Travel across local authority borders can continue for essential antenatal and postnatal education provision and parenting support. Maximise use of Technology Enabled Care and remote monitoring to reduce unnecessary travel. ✓ Breastfeeding support should continue to ensure that breastfeeding is established, however it is recognised that in high workforce pressures situations, staff may need to work flexibly to ensure essential clinical services are maintained.

Intrapartum Care

Normal Service Provision	Moderate to high Workforce Pressures Managed Locally with Contingencies in Place
✓ 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 womenin line with Maternity Critical Care Guidance. • Optimise physiological birth. • Continue delayed cord clamping. • If no other risk factors and induction of labour indicated, offeroutpatient home induction. • Hospital birth is recommended for a COVID-19 positive or symptomatic mother.	✓ As an **essential service**, maternity care continued with potential modifications described within: • Guidance for Workforce Planning for Midwifery Services During COVID-19 (issued August 2021, 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 ofmidwife-led settings and home birth inthe evolving coronavirus (COVID-19) pandemic.

Postnatal Care

Normal Service Provision	Moderate to high Workforce Pressures Managed Locally with Contingencies in Place
✓ Where services can support it they should deliver the full pathway of postnatal care, with appropriate IPC measures in place to protect womenand 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, socialand 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. • 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 hospitaladmission • Black, Asian and other minorityethnic groups • Maternal age 35 years and over • Being Overweight or Obese • Respiratory and cardiaccomorbidities • Pre-existing med conditions suchas Type 1 or 2 Diabetes or Hypertension • Living in areas or households of increased socioeconomic deprivation.	✓ As an **essential service**, Maternity care continued with potential modifications described within: • Guidance for Workforce Planning for Midwifery Services During COVID-19 (issued August 2021, 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. ✓ 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.

✓ Maintain increased vigilance and ensure culturally appropriate care for vulnerable women and have a reduced threshold for face-to-face care, investigation and referral. • All women should be asked about their mental wellbeing at every visit 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. ✓ Continued to develop use of Technology Enabled Care 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-19 positive, self- isolating or showing any symptoms of coronavirus as per national guidance. ✓ National Bereavement Care Pathway(NBCP) early adopter Boards to continue with the pilot across all fivepathways in all sites. ✓ All aspects of normal bereavement care to be provided for both parents and access to bereavement space to continue.	

Neonatal Care

Normal Service Provision	Moderate to high Workforce Pressures Managed Locally with Contingencies in Place
✓ 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-19 positive, self-isolating or showing any symptoms of the virus, as pernational 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. ✓ Resume Bliss Baby Charter process. ✓ 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 Technology Enabled Care and Vcreate to supplement and enhance the routine schedule of care and to increase access/deliver person centred care, subject to individual risk assessment. ✓ Continue and develop processes for supported discharge at home allowing babies and families to be at home earlier (liaison support and service led innovations). ✓ National Bereavement Care Pathway(NBCP) early adopter Boards to continue with the pilot across all five pathways in all sites.	✓ As an **essential service**, neonatal care continued with modifications described within guidance as set out in RCPCH, RCOG andBAPM Guidance. ✓ Parents are permitted to Travel across local authority borders to be with their baby inhospital or attend appointments. Parents who do not have access to a private car, can claim reimbursement for one return taxi journey between their home and hospital, each day, through the Young Patients Family 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.

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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 Best Start can continue commensurate with capacity, staffing levels and virus management. There is 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).

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 andControl 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 Technology Enabled Care. All Boards have a TEC lead and MaternityTeams 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 Boxes, Ready Steady Baby, and bereavement.
  support etc.
- The National Bereavement Care Pathways COVID-19 webpage provides information on support organisations for both staffand patients can be found here https://www.nbcpscotland.org.uk/covid-19/.

Annex One – Workforce Planning Guidance for Midwifery Services during COVID-19 and Beyond Level Zero

Version control	changes	date
V1.1	Updated PJ template	11/01/2021
V1.2	Updated text in sections to reflect learning from earlier phases in COVID-19 pandemic. Inclusion of the real time staffing resource. Acknowledgement of reduced availability of other staff i.e. students in paid employment, redeployed staff and returner midwives. References.	27/07/2021
V1.3	Reference to phases and levels of the pandemic removed with changes to reflect service pressures	18/08/2021
V2.0	Amendments approved as above and clarity around ratios in intrapartum	31/08/2021

This guidance applies during COVID-19 emergency and period of remobilisation, it should not be used when the emergency is over. Please note this should be used in conjunction with Board's local escalation policies.

Aim

To provide clinical reference guidance to support decision making in maternity services during the extreme circumstances of the COVID-19 pandemic and remobilisation. This professional guidance should be used in conjunction with the nationally developed professional judgment template (appendix 1) and real time staffing resource (appendix 1) to inform midwifery staffing requirements.

Driver

During the COVID-19 pandemic it has been recognised that changes have been required in service delivery / clinical models as a result of a number of factors, varying according to specialty and local context. These include increasing demand, reduction in staff availability due to absence, requirement to implement social distancing measures and the protection of pregnant women, high risk groups 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 or identified reduction in need throughout the course of the pandemic. Midwives and the wider maternity workforce have been required to continue care for pregnant women, babies and families and, as an essential service, midwives should not be deployed out with 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 as we move beyond level zero, when services may be required to adapt in response to local COVID-19 pressures, acuity of women and the availability of staff.

The professional judgement staff modelling template was developed in the first wave to provide a consistent approach for clinical and workforce managers. This allowed them 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. In wave two there was a recognised need for a consistent system wide approach to inform identification, recording, mitigation and escalation of risk. The maternity real time staffing resource was developed as part of the COVID-19 system wide approach to real time staffing. The balance must seek to prioritise safe, person-centred care that considers the physical and mental wellbeing of women, their families and staff, within a service where the ability to reduce demand is minimal.

Clinical Guidance for Maternity and Neonatal Care During COVID-19 Pandemic and Beyond Level Zero.

The Scottish Government has issued guidance to Boards related to maternity care during the pandemic 'Delivering Maternity and Neonatal Services: Moving Beyond Level Zero'.

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.

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 Best Start was not in place in all Boards prior to the pandemic.

The impact of the coronavirus pandemic is unprecedented, it has become evident that availability of midwifery staff who usually work in specific clinical areas has reduced due to staff absence. The NHS Scotland Test and Protect contact tracing programme has had a positive impact on reducing community transmission of COVID-19 however this has resulted in high numbers of clinical staff being notified, subsequently requiring maternity staff to isolate and significantly depleting the available workforce. When considering available staff those midwives who were self-isolating or shielding due to COVID-19, in many cases, provided care via telehealth, Near Me or other remote means. As the numbers of staff isolating or absent with COVID-19 increased this significantly reduced the staffing required for direct clinical care. This guidance was updated to included exemptions for critical staffing in July 2021. The guidance for self-isolation was further updated and can be found here.

In some situations, midwifery staffing has needed to be altered, to ensure staff with relevant experience are utilised in the most effective way. During wave one there were opportunities for returner midwives, other available staff from stepped down services and paid employment for students to support the delivery of midwifery care under the direct or indirect supervision of substantive midwives. In the subsequent waves many of these staff were no longer available. To date, details of midwives on the temporary register continue to be shared with boards, with the most recent data being circulated in the week of the 9th of August.

When considering deployment of staff with or without a midwifery registration 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. Therefore, it is 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. All registered midwives can delegate tasks to others in accordance with the NMC code.

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

Purpose
The professional judgement template will assist Boards to scenario plan staffing requirements based on absence and the real time staffing resource will provide a consistent approach to identifying risk. These resources 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 acuity within the clinical setting.

How: The maternity real-time staffing resource will allow the user to enter the staffing number required per reporting period and to identify the minimum number of substantive midwives per reporting period, the number of registrants available from other sources and the number of support staff required. This resource informs identification, mitigation and escalation of risk associated with staffing challenges in a consistent way in real time. This identifies the number of staff required at that time or census point.

The professional judgement template will allow for scenario planning as the skill mix and absence alters. This calculates the WTE staffing requirement as calculated over 7 days.

Scenario Planning for Care Provision
A risk assessment 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 level of risk. When staffing in each stage is no longer sustainable movement to the next stage is advised.

The moving through each level 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 normal service provision. Boards may concurrently be at different stages for antenatal, intrapartum and postnatal care.

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. Resources for clinical supervision and delegation can be found at the bottom of this document. These examples are intended as guidance and should be used in conjunction with local escalation policies at all times.

Antenatal Care
Boards should revert to the previous stage as soon as local context allows, with the ultimate aim of returning to normal service provision at all times with the full schedule of care appointments provided.

Risk level 0 - 3 **Service**	**Staffing**
Zero: **Normal Service Provision** • Full range antenatal services	• Maintain numbers and skill mix of registered to unregistered staff • Care by midwife • Student midwife has direct or indirect supervision depending on need (recognition that students retain supernumerary status which differs from wave one)
One: **Moderate Pressures with Contingencies** • Minimum 8 appointments with minimum of 6 face –to-face appointments • Consider alternative care delivery methods • Consider joining up appointments • Stop antenatal group sessions	As above with additional consideration on the following: • Through risk assessment and decision-making processes allocate women to other available staff matching skills to women's need • Midwife has support of midwifery team dependent on need • No change to students
Two: **Highest Pressures Managed Locally** • Consider alternative care delivery methods	As above with additional consideration on the following: • This stage carries increasing risk in ensuring appropriate supervision of students and delegated roles
Three: **Corporate Escalation** • The highest level of risk	As above with additional consideration on the following: • This stage carries increasing risk in ensuring appropriate supervision of students or other available staff in the delegation of roles. • Students retain supernumerary status but in extremis, consider as part of the clinical workforce with appropriate supervision

Note: students should have normal experience alongside a midwife as part of the practice learning environment.

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-19). Women will have 1:1 care at all times, however provision may not be by a midwife dependent on the service stage.

Risk Level **Service**	**Staffing**
Zero **Normal Service Provision** • Full range of intrapartum options available	• Maintain numbers and skill mix of registered to unregistered staff • 1:1 care by midwife • Students are supernumerary
One: **Moderate Pressures with Contingencies** • Consider reducing care options ensuring mix of midwifery and obstetric led care	As above with additional consideration on the following • Through risk assessment and decision-making processes allocate women to other available staff matching skills to women's need
Two: **Highest Pressures Managed Locally** • Unable to sustain full range birth options. Centralise to AMU/OU • BBA covered by community	As above with additional consideration on the following • One midwife oversees the care of 2 women, providing care to one and the other woman cared for by student midwife with indirect supervision • This stage carries increasing risk in ensuring appropriate supervision of students or other available staff in the delegation of roles.
Three: **Corporate Escalation** • Unable to sustain level 2 or 3. Highest level of risk, restricted birth options without deployment of staff from other clinical specialties or diverting to other locations	As above with additional consideration on the following • One midwife oversees the care of 3 women; the 3 women cared for by student midwife or staff from other available/redeployed specialties • Students retain supernumerary status but in extremis consider as part of the clinical workforce with appropriate supervision
Existing HDU • Maintain services	• Maintain numbers and skill mix of registered to unregistered staff
Additional HDU • Plan for surge capacity as required	As above with additional consideration on the following • Through risk assessment and decision processes upskill proportionate number of staff to ensure skilled staff on every shift

Note: students should have normal experience alongside a midwife as part of the practice learning environment.

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-19).

Level **Service**	**Staffing**
Zero: **Normal Service Provision** • Full range of postnatal services.	• Maintain continuity of carer where possible with numbers and skill mix of registered to unregistered staff. • Care by midwife. • Students are supernumerary.
One: **Moderate pressures with contingencies** • 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	As above with additional consideration on the following • Student midwife has direct or indirect supervision dependent on need recognition that students retain supernumerary status.
Two: **Highest pressures managed locally** • Home visiting based on priority need	As above with additional consideration on the following: • This stage carries increasing risk in ensuring appropriate supervision of students or other available staff in the delegation of roles.
Three: **Corporate Escalation** • Highest level or risk and extremis	As above with additional consideration on the following: • Students retain supernumerary status but in extremis consider as part of the clinical workforce with appropriate supervision

Note: students should have normal experience alongside a midwife as part of the practice learning environment.

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 NHS organisations in Scotland have in place a range of clinical and psychological support services in place to support staff including wellbeing hubs and access to support services. Links to the some of the national resources are available below

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.

Reference / further guidance documents:
Scottish Government Information and Support on Covid-19
Perinatal Network Near Me technology
RCOG & RCM - Guidance for antenatal and postnatal services during Covid-19
SIGN - Maternal Critical Care during Covid-19
NIPEC - Delegation
NES - delegation
Wellbeing Hub
Mental Health Support for Staff
Mental Health Support for Health and Social Care Staff

Appendix 1:

Professional Judgement Template

The professional judgement decision making template and Maternity Real-Time Staffing Resource are available as supporting files published with this document.

Annex Two – Clinical Guidance for Neonatal Nurse Staffing During COVID-19 and Beyond Level Zero

Version control	changes	date
V0.1	Initial Draft	23/04/20
V0.2	2nd draft S Stewart comments from deputy CNO /professional advisors	24/04/20
V1.0	S Stewart comments from deputy chair SPENs group and professional advisors	28/04/20
V2.0	S Stewart Amended template guidance	29/04/20
V3.0	S Stewart updated to version 1.2 of professional judgement template	29/04/20
V3.1	Updated in line with Beyond Level 0 guidance Aligned to maternity guidance and draft for Neonatal nurses group	27/09/2021

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

Aim

To provide clinical reference guidance to support decision making in neonatal services and remobilisation during the extreme circumstances of the COVID-19 pandemic . This professional guidance should be used in conjunction with the nationally developed professional judgment template (appendix 1) and real time staffing resource (appendix 1) to inform nursing/midwifery staffing requirements.

Driver

During the COVID-19 pandemic it is anticipated that changes will be required to service delivery or clinical models as a result of a number of factors which will vary according to specialty. These include increasing demand, reduction in staff availability due to absence, requirement to implement social distancing measures, provision of mutual aid to other health boards or provision of care in social care settings. 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 planned way and that the best possible care can be provided.

In order to achieve a more consistent approach to staff modelling and changes to skill mix in a planned way in neonatal nursing services this clinical guidance has been developed to support clinicians to identify where changes may be required to service and clinical models and the risk mitigating factors which should be considered during the different stages of the pandemic, taking account of the local context where the modelling is taking place.

The professional judgement staff modelling template has been developed to provide a consistent approach for clinical and workforce managers. This allowed them 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. In wave two there was a recognised need for a consistent system wide approach to inform identification, recording, mitigation and escalation of risk

Clinical Guidance for Maternity and Neonatal Care During COVID-19 Pandemic and Beyond Level Zero.

The Scottish Government has issued guidance to Boards related to maternity care during the pandemic 'Delivering Maternity and Neonatal Services: Moving Beyond Level Zero'

Guidance is available relating to clinical care provision in neonatal care from a number of sources including the Royal College of Paediatric and Child Health (RCPCH) and the British Association of Perinatal Medicine (BAPM), and has been collated by the Scottish Perinatal Network at the link below:

https://www.perinatalnetwork.scot/covid-19

Guidance on adaptations which may be required to neonatal nurse staffing is not discussed in these documents.

Nursing and Midwifery in Neonatal Services Staffing During COVID-19

Nurse staffing requirements in neonatal units in NHS Scotland are normally determined using BAPM professional guidance regarding optimal nurse staffing and the Healthcare Staffing Programme workload planning tool, as part of the common staffing method. This recognises the evidence that a higher nurse:baby ratio, especially with nurses and midwives certified as 'Qualified in Specialty' (QIS) in neonatal nursing care , is associated with a better outcome for babies. Professional guidance described in the BAPM Service Standards states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care.

https://hubble-live-assets.s3.amazonaws.com/bapm/attachment/file/41/Service_Standards_for_Hospitals_Final_Aug2010.pdf

Neonatal Nurse Staffing During COVID-19

As the Coronavirus pandemic is an unprecedented situation, it is recognised that it is highly likely that the availability of nursing staff who usually work in neonatal services, including QIS neonatal nurses, will reduce due to staff absence. The NHS Scotland Test and Protect contact tracing programme has had a positive impact on reducing community transmission of COVID-19 however this has resulted in high numbers of clinical staff being notified and subsequently requiring neonatal staff to isolate depleting the available workforce. As the numbers of staff isolating or absent with COVID-19 increased; this significantly reduced the staffing required for direct clinical care. This guidance was updated to included exemptions for critical staffing in July 2021. The guidance for self-isolation was further updated and can be found here.

It will therefore be necessary for nurse staffing to be altered for the duration of the pandemic to ensure staff with experience in neonatal care are utilised in the most effective way. During peak periods it is envisaged that non-neonatal care staff will be required to deliver nursing care under the supervision of experienced neonatal nurses and that skill mix of registered to unregistered staff may have to be altered.

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 neonatal skilled staff effectively and ensure the most effective care to vulnerable neonates.

Consideration should be given to the possibility of utilising staff from other clinical specialties. 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:

- Paediatric or general nurses or midwives who have recent/previous experience in neonatal care
- Paediatric nurses who have experience in paediatric critical care or high dependency care
- Registered paediatric or general nurses or midwives with no previous experience in neonatal care
- Nursery nurses, maternity care assistants and clinical support workers with previous experience in neonatal or paediatric care
- Nursery nurses, maternity care assistants and clinical support workers with no previous experience in neonatal care
- Advanced neonatal or paediatric nurse practitioners where they can be released from medical rotas.

Scenario Planning for Care Provision

A risk-assessment approach should be taken to introducing new staff groups and altering skill mix in the neonatal environment. Some scenarios are provided below for intensive, high dependency and special care categories which are intended to provide some guidance on level of risk when staffing in each stage is no longer sustainable, movement to the next stage is advised. Moving through each stage will be dependent on local availability of staff and should take account of the local context in which the service is delivered. Equally, services should revert to the previous stages as soon as local context allows, with the ultimate aim of returning to a pre-COVID-19 state. Boards may concurrently be at different stages, based on service pressure acuity, complexity of care and availability of staff.

It is also essential, when considering staffing requirements, to use the 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. Resources for clinical supervision and delegation can be found at the bottom of this document. These examples are intended as guidance and should be used in conjunction with local escalation policies at all times.

Neonatal Intensive Care
Standard 1:1:1 care by a QIS neonatal nurse.

level	Staffing
Stage One: **Normal Service Provision** Full range neonatal services	Existing substantive neonatal staff • Maintain numbers and skill mix of registered to unregistered staff • Care by experienced neonatal nurse or those with previous experience in neonatal intensive care/ANNPs • Student nurses and midwives have direct or indirect supervision depending on need (recognition that students retain supernumerary status which differs from wave one)
Stage Two: Moderate Pressures with Contingencies	Base this on reduced skill mix, ratios will need consultation with stakeholder and guidance on nurse to level of baby i.e. critical care national guidance
Stage Three: Highest Pressures Managed Locally	As above
Stage Four: Corporate Escalation The Highest Level of Risk	As above

Neonatal High Dependency Care for 6
Standard 1:2 care by a QIS neonatal nurse either directly delivering care or supervising registered nurses with experience in neonatal care

Level	Action
Stage One:	1 nurse QIS 2 nurses with experience in neonatal care
Stage Two:	1 nurse QIS 1 nurse with experience in neonatal care 1 nurse or midwife with no previous experience in neonatal care
Stage Three:	1 nurse QIS 2 nurses with no experience in neonatal care
Stage Four:	1 nurse with experience in neonatal care overseen by nurse QIS 2 nurse or midwife with no previous experience in neonatal care

Neonatal Special Care for 12 neonates
Standard: 1:4 supervised by nurse QIS

Level	Action
Stage One:	1 nurse with experience in neonatal care 1 nursery nurse/HCSW with experience in neonatal care 1 nurse or midwife with no previous experience in neonatal care or 1 other HCSW with experience in neonatal care
Stage Two:	1 nurse with experience in neonatal care 1 nursery nurse/HCSW with experience in neonatal care 1 nurse/midwife, nursery nurse or HCSW with no previous experience in neonatal care
Stage Three:	1 nurse with experience in neonatal care 2 nurse/midwife, nursery nurse or HCSW with no experience in neonatal care
Stage Four:	2 nursery nurses and/or HCSWs with experience in neonatal care 1 HCSW with no experience in neonatal care Indirect supervision provided by a nurse with experience in neonatal care

Clinical Supervision and leadership
At a time of significant change, it is essential that all staff working out with their normal scope of practice have leadership, and that accountability, roles and responsibilities are clear. Clinical supervision will be particularly important at this time for all staff to support their health and wellbeing. This includes the need to ensure effective and timely clinical supervision is in place, to support staff working in new clinical areas, as part of new teams and undertaking new roles, and to support their wellbeing. Links to the some of the national resources are available below

All registered nurses and 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 neonatal nurses when delegating or supervising staff who have been deployed to neonatal 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

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 nurse 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 available as a supporting document published with this guidance.

Reference / further guidance documents:
Scottish Government Information and Support on Covid-19
Perinatal Network Near Me technology
RCOG & RCM - Guidance for antenatal and postnatal services during Covid-19
SIGN - Maternal Critical Care during Covid-19
NIPEC - Delegation
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Wellbeing Hub
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This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80201-374-0 (web only)

Published by The Scottish Government, September 2021

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS941346 (09/21)