



# Users' experiences of COVID-19 maternity service changes

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*The WRISK project is inclusive of everyone regardless of their gender identification. The project team will always refer to individuals according to their self-determined gender. As the great majority of participants self-identify as women, on occasions we have used the word 'women' for convenience.*

*Throughout the report numbers vary due to missing data and variable applicability of questions to respondents.*

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## Executive summary

The WRISK-COVID study conducted an online survey exploring user experiences and the emotional consequences of COVID-19 risk messaging and 'socially-distanced' maternity care.

All 524 participants had experience of maternity care during COVID-19 restrictions and appreciated the need for service changes and the pressures placed on NHS services. Communication between NHS organisations and individuals was generally regarded as poor and confusing. Virtual antenatal appointments were fully meeting the needs of only a few users. Restrictions placed on partner involvement in maternity care, particularly during scans, emergency attendances, and during labour assessments, caused widespread distress and anxiety. Removal of the home birth service and concentration of labour care in obstetric units was largely viewed as placing women at increased risk of viral exposure, and necessitated women with other children to breach government advice on household mixing. Women with complex pregnancies were concerned that deterioration in their physical health or the wellbeing of their baby could go unnoticed within a system of reduced antenatal and postnatal checks. For participants with previous or ongoing mental ill health there was concern that the pandemic would result in a re-occurrence or deterioration in their condition. COVID-19 restrictions compounded existing failures in hospital based postnatal care to meet the needs of new mothers. On postnatal wards women described being lonely, sad, and struggling physically without visitors or sufficient staff to support and help them. Once home, the combination of reduced professional, family and social support resulted in women feeling isolated and once again concerned early signs of ill health may be overlooked.

Whilst a small number of women were unphased by COVID-19 maternity restrictions, for most, the rigorous implementation of changes has resulted in feelings of distress, anxiety, and isolation. The role of maternity services is to meet the emotional and

physical needs of women and users. Both were found to have been sacrificed to some extent during the acute phase of the pandemic. Recent recommendations to relax birth partner and visitor restrictions are welcomed<sup>1 2</sup>, but allowing local interpretation and implementation, needed to adapt for local infection trends, risks the continued use of stringent measures by organisations and individuals not wanting to change.

## Recommendations

Maternity services are urged to rapidly implement the reintroduction of partners, visitors and support for women to include:

1. Enabling a single asymptomatic person, who is not required to self-isolate, being permitted to accompany women during all antenatal appointments and ultrasound scans.
2. Supporting face to face appointments wherever this is practicable.
3. Offering a choice of planned place of birth including the option of home and midwifery led settings.
4. Enabling a chosen asymptomatic birth partner who is not required to self-isolate, to accompany the woman during labour assessments.
5. Enabling up to two asymptomatic birth partners to remain with a woman during labour.
6. Enabling essential visitors and birth partners access to antenatal and postnatal wards.
7. Offering sufficient flexibility to be compassionate at times of acute need.
8. Identifying and informing women of the lines of communication through which local care arrangements will be updated.

## Background

The COVID-19 pandemic saw universal, radical, and ultra-rapid changes to NHS maternity services. At the onset of the pandemic NHS maternity services were stripped of many of the features implemented to support woman- and family-centred care. The priority shift involved identifying and rapid implementation of the minimum level of clinical services required to preserve safety with development of services in anticipation of unknown numbers of pregnant women sick with COVID-19.

Common changes included a reduction in face-to-face antenatal and postnatal contacts with women<sup>3</sup>, using 'smart devices' for antenatal and postnatal care, a centralisation of services into obstetric led settings, including closing midwifery units and stopping home births; and restrictions on partner and family visiting or attendance with women. Whilst vaccine development and testing is now occurring at an unprecedented rate with positive initial trials results, uncertainty remains as to the duration with which COVID-19 infection control measures will be required<sup>4</sup>.

By the end of March 2020, just weeks after the introduction of COVID-19 service changes, national maternity support groups were reporting high levels of anxiety among women accessing maternity care<sup>5</sup> and were calling for visiting restrictions not to be applied as a blanket to maternity services<sup>6</sup>. More recently, evidence has emerged of pregnant women and new mothers feeling isolated and lacking necessary support<sup>7</sup>.

The WRISK project was developed in response to the growing concern that public health messages targeting pregnant women do not always fully reflect or explain the evidence base underpinning them. During the pandemic UK clinical guidelines relating to COVID-19 have been published and regularly updated by the RCOG in collaboration the Royal College of Midwives and other professional organisations<sup>2</sup>. In contrast guidance for birth partners and maternity visitors has been developed and

amended during the pandemic by NHS England, Welsh Government, Scottish Government, and the Public Health Agency, Northern Ireland, and implemented at NHS organisation level. At the onset of the pandemic restrictions placed on birth partners and maternity visitors throughout the UK was stringent and consistent. Subsequently, advice to NHS organisations on birth partner and maternity visitors throughout the UK has relaxed and diversified, resulting in restrictions based on geography and local opinion- not science. Inconsistencies in public health and infection control advice across the UK cannot be logical, fair, or justified, and has once again highlighted the challenges of accurately reflecting evidence in maternity public health messaging.

COVID-19 maternity risk messaging and service adaptations represented radical and untested service change in a context of widespread anxiety and uncertainty. Whilst some relaxation of restrictions has been seen around visiting and partners accompanying women, guidance across the UK now varies<sup>1 89</sup> and it remains unclear how widely the recommended relaxations of restrictions have been implemented. There is known variation in the way COVID-19 restrictions are currently being implemented within services, and anecdotal examples of individual staff exercising unkind and over-zealous implementation of restrictions continues. The ongoing requirements of social distancing, potential for local lock-downs, and the likelihood that some service changes will become permanent, means it is important we understand the impact that the changes to services have had on users to inform evidence-based recommendations on the organisation of maternity services for the 'new normal' NHS.

## Methods

The WRISK-COVID study conducted an online survey to explore user' experiences of COVID-19 risk messaging and 'socially-distanced' maternity care in the UK. The survey asked respondents about public health advice for pregnant women during the pandemic, and their experiences of antenatal, intrapartum, and postnatal care. The same survey was completed by respondents who were currently pregnant and those who had already given birth. As such, the number of responses vary for each question.

The survey was hosted on SurveyMonkey. Data was collected between June and September 2020. We generated descriptive statistics using Excel and SPSS, and coded free text responses using Dedoose.

## Results

All 524 women completing the survey had experienced maternity care during the pandemic. Most participants were pregnant at the time of taking the survey (n=331, 65.7%), or had given birth during the pandemic to a live baby (n=171, 33.9%). Small numbers of participants had experience of their pregnancy ending in a miscarriage, termination, or the death of their baby. Around half of the participants (239, 45.5%) were expecting or had just given birth to their first baby. Reflecting the proportion of women with an underlying or pre-existing health conditions (n=129, 26.0%); or a pregnancy related health condition (n=150, 30.4%), 40.3% (n=199) of women reported being under obstetric care.

Participants appreciated that the pandemic represented a rapidly changing situation with new emerging information relating to pregnancy, and the need for the NHS to have adapted maternity services to reduce risk to the public and staff.



Many participants had informed themselves on the rapidly changing guidance relating to pregnancy and birth from the RCOG but reported frustration at the lack of direct communication from NHS organisations and individual midwives, often compounded by a lack of continuity in carers.

## Demographic characteristics of participants

The mean age of the 524 participants was 31.8 years. Most participants were married (68.4%, n=262) and heterosexual (93%, n=356). Participants were predominantly White British (85.9%, n=329). A further 9.4% (n=36) participants were 'White Other', including Irish, North African, European, and Middle Eastern. A minority of participants identified as a range of Asian (3.4%, n=13) and Black ethnicities (0.8%, n=3). Many participants were still working in paid employment with 37.4% (n=177) of the survey participants reporting that they were key workers, 15.2% (n=72) of whom were healthcare professionals. 11.6% (n=72) of respondents were in receipt of, or had recently applied for, State benefits.

## Public health advice

The vast majority of respondents, 89% (n=429) either agreed, somewhat agreed, or strongly agreed that pregnant women should practice stringent social distancing. However, 40.8% (n=122) of women said that they found the advice somewhat unclear and confusing, and 16.7% (n=50) said it was very unclear and confusing. Women cited the precautionary principle when explaining why they thought stringent social distancing was important for pregnant women:

*"As the virus is relatively new to us I think it is important to social distance. Just there is not enough data or evidence as to what impact it could have to a pregnant woman. Although some pregnant women have tested positive and given birth with no issues I don't think it is necessarily indicative of how it would progress should I catch it myself. So to me it is not worth the risk."*

They also reflected on the practicality of restrictions, and the negative impacts of stringent social distancing:

*“I understand the importance of social distancing, and I have remained at home throughout lockdown, but my husband is a key worker and has been going into work, having contact with lots of other people, meaning I’ve still been at risk yet I haven’t even been able to meet with my immediate support network (parents) which has been hugely upsetting and distressing during what should be a happy time for us.”*

*“Although stringent social distancing is doubtless the safest strategy for physical health while pregnant during a pandemic, the impact on mental health is also significant and should be weighed against this.”*

There was widespread confusion over the recommendation for stringent social distancing, with many women overinterpreting advice as an instruction to ‘shield’, which had far-reaching impacts on wellbeing:

*“Many pregnant women believed they had to shield and the differences between all the different terminology was quite confusing - self-isolation vs shielding vs distancing...”*

*“It is unclear to me whether pregnant women are at greater risk (some stories in media about death of mothers and sickness in new babies, but very little explanation of whether this is widespread and why that might be). The difference between social distancing and shielding has not always been clear.”*

## Pragmatic and positive

A very small number of women were pragmatic about changes to care and partner involvement with some positive comments, such as looking forward to the postnatal wards being quiet:

*“The scans are for my babies and my own health. It is a luxury if my husband can attend but given the pandemic it’s understandable that he couldn’t make it. Neither of us are negatively affected by him missing 2 scans. (They all look the same anyway) you have to think it the long term picture”*

*“It has been nice to sit in the car and wait rather than in a waiting room. I have felt very alone and unsupported when it comes to having important scans though. I am looking forward to the postnatal ward being a bit quieter as I found the number of visitors a bit overwhelming last time however my husband will have to leave after my c-section and won’t be permitted to come back until I’m being discharged. The midwives have been amazing. I really commend them for all their hard work at such a difficult time.”*

*“I was extremely nervous about attending my 20-week scan at the hospital during the peak of the pandemic. But while I was there I realised how many measures were in place and I was hugely reassured. Since then, I have much more confidence about attending appointments.”*

## Women attending alone

Over 92% of women (n=421) had experienced restrictions on partners attending antenatal care appointments. A high proportion of participants, (83.3%, n=379) had experience of having an ultrasound scan during the pandemic. Many of these women found attending alone to be distressing, particularly when a problem was identified, if they had experienced a previous pregnancy loss, or if the care was unscheduled.

Some women who could afford private care reported booking extra scans so their partner could attend without restrictions.

*"I was disappointed at the 20-week scan when my partner was not allowed to attend. I think it made me feel unnecessarily anxious and upset when I had to enter the room on my own."*

*"Having had a previous missed miscarriage, I have anxiety and trauma issues relating to attending scans. I had to attend a scan to check growth without the support of my partner, along with other checks for reduced movement which caused additional anxiety and panic attacks."*

*"Having my 20-week scan alone, being told there was a problem with the baby was awful. Communication was poor with the sonographer and the consultant, and I was extremely distressed after 2 miscarriages in the past. Then having to relay the information to my partner whilst sobbing on the phone. Every appointment since had been awfully distressing."*

*"It's been extremely difficult for my partner to not be able to attend scans. This is his first child, my first child and we've looked forward to these moments for years. We are lucky we could afford to go for a private scan together."*

*"We have been lucky enough to be able to afford 2 private scans, which means he has been able to be there for some. This has cost us around £750 in total. We are lucky, many people cannot afford this."*

*"We were not told that partners were not allowed before our first scan. Upon arriving at hospital we were greeted rudely by a nurse saying 'no men allowed!' which was very upsetting. Husband had to wait outside the building while I went through the scan by*

*myself. I was also asked not to speak during the scan due to the risk of the virus being transmitted that way, so weren't able to ask my questions. For the second scan I received a phone call the day before informing me of such measures, so at least it was expected. We booked a private scan to allow my partner to see the baby. The only restriction there was for us both to wear masks and use hand sanitiser."*

Women found attending emergency antenatal care alone particularly distressing. They described having to attend when bleeding in pregnancy, for reduced fetal movements, and in other situations when they could be informed that their baby had died – all without a partner for support.

*"I had to go to hospital twice for RFM (reduced fetal movements). He had to wait in the car for an hour, not knowing if the baby was okay. After having a previous miscarriage, this was very traumatic for him. I also needed my husband, I was anxious, having a panic attack and I needed him."*

*"Partner was not able to attend an early scan to investigate bleeding during pregnancy, meaning he was not able to be physically present with me during a distressing appointment."*

*"Partner not allowed to attend early scan (possible miscarriage) - had to wait in car park, not able to attend 12-week scan. Attending 20-week scan was made to feel unwelcome - a tolerated inconvenience."*

*"Awful. I was told at a routine 12-week scan that I'd had a missed miscarriage. I was on my own and my partner was in the car. I had to go through a very difficult scan alone and then also had to relay that information to my husband. It made an already difficult situation much more challenging."*

## Virtual antenatal care

Receiving some antenatal care by virtual means was common with 51.8% (n=243) of participants having experienced 'routine' check-ups with a midwife by phone or video calls. A lower proportion of participants, (29.4%, n=138) had experienced a virtual appointment with a doctor. Very few participants (4.2%, n=17) reported having difficulty with the technology required to access virtual care, but only 12.9% (n=31) considered their needs were entirely met by this mode of care delivery, and 23.3% (n=56) felt their needs were not at all met.

*"It has felt very hands off. I've had two very brief phone calls. Whilst I have been pregnant before, it ended in miscarriage very early, so this feels like the first time I've been properly pregnant. As I haven't been through the NHS antenatal care pathway before it feels a bit daunting with so much uncertainty and such little contact."*

*"I think it has been poorly organised, I was very anxious initially that all the face to face appointments were being cancelled and instead replaced by 5-minute phone calls."*

*"I have not been offered any virtual antenatal care. I have paid privately for antenatal classes and yoga sessions."*

For some participants they were concerned that reduced care may have placed themselves or their baby at increased risk.

*"I had reduced appointments which was difficult considering I am diagnosed with anxiety. The result was that my baby was born a lot smaller than expected and this hadn't been picked up due to reduced monitoring."*

*"A lot has fallen through the cracks. My local midwives seem very overworked/understaffed. I didn't see anyone until I was almost 30 weeks. Before that, I*

*had a phone booking appointment and both 12 and 20-week scans. No other phone calls - nothing. I also didn't get diabetes testing despite being high risk due to family history."*

*"Two of my midwife appts have moved to telephone appointments, including my forthcoming 34-week appointment. At this point I feel worried that urine tests and blood pressure tests that would ordinarily indicate pre-eclampsia are being missed."*

## **Confidence in accessing services**

Many women reported still having some aspects of care delivered in person. For example, 34.9% (n=159) of respondents reported having appointments with a doctor or consultant. When asked how confident they felt about accessing services in person, 56.5% (n=257) of respondents said they felt confident about accessing services in hospital, and 45% (n=205) felt confident about seeing their GP. Conversely, 35.8% (n=163) said they felt unsure or very unsure about accessing services in hospital, and 37.6% (n=171) felt unsure or very unsure about seeing their GP. A worrying minority of 11% (n=50) women said they had missed an antenatal appointment, with the most cited reason being *"I was worried about getting COVID-19"*.

## **Care during labour and birth**

### **Birth plans**

In keeping with a common move to centralise maternity services into hospital, and amidst concerns that ambulance services may not be able to cover maternity calls, many women planning birth at home or in midwifery units were informed their plans would need to change as these options were no longer available. Similar to antenatal care, some women who could afford private care overcame restrictions in the NHS by employing an independent midwife.

*“My local hospital stopped all homebirth services and were saying all women needed to birth in a hospital setting which to me was more unsafe as I had been socially distancing and knew how clean my own home was and who had been in there. My midwife wouldn't support me to have a homebirth because of risk to her and other midwives but would do antenatal check-ups at my home.”*

*“I was extremely disappointed that home birth services were stopped. It presented a completely problematic situation if you had children already as your partner would either have to be with you OR them, or you broke social distancing and had someone at home / they went elsewhere. We used an independent midwife for a home birth in the end so that we could avoid this problem”*

An aspect of change women reported as particularly distressing was that partners were only permitted entry into the maternity unit once labour had been confirmed. This resulted in women in labour needing to enter maternity units alone when in pain and anxious. Women who were being cared for in different Trusts/Health Boards reported a variation in policies on when partners could join them:

*“My partner had to wait outside in the car until the midwives confirmed I was in active labour, this meant I had to walk the corridors of the hospital alone in extreme pain at 7cm dilated carrying my bag and notes.”*

*“These restrictions have caused great distress between me and my partner as this is our first baby and we wanted to do everything together. Also, hospitals have put restrictions on birthing partners and my hospital doesn't let a partner in till 7cm. As this is my first baby my anxiety through the pregnancy has been horrendous.”*

*“Husband missed the birth as wasn't allowed in until I was 4cm so waited at home, but I progressed so quickly that he didn't get back in time. Gutted.”*



Once in labour 14.5%, (n=26), of participants were required to wear a mask or other PPE. For 31.6% (n=56), the wearing of PPE by staff was considered to have had no real impact on them, and 22.6% of participants felt safer due to staff wearing PPE. However, 19.2% of women felt it made communication more difficult, and 13.6% of participants found the wearing of PPE by staff to be unsettling or scary.

### Hospital postnatal stay

Changes to postnatal visiting policies were reported as almost universal, with 88.4% (n=176) of participants stating there had been changes to their Trust or Health Board's policies. Around half (49.9%, n=67) of the participants who had experience of a hospital postnatal stay felt that staff had been too strict with the implementation of visiting arrangements. Generally, women did not feel they went home before they were ready, but many reported being unhappy whilst in hospital.

*"It was awful to be alone after giving birth... I had my twins 12 weeks early via emergency C-section and then my partner had to go home and I was left in a side room, with no husband and no babies. I was only allowed into NICU for 2 hours and my husband and were not allowed to visit together. It was terrible."*

Overall participants reported negative feelings towards policies of restrictive visiting on postnatal wards, with 71.9% (n=77) reported feeling lonely, 43.7% (n=60) being very unhappy and 57.5% (n=77) feeling they needed visitors to provide practical help not provided by staff.

There were some positive consequences to visitors being prohibited from visiting postnatal wards, with 52.2% (n=70) of women agreeing the postnatal wards were peaceful and 49.7% (n=66) stating that they enjoyed the time just with themselves and their baby. Fewer, 29.1% (n=39), said they enjoyed talking with other mothers on

the ward. One woman described many of the distressing aspects of hospital postnatal care experienced by participants:

*"I was unprepared for the post-natal stay in hospital and what the visitor restrictions were. I had a horrible experience on the post-natal ward as due to the lack of visitors I felt isolated, unsupported and overwhelmed. The staff were so busy, so often when you rang for help it took a long time for someone to come to you. As such you only rang the bell when you really needed it. I was unable to pick up my baby initially so if she cried or needed me I had to rely on the midwives or catering staff to pass her to me. Staff lacked time to explain things relating to my care and recovery beyond the basics. There was no time or space for emotional support. I cried through one of my procedures because it meant I was required to stay in hospital for an additional 24 hours.*

*The midwife did not ask why I was crying or explain why the procedure was necessary. I was not offered support to have a shower until the midwife who helped me deliver checked on me when she started her shift 24 hours later. She was very angry that I had not been offered this on the ward. I was never offered support to shower again during my 5 day stay. When I was more mobile even going to the toilet (which was extremely stressful and painful due to my injuries) was difficult because no one would sit with the baby while I went to the bathroom. So I was extremely worried about the baby the whole time I was in there. Once home I heard babies crying every time I ran a tap in my bathroom for several days.*

*No one supported me with breastfeeding. My partner was incredibly distressed at home on his own with no support. Small things like not being able to reach your bag to get snacks, headphones, phone charger etc also made my stay unpleasant. After a difficult birth, being responsible for a newborn for 24 hours a day for five days was utterly exhausting and overwhelming and meant that I slept for only 4 hours in that whole time period. I was readmitted to hospital with a secondary infection 10 days later."*

## Postnatal care at home

While hospital based maternity services were identified as needing to be protected from staff redeployment, this was not extended to community midwifery and health visiting services.

In many areas of the UK, home based postnatal care in the community was reduced during the pandemic, with 82.9% (n=141) of participants having been informed they would receive fewer in-person visits from midwives and health visitors. Where home-based visits had been replaced by virtual contacts, 28.4% (n=25) of participants felt these had not met their needs at all - an even higher proportion than in antenatal care. In particular, 36.7% (n=54) of participants reported that once home they had not received any support with infant feeding.

With visitors to homes from friends and family severely restricted, new mothers reported a mixture of emotions. While 74.7% (n=115) reported feeling overwhelmed, and 79.8% (n=122) 'lonely and isolated', 79.5% (n=120) had also enjoyed having quiet time with their baby and partner; and 62.5% (n=95) considered it had been 'peaceful without visitors'.

The majority of women reported they were confident that they could contact their GP, midwife or health visitor for help - around 10% did not have confidence of this support.

*"My post-natal support hasn't been great after the first week. I feel like I've pretty much been abandoned and left to it. My health visitor spoke to me once for 5 minutes and I've never heard from her again. Luckily I have close family to speak to but I worry for those who don't have the support. I also had an emergency c-section and my 6 week check cancelled so I have no idea if my scar is normal and whether I have healed properly."*

*"I was discharged from my midwife after 10 days and having had one cursory wound check at 5 days. When I suspected an infection my GP refused to see me as I didn't have a temperature and they didn't think the photograph I was asked to send looked like an infection. Had I not pushed to be seen and swabbed, the infection I did have may have gone untreated for even longer and made me ill."*

*"Postnatal care has been awful. Health visitor called me and talked through what was clearly a checklist. I said I had been deeply anxious and traumatised by the ward and she completed a meaningless questionnaire with me. She did not ask me any questions that didn't come from a checklist, it felt entirely pointless and bureaucratic. I have not felt supported at all by any of the postnatal care - all of my support has come from family and friends, which has been wonderful, but the system has completely failed me. I do not feel listened to and do not feel that there is any real support in place, just questionnaires and tick-box checklists to make it look like a response has been given."*

*"Postnatal at the moment feels forgotten. I am just so relieved to hear home visits by midwives and health visitors are returning, especially as my family won't be able to visit as it stands (family in England and Wales have the 5-mile restrictions). Sometimes you just need someone to physically see you to provide reassurance."*

## **Communication**

Many women commented on the helpfulness of the RCOG guidance and had registered to receive updates, but some also commented on the lack of direct communication from their own maternity unit and expressed frustration that they felt better informed on the latest RCOG guidelines than their midwife.

*"I am really surprised that I've had no direct contact from my hospital trust. When I registered as being pregnant, they took my email address and phone number so they could have set up an email programme or text service like my GP surgery has."*

*“As experienced as my midwife is, I don’t think she had read the latest RCOG guidance regarding risk to myself and unborn baby.”*

*“Having access to a community midwife would have been a big help to reduce stress levels. It was never explained to me why the community midwife doesn't answer messages or ever answer the phone. I was less likely to call the hospital antenatal assessment unit for small questions or to check some things.”*

## **Conclusion**

In response to the COVID-19 pandemic maternity services made radical changes with an aim of maintaining a safe level of service, whilst reducing infection risks to women, babies, and staff.

The COVID-WRISK study captured women’s experiences of risk messaging, and the emotional consequences of using maternity services during the COVID-19 pandemic through an online survey. The survey found that the changes to services and the restrictions of partner and visitor access to maternity units caused unintended negative consequences including essential clinical care being missed, confusion over advice, and widespread distress and upset for women. COVID-19 restrictions have resulted in women feeling their antenatal care to be inadequate but has also come at great emotional cost to users including the separation of parents at miscarriage diagnosis. COVID-19 restrictions appeared to have only exacerbated existing reported failings<sup>10</sup> in hospital based postnatal care to meet the needs of women, many of whom have restricted mobility following regional anaesthesia and operative births. Women reported feeling isolated and sad on postnatal wards, but

also frustrated and upset by a lack of staff to help them pick up and care for their baby.

An important limitation of the survey was that our participants did not represent the diversity of users of maternity services. It can only be assumed that for maternity service users who cannot communicate easily due to a lack of English, other communication difficulties, or who experience social disadvantage, COVID-19 restrictions are likely to have had a disproportionately negative impact on their care and maternity experience.

Whilst partners were not permitted to attend NHS scan appointments, women who could afford private scans were able to access a service where their partners were still welcomed.

COVID-19 risk messaging and physical distancing arrangements in maternity care will need to be continued for some time, and the need to divert staff to large scale vaccination programmes will soon place additional strain on NHS services. Compared to at the beginning of the pandemic, when stringent measures were implemented with great urgency, there is now greater availability of PPE and understanding of the virus, and knowledge of arrangements that can protect women and staff whilst facilitating partners and essential visitors. Continuation of the stringent COVID-19 service restrictions within maternity services, implemented at the pandemic outbreak, are now unjustified. All maternity services should ensure they have clear lines of communication with women, and that birth partners and visitors are once again welcomed and valued as essential members of the maternity team.

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