Key messages from the perinatal experiences during the COVID-19 pandemic in Scotland study

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Background

At the onset of the COVID-19 pandemic, pregnant women in the UK were classed as a vulnerable group. This, alongside national guidance on social distancing, resulted in marked changes to maternity service provision that led to considerable alteration in the experiences of women and staff accessing and providing maternity care in Scotland. It also raised concerns about whether inequalities in healthcare would be exacerbated further as a result of the changes. Disadvantaged women were recognised to be at greater risk of economic hardship due to the pandemic, but also to be vulnerable to digital exclusion due to increased reliance on technology in delivery of care.

Key pandemic-related changes across several NHS Scotland Health Boards’ maternity services included increased provision of remote consultations using telephone and video technology, introduction of an online antenatal education package, increased outpatient induction of labour procedures and restrictions on partner and visitor attendance in hospitals. Further changes affecting staff in particular included redeployment to different roles, working from home in both clinical and non-clinical roles and a dramatic increase in virtual meetings. For both staff and women there was the continuing fear of contracting COVID-19 in hospital or health centres.

This briefing summarises a newly published research report, commissioned by Public Health Scotland and Scottish Government, which describes how maternity care has been experienced during the COVID-19 pandemic. Perspectives of both staff and women are represented. The study was carried out by researchers at University of Aberdeen and University of Dundee.
Summary of key findings

Methodology

This study adopted a mixed-method approach involving two interrelated studies. One study took the form of two surveys, one with women service users and one with staff, and the other study involved qualitative interviews with both staff and women service users.

- 2,588 women submitted a survey response: 305 were pregnant; 2,281 had given birth.

- For more than half (57%) of all women, this was their first birth. 15% of women were from low-income households, 8% were aged under 25 years and 3% were from minority ethnic backgrounds.

- 445 maternity staff submitted a survey response from eight professional groups.

- 38 participants took part in qualitative interviews, including 23 women and 15 maternity staff.

Partners involved in care

Many women described how the prospect of having to attend services alone caused anxiety across all maternity pathways, and among those who were required to attend services alone, many described a lasting impact on their mental health.

Women’s sense of isolation was clear although the implications of this varied depending on their personal circumstances. However, attending appointments alone was not perceived as negative by all women.

Among women responding to the survey, most (89%) reported attending antenatal appointments alone; with 67% reporting feeling uncomfortable with this. This was particularly problematic for those with previous experiences of miscarriage, which
compounded their anxiety, and the possibility of having to receive bad news and manage the situation on their own.

Just over three quarters (78%) of women who responded to the survey had the birth partner they wanted with them during labour and/or birth. However, some women could only have their partner or trusted other accompany them during active labour and birth, not during early labour. Many women noted the anxiety associated with the prospect of having to be admitted and be on their own during labour.

Most women (73%) felt they should have been able to have their partner or a supportive person with them more often in the postnatal ward. This factor emerged as one of the main issues driving negative experiences in the postnatal ward.

**Antenatal/parent classes**

Women highlighted how restricted access to antenatal education and their associated peer support networks added to their sense of isolation and the feeling of missing out on the expected ‘normal experience’ of being pregnant and on maternity leave.

Many women utilised private antenatal education. Online NHS resources received mixed feedback with some women reflecting on it positively whilst others described it as inadequate to meet their needs.

Staff highlighted that beyond the formal aspects and direct knowledge transmission of antenatal education, the move to online provision had meant the loss of the informal aspects and indirect benefits of attending antenatal education sessions for women, such as being in contact with other women and opportunities to build supportive peer relationships.
Care being provided close to home

Antenatal care

Just under a third of women (32%) experienced a routine antenatal appointment in their own home. Almost a quarter (24%) of these women were concerned about having people in their home for these appointments due to COVID-19. However, these appointments were most likely to elicit a positive response from women in terms of meeting their physical health needs (81%) and meeting their mental and emotional needs (70%). The majority felt they were offered adequate privacy (89%) and felt involved in planning their care (75%).

Younger women and women from lower income households were more likely to feel concerned about having people come into their home due to COVID-19, less likely to have their physical and mental/emotional needs met, less likely to feel included in their care planning, less likely to have enough privacy and less likely to feel involved in planning their care compared to those from higher income households.

Postnatal care

Almost all (98%) women received postnatal care in-person in their home after the birth. Receiving postnatal care more centred around the home than the hospital was highlighted as positive by families with older children and those with added postnatal care needs such as recovery from a caesarean section, or additional infant care needs such as those linked to jaundice.

Where available, the provision of home-based breastfeeding support was greatly valued by women as part of their positive experiences of home-based postnatal care.

Technology enabled care

For some, the various technologies used in remote appointments got in the way of developing the supportive relationship they would have expected.
For maternity care staff, the virtual delivery of care led to reduced job satisfaction for more than half of staff who responded to the survey. However, most staff who delivered service user-facing care remotely felt this should remain as an option in the future.

**Video**

Video appointments were experienced by 15% of women. Video appointments were generally viewed more favourably compared to telephone appointments but less so compared to in-person appointments.

Just under half (48%) of all staff agreed that they were adequately trained to deliver care this way, 34% disagreed and 19% neither agreed nor disagreed.

Staff indicated that opportunities to build rapport with women and families had worsened (70%), as had opportunities to assess women’s mental health status and emotional wellbeing (74%).

**Telephone**

In total 75% of women responding to the survey experienced a routine appointment by telephone. Generally, women were less likely to report that their needs were met using the telephone compared to in-person appointments, with less than half agreeing that these appointments met their physical needs (49%), mental or emotional needs (44%), and just over half feeling included in planning their care (58%).

Survey and interview data reflected that telephone appointments tended to feel rushed, impersonal, lacking in support and were experienced as one-sided (information flow from midwife to woman). Women found it difficult to establish the required level of communication and connection in the context of a telephone consultation.
Mental health

Of those who had to attend services alone and outwith the home, many described a lasting impact on their mental health. Many women also noted how any pre-existing or emerging anxieties and concerns, as well as the need for connection and reassurance, were amplified during the pandemic. Some women felt that such issues had not been identified and addressed appropriately as part of the antenatal care they received.

Of the 323 women who felt they needed additional mental health support, 70% found it difficult to be seen by a mental health specialist as part of their maternity care.

Three in four staff survey respondents felt that video and telephone appointments meant they had less opportunity to assess women’s mental health status/emotional wellbeing as well as assess for signs of abuse.

Maternity workforce

Four hundred and forty-five staff completed the survey, including midwives, obstetricians, maternity health care support workers, anaesthetists, sonographers, student midwives, maternity admin team members and less than five in other roles. Fifteen maternity staff contributed to qualitative interviews.

Work-life balance for staff

Staff who responded to the survey indicated that changes in maternity services impacted on their job satisfaction. Amongst these was increased access to outpatient induction of labour (45%) and working from home in a service user-facing role (42%).

Changes most linked to decreased job satisfaction were replacement of in-person appointments with video technology (63%), replacement of in-person appointments with telephone appointments (58%) and working in a different role (56%).

Most staff (66%) were comfortable providing care from home and 71% agreed that working from home should remain as an option in the longer term.
Staff’s resilience and ability to cope with stress, as well as to support stressed colleagues, was a defining feature of how they worked through everyday challenges across all levels and professional groups.

Staff also described the benefits of having gone through a significant learning curve to embed new ways of working and tools such as digital platforms in their everyday work practices. Many staff survey respondents reported a hope that virtual training, meetings and networking will remain in the long term and some interviewees reported innovative ways of delivering care.

Conclusions

The findings of this study highlight that socially disadvantaged women are more likely to experience poorer quality maternity care when technology is used to replace in-person appointments. Similarly, women with mental health conditions are less likely to receive good quality care across a range of appointment types and care settings. Consideration should be given to prioritising care at home to women with greatest social adversity. Use of technology to deliver appointments has benefits for some women and for specific appointment types but should not be a default approach. Virtual appointments should be subject to very careful consideration before being adopted for women in adverse social circumstances or for those with mental health conditions. Pressure on maternity staff both at home and at work mean that many are unable to deliver the care that they want to provide, but awareness of this among staff has promoted peer-support. Future maternity care policies should consider how antenatal education can promote peer-to-peer interactions for women, how antenatal care can support relationship-building with midwives, how visiting policies could promote maternal-infant bonding and how partners can be included in all aspects of the maternity care journey.
Considerations for policy

1. The psychological and practical benefits of women being able to involve their partners at all stages of maternity care should be considered as a matter of urgency, with a view to easing restrictions where these remain in place.

2. In order to minimise inequalities in antenatal care provision, routine assessment of women’s financial status at booking and whether it may affect their ability to attend antenatal appointments should prompt early intervention to ensure financial support.

3. The benefits of in-person consultations for younger and financially disadvantaged women, and those with mental health conditions, should be taken into account when planning delivery of care.

4. Staff resources and support should be developed to ensure that continuity of carer and personalised care can be provided to all pregnant women.

5. Recognising the high value women place on meeting other pregnant women during pregnancy, antenatal education should be delivered in a manner that also promotes peer-to-peer interaction.

6. Technology used to support care delivery should only be utilised when preferred by both women and staff and when it is judged not to impact on both physical and mental health needs assessment.

7. Outpatient induction of labour should be considered as a routine option in all units where safe to do so.

8. Benefits and disbenefits to women and babies of restricting postnatal visiting to partners/siblings should be considered in future family-friendly visiting policies and in future research.

9. Virtual staff training/meeting attendance options should remain long-term as this is expected to increase staff morale, inclusion and skill development.