

Title

Experiences of maternity care during the COVID-19 pandemic in the North of England: implications for perinatal mental health and service delivery

Authors

Stacey, T., Darwin, Z., Keely, A., Smith, A., Farmer, D., Heighway, K.

Abstract

Background: During 2020, UK maternity services made changes to service delivery in response to the COVID-19 pandemic. Aims: To explore service users' and their partners' experiences of maternity services in the North of England during the COVID19 pandemic. Methods: Respondents (n=606) completed a co-produced survey during August 2020. Data were analysed using descriptive statistics and content analysis. Findings: Five major categories were identified: Valuing support from health professionals, Feeling lost in the system and let down by the system, The impact of restrictions to partners and others, Virtual contact is not the same as in-person contact, The need for emotional and psychological wellbeing support. Conclusion: The changes implemented may have compromised mental health and wellbeing in a critical period of vulnerability. Bringing stakeholders together can maximise learning from the emergency measures, to better inform future service provision. Work is needed to better hear from minoritised groups and ensure they are not further marginalised by changes

Keywords

COVID-19; maternity care; experience; perinatal mental health; virtual appointments; survey;

Key points

- The majority of service users were satisfied with their experience of maternity services and appreciated the care provided during a challenging time. Those that experienced continuity of care felt that they benefited from this.
- Although interactions with individual health professionals were largely described as positive, some service users and partners felt disregarded and lost in the system, as well as let down by the system.
- The impact that restrictions relating to partners and other birthing companions has had on both the service users themselves and their partners was a major area of concern, and commented on in relation to every element of care, in particular ultrasound appointments and postnatal care.
- Emotional and psychological wellbeing support should not be forgotten during this period: service users experienced both the pandemic and the altered care/restrictions that have happened in response to the pandemic as having an impact on their wellbeing and some felt that mental health had not been addressed.
- Virtual contact is not a substitute for in-person contact; service users wanted more contact and for more of the contact to be in-person.
- The pandemic and the associated changes and restrictions may compound existing inequalities; service users from BAME communities were generally less satisfied with the care they received than others.

Reflective questions

1. How could midwifery practice become more inclusive of partners in maternity care, not just during this pandemic?
2. Why might service users and their partners have felt disregarded or lost in the system? What learning can we take to inform future services?
3. What specific factors may have had a direct impact on health inequalities for women from socially disadvantaged and BAME communities?
4. How might you ensure that all women who access the maternity service (particularly those who are not always well represented) have an opportunity to provide feedback and be engaged in service improvement?

MAIN PAPER

Introduction

The COVID-19 pandemic has had a profound effect on almost every aspect of life across the world with unprecedented changes to health service provision and considerable mortality. In March 2020 the UK implemented a national lockdown requiring all NHS maternity services to make changes to their service delivery in order to protect service users and staff, and to ensure continued provision of essential care; with services across the NHS advised to plan for being staffed at 20-80% capacity. The Royal College of Obstetricians and Gynaecologists (RCOG) regularly updated evidence-informed guidance, however Trusts varied in their responses to this evidence and to the Government guidance. The changes introduced included social distancing and infection control measures within hospitals and other clinical settings, postponement of 'non-essential' services, an introduction of virtual appointments and the reduction of footfall through buildings, including through introducing visiting restrictions. Community services were also impacted with, in many cases, access to GP surgeries for antenatal care being suspended.

Pregnancy and becoming a parent are times of major change for anyone. Experiences in this period can carry impacts that last for many years and across generations. These experiences can be affected by many factors including personal circumstances, the care that people receive during this time and the support that they have around them. Evidence about expectant and new parents' experiences during the COVID-19 pandemic is now emerging. In Sweden, pregnant women's concerns about their own, their partner's and their child's health increased dramatically as a result of the COVID-19 pandemic (Naurin, Markstedt et al. 2020). In the UK, a survey of over 5,000 people (predominantly pregnant people and parents of babies aged ≤ 24 months) found that families have been affected in diverse ways, that existing inequalities in early life experiences have worsened, and that the pandemic will cast a 'long shadow' through strained relationships and impacts across generations (Best Beginnings 2020).

Locally, a working group of service providers, commissioners and the Maternity Voices Partnerships was established to understand the potential impact of the pandemic and the

changes to service delivery, and to ensure that learning informed the shape of future services. A survey was conducted to explore service users' and their partners' experiences of maternity services in two NHS Trusts in the North of England during the initial COVID-19 pandemic lockdown and local restrictions (March-August 2020).

Methods

To ensure relevance across stakeholders, a service improvement survey was co-produced by two NHS Trusts, three local Maternity Voices Partnerships (MVPs), three Local Authorities (LAs) and four Clinical Commissioning Groups (CCGs). A steering group was set up to scope and plan the work, which included the agreement to proceed and what to focus on. The initial stages included all the organisations listed and we discussed in detail what we wanted to look at. A smaller working group was established to develop the detail of the survey which was then shared with the steering group to get feedback; this was an iterative process until the survey was finalised. The survey included satisfaction measures and open-ended questions (*'what was good'*, *'what could have been better'*) across various aspects of maternity services. The final question asked for: 'anything else you would like to tell us about the maternity care you have received'. Socio-demographic data were also collected. The survey was made available online or by hard copy for four weeks during August 2020 via social media, NHS, MVP, LA, CCG websites and community newsletters. It was also made available via Healthwatch organisations across the area, feeding and family support groups and community and voluntary sector groups that focus on maternity and supporting families. The local Higher Education Institution was approached to lead on the analysis of the data.

Descriptive statistics (frequency and distribution) of the demographic data and the satisfaction measures were generated using SPSS. The Pearson Chi Square test, was used in order to test whether there were significant differences between demographic groups. The findings from the free text responses to open-ended questions were analysed using qualitative content analysis. Two team members followed an inductive process of preparation and organising (Elo and Kyngäs 2008), independently coding the data, using open coding and then grouping these under higher order headings to create categories (Vaismoradi, Jones et al. 2016). These were further refined by meeting to compare and discuss initial codes and

categories, with the resulting categories then discussed further with the full team. We report here the key categories that were relevant across maternity care experiences. The full questionnaire and responses relating to specific aspects of care were also analysed and presented in the full report that was written for the working group (Smith, Darwin et al. 2020).

In this paper we use 'women' to mean service users who are gestational parents, when we refer to partners, this refers to the woman's intimate partner, other co-parent, birthing companion or family member. It was not always clear in some of the responses whether those completing the survey were service users or their partners, in these cases we identify them as 'respondents'.

As this was designed as a service evaluation, formal ethical approval was not required. Relevant approvals were given by the two Trusts involved. Ethical principles were adhered to, for example potential participants were informed of the purpose of the survey; taking part was voluntary, without undue influence to take part. All responses were anonymised. As part of the survey, participants were signposted to other services including those able to provide support with answering the survey (due to language or health literacy for instance) and those able to provide specific support around midwifery. In addition, in acknowledgment that the survey may raise difficult issues, when it was posted we shared contact details of other organisations who provide advice and support; for example concerning mental health.

Local changes to maternity services March-August 2020

Changes to services included:

- Trust responses to national hospital visiting restrictions to reduce footfall meant that partners could not accompany women to scans or appointments.
- Local GP surgeries also needed to reduce footfall, resulting in some midwifery community clinics moving to hub or hospital settings.

- Certain appointments, where physical assessment was considered to be clinically safe, including the initial booking appointment, were conducted via telephone rather than in-person.

In addition, other wider support services for pregnant women were affected in similar ways to maternity, for example reduced in-person contact for GP clinics, stop smoking services, health visiting, and social care. There was no change in place of birth options within the two local Trusts.

Results

In total, 606 respondents answered at least one element of the survey. There were no notable differences between Trusts and data are presented together.

Descriptive statistics

Table 1 describes the participant characteristics and overall satisfaction levels. Overall, there remained a relatively high level of satisfaction with the care received, between 67-87% of respondents said that their experience was good or very good for each element of care – Table 2. However, there were some differences in levels of satisfaction: women aged between 18 and 24 were generally the least satisfied with their experience of care and those aged between 35 and 39 were the most satisfied. Women who identified as lesbian or bisexual were significantly less satisfied with their antenatal care compared to women who identified as heterosexual. Women from BAME communities were under represented in the survey (8% of respondents, compared to approximately 25% of the birthing population in the area) and generally less satisfied with their care, at each stage, compared to white women. The only notable comment offering insight into these differences within the free text was:

‘There is most definitely a negative experience for people of BAME when being treated by staff (this is backed up by national maternity data). Focussing on training/recruiting staff who look like the community you serve will go a long way in improving care.’

Qualitative content analysis

The analysis of the free text comments identified five major categories, summarised below.

Valuing support from health professionals

Many respondents acknowledged the challenges of the pandemic for everyone including health professionals and services; some explicitly expressed gratitude for the care that was received.

'Thank you for working through the pandemic, for continuing to provide good support, reassurance and service during this time.'

'Thank you for bringing my baby into the world so safely during a really scary time.'

Interactions with individual health professionals were largely described in positive terms.

Feeling lost in the system and let down by the system

Some women and partners felt lost in the system. Whilst some aspects may reflect pre-existing system issues, several participants experienced this as feeling forgotten about and let down by the system. Examples included not responding to service users' attempts to contact, changes to care provision not being communicated effectively, lack of continuity or feeling dismissed when concerns were raised:

'No one contacted me during lockdown. I think they forgot about me.'

'Since birth we have been let down by the system and have had no support.'

'I saw a different midwife nearly every time - zero continuity of care. One didn't even know how far along I was...'

The impact of restrictions to partners and others

The greatest area of concern (indicated both by frequency and strength of comment) was the impact that restrictions relating to partners has had on both the service users themselves and their partners; including their mental health, couple relationship, social recognition as a parent and bonding with the baby. Although some respondents acknowledged the need for

some restrictions, concern was expressed in relation to every element of care, in particular ultrasound appointments and postnatal care.

Many women felt distressed and anxious when attending antenatal appointments and scans alone and described a need for 'moral support' from their partner, with partners themselves feeling helpless/powerless.

'I felt very anxious and lonely attending appointments and scans by myself throughout the pandemic. I suffer from anxiety and felt very vulnerable on my own without my husband.'

'While we understand about COVID 19 causing restrictions on hospital visiting and births, my husband feels that he let me down massively while I was in hospital attempting to be induced, which ended up in a c section.'

This was particularly heightened where there were pregnancy complications in the current pregnancy or past pregnancy loss or baby loss:

'After a missed miscarriage and threatened miscarriage and not being able to have my husband with me I felt very alone and anxious.'

'We have had a very difficult pregnancy and receiving bad news on your own is not good.'

They felt as though their partners were not able to share key life-changing events with them, potentially impacting on relationships:

'Partners need to be able to attend scans and appointments. It's led to my partner feeling very detached from the situation and myself feeling alone.'

They felt it negatively impacted on their partner's mental health and ability to transition to parenthood and bond with their baby:

'He thinks that he should've been allowed to stay for longer than the 2 hours provided to support both me and the baby. His mental health suffered as a result of not being close to his baby.'

'Partner needed to be more involved for the mental health of himself and the mother and to build a bond with baby.'

Partners felt that they were not able to provide appropriate support or advocacy:

'Mental health care wasn't great, my partner rang in worried about my mental health on day 3 or 4 in hospital on my own with baby and I was told by a midwife "it's just motherhood" and it was dismissed.'

'As father of the baby (he) felt very removed from the experience and the unknown of having me in hospital for 4 days for induction not able to visit to understand what was going on and didn't feel like he was able to support me as he did the first.'

There was also suggestion that services may not have recognised partners of LGBTQ service users in the same way as other (male) partners were recognised:

'Wife wasn't allowed on the ward to collect me and our daughter yet other men were.'

Virtual contact is not the same as in-person contact

Although some positive comments were made about virtual appointments being convenient, avoiding the need for travel or childcare, overall satisfaction was lower for virtual compared to face-to-face (in-person) appointments. The responses suggested that virtual appointments might be appropriate at times (and for some people) but that it was not seen as a substitute for face-to-face contact in general.

Concerns were raised about not having physical checks:

'I have concerns about the lack of early blood pressure and urine checks - I ended up purchasing my own and monitoring independently.'

'Midwife was excellent. It was the same midwife who I'd had all throughout my pregnancy so I was very lucky. She knew me and also knew the baby and noticed warning signs early on about his feeding so he was rushed back into hospital at 6 days old with suspected sepsis. There was no way this would have been picked up on a virtual appointment!'

'Telephone appointments are terrible for assessing mental health or domestic abuse issues.'

'I know we have to (be) mindful of the virus but I really worry for any babies that are being neglected or abused, their safeguards have completely disappeared.'

There was a concern that telephone calls compromised communication and rapport, with some suggesting that video calls may help to overcome some of the barriers, continuity was also identified as important:

'Difficult to build rapport over the phone.'

'More video/face to face checks as women often say we're ok but our body language & expressions say otherwise.'

'The phone call itself was fine and I was still able to have continuity of care by speaking to the same midwife I would normally see.'

The need for emotional and mental wellbeing support

Service users experienced both the pandemic and the altered care/restrictions that have happened in response to the pandemic as having an impact on their emotional and psychological wellbeing, including heightened anxiety. Service users described how, at times, they felt abandoned, lonely, alone, isolated and scared; this impacted on their mental health and their ability to enjoy and connect with their pregnancy. Some identified this as further compounded by their limited ability for contact with other pregnant people or parents.

'I've felt unsupported and terrified during my first pregnancy. I don't have anyone telling me how I am feeling is normal or checking in on my emotional wellbeing'

especially as I was on anti-depressants before I was pregnant. No one has checked in on me knowing my medical history. It's been so upsetting and scary.'

'I've found it hard to be excited or connected with my pregnancy, I think I could have benefited from more interaction with other pregnant women or people in general.'

Some identified their experiences of care and restrictions as having an impact on their emotional and psychological wellbeing. There were examples where respondents felt mental health needs were missed or dismissed:

'I have been suffering from postnatal depression and have felt that phone calls have simply not been sufficient to support me during this time.'

'Someone could have just listened to me. I sat crying in an appointment and the midwife just brushed over it as "over tired mummy of 3"'

Discussion

This co-produced survey provides insight into the impact that the COVID-19 pandemic and subsequent changes in maternity services has had on service users and their partners in the UK. It is also an example of the power of collaboration, with key stakeholders engaging throughout the project, from co-production of the survey to the services' rapid response to the survey's findings, with action plans now in place at each Trust. Examples of rapid responses included: midwives contacting every woman on their caseload who had not been seen in the past two weeks to do a wellbeing check and an increase in communication related to COVID-19 and the effect on maternity services on Trust websites.

Our findings are consistent with the few other reports published to date on women's experiences of UK maternity services during COVID-19, which have also identified the distress caused by the restrictions to partners' involvement and the perceived barriers to care during this period (Karavadra, Stockl et al. 2020, Sanders, Blaylock et al. 2020). By adopting a local emphasis, we had 'buy-in' for this learning to shape future service change.

Restrictions and their implications appear inconsistent with current policy, including increasing the emphasis on perinatal mental health, the need for trauma-informed maternity services and ambitions to be more partner-inclusive and family-focused (NHS Long Term Plan 2019). Although there has been new government policy for women to have someone with them through the pregnancy continuum (NHS 2020) many organisations have found it difficult to meet the criteria, in the ever-changing challenge of the pandemic it is likely that restrictions will continue in some form.

The potential long-term impact of the pandemic for perinatal mental health and relationships cannot be underestimated, for women, their partners or their children (Best Beginnings 2020, Naurin, Markstedt et al. 2020). Moreover, there is potential for existing inequalities to be deepened (Best Beginnings 2020). Perceived support from healthcare staff may be protective against the development of depression and post-traumatic stress symptoms (Ostacoli, Cosma et al. 2020) and many respondents comments on the positive impact of support from individual midwives. However, we also found some indication of lower satisfaction amongst women from a BAME background; groups that are at increased risk of developing complications of COVID-19 and more likely to be die from the virus (Knight, Bunch et al. 2020, MBRRACE 2020)

We recognise the flexibility of staff and services to respond to this unprecedented crisis, working in incredibly challenging circumstances, with workload pressures and dealing with their own stress and anxiety regarding the virus. **The pandemic also disrupted arrangements for student midwives' placements and their ongoing learning.** It has sped up some thinking around different ways of working, which may be good going forward but we need to remain alert to the impact of any emergency measures. This situation may provide the opportunity to increase the personalisation of services. For example providing more flexible ways of working through offering remote appointments, which may be welcomed by some service users at some times, but not others. Our findings echoed those reported elsewhere, indicating that for some people, virtual clinics may be less acceptable and present barriers to care (Karavadra, Stockl et al. 2020). We need to recognise that efforts to protect one area of public health may have unintended consequences and that these could undermine gains previously

secured in another. We need to work holistically and weigh up particularly potentially competing public health approaches.

Strengths and limitations

This survey was co-produced by key stakeholders in maternity care provision within the region and has had a direct and immediate impact on service delivery. It provides an excellent example of the power of collaboration between service users, providers, commissioners and Higher Education Institutions. Participants provided extensive free text responses, providing rich survey data. Although there were over six hundred responses, there are almost a thousand births each month across the two Trusts.

Surveys have limitations in that it is not possible to ask further question to explore or clarify responses. A number of questions were not answered and with hindsight, the survey design did not adequately capture certain sociodemographic data (e.g. service user/partner, family form, socioeconomic indicators). The gender data suggests that few partners completed the survey and it may be that alternative recruitment routes, or having two tailored surveys (for service users and for partners) would have promoted participation. Although there was wide circulation of the survey, respondents were predominantly white British, and therefore the findings may not be representative of women from BAME backgrounds. Such under-representation has been noted in previous surveys conducted by the MVP, and we continue to explore ways to gain feedback from seldom heard groups. Few respondents identified themselves as having a disability, indicating that the findings may not be representative of women with disabilities. The survey did not capture maternity staff or student experience of the impact of lockdown, nor did the questions distinguish between experiences concerning care from different members of the maternity team.

Implications for practice

While this survey has found that there was considerable satisfaction with maternity services and appreciation for the need to respond to the acute and real threat posed by the pandemic, there is evidently a great deal to learn, both in relation to immediate adjustments to service

delivery, but also to long term planning. Implications identified through the survey and proposed for consideration for Trusts locally were:

1. Trusts need to find a way to involve partners more fully in the childbirth journey.
2. There is a need to ensure that emotional and psychological health support is not compromised, particularly at a time of heightened need.
3. Enhanced sign posting and clear communication is necessary to ensure that service users do not get lost in the system and that they and their families have trust in the system.
4. Although there is the acknowledgement of the need to restrict some in-person appointments, in some circumstances more in-person contact is needed than has been provided during the first period of lockdown; virtual appointments should not be seen as a substitute for in-person care on a longer-term basis for the majority of service users.
5. Issues of equity need to be considered; there needs to be work to ensure that minoritised groups are not further marginalised by changes, including: how to improve the experience and care of service users from BAME communities; addressing issue of health literacy and digital inclusion; and recognising diverse family forms.

Since the dissemination of the findings of this survey, there has been a high level of joint working with engagement in each Trust, working alongside MVPs to try and ensure that as far as possible, the recommendations are addressed.. Both Trusts have started action plans and reviewed services in view of the feedback from the survey, for instance one of the Trusts has introduced three touchpoint letters through pregnancy which have been translated into five languages to help mitigate the sense of *'feeling lost in the system'*. This has been further supported by the new NHS release on 14.12.20 (NHS 2020) which asks trusts to be 'creative' towards the aim to allow partners to support women throughout the maternity pathway at the same time as the priority being to prevent the spread of the virus. We are aware that as the situation continues to change new national guidance will be rolled out, these findings may help guide Trust responses to the situation and to assist in longer term planning of services.

Conclusion

The pandemic has presented and continues to present considerable challenges for services. The changes implemented may have compromised mental health and wellbeing in a critical

period of vulnerability. Changes introduced in the interest of public health may threaten other areas of public health; bringing together diverse stakeholder perspectives offers ways to consider these potentially competing needs. Work is needed to better hear from minoritised groups and ensure they are not further marginalised by changes.

References

Best Beginnings, Home Start, Prent Infant Foundation. (2020) Babies in Lockdown. Listening to parents build back better

<https://babiesinlockdown.files.wordpress.com/2020/08/babies-in-lockdown-main-report-final-version-1.pdf> (accessed 5 January 2021)

Elo, S. and H. Kyngäs (2008). The qualitative content analysis process. *J Adv Nurs* **62**(1): 107-115.

Karavadra, B., A. Stockl, E. Prosser-Snelling, P. Simpson and E. Morris (2020). "Women's perceptions of COVID-19 and their healthcare experiences: a qualitative thematic analysis of a national survey of pregnant women in the United Kingdom." *BMC Preg Childbirth* **20**(1): 600.

Knight, M., K. Bunch, N. Vousden, E. Morris, N. Simpson, C. Gale, P. O'Brien, M. Quigley, P. Brocklehurst and J. J. Kurinczuk (2020). Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study. *BMJ* **369**: m2107.

MBRRACE-UK Maternal Report (2020):

[https://www.npeu.ox.ac.uk/assets/downloads/mbrpace-uk/reports/MBRRACE-UK Maternal Report 2020 v10 FINAL.pdf](https://www.npeu.ox.ac.uk/assets/downloads/mbrpace-uk/reports/MBRRACE-UK%20Maternal%20Report%202020%20v10%20FINAL.pdf) (accessed 5 January 2021)

Naurin, E., E. Markstedt, D. Stolle, D. Enström, A. Wallin, I. Andreasson, B. Attebo, O. Eriksson, K. Martinsson, H. Elden, K. Linden and V. Sengpiel (2020). "Pregnant under the pressure of a pandemic: a large-scale longitudinal survey before and during the COVID-19 outbreak." *Eur J Public Health*. doi: 10.1093/eurpub/ckaa223

NHS (2019) The NHS Long Term Plan <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/> (Accessed 11 January 2021)

NHS 2020 'Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers. Published 14.12.20

<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C0961-Supporting-pregnant-women-using-maternity-services-during-the-coronavirus-pandemic-actions-for-NHS-provi.pdf> (Accessed 11 January 2021)

Ostacoli, L., S. Cosma, F. Bevilacqua, P. Berchiolla, M. Bovetti, A. R. Carosso, F. Malandrone, S. Carletto and C. Benedetto (2020). "Psychosocial factors associated with postpartum psychological distress during the Covid-19 pandemic: a cross-sectional study." *BMC Preg Childbirth* **20**(1): 703.

RCOG 2020 COVID-19 virus infection and pregnancy

<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/> accessed 5/12/2020

Sanders J, Blaylock R on behalf of the Wrisk Team 2020. Users' experiences of COVID-19 maternity service changes. Cardiff.

Smith A, Darwin Z, Farmer D and Stacey T. 2020. Using maternity services during COVID-19. https://www.wakefieldccg.nhs.uk/fileadmin/site_setup/contentUploads/Get_involved/Engagement_Reports/Covid-19_Maternity_Report.pdf (Accessed 11 January 2021)

Vaismoradi M, Jones J, Turunen H and Snelgrove S 2016. Theme development in qualitative content analysis and thematic analysis. *J Nurs Educ Pract* **6**(5): 100.