Position Statement: Midwifery units and COVID-19
For release on 31st March 2020

Midwifery units (MUs) can make a positive contribution when NHS maternity services are stretched to the limit by the effects of Covid-19. The Midwifery Unit Network (MUNet) is committed to supporting NHS senior managers and frontline staff by collaborating in the pursuit of constructive solutions to the current unprecedented challenges.

MUNet is concerned about the care options available for women with uncomplicated pregnancies or those who prefer an out-of-hospital birth. During the COVID-19 pandemic, health systems all over the world are stressed to their maximum capacity by increased workloads and lack of staff due to sickness. The population is advised *not* to attend a hospital setting unless strictly necessary, yet this advice seems to apply to all but healthy women during childbirth. Throughout this crisis, women will continue to be pregnant and give birth, deserving the same right to safe maternity services and compassionate care as they always have (1).

Hospital facilities are at high risk of being contaminated with Covid-19 as a significant but unknown percentage of carriers are asymptomatic. Furthermore, NHS staff who may have been exposed to the virus, have limited access to diagnostic testing and PPE equipment. Skilled and dedicated healthcare staff are overworked, and units understaffed.

Midwifery units, also known as birth centres, are being closed across UK or re-purposed for women who have COVID-19 or as isolation wards for non-maternity patients. Closures are affecting community-based, Freestanding Midwifery Units (FMUs) in particular. A survey of heads and directors of midwifery from across the UK, conducted by the Royal College of Midwives (RCM), has found that 21% of MUs have closed of which 11 units were turned into COVID-19 isolation units (2).

There is clear and well-documented evidence that for women with uncomplicated pregnancies, giving birth in a MU is safer due to lower rates of unnecessary intervention for the mother (3, 4). Birth in MUs is as safe for the babies of these women as birth in an Obstetric Unit (OU or hospital delivery suite). Providing maternity care for women with uncomplicated pregnancies in midwifery units has been shown not only to reduce unnecessary interventions during childbirth but also to decrease costs to healthcare systems and improve women´s satisfaction of their birth experience (5-7). The current NICE guidance on planning place of birth for healthy women with uncomplicated pregnancies recommends that women are offered the choice of all four birth settings (home, freestanding midwifery unit, alongside midwifery unit, obstetric unit) and that women are advised that birth in a midwifery unit is particularly suitable for them (8).

In this exceptional situation we recommend that maternity services build on existing infrastructure, which includes out of hospital birth as part of the core provision and ringfencing and protecting AMUs in acute hospital settings. Services should expand the opportunity for women who are healthy and have no pregnancy complications to give birth in a midwifery unit as the default option, provided they have no symptoms of Covid-19. This will ensure that 'low-risk' women have access to optimal care and keep hospital obstetric units free for those with obstetric needs or medical need due to suspected Covid-19.

During this unprecedented strain on acute hospital services, supporting the obstetric unit and other hospital services, including ITU and anaesthetic services, involves avoiding the admission into higher level care such as the obstetric unit unless clinically necessary.

Maintaining, expanding or creating new MU services would benefit women, babies and services in two key ways:

a) Reduction in the number of obstetric interventions which put further strain on resources and staff and possible admission to high dependency or intensive care units.
b) Reduction in the risk of infection from hospital settings for women, their babies, their birth supporters and midwives skilled in midwife-led birthing care in MU settings.

During the COVID-19 crisis it is important to:

1. **Keep what works and is evidence-based**: we recommend that maternity services should strategically *re-open* and *increase* activity in the existing FMUs by sustaining staffing levels and recommending and encouraging eligible women to give birth there. In a similar vein, we encourage AMUs within large hospitals to continue to open admissions to women with uncomplicated pregnancies, to operate as a 'separate birthing space' and to ringfence the skilled staff who work there to prevent re-deployment to the main OU to minimise coronavirus cross-infection risk.

2. **Create pop-up midwifery units where needed**: where FMUs do not already exist, with collaborative planning and support, 'pop-up' FMUs can be created effectively and quickly, close to acute services (but in a separate building) following the example of the Netherlands (9).

3. **Utilise and mobilise midwifery skills appropriately**: supporting a midwife-led, physiological birth outside of an obstetric setting is a skill with a defined philosophy (10). Home birth and caseload midwives have an abundance of skills which are well-placed in a MU setting. Independent Midwives (IM) may be able to support MUs if Trusts take the necessary decisions that will facilitate IM collaboration with NHS Trusts. Similarly, midwives returning to practice to help overstretched maternity services can be deployed locally in MUs and to give additional support in primary care settings as can midwifery students, doulas, experienced maternity support workers and other volunteers.

4. **Establish COVID-19 operational procedures for transfer from FMUs and homebirth**: new emergency Standard Operating Procedures (SOP) can be established for supporting the safe transfer from FMUs to the OU. Firstly, the majority of non-emergency transfers can be facilitated by private transport or taxi. Secondly, in cases of emergency transfer there should be an escalation procedure involving private ambulance, the army or other alternative solutions. Services should be thinking seriously about those alternative solutions.

5. **Network and share knowledge**: This epidemic is teaching us that we are all interconnected. We must learn from other services and other countries, share knowledge to maximise the spread of solutions (11).

We understand the difficult situation and ethical considerations our maternity services face at this current time. Maternity services need to be considered an essential service which should be maintained fully to avoid harm to maternal and child health in both the short and longer term. We need to join forces, strategically finding the best solutions for dealing with the current crisis. It is essential that throughout these difficult times we focus on our duty of care to women and their families. We need transformational midwifery leadership and lateral thinking.

Statement by Midwifery Unit Network Director team

For further information please contact: support@munetwork.org

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