Royal College of Obstetricians & Gynaecologists

Framework for staffing of obstetrics and gynaecology units during the COVID-19 pandemic

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Information for healthcare professionals

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Table of updates

Version	Date	Summary of changes
3	21.05.20	**Title**: Minor change (document referred to as a framework not guidance).
3	21.05.20	**1**: Inclusion of a link and reference to NHS England guidance on temporary reorganisation of intrapartum care services during the COVID-19 pandemic.
3	21.05.20	**4**: Specific recommendations to consider the needs of women of black, Asian or minority ethnic backgrounds when modifying services, following findings of UKOSS COVID-19 in pregnancy survey report.
3	21.05.20	**4**: New reference to restoration of services.
3	21.05.20	**6**: New section on restoration and recovery of services.

1. Introduction

The COVID-19 pandemic presents specific challenges to maternity and gynaecology services. It is imperative however that safe, equitable, effective and quality care is maintained for all women using maternity and urgent or emergency gynaecology services. Maternity and gynaecology services must therefore be remodelled with the aim of safeguarding effective and quality care for women during and after pregnancy, and the provision of emergency and urgent gynaecology care. Any rationalisation of services should be kept under constant review.

General principles for the safe organisation of maternity services are available in the RCOG's guidance on coronavirus (COVID-19) in pregnancy and in the NHS England guidance on the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic.

2. Development of this framework

This framework has been developed to support Maternity and Gynaecology Leads to optimise the deployment of available staff and to guide priorities for staffing during the evolving COVID-19 pandemic.

This document serves to:

1. Provide options for staffing obstetrics and gynaecology units in response to acute staff shortages.

2. Provide an overall framework for clinical leads to use when prioritising the rationalisation of services in response to acute staff shortages. Details for each particular service are available on the RCOG hub for COVID-19.

This framework is not exhaustive and sits alongside RCM/RCOG guidance for provision of midwife-led settings and home birth during the pandemic, available via the RCOG hub here.[1] Local conditions and considerations will determine how it is best applied.

3. Optimal deployment of obstetrics and gynaecology staff during the COVID-19 pandemic

3.1 Staffing considerations for obstetric services

Obstetric services staffing considerations		
Phase 1 Low-level staff shortage 10-20% staff reduction	Phase 2 Medium-level staff shortage 20-40% staff reduction	Phase 3 High-/critical-level staff shortage 40% and above staff reduction
Cancel or reduce non-critical, non-COVID-19 related activities, including non-urgent internal management meetings Ensure staff have access to remote working facilities and consider use of clinically well but self-isolated and shielding doctors to deliver telemedicine safely from within their isolation setting Identify staff who should avoid patient-facing roles early; redeploy these colleagues to teleconsultations or other non-patient facing roles where social distancing can be practised Consider whether some gynaecologist colleagues may be able to support elective work in obstetrics Request staff to cancel study leave, elective activity in the private sector and other external non-COVID-19 related responsibilities Suspend any non-essential managerial duties of clinical managers, to temporarily increase their clinical duties Consider flexible working for full-time doctors to accommodate local department needs Approach doctors on part-time contracts to establish whether they are able to contribute additional hours Approach research clinicians with the necessary clinical skills to request they reduce research (where safe) and contribute additional hours to the clinical service Consider novel options to support childcare for working staff Make arrangements with local maternity units for sharing clinical staff where their units are differentially affected; temporary contract arrangements may need to be prepared Implement maternity unit induction and drills and skills or simulation sessions, focused on emergency and COVID-19 obstetric scenarios, specifically to refresh the skills of colleagues who have recently stopped working in acute obstetrics	Where shortages affect theatre operating capabilities and where available pathways exist, consider the use of theatre capacity from the private sector, with appropriate senior clinical cover Create senior staff rotas which can provide support for the reducing availability of staff at all levels Consider changes to the usual delivery of service, where needed, by consultants or Speciality and Associate Specialist doctors acting down, both in and out of hours	Consider requesting staff to rearrange annual leave but note impact on wellbeing Request obstetric consultants with limited or no on-call commitments to work additional weekend days and/or evenings

3.2 Staffing considerations for gynaecology services

Gynaecology services staffing considerations		
Phase 1 Low-level staff shortage 10-20% staff reduction	Phase 2 Medium-level staff shortage 20-40% staff reduction	Phase 3 High-/critical-level staff shortage 40% and above staff reduction
Cancel or reduce non-critical activities, including but not limited to routine non-urgent internal management meetings and preparation for CQC inspections Ensure staff have access to remote working facilities Identify and consider use of clinically well but self-isolated and shielding doctors to deliver some telemedicine from within their isolation setting Release senior trainees from gynaecology theatres to deliver obstetrics and 'double up' consultant gynaecologists in cancer and emergency theatre where assistance is required Divert gynaecologists to elective and/or emergency caesarean section lists	Stop or significantly reduce gynaecology workload for seniors working in both obstetrics and gynaecology, and ask those who perform only gynaecology to take on the remaining gynaecology work, if appropriate Consider asking gynaecology consultants to work with nursing staff and/or recently qualified doctors to run emergency gynaecology services	

4 Overall guidance of reconfiguration of services during the COVID-19 pandemic

Safe, equitable, effective and quality care for all women using maternity and gynaecology services requires a minimal level of service to be delivered at all times. For all women's health services, this must include the following:

- The provision of evidence-based, equitable, safe, compassionate and respectful care for physical and mental health, wherever and whenever care takes place, by remote access if necessary
- The provision of clear pathways for accessible patient advice and help
- The protection of women, particularly those from groups who are vulnerable to the potentially severe effects of COVID-19, including women from Black, Asian and minority ethnic (BAME) backgrounds, and of nosocomial infection
- The protection and support of all staff, including their mental health needs

- Adherence to national guidance on infection prevention and control, and on the use of personal protective equipment (PPE)

- Maternity and gynaecology care for all women identified as high risk, including women from vulnerable groups and with mental illness, must be continued with minimal disruption

- Maintaining essential and urgent cancer treatments[2]

- Providing emergency gynaecology and early pregnancy care, with pathways for the escalation of care and the provision of emergency surgery where required

For maternity services, the minimal level of service must also include the following:[3]

- Supporting family bonding and expected standards of care as far as possible, in particular:
  - Supporting the attendance of a birth companion
  - Keeping a woman and her newborn baby (or babies) together, unless separation is absolutely necessary

Where services are modified, this should be with an awareness of the future restoration of services as staffing stabilises.

4.1 Modifications to maternity services

Detailed guidance for each service is available from the RCOG hub for COVID-19 in pregnancy. Further guidance for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic in England is available here.[4]

Maternity services departmental considerations		
Phase 1 Low-level staff shortage 10-20% staff reduction	Phase 2 Medium-level staff shortage 20-40% staff reduction	Phase 3 High-/critical-level staff shortage 40% and above staff reduction
Antenatal care		
Establish clear pathways for the maternity triage and day assessment units Consider creating a telephone hotline or email inbox for urgent enquiries from pregnant women, to be reviewed and responded to by senior clinicians Ensure facilities are available for telephone and video consultation, and facilitate the availability for electronic patient notes and recording, if not already available	Consider modifications to antenatal scanning services in line with RCOG guidance for antenatal screening and ultrasound in pregnancy in the evolving coronavirus (COVID-19) pandemic Consider modifications to fetal medicine services in line with RCOG guidance	

Identify low-risk consultations in antenatal pathway which could be safely conducted via telephone or video consultation, in line with RCOG/RCM guidance on modifications to antenatal care Establish clear pathways for the remote antenatal care of high-risk women, where appropriate and possible; this includes implementing home blood pressure and urine monitoring Where face to face consultations are required, these should be organised to limit the number of sequential hospital appointments Consider replacing tours of the maternity unit and antenatal classes with virtual tours and videoconferencing	
Intrapartum care	
Consider a modified outpatient induction service for low-risk women (e.g. by extending the list of indications if safe to do so) Consider limiting induction of labour to women with clear fetal or maternal indications Identify women early for elective/planned caesarean birth and consider consolidating pre-assessment clinics and consent in scheduled face-to-face consultations	Consider centralisation of births; this may be required if similar shortages are seen in midwifery staffing and ambulance provision; see guidance from RCM/RCOG[1]
Postnatal care	
Implement enhanced recovery and discharge programmes, where appropriate, to facilitate prompt discharge Offer and discuss contraception with postnatal women before discharge	Consider telephone and video consultations for postnatal reviews and community breastfeeding support where physical examination isn't required

4.2 Modifications to gynaecological services

Detailed guidance for each service is available from the RCOG hub Coronavirus (COVID-19) and gynaecological services.

Gynaecology services departmental considerations		
Phase 1 Low-level staff shortage 10–20% reduction in gynaecology staff and/ or staff shortages elsewhere (e.g. theatres)	Phase 2 Medium-level staff shortage 20-40% staff reduction	Phase 3 High-/critical-level staff shortage 40% and above staff reduction
Departmental considerations		
Establish clear pathways for the triage of women needing urgent assessment Ensure facilities for telephone and video consultation are available and facilitate electronic patient records, if not already available Cancel non-urgent elective gynaecology outpatient clinics and surgery; where possible, consider changing existing appointments to telephone consultations with follow up appointments after COVID-19 pandemic Conduct multidisciplinary team meetings via videoconferencing Use guidelines available to consider modifications to early pregnancy services[6] Where available pathways exist, consider the transfer of some essential gynaecology elective work to the private sector, to aid with theatre capacity issues, with appropriate senior clinical cover	Consider the triaging of referrals into locally agreed categories for urgency, where appropriate Aim to maintain time-critical oncology services as close to normal, using networks where available Triage oncology surgical cases according to BGCS guidance[5]	

5. Communication with women and their families regarding service changes during the COVID-19 pandemic

The COVID-19 pandemic and the changes necessitated to ensure safe care are understandably worrying for women and their families.

Where decisions are taken to convert appointments to remote consultation, or where appointments have been delayed or postponed, clearly document the decision process taken in making this change and communicate the outcome and rationale to the woman. Language should be clear and transparent, and efforts should be made to ensure important information is available in other commonly spoken languages and other accessible formats.

Input into planning and changes to services should be sought from local service user/patient groups, including Maternity Voices Partnerships (MVPs) and Maternity Services Liaison Committees (MSLCs). The presence of existing relationships will enable this to be done rapidly and where possible, plans and communications should be co-produced. General information regarding service-wide modifications should be disseminated through social media, trust or board websites, and other channels where available. Local charities can also be useful in the dissemination of important information.

6. Restoration and recovery of services

Where staffing levels allow, the immediate restoration of services should be prioritised to enable choice, safety and access to high-quality care. A framework exploring how this may be achieved can be found here.

References

1. Royal College of Midwives, Royal College of Obstetricians & Gynaecologists. Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic. Information for healthcare professionals. 2020 [Available from: https://www.rcm.org.uk/media/3893/2020-04-17-guidance-for-provision-of-midwife-led-settings.pdf] accessed 20 April 2020.

2. Clinical guide for the management of cancer patients during the coronavirus pandemic. March 2020 [Available from: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0119-_Maintaining-cancer-services-_-letter-to-trusts.pdf] accessed 20 April 2020.

3. Renfrew MJ, Cheyne HL, Hunter B, Downe S. with Sandall J, Spiby H, Dykes F, Lavender T, Page L. Optimising maternity services and maternal and newborn outcomes in a pandemic: a rapid analytic scoping review. 2020. Royal College of Midwives, London.

4. NHS England. Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic. [Available from: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0241-specialty-guide-intrapartum-maternity-care-9-april-2020.pdf] accessed 30 April 2020

5. British Gynaecological Cancer Society, Royal College of Obstetricians & Gynaecologists. BGCS framework for care of patients with gynaecological cancer during the COVID-19 pandemic. April 2020 [Available from: https://www.bgcs.org.uk/wp-content/uploads/2020/04/BGCS-RCOG-framework-for-care-of-patients-with-gynae-cancer-during-COVID19.pdf] accessed 22 April 2020.

6. Royal College of Obstetricians & Gynaecologists. Guidance for rationalising early pregnancy services in the evolving coronavirus (COVID-19) pandemic. April 2020 [Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-21-guidance-for-rationalising-early-pregnancy-services-in-the-evolving-coronavirus-covid-19-pandemic.pdf] accessed 22 April 2020.

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