What beneficial innovations/ changes have occurred in your specialty/discipline and within patient pathways? Guidance: e.g. impacting on patients, staff or the wider system. What specific need prompted this change? How long has the change been in place? At what scale did the change happen?

1. Virtual antenatal education

As social distancing restrictions have prevented antenatal education classes from going ahead in person, a number of Trusts have begun to provide antenatal education via online video platforms. Examples include Guys and St Thomas breastfeeding and Lewisham and Greenwich virtual parent education.

2. New communication pathways for antenatal women

A number of Trusts have set up email addresses and/or telephone lines for women to contact with questions or concerns. This change was introduced to cope with increased enquiries due to rapid changes to services as well as general anxiety driven by the threat of COVID-19.

3. Caring for healthcare staff

The pandemic has highlighted the important role healthcare professionals perform in our society and has encouraged many to adopt measures to assist health care professionals to cope with the pressures they are experiencing. For example, some Trusts set up 'wobble rooms' which maternity (and other) NHS staff can visit when they are feeling overwhelmed, and where they can access information on further support including counselling, psychology support and support in relation to traumatic incidents as well as (potentially) stress toys, music, diffusers, water and snacks. As far as we are aware, wobble rooms have been set up at Northern Lincolnshire and Goole, Doncaster and Bassetlaw, and the Royal United Hospitals Bath. Another positive innovation has been the NHS mental health hotline for NHS staff.

4. Home use of mifepristone and misoprostol (abortifacients)

Even prior to the COVID pandemic, many women struggled to access abortion services for example, where they live in a rural area or where their movement was restricted by a violent partner. When COVID broke out, women's access to abortion services was further threatened by social distancing requirements and limitations on services. These factors combined could have caused women to be prevented from accessing abortion services within the legal times frames. In addition, due to intense financial and other pressures created by the pandemic, women have found themselves in need of abortion services more often than would normally be the case. As such, it was imperative to find a way to ensure women could access abortion services in a time sensitive manner.

On 30th March 2020 in England (and 31st March in Wales), the Department of Health and Social Care in England and the Welsh Government issued new and temporary approvals to permit the home use of mifepristone as well as misoprostol up until 10 weeks' gestation. The Scottish Government has also issued an approval which allows home use of

mifepristone and misoprostol without defining a gestation. This regulatory change enables abortion providers to offer a ‘remote' early medical abortion service, whereby the consultation takes place via video or teleconference, and a treatment package is sent to the woman’s home by courier, post or by other means.

Describe the impact of these innovations/ changes (so far)? Guidance: Please include any specific, relevant evidence of impact if available. If no evidence is available please describe the intended impact. Have there been any unintended consequences? Examples of impact may include patient outcomes, safety or experience; population health or wider system outcomes; staff satisfaction; improved efficiency or productivity.

1. Antenatal education

Anecdotally, virtual classes facilitate greater attendance by providing a more flexible mode of attendance. This could facilitate greater engagement with antenatal education, which has many benefits. An independent review commissioned by the Department of Health concluded that ‘group based social support including antenatal preparation for parenthood classes can be effective in supporting women with sub-threshold symptoms of depression and anxiety.’ There was also some evidence that antenatal education improved maternal psychological well-being, parental confidence, and satisfaction with the couple and parent-infant relationship in the postnatal period. (Schrader McMillan A, Barlow J, and Redshaw M. Birth and beyond: a review of the evidence about antenatal education. Warwick: University of Warwick; 2009). As such, amongst other positive effects, antenatal education could go some way to addressing the prevalence of perinatal mental health problems. Currently 1 in 5 women experience perinatal mental health problems (Royal College of Psychiatrists, 2019).

2. New communication pathways for antenatal women

Anecdotally new communication methods were extremely popular and were helpful in addressing simple questions and advising women as to changes in services. Logically, the availability of telephone and email services could free up time in midwifery and consultant appointments by enabling women to ask administrative or general questions via other channels. This could also go some way to improving women’s experience and understanding of the maternity care system.

3. Caring for health care staff

Anecdotal feedback from staff on wobble rooms has been overwhelmingly positive. We believe it is vitally important to maintain, adapt, and improve such measures beyond the pandemic. Even prior to the COVID-19 outbreak, excessive workloads and lack of resources were causing burn-out and high stress levels in midwives and other maternity staff. In 2018, only 26% of midwives reported having time to take a break and 64% reported feeling unwell due to stress. Mental health support, in a variety of forms (e.g. wobble rooms and hotlines) is crucial to protect our NHS workers going forward.

4. Home use of mifepristone and misoprostol (abortifacients)

Remote consultation and provision of early medical abortion services have enabled abortion providers to protect staff and clients from the impact of the virus, while enabling women who are unable to leave their houses to access services. The service has also facilitated access to abortion services for many women who, previous to the pandemic, were unable to access abortion services due to their circumstances, for example where they live in a remote location, due to familial pressures, or due to restrictions on their movement imposed by a violent partner. This is evidenced by the British Pregnancy Advisory Service (BPAS) which reports that since the regulations were changed (to enable remote consultation and provision), requests to illegal online services have ceased and women are now able to access care within the healthcare system.

Based on service evaluations conducted by BPAS (which provides approximately 40% of abortions in the UK) and Marie Stopes, the remote consultation and provision service has also decreased waiting times in line with NICE guidelines, helped to preserved dedicated services, and increased patient satisfaction.

BPAS reports that:

- as a result of the ability to provide a remote service, the average service-wide waiting time to consultation (and treatment in the case of Early Medical Abortions) was reduced from 8 days to just over 1 day (now falling within the NICE recommended waiting period) and the average gestation for treatment was reduced from 8.1 weeks to 6.8 weeks;
- the introduction of teleconsultations as standard (now accounting for 97% of consultations) has increased the number of BPAS appointments available to clients and has preserved dedicated services for women within CCGs;
- 97% of clients reported that they were satisfied or very satisfied with their experience with BPAS; and
- 60% of clients reported that without BPAS's remote service, they would have found it difficult to access abortion care.

Marie Stopes reports that:

- 99.6% of surveyed patients felt able to ask questions or raise concerns
- 100% felt they could talk privately during the consultation
- 98.9% felt confident about how far along they were in their pregnancy based on their dates
- 80% preferred telemedicine to seeing a doctor or nurse in clinic
- 74% would prefer remote consultation (or not be concerned in 8%).

Relatedly, it should also be noted that Early Medical Abortion (EMA) is a safe and effective method of termination during the first 10 weeks of pregnancy. The World Health

Organisation has demonstrated that 'the rate of complete abortion among women using home-based medical abortion across diverse study settings is high (~90%), and there is no evidence of a difference in effectiveness when compared to clinic-based protocols (WHO, 2011).

In addition, NICE has recommended that providers should consider abortion assessments by phone or video call and in a range of settings to meet the needs of women. This recommendation was based on moderate quality evidence from five studies collated by NICE found that community prescribing and telemedicine improved access to abortion services, increased flexibility and facilitated a more patient-centred approach to care.

What is needed to sustain the change/innovation? Guidance: What is needed to continue this change now and in the coming months? What would be needed to scale-up regionally or nationally? What challenges have you faced in implementing the change?

1. Antenatal education

Guidance and support for Trusts as to which online platforms are appropriate to facilitate virtual classes. Potentially translation services.

2. New communication pathways for antenatal women

The establishment of guidance for Trusts on setting up and maintaining email and telephone lines for antenatal women.

3. Caring for health care staff

Investment in the provision of measures like wobble rooms to support NHS staff, as well as guidance for Trusts on establishing these and similar measures. Continued investment and provision of the NHS mental health hotline and related services.

4. Home use of mifepristone and misoprostol (abortifacients)

The current approvals which enable an early medical abortion to take place within a woman's home are temporary. At the expiry of the Coronavirus Act 2020, the approvals will also expire. After their expiry, the system will revert back to it's previous state, which requires that women visit a clinic to be administered the first drug (mifepristone), after which women are permitted to return home to take the second drug (misoprostol). To make the change permanent (to allow women continued access to a remote consultation and provision service) the regulations would need to be altered permanently. This would require the Secretary of State for Health and Social care to permanently approve women's homes as licensed premises for such purposes.

What, if anything, hasn't worked so well? Guidance: Please highlight any changes which you feel would not have value for the future.

1. Antenatal education

There have been issues with various platforms e.g. security risks when using zoom, inability to access Microsoft Teams.

2. New communication pathways for antenatal women

Nothing to report.

3. Caring for health care staff

Nothing to report.

4. Home use of mifepristone and misoprostol (abortifacients)

Clinical guidelines indicate that early medical abortion is not appropriate beyond 14 weeks gestation. As the remote service does not entail a routine scan to determine gestation, some concerns have been raised that women's gestation will not be accurately assessed, allowing early medical abortion to go ahead at an inappropriate gestation. The risk that an early medical abortion could be prescribed for a woman whose gestation has exceeded 14 weeks is acknowledged, but very small (Royal College of Obstetricians and Gynaecologists, 2011). BPAS reports that they are investigating 9 cases in which the gestation was greater than assessed. This represents only 0.11% of BPAS clients since the end of March. BPAS is investigating all 9 cases to establish learning points in such cases.

Some have also raised the risk that an ectopic pregnancy may be missed. However, as BPAS raises, assessment for the likelihood of ectopic pregnancy is an important component of the remote consultation. In addition, the rate and risk of ectopic pregnancy is low in the UK. According to NICE, the rate of ectopic pregnancy is 11 per 1,000 pregnancies, with a maternal mortality of 0.2 per 1,000 estimated ectopic pregnancies.

5. General comments not related to specific innovations:

Restoration of aservice is more difficult than stopping it – where homebirth services have been completely stopped, it has proved really difficult to reinstate in some areas.

Centralisation into hospitals of maternity care was chosen as the key method of managing the pressures – the other methods that could have been employed to seek to keep services more fully running were less than fully utilised ie using senior student midwives more fully; using returning midwives more fully (eg 2nd on for homebirths for both of these groups…).

The care has suffered as a result of moving to a 'National Hospital service' – this has meant a reduction in community based support – for feeding, for perinatal mental health; identifying safeguarding issues; offering additional monitoring for COVID positive women (virtually) to monitor their symptoms.

The last part of the survey was contact details and asking if we were happy to be contacted to which I said yes.