Witness Name: Dr Edward Morris
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF Dr Edward Morris, Former President of the Royal College of Obstetricians and Gynaecologists (RCOG)

I, Edward Morris, will say as follows: -

1. The Royal College of Obstetricians and Gynaecologists (RCOG or the College) is a registered charity, with a mission to set standards to improve women's health and the clinical practice of Obstetrics and Gynaecology (O&G) in the UK and across the world. As the professional body for Obstetricians and Gynaecologists in the UK, the RCOG supports and represents over 8,000 members across England, Scotland, Wales and Northern Ireland, as well as another 8,000 globally.

2. The RCOG develops education, training and exam programmes for doctors wishing to specialise in O&G, publishes clinical guidelines, sets standards for high-quality women's healthcare, and provides a Continuous Professional Development programme for qualified O&G clinicians. The College plays a key role in contributing to public policy development that affects women's health outcomes, the wider health system, and our members. We regularly advise the Government and other public bodies on such matters. The RCOG is not a public body, and its remit is based upon both its mission as a registered charity and its role as a professional body; to raise the profile of women's healthcare and raise the standards of professional practice in Obstetrics and Gynaecology. The College holds no statutory or regulatory responsibilities.

3. I have been a Consultant Obstetrician and Gynecologist working at the Norfolk and Norwich University Hospital since 2001, specialising in endometriosis and menopause care. I have held many roles focusing on patient outcomes and patient safety, advising Government, as well as regulatory and monitoring bodies, in these areas. I am the immediate past President of the RCOG and before this held the role of Vice President for Clinical Quality between 2016 and 2019. I was the inaugural Chairman of the RCOG Safety and Quality Committee. Since finishing my term as RCOG President in December 2022, I have held the post of Regional Medical Director for the East of England at NHS England. In June 2023, I was awarded Commander of the Order of the British Empire (CBE) in recognition of my contribution to improving the health of women and girls across the world and championing their sexual and reproductive health rights.

4. As President of the RCOG between December 2019 and December 2022, I was responsible for leading the College throughout the COVID-19 pandemic and over the period being considered by the Inquiry. As President, I was supported by a team of Officers, all of whom were elected by RCOG Fellows and Members and are senior leaders and experts in the field of O&G. Governance and leadership were also supported by RCOG Council, and the RCOG Board of Trustees, as per the existing governance procedures of the College.

5. In light of the intention of this Inquiry to ensure lessons are learned from the pandemic, the College and I wish to use this witness statement to speak candidly about the difficulties that pregnant women and maternity care services faced during the pandemic. It is essential to highlight to the Inquiry the importance of proactively and systematically considering the unique needs of the pregnant population in response to future pandemics and public health crises, as well as focusing action to mitigate as far as possible any impact on the delivery of high-quality, personalised and safe maternity care.

6. The COVID-19 pandemic presented our health system and its leaders with unprecedented challenges, necessitating a need to respond to multiple urgent priorities at pace. This statement focuses on the impacts in maternity care and on pregnant women, but I want to acknowledge the commitment and dedication shown by so many in Government and across the entire NHS in response to the many significant challenges brought about by the COVID-19 pandemic.

7. As a College, the RCOG worked extremely hard to ensure that our contribution to the UK's response to the COVID-19 pandemic at all times addressed the needs of pregnant women and wider women's healthcare, be that through the guidance we provided to our members and the wider maternity system, the information and advice we provided to pregnant women and their families, or the advocacy we undertook. The College received no funding for this work which required a substantial amount of organisational resource to deliver at a time when, like many other charities and businesses, the College faced economic challenges, including the furloughing of staff.

8. There were times during the pandemic when the College led, in partnership with the Royal College of Midwives (RCM), on the provision of guidance and support for maternity professionals, maternity services and for pregnant women, as this guidance was not always forthcoming in a timely manner from Government and arms-length bodies. It is important for the Inquiry to consider and recognise the role and contributions of healthcare charities and professional bodies, such as the RCOG and the RCM, in supporting the UK Governments, the NHS and public health bodies in responding to the COVID-19 pandemic, and how critical such organisations were in providing the expertise and additional capacity required.

9. The issues I cover throughout this witness statement are based on the areas of interest set out by the Inquiry in a request to the RCOG. They cover (in this order): the College's engagement with Government and other public bodies; RCOG's guidance and information for healthcare professionals and for pregnant women and the wider public; the impact of the pandemic on pregnant women and maternity care, including the impact on antenatal, postnatal and intrapartum care; the impact of restrictions on birth partners and visitors in maternity services; the impact of COVID-19 on pregnant women; inequalities in maternity care in relation to the COVID-19 pandemic; the availability of maternity care professionals during the COVID-19 pandemic; infection prevention and control measures in maternity settings; and finally RCOG's support during the COVID-19 pandemic for its membership.

RCOG's engagement with Government and other public bodies

10. The College has been asked by the Inquiry to provide a summary of the nature of its working relationships in responding to the COVID-19 pandemic with the following

stakeholders across each of the four UK nations: Chief Medical Officers, national NHS and public health bodies, Secretaries of State and Ministers responsible for health and care, and national guideline development bodies. The College held existing relationships with many of these stakeholders, having historically worked closely with individuals and teams to support and influence policy, practice and delivery of services across maternity care and women's health. During the pandemic, the RCOG, led by myself as President, maintained a close working relationship with many individuals and bodies identified as of interest to the Inquiry.

11. In response to the emerging pandemic the RCOG and our colleagues at the RCM began to receive many requests for advice and calls for guidance from our respective members, as well as more widely from the public and other stakeholders such as maternity charities. The RCOG worked in close partnership with the RCM throughout the pandemic, and the strength of this partnership was central to both Colleges' pandemic response.

12. In order to meet the urgent need and demand for expert guidance and advice for healthcare professionals working in maternity and neonatal care settings, the RCOG and the RCM brought together key stakeholders into a COVID-19 Guidance Cell (the Cell), which acted as the central mechanism for the RCOG response to the pandemic. The Cell provided expert clinical input and advice, and met frequently to respond to emerging evidence with regards to the new virus, evolving Government advice, guidance and changes in legislation. Membership of the Cell evolved over time and involved representatives from professional bodies including the RCM, the Royal College of Paediatrics and Child Health (RCPCH), the Royal College of Anaesthetists (RCoA), and the Obstetric Anaesthetists' Association (OAA). Membership of and engagement with the Cell also regularly included stakeholders listed above as of interest to the Inquiry. For example, initial membership of the Cell included the clinical adviser to the Chief Medical Officer for England, and representatives from Public Health England (PHE), Health Protection Scotland (HPS), and NHS England and Improvement.

13. The level of engagement and collaboration with the RCOG from each of the stakeholders listed above varied by organisation and across each of the four UK nations. The College's level of engagement with individual stakeholders depended on the need at different points in the pandemic for collaboration and coordination in order to most

effectively address the needs of pregnant women, and support maternity services. Whilst capacity challenges within individual organisations restricted engagement at times, the College valued enhanced collaboration from highly committed individuals and teams who recognised the challenges the pregnant population and their families faced, and were eager to support the work of the College.

14. The College maintained regular contact with at least one senior stakeholder with influence on, or responsibility for, maternity care and women's health from each of the four home nations. This collaboration was essential to ensuring guidance was suitable and consistent across different health systems in order to provide the best care possible for pregnant women and those accessing wider reproductive and gynaecological healthcare services during the pandemic. The key contact(s) and the organisations they represented varied by nation, and as a College we relied upon these contacts to act as a conduit for two-way communication between the RCOG and UK Governments, NHS and public health bodies in each nation. Overall, most engagement was with maternity stakeholders in England due to the size of the population. The RCOG had lesser but still substantive engagement in Scotland and Wales, and less regular engagement with stakeholders in Northern Ireland.

15. Regular engagement with national clinical leaders was central to the RCOG's ability to contribute to the UK COVID-19 response. National clinical leaders that the RCOG engaged with included (but were not limited to): the Chief Medical Officer (CMO) for England, Professor Sir Chris Whitty; the Deputy CMO for England, Professor Dame Jenny Harries; the Chief Nursing Officer (CNO) for England, Dame Ruth May; the Chief Midwifery Officer for England, Jacqueline Dunkley-Bent; the CMO in Scotland, Dr Catherine Calderwood; the Senior Medical Officer for Maternity and Women's Health in Scotland, NR NR; National Clinical Director for Maternity at NHS England, Dr Matthew Jolly; National Specialty Advisors for Obstetrics at NHS England, Dr Misha Moore, NR NR and Dr Donald Peebles; the National Medical Director at NHS England, Professor Stephen Powis; the Senior Medical Officer for Maternal and Child Health in Welsh Government, Dr Heather Payne; and the Senior Medical Officer in Northern Ireland, Dr Carol Beattie.

16. Alongside collaboration with national clinical leaders, RCOG regularly engaged with working-level officials in Government and arms-length bodies, principally the maternity team in the Department for Health and Social Care, the Maternity Transformation Programme at NHS England, and colleagues in Public Health England and Health Protection Scotland. Direct engagement with Secretaries of State and Ministers across all four nations responsible for health was less common, and tended to be via correspondence with clinical leaders or informal correspondence with Special Advisors (spAds), with no letters regarding maternity care directed at Government Ministers.

17. Through these relationships with stakeholders, the RCOG was able to advise Government and arms-length bodies in relation to COVID-19 and women's health. This advice pertained to the health of pregnant women, guidance for professionals on the delivery of maternity and gynaecological care, and the occupational health of pregnant women and healthcare workers. Much of this advice was provided following requests from Government or NHS stakeholders for input into or review of planned guidance or policy changes. Channels of communication also allowed the RCOG to raise issues where necessary, and to ask for reciprocal input into RCOG guidance and resource development. The majority of advice to Government, public health and NHS bodies from RCOG was provided via email correspondence, phone calls, virtual meetings and WhatsApp messages. This correspondence was frequent, particularly in the early months of the pandemic when correspondence was often exchanged daily.

18. From the College's perspective, we maintained effective working relationships with Government, NHS and public health bodies throughout the pandemic, with the majority of communication and collaborative work being well-coordinated and complementary. There are many examples where guidance was jointly developed and correspondence early in the pandemic highlighted the benefit of close collaborative working with stakeholders such as NHS England and noted the benefit of consolidating collaborative working going forward. Over the period of the pandemic, there were however some examples where there was less clarity over responsibility for delivery of guidance and resources, which we detail later in this witness statement.

19. There needs to be adequate capacity within arms-length bodies across the NHS and public health to facilitate a swift response in the event of a pandemic or public health crisis.

This must include clear routes for urgent engagement with professional bodies and specialist organisations to collaborate and coordinate efforts to respond to the pandemic or public health crisis, where roles and responsibilities are clearly defined for the development and delivery of guidance for maternity professionals and information for pregnant women and their families.

Guidance and information for healthcare professionals working in maternity care and women's health

20. As the professional body for Obstetricians and Gynaecologists in the UK, a key part of the RCOG's remit is the development of clinical guidance. Clinical guidance developed by the RCOG is used by healthcare professionals to inform clinical best practice, they can also be used by commissioning bodies to inform the services they provide, and by providers (such as NHS Trusts or Health Boards) if they opt to use them to inform their clinical and operational policies at provider-level. RCOG guidance presents recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians/gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available. This means that RCOG guidance are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

21. Through the vehicle of the COVID-19 Guidance Cell, the College produced a comprehensive suite of guidance for healthcare professionals relating predominantly to the delivery of maternity services and the care of pregnant women during the COVID-19 pandemic. At the request of the office of the Chief Medical Officer, the RCOG, the RCM and the RCPCH led on developing guidance on managing COVID-19 in pregnancy. This work was in collaboration with NHS England, PHE and HPS, as well as other professional bodies and expert organisations including the RCoA, the OAA, and RCOG specialist societies [EM/1 - INQ000308950]. EM/1 - INQ000308950 provides a list and brief description of all RCOG Specialist Societies, many of whom collaborated on guidance during the COVID-19 pandemic.

22. In the early months of 2020, there was limited evidence around the impact of COVID-19 in pregnancy. Alongside this, the wider health system and Government response to the emerging pandemic was quickly evolving, with new guidance and regulation being introduced rapidly. The RCOG guidance development process was equally rapid, with the first version of 'Coronavirus (COVID-19) Infection in Pregnancy: Information for healthcare professionals' published on 9th March 2020 [EM/2 - **INQ000176662**]. A further four iterations of the guidance were published within the month of March 2020.

23. The standard process for the development of RCOG Guidance follows a robust and comprehensive production process, overseen by a guideline committee, and takes many months from proposal to publication. An information leaflet describing the RCOG guidelines process is exhibited with this statement [EM/3 – INQ000308972]. It was recognised early that this process would not fulfil the urgent need for guidance on the frontline of a global pandemic and instead a decision was made to develop RCOG's first ever 'living guidance'. The early versions of the guidance were drafted collaboratively by RCOG Officers and Clinical Fellows (O&G doctors, often in specialist training, who are seconded to the RCOG to support the work of the College). The RCOG Clinical Fellows, supported by the RCOG library undertaking frequent literature searches, identified new sources of evidence as they became available and extracted relevant data. This emerging evidence would be presented at meetings of the COVID-19 Guidance Cell, which met at least daily at the beginning of the pandemic. The Cell would review the emerging evidence, and identify necessary additions or changes to guidance as appropriate. Due to the speed at which evidence emerged, the Cell members frequently communicated outside of meetings via WhatsApp and email, and additional extraordinary meetings were called when necessary. This enabled the guidance to be updated and communicated on a weekly basis at the start of the pandemic, providing frontline maternity professionals with the best up-to-date advice. Following the end of the first wave of COVID-19, the situation had stabilised enough to reduce the need to update the guidance so frequently.

24. In order to manage a significant increase in queries from healthcare professionals and the public, on 23rd March 2020 the RCOG set up a COVID-19 email inbox to provide a central contact point for RCOG members, healthcare professionals and for members of the public. The inbox was monitored throughout the pandemic. All responses to these queries received were drafted by RCOG staff based upon our published guidance and

information and were reviewed for accuracy by RCOG Clinical Fellows before they were sent. Over the period it was open, the College received and responded to 1682 queries sent to the COVID-19 inbox. The inbox was also used by RCOG and RCM members to provide feedback on the guidance, and ask for additional topics to be covered. These requests were then considered by the COVID-19 Guidance Cell.

25. This new process for developing 'living guidance' enabled the College, almost always in partnership with other expert organisations, to produce additional guidance to support the delivery of maternity and gynaecological healthcare during the pandemic. This included guidance on: antenatal and postnatal services, antenatal screening and ultrasound, COVID-19 and abortion care, early pregnancy services, fetal medicine units, staffing frameworks, maternal medicine services, midwife-led settings and home birth, occupational health, restoration and recovery, and testing and triage. Guidance was communicated to RCOG members through existing communication channels, which were membership emails, the RCOG website and social media accounts, alongside an option for members to be notified via email each time guidance was updated. A full summary of all RCOG guidance produced during the pandemic has been provided with this witness statement [EM/4 – INQ000308983]. All versions of the guidance can be provided to the Inquiry if requested.

26. From guidance published on 21st March 2020 onwards, the College was transparent about this process; clearly communicating through the use of a standardised statement across all guidance that the advice provided was based on a combination of the best available evidence, good practice and expert advice, and that the guidance was a 'living' document that would be updated as and when new information became available [EM/5 – INQ000308994]. The statement clearly outlined that, as with all RCOG guidance, the ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available. A similar statement was also applied to information provided by the College for pregnant women. These standardised statements ensured the College was transparent about the process it was following to deliver a regular stream of frequently updated guidance and information in response to the rapidly evolving, but initially limited, evidence base.

27. As I mention above, the College worked closely with Government and arms-length bodies, chiefly NHS England and Public Health England, on the development of guidance for maternity services, and this was predominantly a positive experience. However, there were times when guidance which we felt should have been the responsibility of the Government, NHS or public health, was not forthcoming or was too slow to appear. As a result, the RCOG and the RCM stepped forward to develop guidance that was outside our established remit as a charity and professional body - such as guidance for pregnant healthcare workers. This was done to fulfil an urgent need from the frontline. Understandably, with the speed at which the pandemic emerged, at the very start of the pandemic there are also examples of replicated efforts between the Colleges and NHS England and Public Health England on the development of guidance, but effective communication quickly addressed this.

28. In the event of a pandemic or public health crisis, professional bodies are well-placed to develop clinical guidance within their specialty. The RCOG demonstrated this with the COVID-19 in Pregnancy guidance. It is the responsibility of Government or the NHS to develop overarching guidance on changes to the delivery of care that might be necessary in the event of a pandemic, such as on infection control or rationalising care. As the College did during the COVID-19 pandemic, professional bodies can contribute clinical expertise and develop guidance that provides evidence to guide decisions on rationalising care (for example on safe modifications to pathways) and specialty-specific applications of general guidance on subjects such as infection control or testing. The RCOG will always support the Government and NHS response to a pandemic or public health crisis by providing clinical expertise, but there must remain capacity in these organisations to take the lead on timely, comprehensive overarching guidance.

29. The development and sign-off processes led by arms-length bodies including NHS England and Public Health England also sometimes caused delays in publishing guidance critical to supporting frontline delivery of care, or information and resources for pregnant women. These sign-off processes, from an external stakeholder point of view, often appeared complex and inflexible given the extreme circumstances. Early in the pandemic, the RCOG was informed that it was mandatory for any guidance going out to the System via NHS England to go via the Single Point of Contact (SPOC) system. The benefit of SPOC from an external stakeholder organisation's point of view was the potential for

guidance to be taken up more comprehensively and consistently by the system, but the RCOG had concerns that the process could create an additional barrier in ensuring that maternity professionals had access to the most up-to-date guidance. Following engagement with NHS England, it was agreed that RCOG guidance, once it had been through our robust internal review process, would be published on our website and communicated directly to our members, and would be sent to the SPOC team for information. There was no point at which RCOG publications were challenged by SPOC.

Information and advice for pregnant women and girls

30. Throughout the pandemic, the RCOG played a key role in providing information and advice for pregnant women and their families. A key function of the College as part of its standard guidance development process, and with involvement from its Patient and Public Involvement Team, is the production of patient information materials for healthcare professionals to disseminate to their patients and for patients to access directly via the RCOG website.

31. Information for pregnant women about COVID-19 was published on the RCOG website in an accessible Question and Answer (Q&A) format. The College published its first Q&A for women and families on COVID-19 in pregnancy on 9th March 2020, to coincide with the publication of the first version of RCOG clinical guidance on COVID-19 in pregnancy [EM/6 – INQ000308998]. The RCOG Q&A for pregnant women and families was continually updated throughout the COVID-19 pandemic to reflect the most up-to-date RCOG clinical guidance and the guidance and regulations from Government and arms-length bodies. Additional questions were also included in the Q&A based on queries the College was receiving directly from women or women's groups through the RCOG COVID-19 inbox, or through social media and media requests. Over the period the Inquiry is considering, the RCOG produced 26 versions of the Q&A for pregnant women and their families.

32. It is of the utmost importance to ensure that information for pregnant women during a pandemic or public health crisis is high quality and evidence-based, and kept up-to-date. Pregnant women often feel anxious and uncertain when it comes to making the right decisions for the health of them and their baby, and the pandemic showed how this anxiety

increased when evidence around risk was lacking, or when guidance was seen as confusing. A study published in June 2021 titled "Anxious and traumatised": Users' experiences of maternity care in the UK during the COVID-19 pandemic' (Sanders & Blaylock) looked to understand the impact of COVID-19 public health messaging on maternity care users. With data collected between June and September 2020, a survey undertaken as part of the study showed that over half of pregnant women surveyed said they found public health advice related to COVID-19 either somewhat, or very, unclear and confusing [EM/7 –INQ000308999]. This confusion created anxiety amongst the pregnant population, many of whom wrote to the RCOG through the COVID-19 inbox or on social media to request clarification.

33. One key example of this was at the start of the pandemic when the Government took the precautionary measure to define pregnant women as at increased risk from COVID-19, or in the 'clinically vulnerable' group. This decision was based on the principle that, although there was no evidence at the time that COVID-19 carried higher risk for the pregnant population, the changes in the immune system as a result of pregnancy are associated with more severe symptoms in other viral infections such as influenza.

34. On 16th March 2020, the Government outlined which groups should adhere to limitations on social contact most stringently, and this included pregnant women. The Chief Medical Officer, Professor Chris Whitty, then signposted to RCOG guidance in response to a follow-up question from a journalist. However, as the College had not been adequately briefed on the decision to include pregnant women in this category as a precaution, our guidance did not align with this message. The College's position at this time was that pregnant women did not appear to be more susceptible to the consequences of infection with COVID-19 than the general population [EM/8 – INQ000309000]. Although, as established in the press release exhibited with this witness statement [EM/9 – **INQ000176664**], we were supportive of the Government taking a precautionary approach for pregnant women in light of limited evidence, the impact of this decision not being adequately communicated with the College in advance was significant. It resulted in RCOG guidance, which the Chief Medical Officer had pointed to during the briefing, not aligning fully with the Government's messaging, causing additional unnecessary confusion for pregnant women and their families.

35. Delays in ensuring access to evidence-based, high-quality information can create a vacuum which is very quickly filled by misinformation, or worse still with disinformation. This can lead to pregnant women making decisions based on information that is inaccurate or incorrect, and engaging in behaviours that are detrimental to their health or the health of their pregnancy. It can also create a loss of trust in institutions including Government, public and professional bodies. This loss of trust could inhibit organisations reaching pregnant women and the wider public with important information about their health in the future.

36. Initially, the RCOG was clear it would prefer information for pregnant women to be held centrally on the NHS website, given this was an established channel for disseminating such information and had the highest possible reach. However, through communications with the NHS UK on the process for updating information on the NHS website, we felt that if detailed information and advice for pregnant women was held by the RCOG, we could more easily ensure it was reviewed and kept adequately up-to-date at the speed required. This was agreed by NHS England. The RCOG therefore continued to provide Q&As for pregnant women on our website as best we could with the limited resources we had, under significant time pressure.

37. By 16th March 2020, the NHS UK website linked to the RCOG Q&A for pregnant women. In a leaflet accompanying a letter sent by the Prime Minister to all UK households at the end of March 2020, the RCOG was referred to as the place to go for information regarding pregnancy and COVID-19. The College quickly became a central reliable source of information for pregnant women and their families on COVID-19 in pregnancy. Our channels to directly communicate with women grew, with significant growth in our social media reach (our Instagram audience grew by 386% in 2020) and a significant and sustained high level of media enquiries with regards to COVID-19 in pregnancy. We also collaborated with organisations with a strong reach directly to women, such as MumsNet, with whom we developed collaborative resources such as YouTube videos.

38. The study referenced above, titled “Anxious and traumatised”: Users’ experiences of maternity care in the UK during the COVID-19 pandemic, noted that ‘many participants had informed themselves on the rapidly changing guidance relating to pregnancy and birth from the RCOG but reported frustration at the lack of direct communication from NHS

organisations' [EM/7 – INQ000308999]. This demonstrates the importance of direct communication from Government and NHS at a national level, supported by individual providers.

39. Being a central source of information for pregnant women and their families came with challenges as a non-governmental organisation. At times, the College was placed in a difficult situation where we were required to interpret central Government guidance and regulations put in place to reduce the spread of COVID-19 and protect the public, and communicate how these specifically related to pregnant women, and to the delivery of maternity care. This was sometimes challenging when changes to guidance relevant to pregnant women were not always communicated in advance to us by Government or NHS stakeholders, limiting our ability to ensure pregnant women had timely access to correct, accurate advice and information. It was also challenging because we did not initially have the established communication channels and budgets to ensure our information reached pregnant women, which Government and arms-length bodies already had.

40. It is the view of the RCOG that in the event of a future pandemic or public health crisis, there must be provision for increasing capacity so the Government and its arms-length bodies can provide information and advice that can be updated and communicated at pace to the population, tailored to specific groups as appropriate. The RCOG and other non-governmental bodies were called upon during the pandemic to provide up-to-date, tailored communication of the impact of COVID-19 in pregnancy and the impact of evolving Government guidance and regulations on the pregnant population. Notwithstanding the fact that the RCOG is proud of the positive and substantial contribution it made to providing information and advice to pregnant women during the COVID-19 pandemic, we believe this should have been the responsibility of Government and arms-length bodies first and foremost.

Advice for pregnant healthcare workers and occupational health guidance

41. The speed at which the COVID-19 pandemic started to impact hospital settings meant that even prior to the announcement on 16th March 2020 advising pregnant women to stringently follow advice on reducing social contact, the RCOG was receiving requests for advice from pregnant healthcare workers. The RCOG had reservations about providing

guidance for pregnant healthcare workers, as providing occupational advice did not fall within our established remit as a charity and a professional body. I raised this challenge with stakeholders in the Chief Medical Officer's team, and at NHS England, via an email stating we would defer to official CMO or PHE advice with regards to pregnant healthcare workers. Stakeholders acknowledged this challenge, and agreed to raise it with the Deputy Chief Medical Officer.

42. However, in light of continued queries to the RCOG from pregnant healthcare workers and what was felt as a slower than hoped for response from Government bodies, pressure built to meet this need. On 18th March 2020, I shared a draft of guidance for pregnant healthcare workers with stakeholders including Dr Jenny Harries and Dr Catherine Calderwood for review, which opened up a discussion between stakeholders and officials with regards to the gestational age where it was felt women should be considered at higher risk. This was in the context of the fact that pregnant women were now included in the 'clinically vulnerable' group and encouraged to stringently follow advice on social contact as a precaution. Given there were significant numbers of pregnant healthcare workers in the NHS, it was important also to consider the impact of any guidance on staffing levels. The College was concerned that without a change in the broader official Government guidance to delineate risk between pregnant women before and after 28 weeks' gestation (the point at which stakeholders agreed the risk increased) it would be difficult for guidance to be implemented. However, whilst this change was never made formally in Government advice, the College's decision to base occupational health advice on the increased risk to pregnant women after 28 weeks' gestation has been shown to be sensible, with evidence now showing this reflects the risk in relation to pregnancy and COVID-19.

43. The occupational health advice published by the RCOG and the RCM was based on the clinical evidence available at the time. It outlined the risks of contracting COVID-19 in pregnancy, and was based around the central aspect of existing protections in law for pregnant women and the need to conduct a risk assessment. The College was clear that in light of limited evidence, pregnant women of any gestation should be offered the choice of whether to work in direct patient-facing roles during the pandemic, and this choice should be supported by their employers. It also provided advice on suitable alternative duties.

44. Following review and agreement from Jenny Harries, Catherine Calderwood and Professor Chris Whitty, RCOG and RCM joint guidance for pregnant healthcare workers was included in an updated version of the RCOG Coronavirus (COVID-19) Infection in Pregnancy guidance [EM/5 – INQ000308994], and then published as separate guidance [EM/10 – NQ000308951]. As lockdown restrictions lifted, and as a result more pregnant women required occupational health guidance as their workplaces re-opened, we felt it important to reiterate our position that the responsibility for provision of occupational health advice for pregnant workers needed to sit with PHE. With the RCM and the Faculty of Occupational Medicine (FOM), RCOG wrote to PHE on 18th May 2020 to ask them to take on the role of delivering this guidance, offering our support as clinical advisors [EM/11 – INQ000308952]. A response to this letter was not received until 11th June 2020, and did not show a willingness to engage with the College or to deliver the requested guidance [EM/12 – **INQ000280470** The College then spent months encouraging Government via emails and meetings to take responsibility for the occupational health guidance for pregnant women. In September 2020, we took the decision with the RCM and the FOM to archive our guidance on Occupational Health, making it clear that organisations could continue to use the clinical risk assessments and information that had been included in the broader RCOG Coronavirus (COVID-19) Infection in Pregnancy document [EM/13 – INQ000308954]. In October 2020, the DHSC agreed that its maternity policy team would be responsible for developing guidance on Occupation Health, to which the College contributed clinical expertise throughout the pandemic.

The impact of the COVID-19 pandemic on pregnant women and maternity care

45. The forum provided by the COVID-19 Guidance cell ensured RCOG and other key national stakeholders were able to closely monitor issues arising that were impacting pregnant women and maternity care services and act wherever possible to lead on or support action to address these issues, when appropriate.

46. Women's access to and experience of maternity care across primary, secondary and community care services was significantly impacted by the COVID-19 pandemic. The additional pressure on the health service due to the need to care for patients with COVID-19, the impact of staff sickness and isolation on available capacity, and the impact of infection control measures in health settings and in the community, all created significant

challenges to the delivery of quality maternity care throughout pregnancy and the postnatal period. A lack of timely clear information and guidance, tailored to the unique needs and health of pregnant women, from Government and arms-length bodies also added to understandable anxiety and uncertainty felt by pregnant women during the pandemic, which also created additional barriers to high-quality maternity care.

The impact of the COVID-19 pandemic on antenatal and postnatal care

47. High-quality antenatal support is an essential element of maternity care. It provides the opportunity to identify and address potential clinical problems for mother or baby arising in pregnancy such as pre-eclampsia, gestational diabetes, asymptomatic urine infection and poor growth of the baby, and reduces the chance of poor outcomes for both women and their babies. Antenatal care is essential for all pregnant women, but is particularly important to identify and support women with underlying medical conditions or obstetric complications.

48. At the start of the pandemic, there were instances reported to the College and directly to me in my own Trust, where blanket changes to service provision to maximise capacity to manage COVID-19 patients were not based on evidence and did not recognise the importance of antenatal appointments as part of an essential service. For example, the blanket cancellation of outpatient care and the move to telephone or remote appointments being applied to antenatal care, with reports from colleagues that some Trusts were moving to implement changes to antenatal services that would make them predominantly remote. It was crucial, when services were managing with limited capacity during the pandemic, that modifications to the delivery of antenatal care were implemented based on available evidence in order to safeguard outcomes for women and their babies. At the RCOG and the RCM, we felt we had a role in supporting maternity unit staff in communicating this to service managers in order to protect the delivery of safe antenatal care.

49. To provide support for maternity services implementing safe, evidence-based modifications to antenatal care, the RCOG published several pieces of guidance: guidance for antenatal and postnatal services in the evolving pandemic [EM/14 – **INQ000176666** which was first published on 30 March 2020; guidance for antenatal

screening and ultrasound in pregnancy [EM/15 – INQ000308956] which was first published on 23 March 2020; and guidance for maternal medicine services [EM/16 – INQ000308957] which was first published on 3 April 2020 and provided specific recommendations on the delivery of services that support women with co-morbidities (medical conditions) that require additional antenatal monitoring and care.

50. In the early days of the pandemic, the COVID-19 Guidance Cell was made aware of reports from members and midwifery colleagues that there was an increase in women not attending antenatal appointments. This was likely to be at least in part due to the strength of the 'stay at home' messaging and the Government's decision to take the precaution to categorise all pregnant women as 'clinically vulnerable' and advising them to avoid all unnecessary social contact. Findings from surveys undertaken between June and September 2020 in the study "Anxious and traumatised": Users' experiences of maternity care in the UK during the COVID-19 pandemic' (Sanders & Blaylock) support the reports we were receiving at the time. With 11% of respondents saying they had missed an antenatal appointment, with the most cited reason being worry about contracting COVID-19 [EM/7 – INQ000308999]. The College was seriously concerned to hear that women were not attending for antenatal care, as non-attendance would adversely impact outcomes for women and their babies. A study on the 'Change in the Incident of Stillbirth and Preterm Delivery During the COVID-19 Pandemic' (A Khalil et al, August 2020) looked at the early months of the pandemic did show an increase in adverse outcomes for women who were not infected with the SARS-CoV-2 virus, and these could be linked to a reluctance to attend hospital settings [EM/17 – INQ000308958].

51. The College's messaging throughout the pandemic was unambiguous that antenatal care was essential, and consistently put emphasis on the need for women to attend their antenatal appointments through our Q&As for pregnant women and families, and through media and social media. RCOG published its first guidance on modifications to antenatal care in response to this concern on 31 March 2020, and were very clear across our messaging directed at services and directly at women that antenatal care was essential care, and should be attended [EM/18 – **INQ000176665**]. RCOG guidance on modifications to antenatal care provided frontline staff with evidence on the safe introduction of changes to antenatal care that safeguarded essential parts of the service, whilst increasing the use of remote care wherever it was deemed safe. Guidance was clear that services must

maintain a minimum of six face-to-face consultations during pregnancy. A national survey of obstetric units was undertaken between May and July 2020 with the aim of exploring modifications to standard care. The findings of this survey were published in November 2020 in a study titled 'Maternity services in the UK during the coronavirus disease 2019 pandemic: a national survey of modifications to standard care' (J Jardine et al), which was co-authored by experts in obstetrics and midwifery, including myself and other RCOG representatives. The study found substantial modifications to antenatal care, with 70% of units reporting a reduction in antenatal appointments, and 89% reporting using remote consultation methods [EM/19 – **INQ000176659**] The survey showed that many units had implemented the recommended modifications to services proposed in RCOG guidance, in order to maintain safe levels of care while managing reduced capacity caused by the COVID-19 pandemic.

52. The increased use of remote appointments for antenatal care during the pandemic was required as a pragmatic approach to balance the need to reduce the risk of transmission of infection to both pregnant women and healthcare staff, with the need to ensure the continuation of essential antenatal services. The RCOG guidance aimed to support NHS organisations to implement remote appointments safely and to provide clarity on the minimum number of face-to-face appointments required to ensure safe levels of care. Studies that heard from women during and following the pandemic have shown that experiences of remote appointments were mixed and, whilst there were benefits, for many women remote appointments did not always meet their needs. Studies that illustrate experiences of remote appointments during the pandemic include; 'Maternity care during COVID-19: a qualitative evidence synthesis of women's and maternity care providers' views and experiences' (S J Flaherty et al, May 2022) [EM/20 – INQ000308962], and a study I co-authored titled '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' (B Karavadra et al, October 2020) [EM/21 - INQ000308963].

53. Although the modifications to antenatal care introduced by many maternity services during the pandemic were almost certainly necessary in the circumstances, it is crucial that the impact these changes had on women and their families is recognised and that the essential nature of antenatal care and support is truly recognised in responses to future

pandemics and public health crises. It is also important that these services are prioritised and protected as far as possible in the future.

54. The RCOG issued some advice within our published guidance on the increased use of technology in maternity services during the pandemic to allow appointments and care to take place remotely when safe to do so. There was no reliable evidence on the replacement of face-to-face appointments with remote appointments, and therefore guidance was based on evidence for the need for at least six face-to-face antenatal appointments for women considered to be at low risk. Guidance was clear that remote appointments could be used to replace some routine appointments, as well as for providing enhanced support (additional to face-to-face appointments) for women at risk of or currently experiencing mental health problems, and for maintaining additional contact with families living with a range of vulnerabilities or where safeguarding concerns existed. RCOG guidance was clear throughout the pandemic that pregnant women would continue to need at least as much support, advice, care and guidance in relation to pregnancy, childbirth and early pregnancy as before the pandemic, and that there must be a continued focus on supporting women with multiple complex needs. We were clear that women living with increased or complex needs including poverty, homelessness, substance misuse, being an asylum seeker, experiencing domestic abuse, or mental health problems required timely expert support, and that care should be personalised, with individual care plans.

55. The RCOG was also concerned about the impact of the COVID-19 pandemic on women experiencing domestic abuse. Reports at the start of the pandemic of an increase in domestic abuse were widespread. There is evidence, even prior to the pandemic, that pregnancy is a time when domestic violence can often start or worsen. The MBRACE-UK rapid report 'learning from SARS-CoV-2-related and associated maternal deaths in the UK' was published in August 2020 and looked at data from the first three months of the pandemic (March – May 2020). It showed that of the 16 pregnant or postnatal women who died during that period, four died by suicide and two due to domestic violence [EM/22 – **INQ000221912**. In November 2020, the RCOG, alongside the RCM and the Royal College of Psychiatrists, launched a campaign called 'All the women we won't miss' which supported healthcare professionals to spot signs of violence and abuse, and direct women to places of safety and support [EM/23 – INQ000308965]. It is crucial that, as outlined

above, pathways introduced during the pandemic (such as increased use of remote appointments) do not prevent healthcare professionals from identifying and acting on concerns around domestic abuse.

56. On 30 March 2020, the RCOG also published a specific piece of guidance on self-monitoring of blood pressure at home in pregnancy, in order to reduce the need for face-to-face consultations whilst maintaining safe care [EM/24 – INQ000308966]. This guidance was for pregnant women who required blood pressure monitoring throughout antenatal and postnatal care, particularly those who require it more frequently such as those with chronic hypertension, gestational hypertension or pre-eclampsia. The guidance was based on the previously available evidence on the safe and effective use of home blood pressure monitoring in pregnant women.

57. The COVID-19 pandemic also had a substantial impact on the delivery of postnatal care. Acute staffing pressures in maternity settings created instances where staff were redeployed away from postnatal wards to support the delivery of intrapartum care, and this likely had an impact on womens' experiences of care. This was exacerbated by limitations to visitation in postnatal wards, meaning women were often left to look after their baby with limited support on wards. This, alongside concern among women and healthcare professionals regarding in-hospital transmission of COVID-19, created an environment where women were often discharged from postnatal settings faster than they ordinarily would. Rapid discharge from postnatal settings sometimes reduced the care and support provided, in particular around breastfeeding. We also know that restrictions on social contact throughout the pandemic increased women's experiences of isolation and loneliness during the postnatal period, and that women felt that both informal support (from friends and family) and formal support (from healthcare professionals) were not sufficiently bridged virtually. These experiences were highlighted in a study published in September 2022 titled 'Postpartum women's experiences of social and healthcare professional support during the COVID-19 pandemic: a recurrent cross-sectional thematic analysis, published (L Jackson et al.) [EM/25 – INQ000308967]. RCOG guidance on postnatal care was clear that it should be individualised according to the needs of the women and the newborn baby, recommending a minimum number of contacts [EM/14 – **INQ000176666**]. Our guidance also encouraged services to prioritise face to face visiting for women with known psycho-social vulnerabilities, experience of operative birth, premature or low

birthweight babies, or other medical or neonatal complexities. We encouraged continuity models of care to continue wherever possible when these were in place, even in the delivery of remote postnatal care.

The impact of the COVID-19 pandemic on intrapartum care

58. The COVID-19 pandemic had a major impact on the delivery of intrapartum care. Service reconfigurations and modifications were introduced to intrapartum care to mitigate against the impact of pressure on services created by the pandemic, as well as guidance recommending changes to intrapartum care for women who had suspected or confirmed COVID-19. We know that changes to intrapartum care impacted the choices that women had in terms of their birth plan, and in particular around their choice of place of birth. One study titled 'Giving birth in a pandemic: women's birth experiences in England during COVID-19' (E Aydin et al, April 2022) found that 25% of respondents reported their birth plan changed due to the impact of COVID-19 [EM/26 – INQ000308968]. For many women, this alone may have created a poorer experience of childbirth. Restrictions on birth partners was an important issue consistently raised by women and their families throughout the pandemic, negatively affecting their experience of labour and birth. A more detailed consideration of the challenges associated with allowing visitors in maternity settings, and restrictions on birth partners, will be covered later in this witness statement.

59. For women with suspected or confirmed COVID-19 when they went into labour during the pandemic, RCOG guidance on Coronavirus in Pregnancy provided advice to healthcare professionals on provision of high-quality care that mitigates the risk of fetal deterioration due to infection, and recommended birth in an obstetric unit. Guidance was clear that there was no evidence to favour one mode of birth over another in women with COVID-19, unless the woman's condition demanded urgent delivery. Guidance was clear that having COVID-19 should not limit a woman's access to a full range of pain relief options. However, as it was considered that there might be a risk of infection via faeces and concerns over Personal Protective Equipment (PPE), joint RCM and RCOG guidance recommended against the use of birthing pools for COVID-19 positive women [EM/2 – **INQ000176662**

60. From the start of the pandemic, the priority of the RCOG, alongside our colleagues at the RCM, was to support the NHS to prioritise the delivery of safe, quality intrapartum care that safeguarded positive outcomes for women and their babies. It was clear from the start of the pandemic that there was a strong likelihood that staffing shortages in maternity care would put acute pressure on service delivery. Practical guidance was led by the RCM and jointly published by the RCOG/RCM on 9th April 2020 on the provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic [EM/27 – INQ000308969]. This set out a staged approach which supported, whilst staffing levels and ambulance services were able, the continuation of home births and births in midwife-led units for low-risk pregnant women, in order to reduce the risk of transmission of COVID-19. This later moved to centralisation of services into midwife-led units and obstetric units, resulting in restrictions to and then suspension of home birth services. It was clearly communicated that the changes in the guidance should be reviewed daily and services re-instated as soon as safely possible. RCOG also published a framework for staffing of O&G services which also recommended evidence-based changes to clinical practice with regards to induction of labour and consolidating appointments for women due to be admitted for planned caesarean birth, with formal guidance published in PDF form on 22 May 2020 [EM/28 – INQ000308970].

61. The RCOG was consulted and provided clinical input on the publication of NHS England guidance on the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic, which was first published on the 9th April 2020 [EM/29 – **INQ000421169**]. The RCOG welcomed this guidance from NHS England, and linked directly through to it from our guidance as appropriate. The guidance was clear that maternity care was a core service that required adequate staffing and access to facilities. The guidance also set out the need for services to implement a progressive approach to keeping as many birth options open for as long as possible and setting out conditions that Trusts must meet before suspending intrapartum care options. The guidance also provided clear instructions for the system on the importance of working across Local Maternity Systems to manage capacity.

62. Findings from the study 'Maternity services in the UK during the coronavirus disease 2019 pandemic: a national survey of modifications to standard care' (J Jardine et al), which collected data in May and June 2020, showed significant changes to the delivery of

intrapartum care. 48% of respondents reported removal of previously offered birth settings (either home births or midwife-led units), 26% reported changes in provision of water births, 9% reported additional resources (staff or space) requested from another local maternity unit, 14% reported suspension of some indications for induction of labour, and 4% reported that their service was unable to support caesarean sections without clinical indication [EM/19 – **INQ000176659** .

63. These major changes to intrapartum care had an impact on women's experiences of care. It is important, however, to recognise that modifications to care strongly mirrored the evidence-based guidance that was produced at the time on reorganisation of care, and were a necessity to protect women and their babies. The pressures on maternity services that pre-dated the pandemic, in particular well-recognised staffing shortages, exacerbated the need to introduce these changes to care.

Birth partners and visitors in maternity care services

64. Throughout the pandemic, the impact of visitor restrictions in hospitals had a profound impact on the experiences of maternity care for women and their families. This in turn had an impact on the maternity professionals caring for them. Maternity services faced a major challenge: the need to balance the importance of birth partners and support people for women throughout their maternity journey, with the need to protect women and the healthcare professionals that work in maternity services from contracting COVID-19. Protecting staff is an important responsibility of an employer, and has a clear link back to delivering quality care for women, as staff sickness and isolation due to COVID-19 jeopardises safe staffing levels. The College faced the challenge of ensuring its guidance maintained the right balance in advocating on behalf of the safety of RCOG membership and other maternity staff, whilst advocating for women for whom restrictions on partners and support people in maternity care was undoubtedly having a negative impact on their experiences of care.

65. At the start of the pandemic, blanket NHS and Government guidance on the suspension of visitors to hospital was implemented, but provided exceptional circumstances, including being a birthing partner accompanying a woman in labour. There were examples in the media and shared through social media of overly strict application

of restrictions on birth partners, with stories of birth partners missing the birth because they were allowed in only when women were in active labour. This created additional anxiety for women prior to or in early labour who reportedly felt concerned that their birth partners would not be present to support them through active labour and the birth of their baby. RCOG guidance on COVID-19 in Pregnancy was clear that women should be permitted and encouraged to have a birth partner present during their labour and birth, at a minimum, pointing to clear evidence that having a trusted birth partner present throughout labour is known to make a significant difference to the safety and wellbeing of women in childbirth.

66. Having to attend ultrasound scans alone had a particularly stark impact on many women and their partners and families. Studies looking back at women's experiences have shown that this was particularly distressing for women who received bad news at a scan, and for women who had previously experienced pregnancy or baby loss. These experiences are explored in depth in the study 'Companionship for women/birthing people using antenatal and intrapartum care in England during COVID-19; a mixed-methods methods analysis of national and organisational responses and perspectives' (G Thomson et al, January 2022) [EM/30 – **INQ000236184**]. At the start of the pandemic, blanket Government and NHS guidance on hospital visiting meant that women had to attend ultrasound appointments alone, and this was reflected in RCOG guidance. Early in the pandemic this created concern from the public and from services regarding these limitations, and there were reports of women and their partners who could afford to do so choosing to access private scans so that partners could attend. There was much interest in women being able to FaceTime or Skype their partners into the scan, but we supported a joint position led by the Society and College of Radiographers (SCoR) against this for several reasons: it increased the length of time that sonographers and women were in close contact, thereby increasing the risk of transmission of infection; it could lead to women having a taut abdomen and impeding scanning; and it could increase the risk of distraction for the sonographer. The College instead encouraged policies that allowed women to share their experiences through a 10-30 second clip of the scan of the fetus at the end of examinations [EM/31 - INQ000308974].

67. Restrictions, most acutely at the start of the pandemic when blanket national policies were in place, were also applied to antenatal appointments and postnatal wards.

Restrictions to visitors in postnatal wards (for example, allowing no visitors or just one for short periods) were almost universal. In "Anxious and traumatised": Users' experiences of maternity care in the UK during the COVID-19 pandemic' (Sanders & Blaylock), many respondents reported that restrictions on postnatal wards had made them feel lonely, very unhappy, and in need of practical help which was not provided by staff [EM/7 – INQ000308999].

68. It is important to recognise that restrictions on partners and others providing support for women in antenatal settings, during scans and postnatal care, were also put in place to protect the staff working in those settings. Maternity professionals were often working in environments that were not conducive to reducing transmission of COVID-19 from women and partners or visitors. Much of the NHS maternity estate did not have adequate ventilation, and many units did not have adequate facilities with the space to maintain social distancing. In particular, ultrasound scans often take place in smaller rooms where clinicians are required to be in close contact with women; and labour and postnatal wards frequently do not have space to maintain an adequate distance between women. It is understandable that increasing the number of people in these spaces by including partners and visitors was a cause for concern to staff. This must be viewed in the context of the shortages of PPE outlined in this witness statement, and, especially at the start of the pandemic, no access to rapid testing.

69. For many providers, limiting attendance at appointments and scans likely felt the only feasible measure they could take to protect staff against contracting COVID-19, given the high rates of COVID-19 in the community and high numbers of asymptomatic carriers at the time. This situation was unsatisfactory for women and their families, and for the healthcare professionals supporting them who deserved to feel protected against COVID-19, but also able to deliver a positive experience of care to their patients.

70. Once national restrictions on hospital visiting were lifted across each of the nations after the first national lockdown, local organisations were then responsible for setting their own level of restrictions, based on local transmission levels of COVID-19. In July 2020, national guidance was published in Scotland, Wales and Northern Ireland on the reintroduction of visitors into hospitals and maternity settings, creating variation between

England and the devolved nations. There were also significant inconsistencies in restrictions across local Trusts in England.

71. The speed at which services reintroduced visitors in maternity settings, particularly in England, was seen by many women and advocacy groups as too slow, and there continued to be significant and growing media coverage of continued restrictions, and disparity in restrictions amongst different maternity units. An article by G Iacobucci published in the BMJ in October 2020 titled 'Partners' access to scans and birth is a postcode lottery, data show' highlighted findings from freedom of information (FOI) requests from public health academics at the University of Cambridge on restrictions on access to maternity services. FOIs found that at the end of August 2020, only 20 Trusts (25%) had lifted restrictions on partners and supporters' attendance at the 12-week scan, and 31 (38%) for the 20-week scan [EM/32 – INQ000308975]. It was also widely reported in the media that there was significant geographic variation on restrictions, which although in part likely reflected different local rates of COVID-19, was seen as a postcode lottery. A study exploring the impact of COVID-19 on companionship for women using maternity services in England during the pandemic found that policies on visitation had been inconsistently applied within English maternity services and concluded that in some cases policies were not justified relative to the risk posed and were applied indiscriminately [EM/30 – **INQ000236184**

72. To address this 'postcode lottery', the College felt it was important that NHS England published a national framework to support reintroduction of visitors in maternity settings. It was our position that this should be based on individual risk assessments and be flexible to local COVID-19 rates, so that it balanced protecting staff with giving women the support they need. Emails in July 2020 between RCOG, RCM, SCoR and NHS England show drafts of a proposed framework. The College appreciated the opportunity to feed into the development of such a framework, but felt strongly it should belong to NHS England and that they should publish it as quickly as possible. Getting this document published took far longer than was satisfactory, against the backdrop of women experiencing frustration and concern from a lack of flexibility and continued limitations on partners attending appointments and scans. The framework was then published on the 8th September 2020 [EM/33 – **INQ000280496** and was followed up with a letter to Directors of Nursing and Heads of Midwifery from NHS England to flag the new framework.

73. As COVID-19 rates increased nationally in the autumn of 2020, and the 'second wave' of the pandemic began, there was concern from women and advocacy groups that services would reinstate blanket bans on visitors and that the NHS England framework would be disregarded. This was followed by a decision by NHS England, at the request of the Secretary of State for Health and Social Care, to review the framework and update it in response to continued concerns being raised in the media and in Parliament that services continued to be overly restrictive on partners and visitors in maternity care, and that this was having a negative impact on women's experiences of care. RCOG contributed to the development of this updated guidance and, alongside the RCM and the SCoR, provided feedback on several iterations of the guidance to try and ensure there was a balance in the guidance so that it better met women's needs, whilst also continuing to provide adequate protection for our respective members. Some of the feedback provided by myself and colleagues at the time expressed concern that the guidance was taking a direction that the College would find difficult to endorse as it did not properly consider a number of practical and logistical concerns and did not consider fully the risk to staff. Although RCOG, RCM and SCOR continued to provide feedback on each version of the guidance, it was a joint decision that we would not endorse the guidance as we were not confident that all of the concerns we had raised, which were based around ten principles outlined by the RCM in a press release on 15 December 2020 [EM/34 – **INQ000280527** and supported by the RCOG in a press release on 16 December 2020 [EM/35 – INQ000308978]. During this period, there was also a lack of clarity around changes to legislation on isolation and whether these prevented COVID-19 positive women from having a partner or support person with them in labour. Until this was addressed it caused additional anxiety amongst pregnant women. Updated NHS England guidance was then published in December 2020 which continued to be used in England throughout the pandemic.

74. Some important learning from the COVID-19 pandemic in relation to maternity care services relates to the decisions made around birth partners and supporting people, and visitors in maternity settings. Much of this learning can be applied in the future only by addressing some of the underlying issues that made it so challenging to increase access for partners and support people in maternity settings during the COVID-19 pandemic. The NHS maternity estate needs to be fit-for-purpose, there needs to be good quality

ventilation systems, additional clinic space that allows for infection control measures to be properly implemented, and maternity wards need to be large enough to allow for the space between beds to properly socially distance. Pandemic preparedness with regards to PPE and to testing capacity would have also better supported maternity services to welcome support people and visitors far more rapidly.

75. With regards to birth partners in labour and birth, overly stringent application of guidance on birth partners resulted in instances where no birth partner or support person was present during active labour and birth. There were also reports in the media that women felt they had no option but to have a vaginal examination to prove they had entered active labour in order for their partner to be allowed to join them. The restrictions on birth partners during labour and birth during the COVID-19 pandemic were not acceptable, and have had an impact on women and their families. The NHS must learn from this, and ensure it is always able to maximise the amount of time a birth partner can be present during labour.

76. There is also learning in respect of partners and support people attending antenatal appointments, scans and being present on the postnatal ward. It is important that those developing guidance recognise the impact this had on experiences of maternity care for women and their families, and that guidance and policies always consider partners and support people in maternity settings as exceptional cases when it is necessary to implement restrictions on hospital visitors. Women and their birth partner or support person should be considered as a patient unit.

Impact of COVID-19 on pregnant women

77. At the start of the pandemic, there was a lack of evidence on the effect of COVID-19 on pregnant women, and whether there was an increased risk to pregnant women of severe illness from the virus. Early guidance produced by the RCOG stated that pregnant women did not appear more likely to contract COVID-19, but that pregnancy itself alters the body's immune system and response to viral infections in general, which can occasionally be related to more severe symptoms, and that this would likely be the same for COVID-19. Guidance also noted that there was no evidence to suggest there was an increased risk of miscarriage or early pregnancy loss in relation to COVID-19, and no

evidence of intrauterine fetal infection (infection passed through the womb to the fetus through the womb) so it was therefore unlikely that there would be congenital effects of the virus on fetal development [EM/2 – INQ000176662].

78. In line with the precautionary approach taken by the Government at that stage to include pregnant women in the group considered as 'clinically vulnerable' and asking them to avoid all unnecessary social contact, the RCOG provided guidance for healthcare professionals and directly to women on the current evidence, including highlighting that in other types of coronavirus (MERS, SARS) infection, the risk to the mother increased during the last trimester of pregnancy, and therefore women who were over 28 weeks' gestation could potentially be at higher risk [EM/5 – INQ000308994]. Throughout the pandemic, the RCOG guidance and advice for pregnant women continued to communicate the evidence as it evolved in relation to COVID-19 in pregnancy to allow healthcare professionals and women to make informed decisions around their care.

79. Since the start of the pandemic, there has been a growing body of evidence on the impact of COVID-19 in pregnancy such that there is now a far more comprehensive understanding of how COVID-19 affects pregnancy – all of which is included in the most recent version of the COVID-19 in pregnancy guidance, published in December 2022 [EM/36 – INQ000280483. Current evidence shows that pregnant women appear no more or less likely to contract COVID-19 than the general population, unless they have certain co-morbidities, these include pre-existing diabetes, a higher body mass index (BMI), and gestational diabetes on insulin. The majority of pregnant women infected with COVID-19 are asymptomatic, and most symptomatic pregnant women experience mild or moderate symptoms. However, pregnant women are at increased risk of severe illness from COVID-19 compared to non-pregnant individuals, especially in the third trimester when hospital admissions for COVID-19 appear to be more common. The overall risk of death from COVID-19 in pregnancy still remains low.

80. Up-to-date studies on the impact of COVID-19 on first and second trimester pregnancy loss (miscarriage) continue to show no increase in the risk of fetal loss prior to 20 weeks of gestation [EM/36 – INQ000280483][1]. Pregnant women with symptomatic COVID-19 are

[1] *See page 14 of 61 of RCOG COVID-19 in Pregnancy guidance (version 16)*

twice as likely to have a baby born early which exposes the baby to the risks associated with prematurity. However, this increased risk of preterm birth is not due to women being more likely to go into early labour. Rather, it is iatrogenic; in other words, it is more likely that the baby needs to be delivered early so that the woman can be treated effectively. International studies have also found that pregnant women who tested positive for COVID-19 at the time of birth were more likely to develop pre-eclampsia, more likely to need an emergency caesarean section, and had a risk of stillbirth twice as high [EM/36 – **INQ000280483**][2]. Nevertheless, the actual number of stillbirths in the UK associated with COVID-19 remains low.

81. Studies have found that pregnant women from Black, Asian and minority ethnic backgrounds were more likely than other women to be admitted to hospital for COVID-19 [EM/36 – **INQ000280483**][3]. Pregnant women over the age of 35, who had a BMI of 25 or over, or who had pre-existing medical conditions were also at greater risk of developing severe illness and requiring hospital admission. Living in an area or household with greater social and economic disadvantage is also known to increase the risk of developing severe illness in pregnant women.

82. RCOG's central guidance on coronavirus infection in pregnancy focused predominantly on the delivery of safe maternity care for all women during the COVID-19 pandemic, but in particular pregnant women with suspected or confirmed COVID-19. From March 2020, the guidance also provided advice for healthcare professionals on the care of pregnant women with moderate/severe symptoms of COVID-19 admitted to hospital during pregnancy and not in labour. Early in the pandemic, this guidance was based on clinical expertise of managing illness and infection during pregnancy. It pointed to the guidance available for care and treatment of adults diagnosed with COVID-19 (WHO, NICE) and then provided particular considerations for the care of pregnant women.

83. In the early months of the pandemic, clinicians caring for patients with severe COVID-19 built an understanding of effective management of this new disease, and clinical trials were started to identify safe and effective treatments for the care of patients with COVID-19. As guidance was strengthened on the care of adults requiring hospital admission for

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[2] *See page 7 of 16, RCOG COVID-19 in Pregnancy guidance (version16)*
[3] *See page 13 of 61, RCOG COVID-19 in Pregnancy guidance (version 16)*

COVID-19, RCOG guidance continued to signpost to this and provided additional advice specific to the care of pregnant women. As clinical trials identified safe and effective treatments for the care of patients with COVID-19, where these trials included pregnant women (e.g. the RECOVERY trial), and this evidence was communicated through RCOG guidance. Most clinical trials for COVID-19 treatments did not include pregnant women, at least in the initial safety phases, and therefore management of moderate to severe COVID-19 in pregnancy and use of antivirals and therapeutics relied upon clinical judgement, where the potential risks of any therapy were balanced against the benefits. The College consistently highlighted the importance of a multidisciplinary team (MDT) discussion when pregnant women were admitted to hospital with COVID-19 [EM/2 – **INQ000176662**].

84. Our guidance provided supporting information where the evidence was available on the care of pregnant women with severe COVID-19 and additional considerations relating to pregnancy, e.g. where additional or alternative tests and treatments should be considered [EM/2 – **INQ000176662**. In 2021, an MBRRACE review of the care of all pregnant and postnatal women who died with COVID-19 found that only one of the ten women who died was treated in accordance with the guidance developed by the RCOG [EM/37 – INQ000308980]. This demonstrated the importance of our guidance in caring for pregnant women with COVID-19. The College communicated this evidence to its members and key stakeholders as soon as it was published to emphasise the importance of following the regularly updated guidance [EM/38 – INQ000308981]. Throughout the pandemic, members were encouraged to sign up to receive alerts each time a new version of the guidance was updated; 15,000 individuals signed up for these updates. By the end of June 2021, the COVID-19 hub on the RCOG website had received over 5.2 million unique views, with both healthcare professionals and women regularly relying on RCOG guidance and information.

Inequalities in maternity care

85. Prior to the COVID-19 pandemic, existing evidence showed significant disparities in pregnancy outcomes for women and their babies in black, Asian and minority ethnic women compared to white women. The MBRRACE-UK 2019 report found that black women were five times more likely to die in childbirth than white women [EM/39 –

INQ000308982]. It was therefore immediately concerning to the College when evidence begin to emerge at the start of the pandemic that those from a black or ethnic minority background may also be at higher risk of developing severe complications from COVID-19. In April 2020, the College was made aware of UK Obstetric Surveillance System (UKOSS) data that was going to be presented to the Secretary of State for Health and Social Care on the significantly higher prevalence of COVID-19 amongst black and ethnic minority women. This data showed that between the 1st March 2020 and the 14th April 2020, 56% of pregnant women admitted to hospital with COVID-19 were from black or ethnic minority groups, showing a massive over-representation of this group of women compared to white women [EM/40 – INQ000308984]. Throughout the pandemic, the College supported UKOSS in their work to continue to explore the unequal impact of COVID-19 on pregnant women from black and ethnic minority backgrounds.

86. From May 2020, RCOG guidance stated that women from a black or ethnic minority background should be advised that they might be at higher risk of COVID-19 complications and they must seek help early if concerned [EM/41 – INQ000308985]. The guidance advised clinicians to be aware of this increased risk, and have a lower threshold to review, admit and consider multidisciplinary escalation of women from a black or ethnic minority background. The College contributed to communications and development of resources from NHS England to provide information for women and clinicians about the increased risk of COVID-19 complications for black and ethnic minority women.

87. The College also continued to raise our concerns about the unequal impact on black and ethnic minority women of COVID-19 in pregnancy throughout the pandemic with senior clinical leaders in the NHS and with officials in Government. It was a key theme of our response to the Women and Equalities Select Committee Inquiry into the unequal impact of COVID-19 on people with protected characteristics [EM/42 – **INQ000176670**

88. By November 2020, the College had also secured funding from the Health Foundation to undertake a study to investigate how changes to maternity care during the COVID-19 pandemic affected existing inequalities in maternity care. The COVID Maternity Equality Project (CMEP) study aimed to identify changes to outcomes for women and babies during the pandemic. It considered whether these were related to particular changes in maternity care and identified units - called positive deviant trusts that had demonstrated a substantial

reduction in disparities in outcomes between women of different ethnic groups. The study found that positive deviant trusts had increased staffing resources or implemented productive re-allocation of staffing expertise, and also increased proactivity and flexibility in the delivery of care. The learning from this survey provides supporting evidence to ensure that inequalities are not exacerbated, and are actively reduced, in the event of a future public health crises or pandemics. Equally this evidence should be applied more broadly to improving maternity care and reducing inequalities in outcomes.

The availability of maternity care professionals during the COVID-19 pandemic

89. It is first important to recognise that availability of staff in maternity services before the pandemic began was inadequate to consistently deliver safe, quality, personalised care. The 2021 NHS England Getting It Right First Time (GIRFT) programme national specialty report in maternity and gynaecology cites findings that in 2019, 87% of obstetric units reported gaps in their rotas, with 83% of units reporting requiring locum cover [EM/43 – INQ000308987]. Midwifery shortages were also acute prior to the pandemic; an RCM survey at the start of March 2020 showed that 80% of maternity units had midwife vacancies, and redeployment of midwifery staff to cover essential services such as labour ward was already common. The pandemic therefore put additional pressure on a service that was already struggling with low staffing levels, which had no reduction in the demand for its services during the pandemic.

90. The availability of obstetricians and other professionals involved in maternity care was impacted by a number of factors during the COVID-19 pandemic. This included those staff who were shielding as they were defined as clinically extremely vulnerable, alongside a greater number of staff who were defined as clinically vulnerable (some of whom because they were pregnant) who, following a risk assessment, were redeployed from frontline care. Some of these professionals were able to work remotely to support remote appointments or clinics. Availability of maternity professionals was also impacted by staff sickness and isolation rules, particularly when access to testing was challenging at the start of the pandemic.

91. At the start of the pandemic, the College received reports from RCOG Fellows and Members that some units and hospitals were redeploying staff away from maternity

services to support other areas of the hospital as part of the response to COVID-19. As a result, the College undertook a survey in June 2020 to understand the extent of redeployment [EM/44 – INQ000308988]. It found that there was significant redeployment of medical staff, in particular junior grade doctors and locally employed doctors, away from maternity services. The survey found that these roles were predominantly covered by O&G consultants, Specialty and specialist (SAS) doctors and senior trainees. We also know that many consultant gynaecologists were moved from gynaecology to support obstetric services with support and training from colleagues.

92. This redeployment away from an essential service was a significant concern for the College, and we acted to try to prevent it from continuing wherever possible. We issued recommendations in June 2020 directed at the NHS both nationally and locally that the maternity workforce should not be redeployed, and that the same standards should apply to the maternity workforce as the emergency department workforce. RCOG Vice President for workforce and professionalism, Dr Jo Mountfield, and I then wrote to Professor Steven Powis, the National Medical Director for NHS England, to highlight the results of the survey, offering support and recommendations for future decision-making in the event of a future increase in rates of COVID-19 [EM/45 – INQ000308989]. There is no record of a written response to this letter, but regular engagement was taking place with Professor Powis and the team at NHS England at this time and it was verbally agreed that we would write directly to providers. In September 2020, the College then wrote to all NHS Trusts and Health Boards calling on them to not redeploy maternity staff in the second wave of the COVID-19 pandemic [EM/46 – INQ000308990]. We then conducted a follow-up survey, published in December 2020, which showed that the majority of redeployed staff had since been returned [EM/47 – INQ000308991].

93. The Government and the NHS must invest in the maternity workforce in order to ensure that staffing levels are adequate to consistently provide high-quality, safe and personalised maternity care at all times. This is particularly important in preparing for the potential impact of future public health crises or pandemics. Redeployment of maternity professionals should never happen. Maternity care is an essential service and demand for care does not change regardless of the wider circumstances. Training in maternity care is specialty-specific and the knowledge and skills required to provide high-quality care take years to acquire, making redeployment of non-specialists into maternity care challenging.

It also threatens the loss of knowledge and skills of maternity specialists in the longer term, if they are redeployed outside of maternity settings for prolonged periods.

Infection Prevention and Control (IPC) measures in maternity settings

94. It is well recognised that access to PPE was a significant challenge for frontline health and care services in the pandemic, particularly in the early months where stocks of PPE were limited and nationwide shortages were widely reported. Whilst testing capacity was still being established, maternity professionals were continuing to work in a service where patient demand was not affected by the pandemic – women were still coming in to have babies at the same rate. Maternity professionals were rightfully concerned that, given early understanding of the asymptomatic nature of many people with COVID-19, they were putting themselves at risk looking after patients who may have COVID-19 with no symptoms. Challenges accessing PPE were a concern for RCOG members and other maternity professionals, and this was communicated through various channels including regular meetings coordinated by the Academy of Medical Royal Colleges with senior leaders in NHS England. It was also a central point in the RCOG's response to the April 2020 Health and Social Care Select Committee Inquiry into the delivery of core NHS services during the pandemic [EM/48 – INQ000308992].

95. There was also confusion early in the pandemic with regards to infection control guidance on adequate PPE, and how this should be applied to maternity care settings. This was in the context of maternity professionals feeling at risk of contracting COVID-19 and taking the virus home, and an understandable fear of a relatively unknown virus. Concerns were raised by RCOG members and Officers as to what constituted an Aerosol-Generating Procedure in a maternity context (in particular, whether Entonox use increases aerosolisation), the evidence of higher risk of transmission associated with different stages of labour (including whether 'splashing' of bodily fluids during labour would increase risk), levels of PPE necessary for caesarean births, and on ventilation in theatres. Answers were sought via email in March 2020 from colleagues in both Public Health England (PHE) and Health Protection Scotland (HPS) and the College raised the importance of public health agencies taking a lead on guidance, and providing evidence to support the decisions made relating to guidance. There were times when the College felt that recognition of the risk faced by maternity professionals was not reflected in guidance published by Public Health

England and NHS England on the use of PPE; an example of this was when the College decided against endorsing guidance from NHS England on PPE use for women in labour (published in March 2020) because of a lack of FFP3 masks included in the guidance.

96. Reports in the media of widespread PPE shortages were reinforced through feedback the College received from RCOG and RCM members in maternity settings. In the RCOG statement to the Health and Social Care Select Committee in May 2020 we said that we remained concerned that PPE was not always available as specified in the guidance issued by Public Health England, and asked the Government to be as transparent as possible in communicating the challenges facing supply [EM/49 – INQ000308993].

97. Despite concerns that PPE in maternity settings was not adequate, the College recognised the importance of not publishing guidance on PPE from the RCOG that did not align with that being published by public health agencies. Therefore we actively worked to influence the guidance being published by Public Health England and others with the ambition of improving adequacy of PPE in maternity settings. This included writing to the Director of Health Protection on 26th March 2020 to emphasise the lack of progress in this area [EM/50 – INQ000308995]. I then met with PHE and NHS England on 27 March 2020 and expressed the worries that our members were sharing with the College, which resulted in PHE providing an opportunity for the RCOG and its specialist societies to feed into updated guidance – a summary of which we have provided with this witness statement [EM/51 – INQ000308996]. From version 4.1 of RCOG COVID-19 in Pregnancy Guidance (published 26th March 2020), specific advice regarding PPE use in labour was included [EM/52 – INQ000308997].

98. The College recognises that developing comprehensive guidance for all specialty areas with limited evidence about the nature of a new virus put public health agencies and national NHS bodies under extreme pressure. However, it is important to reflect candidly on a process that was far from satisfactory for maternity professionals on the ground who needed clear evidence-based guidance on infection control, and for professional bodies like the RCOG trying to develop clear guidance. The College believed that there needed to be significantly more capacity in Public Health England to be able to both develop the comprehensive IPC guidance necessary at pace, and also to provide crucial support and public health expertise to organisations developing specialty-specific guidance.

99. The College also wishes to make a broader point about access to PPE for our members and all healthcare professionals working in maternity care. The acute pressures on supply of PPE at the start of the pandemic undoubtedly had an impact on guidance that was produced. It created a situation where it was necessary to limit use of PPE, particularly PPE that provided the highest levels of protection, to ensure that clinicians who were managing COVID-19 positive patients in intensive care were adequately protected. Not only did this have an impact on individual staff who felt at risk, but it also increased transmission of the virus and impacted staffing numbers at a time of extreme pressure on maternity services. Future pandemic preparedness that ensures adequate PPE across all settings, and allows a less restrictive and more precautionary approach to PPE would mitigate against these impacts.

100. It is also important to recognise that the use of appropriate PPE in the pandemic had an impact on clinical decision-making and patient care. Most crucially, obstetric decision-making during intrapartum care must often be rapid in order to safeguard maternal and neonatal safety, so putting on PPE can risk delaying emergency care, in particular emergency caesarean births. RCOG guidance recognised the importance of clinicians factoring in additional time required to put on PPE when making decisions about emergency care. The College was also aware from the start of the pandemic that increased use of PPE was likely to create communication barriers between maternity staff and women; RCOG guidance recognised the known challenges associated with communication in full PPE and reiterated the importance of maternity staff recognising the impact this might have in maternity settings.

RCOG support for Fellows and Members

101. As many organisations were required to do in response to the COVID-19 pandemic, the RCOG had to make significant changes to the way it operates in order to continue to support our Fellows and Members during the pandemic. Our examinations programme, our membership processes, and our education and training offer had to change to ensure we could still deliver for our membership by facilitating essential training, process qualifications, support career progression and offer continued learning and development opportunities.

102. RCOG delivers a programme of exams to trainees in Obstetrics and Gynaecology to enable their progress through specialty training. At the start of the pandemic, we were required to cancel exams that were set to be in person, which had a clear impact on trainees. However, a position statement from the Academy of Medical Royal Colleges, COPMED and the GMC made it clear to trainees that they would not be disadvantaged due to missing exams or training opportunities when it was out of their control due to the pandemic (ex). The RCOG was able rapidly accelerate an existing programme of work to introduce digitally delivered exams for trainees, and by September 2020 launched a new system to deliver our MRCOG and DRCOG exams, that saw us transition our written exam provision (MRCOG Part 1 & 2, and DRCOG) from a paper-based to a computer-based format. In the year to 30 June 2021, 6,500 candidates completed these digital exams.

103. The RCOG was also able to continue to award qualifications to and register new members, although we were unable to hold membership ceremonies during 2020 and much of 2021. Ceremonies with some restrictions and limited numbers were introduced from September 2021, which was welcomed by new members.

104. In terms of education and training, the College switched all of our Core Knowledge e-learning content to public open access during the pandemic, to support our members with their Continued Professional Development (CPD) and assist medical students who were having difficulty accessing O&G study materials. We also moved a large number of our courses and events online, so could continue to offer interactive learning opportunities to O&G doctors throughout the pandemic, including hosting our first ever digitally delivered World Congress in 2021.

105. Throughout the Covid-19 pandemic the College worked to maintain access to training and critical assessments as well as ensuring where possible that doctors in training continued to progress at the expected rate. In May 2020 the GMC approved a set of derogations to O&G curricula requirements which were supported by the Statutory Education Bodies. Where disruption to training was unavoidable, these derogations enabled progression where it was safe for patients and supportive of trainee wellbeing.

106. The College recognised the issues surrounding the delivery of high-quality gynaecological surgical training during the COVID-19 pandemic and the disruption this had on routine and elective surgery. Practical training in all craft specialties was compromised. The College published a training in gynaecological surgery recovery plan in May 2021 that outlined a set of principles and recommendations to facilitate effective restoration at national, regional and local level [EM/53 – INQ000328959]. It considered the demands and pressures placed on the service balanced against the widening deficit in the provision of training caused by the pandemic. The priority, as always, was to remain committed to maintain safe and effective standards in gynaecology.

107. The College also took action to support our members' wellbeing and promote positive workplace cultures throughout the pandemic. We know that many of our members felt a huge strain on their mental health and wellbeing as a result of the COVID-19 pandemic, although as a College we did not collect data on this. In 2021, we launched an online Wellbeing Resource Hub to help signpost our members to sources of support and feature many of the new wellbeing resources developed to support NHS staff during the pandemic; the College continues to update this hub regularly.

108. At the College we have long recognised the link between workplace culture and patient safety, and at a time of intense pressure during the COVID-19 pandemic, it was more important than ever to ensure healthcare staff felt valued and safe. In 2021 we updated our joint statement with the RCM on undermining and bullying in the workplace, and relaunched our Workforce Behaviour Toolkit. The toolkit supports the development of positive workplace cultures, supports clinicians to speak up when they encounter poor workplace behaviours, promotes understanding of what poor workplace behaviour looks like and its impact on individuals, teams, organisations and importantly on the women and families maternity professionals care for.

Learning lessons to deliver safe, high-quality maternity care in a public health crisis

109. I trust this full and evidenced response demonstrates the full contribution the RCOG made during the COVID-19 pandemic in relation to the module in question. The College and I have reflected in some depth on that period and considered the learnings that we would like the Inquiry to recommend are taken forward to support the UK's response to

future pandemics and public health crises, specifically in relation to the health of pregnant women and the delivery of maternity care services.

110. I am incredibly proud of the work of the College during the COVID-19 pandemic and of course, that of our membership and the wider maternity workforce who worked tirelessly in the face of no small personal risk on the frontline, providing high-quality, safe care for women. On behalf of the College, I would like to express my thanks to each of them for their sacrifice and commitment.

111. The overall response to future pandemics and public health crises must consider the unique nature of pregnancy and the postnatal period, and actively and systematically consider the needs of this group. The implementation of public health measures to respond to a pandemic must consistently consider pregnant women, and carefully balance the need to be cautious in order to protect the health of women and their pregnancy, whilst striving to provide clear communication on known risks. Communication of new guidance and regulations must be tailored to pregnant women and their families, and kept accurate and up-to-date to avoid misinformation and disinformation from spreading.

112. There must be capacity in Government and in arms-length bodies to react rapidly and flexibly to an emerging pandemic or public health crisis, and they must be resourced and empowered to work closely and collaboratively with non-government organisations. It is the role of Government and arms-length bodies to deliver timely guidance and support for the health system. Where clinical guidance or specialty-specific guidance is developed by expert organisations such as Royal Colleges and charities, this must be supported and endorsed by Government and its arms-length bodies, as well as ensuring this guidance is communicated to, and taken up, by frontline services.

113. Maternity services must be prioritised and protected in a pandemic. It is clear that the impact on maternity care during the COVID-19 pandemic was significant, and I have outlined many examples of where women's experiences were inadequate. Demand for maternity services does not change as a result of a pandemic, and women must continue to be able to access high quality antenatal, intrapartum and postnatal care. Changes to the delivery of care must be based on clear evidence of safety and not be to the detriment of the experience and care for women and their families. This involves ensuring that

overarching changes to ways of working to aid public health measures (such as moving to remote delivery of care, or reducing visitors in hospitals) are not applied to maternity settings without full consideration of the way in which these measures will impact the delivery of care. Women and their birth partners must always be considered as part of a patient unit, and visiting guidance should reflect this whilst also ensuring that services are able to protect maternity staff. Maternity professionals must be protected from redeployment, in all but the most exceptional of circumstances.

114. We must not just confine the learnings of this Inquiry to future pandemics. Instead we must recognise that much of the learning expressed in this statement can be applied far more widely to ensure the delivery of consistent high-quality, personalised and safe maternity care. Maternity services have remained under sustained pressure for many years, which was exacerbated by the impacts of the COVID-19 pandemic. As a nation we must recognise the value in long-term, sustainable investment into maternity services and wider care and support services for pregnant and postnatal women.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 16/11/23