

Falling through the cracks:

the impact of COVID-19 on postnatal care in primary care

POSTNATAL CARE

Postnatal care has always been the 'Cinderella' of maternity services, both in primary and secondary care.^{1,2} One illustration of this is that until the most recent GP contract there was no requirement for a GP practice to provide a maternal postnatal check. Prior to the COVID-19 pandemic the provision of services to postnatal women showed wide variation across the country.¹ With a paucity of more recent research to establish what best postnatal care looks like, it is difficult to provide evidence-based practice. In 2014 the annual Chief Medical Officer for England's report came to the conclusion that postnatal care in England was 'not fit for purpose'.² Since then community postnatal services, such as health visitor provision, have seen funding cut and services have become increasingly fragmented.³ The Royal College of General Practitioners (RCGP) issued a statement in 2017 recognising that GP training is not adequate when it comes to the provision of maternity care in the community, while also acknowledging that GPs are best placed to coordinate joined-up care across services.⁴ Successive confidential inquiries into maternal deaths have also repeatedly highlighted the need for joined-up care to prevent women 'falling through the cracks'.⁵

COVID-19 has disproportionately affected people from black, Asian, and ethnic minority (BAME) backgrounds, as well as those in the most deprived areas. We know that these groups of women are most at risk of maternal death, with maternal death rates twice as high in Asian women, and five times higher in black women compared with women of white ethnicity.⁵ Although we tend to think of maternal deaths occurring during pregnancy and at the time of delivery, the single biggest period of risk is the postnatal period. The current maternal death rate is 9.16 per 100 000 maternities, with 45% of

Box 1. Key messages

- Until February 2020 there was no requirement under the GP contract to provide a maternal postnatal check.
- The postnatal period is the single biggest period of risk for maternal death,⁵ higher than either the antenatal or intra-partum period.
- The women who are at highest risk of maternal death are from black and Asian ethnic groups, and also those with the lowest socioeconomic status.⁵ These are the same women who are disproportionately affected by COVID-19.
- One consequence of the COVID-19 pandemic is that there has been a reduction in face-to-face contact in clinical settings⁹ and in home visit provision⁸ during the postnatal period.
- Suicide is the leading direct cause of death in the late postnatal period.⁵ We do not yet have evidence of the effect COVID-19 has had on maternal mental health, but it is likely that the reduction we have seen in personal support networks has had a detrimental effect.
- If we miss opportunities to provide postnatal care, this may have a direct consequence on women's long-term health. We know that women with gestational diabetes have an increased lifetime risk of type 2 diabetes, and women with pre-eclampsia and gestational hypertension have an increased lifetime risk of cardiovascular disease. The postnatal check provides an important opportunity for patient education and lifestyle modification.

these deaths occurring in the immediate postnatal period.⁵ The late maternal death rate (after 42 days but <1 year after the end of pregnancy) is even higher at 13.7 per 100 000 maternities.⁵ The effects of the pandemic on maternal death rate, and in particular in the BAME groups, are yet to be fully seen. There is emerging evidence that adverse antenatal outcomes such as stillbirth have increased dramatically,⁶ yet, we still have no evidence on the effect the pandemic has had on postnatal care.

CARE SINCE THE PANDEMIC

Since March 2020 the provision of postnatal care has likely become even more inequitable. At the height of the pandemic women were being asked to give birth, undergo scans, and undergo management for fetal loss without the support of a birth partner.⁷ The effect of this on a woman's mental health is likely to be detrimental. Women who had recently given birth were then discharged into the community with midwives and health visitors only able to

offer one or two home visits,⁸ and RCGP guidance recommended that postnatal checks at GP surgeries should be done partially or wholly remotely with the provision that, if there are outstanding issues after this, a face-to-face appointment could be offered at the same visit to the practice as the infant vaccination appointment.⁹ This reduction in face-to-face contact increases the risk that warning signs of problems for women and their babies have been missed and also increases the risk of women 'falling through the cracks'.⁵ The countrywide lockdown also meant that this change in healthcare support occurred in the context of vastly reduced family and community support networks.⁷

The postnatal period is already a time of increased mental vulnerability, and vastly reducing a woman's support network will only act as a large risk factor for poor mental health. Anecdotal evidence points to a huge increase in mental health problems among women who gave birth during the pandemic. The Maternal Mental Health Alliance estimates that up to two-thirds of women who gave birth during the pandemic have experienced some form of perinatal mental health problem, up from one-third of women in the pre-pandemic period.⁸ This is especially important given that, for a number of years, suicide has been the leading cause of late maternal deaths.⁵ The reduction in face-to-face contact also means that morbidity from complications during pregnancy, pelvic floor, and other

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postnatal problems are also more likely to be missed. Many of these problems have health implications both in the short and longer term, if they are not picked up and addressed in a timely manner [Box 1].

CONCLUSION

The Royal College of Obstetricians and Gynaecologists' *Better for Women* report, released in December 2019, highlighted the vital role that GPs have to play in improving postnatal care and providing joined-up care across services. It also highlighted the urgent need to harness the information gathered about a woman and her health during pregnancy, and the need to use these data to develop a life course approach to women's and children's health.¹⁰ As we face 2021, with no end to the COVID-19 pandemic in sight, it is absolutely vital that postnatal care in the community is prioritised both for the health of women and their babies. Women need increased access to face-to-face care, and they need to know

how and when to access help. We cannot afford, as a society, for these women and their children to fall *'through the cracks'*:⁵

Rebecca MacGregor,

GP Trainee, Coventry and Warwickshire Vocational Training Scheme, Coventry.

Sarah Hillman,

National Institute for Health Research Clinical Lecturer in Primary Care, Unit of Academic Primary Care, Warwick Medical School, Coventry.

Debra Bick,

Deputy Dean Research, Clinical Trials Unit, Warwick Medical School, Coventry.

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EMAIL ADDRESS FOR CORRESPONDENCE

Sarah Hillman

Email: S.Hillman@warwick.ac.uk

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