

# Descriptions of services for pregnant women with complex social factors

2012

These service descriptions accompany the clinical guideline: 'Pregnancy and complex social factors: a model for service provision' (available online at [www.nice.org.uk/guidance/CG110](http://www.nice.org.uk/guidance/CG110)).

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The purpose of this document is to promote shared learning. It showcases the examples from practice that were identified in appendix D of the [full clinical guideline](#) and provides the contact details of the people involved so that further information can be obtained.

In July 2012, the status of the services was reviewed and updated. Reference to the NICE pathway for pregnancy and complex social factors has also been added, together with some minor editorial updates.

This tool is not NICE guidance. NICE and the National Collaborating Centre for Women's and Children's Health are not endorsing or recommending these services.

Implementation of the guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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## Introduction

The guideline 'Pregnancy and complex social factors' was developed in collaboration with the Social Care Institute for Excellence and applies to all pregnant women with complex social factors. It contains a number of recommendations on standards of care for this population.

The guideline is for professional groups who are routinely involved in the care of pregnant women, including midwives, GPs and primary care professionals who may encounter pregnant women with complex social factors in the course of their professional duties. It is also for those who are responsible for commissioning and planning healthcare and social services. In addition, the guideline is relevant to professionals working in social services and education or childcare settings, for example school nurses, substance misuse service workers, reception centre workers and domestic abuse support workers.

This document has been compiled to showcase the examples from practice that were identified in the full guideline, to help those responsible for implementing the recommendations in the NICE guideline gain an understanding of what services for pregnant women with complex social factors could look like.

The group of experts who developed the guideline did not evaluate the effectiveness of the services described in this document. NICE and the National Collaborating Centre for Women's and Children's Health are not endorsing or recommending these services.

## Services detailed in this document

Service name	Status at time of update (July 2012)	Links for further information
<b>Services for women who misuse substances</b>		
The PrePare Team, Edinburgh.	Continues as detailed in this document.	<a href="#">Link within this document</a> <a href="#">Email for information</a>
Kings College Hospital, London	Continues as detailed in this document.	<a href="#">Link within this document</a> <a href="#">Email for information</a>
The Women's Alcohol And Drug Service, Nottinghamshire	Renamed the Malting Community Drug Service. This service continues as detailed in the document.	<a href="#">Link within this document</a> Phone Diane Best, Drug and Alcohol Liaison Midwife 01623 408432 for more information
Manchester Specialist Midwifery Service, Manchester	The details of this service have been updated.	<a href="#">Link within this document</a> <a href="#">Email for information</a>
<b>Services for women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English</b>		
St Mary's Hospital, Manchester	The service was initially a pilot. Continues as detailed in the document.	<a href="#">Link within this document</a> <a href="#">Email for information</a>
The Royal Berkshire Hospital, Reading	The details of this service have been updated.	<a href="#">Link within this document</a> <a href="#">Email for information</a>
Kings College Hospital, London	The details of this service have been updated.	<a href="#">Link within this document</a> <a href="#">Email for information</a>

Service name	Status	Links for further information
<b>Services for women younger than 20</b>		
Brighton and Mid-Sussex, Brighton and Mid Sussex	The details of this service have been updated.	<a href="#">Link within this document</a> <a href="#">Email for information</a> <a href="#">Website for information</a>
<b>Services for women experiencing domestic abuse</b>		
Nottingham CityCare Partnership (formerly CitiHealth).	The service provider is now named Nottingham CityCare Partnership. The service continues as detailed in this document.	<a href="#">Link within this document</a> <a href="#">Email for information</a> <a href="#">Website for information</a>
<b>Services and information for all women with complex social factors</b>		
Imperial College Healthcare NHS Trust, London.	The details of this service have been updated.	<a href="#">Link within this document</a> <a href="#">Email for information</a>
The Women's Wheel, London	Continues as detailed in this document.	<a href="#">Link within this document</a> <a href="#">Email for information</a> <a href="#">Website for information</a>
Hackney Maternity Helpline, London	Continues as detailed in this document. Now part of mainstream services.	<a href="#">Link within this document</a> <a href="#">Email for information</a> Websites for information: <a href="#">London Borough of Hackney</a> and <a href="#">Homerton Maternity Services</a>
Centering Pregnancy, Kings College London	Continues as detailed in this document. This started as a pilot and is being rolled out further.	<a href="#">Link within this document</a> <a href="#">Email for information</a>

## **Services for women who misuse substances**

### ***The PrePare Team, Edinburgh***

The PrePare team in Edinburgh is a multi-agency service for pregnant women who misuse substances. It offers antenatal care and postnatal care for up to 6 months after birth. It was established in July 2006. It is staffed by two full-time addiction nurses, a full-time health visitor, a full-time midwife, a full-time senior nursery officer, one full-time and one part-time (0.5 WTE) nursery officers, a full-time manager (with a social work background) and a part-time administrator. The PrePare team has expanded to increase provision because they are dealing with more cases of alcohol misuse. The addiction nurse has a postgraduate qualification in addiction. The other staff have attended various study days on addiction, blood-borne viral infections, and so on. The team has many years of experience working with families who have difficulties with substance misuse and other social issues, including poverty and poor housing. The midwife was a community midwife in areas with a high incidence of drug misuse before she joined the team.

PrePare is an outreach programme and appointments are held where they are needed. There is a drop-in session with the midwife and addiction nurse every Thursday from 2–4 p.m. at the Harm Reduction Service in Edinburgh. Appointments can be held at doctors' surgeries where appropriate, and the midwife can hire rooms in children's centres or do home visits. Full risk assessments are undertaken when assessing safety for home visits. A high proportion of home visits undertaken by the team are done jointly, with team members supporting each other in their interventions.

The team does not have group sessions. There are parentcraft classes for pregnant women with additional needs but women whose drug misuse is very chaotic don't turn up to these.

Women whose drug misuse is more stable see the community midwives and other mainstream services. If they stop turning up to appointments they can be referred to the PrePare team.

Ideally, this population should see the obstetrician, and referrals are made, but the women frequently do not turn up for appointments. In these cases the obstetrician is kept up to date by telephone calls and email.

There is a weekly team meeting to discuss new referrals and allocations as well as case planning. A package of care is determined by the team and the orange book guidelines for Lothian's 'Working with children living in families affected by parental substance use' are followed.

### **Access to care**

PrePare accepts referrals from all agencies as well as from individuals; however, 51% of referrals received to date<sup>1</sup> came from community midwives. The estimated number of pregnant women who misused drugs in the Lothian area was approximately 150, and in about 80 of these women the drug misuse was chaotic. The rest were stable methadone or alcohol users.

The women referred to PrePare must: have suspected or known illicit drug or alcohol use; be older than 16 years; have a confirmed pregnancy; and not be engaging with mainstream services. Additionally, they may have had experience with child protection concerns relating to previous children.

The aim is for PrePare to work with 40–50 women in a year. These are the women with the most chaotic drug misuse, and many are involved in criminality or the sex industry to fund their drug use.

### **Additional consultations**

The antenatal appointments are more frequent and longer than those in standard antenatal care. They happen every 2 weeks and are at least an hour long. The midwife's main remit is the health of the woman and baby, but the midwife can also help with benefits, child protection issues and other problems.

Either the midwife or the nursery officers will regularly take women to hospital to have scans.

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<sup>1</sup> Correct at time of publication of service description in CG110 Pregnancy and complex social factors [full guideline](#), September 2010

The addiction nurse deals with the drug or alcohol problems, seeing women as often as necessary. The emphasis of the treatment they receive is to establish stability within a harm reduction principle.

When engaging with this group of women, the nursery officers establish a supportive relationship while undertaking a comprehensive assessment of the women's situation and understanding of parenting. This is used in recommendations for the child protection process and long-term plans for the care of the child.

### **Attendance**

The team spends a lot of time trying to engage women who do not attend, by texting, phoning and making home visits. Later in the pregnancy, when the woman is more used to the team, attendance is better. The team gives out mobile numbers and can be contacted every day from 8 a.m. to 6 p.m., and there is a Thursday afternoon drop-in session.

The women are encouraged to take part in meetings and home visits by a team ethos of acceptance and of not judging service users. The relationship is based on openness and honesty; women are given choices about their care and have an active role in making decisions. However, it is made clear what impact these choices will have on planning for the baby's needs.

### **Interfaces and links with other services**

The PrePare team communicates well with other agencies. These agencies refer women to the team and PrePare refers women to other agencies as needed.

PrePare works closely with DTTO (Drug Treatment and Testing Order), a new programme in which, instead of going to prison, drug users are given court orders requiring them to attend weekly testing, screening and counselling.

PrePare works with the prison service and the drugs referral team, which can help women access education. The cases are complicated and a high proportion of women experience domestic violence. These women also have more complicated drug and alcohol problems than other women with whom PrePare works.

## **Audit data**

At the time of writing, the PrePare team is undergoing an evaluation by Capital City Partnership.

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## ***Kings College Hospital, London***

Kings College Hospital (KCH) employs a midwife full time to work with pregnant women who misuse substances. She did an 8-week course 4 years ago on drug awareness, and has level 3 safeguarding. Mostly she has learnt from experience or is self-taught.

KCH offers an addiction service, the Woodvine service, run by an addiction service nurse and a doctor at the hospital antenatal clinic. This is so that the women's antenatal care is normalised.

The midwife has a clinic at the hospital. She also works out of rehabilitation centres and day centres, and will do home visits. Often the women she sees have fewer appointments than are recommended in standard antenatal care because these women are difficult to engage. It can take three or four contacts before the midwife actually meets the women. The midwife allows a minimum of 45 minutes for appointments.

The women see the obstetrician on the same basis as women who do not misuse substances. Being a substance misuser does not automatically mean a referral.

KCH runs a parenting group for women who misuse substances, but finds that women who are going through rehabilitation do not want to mix with the women who are still actively misusing substances. Instead of antenatal classes, the midwife has a one-to-one 2-hour appointment with each woman at 36 weeks.

## **Access to care**

Women are mainly referred after booking when they have disclosed their drug use. They are referred by community midwives, GPs, drug agencies, social workers and

prisons. The caseload is divided into: minimal, brief and active. In a year<sup>2</sup> 70–75 women are referred. Of these, approximately 35 are considered brief service users and around 35 are service users.

### **Attendance**

Attendance is a big problem; half of the midwife's time is spent following up women who do not attend. She allows two non-attendances and then actively seeks the women, phoning their homes and/or speaking to their social workers or drug workers.

### **Interfaces and links with other services**

The midwife works with: prisons and the probation service; voluntary agencies that work with sex workers; domestic violence refuges; the drug team; housing services; neonatologists; and social workers. An information leaflet has been developed for women and healthcare professionals with the contact details of all the relevant agencies.

The coordination of care has become easier now that the KCH service is more established and other professionals know the midwife's role.

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### ***The Maltings Community Drug service (previously Women's Alcohol and Drug Service [Wands]), Nottinghamshire***

The Maltings Community Drug service is provided in conjunction with usual antenatal care. The substance misuse midwife has a diploma in substance misuse and training in a number of related areas. As well as the drug and alcohol liaison midwife employed by substance misuse services, there are specialist antenatal clinics in both hospitals covered by the service. The specialist clinics are run by the midwife, obstetric consultant, a drug treatment worker and a sexual health worker, and the women can access all these services at the clinic. Appointments can cover a wide

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<sup>2</sup> Correct at time of publication of service description in CG110 Pregnancy and complex social factors [full guideline](#), September 2010

variety of issues, including emotional problems, mental health issues and housing problems.

Appointments outside the clinics are held anywhere that the woman will find easy to get to, and where she and her midwife will be safe. Locations can include antenatal clinics, GP surgeries, home, children's centres, probation offices, substance misuse service premises, family centres and hostels. Women can bring their children to the appointments. Taxis can sometimes be provided to help women get to appointments, particularly if they have pre-school children.

The service does not have any special group sessions for these women but is looking at setting these up in the future.

### **Access to care**

Women are referred from a variety of sources, including community midwives, drug treatment services, probation services, arrest referrals and GPs. Women can also self-refer. This is a dedicated service for women who misuse substances. Around 60–70 women are seen each year. The total number of women seen by the service in the last year<sup>3</sup> was 219; this included pregnant women and women who were experiencing domestic abuse.

### **Attendance**

The service works in a proactive way with women to help them attend appointments and receive the care they need. The liaison midwife follows up women who do not attend. If a woman finds it really difficult to get to clinics, the liaison midwife or the community midwife can offer extra home visits. Other workers who are involved in the care of the woman are also encouraged to help her to attend.

### **Interfaces and links with other services**

The dedicated service coordinates its work with that of other services involved in the care of a particular woman, such as other drug and alcohol treatment services, the criminal justice service (for example, the probation service) and social services. Multi-agency meetings are held regularly.

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<sup>3</sup> Correct at time of publication of service description in CG110 Pregnancy and complex social factors [full guideline](#), September 2010

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### ***Manchester Specialist Midwifery Service***

Manchester Specialist Midwifery Service (MSMS) has operated since April 2001. It specialises in providing a service to women and their families in whom drug or alcohol misuse and mental health problems are identified. It also supports and coordinates care for women with HIV who are identified through the antenatal HIV screening programme. The present service originates from the drug liaison midwife post (1995–2001), which was jointly commissioned by maternity and drug treatment services and identified a wide range of unmet needs in vulnerable women accessing maternity care.

A consultant midwife leads MSMS and has responsibility for service development and line management. The team consists of five specialist midwives – two covering HIV and sexual health (one band 8a, one band 6), one covering perinatal mental health (band 7) and two specialising in drugs and alcohol (band 7) – and a personal assistant.

All team members are employed by Central Manchester University Hospitals Foundation Trust (CMFT) and based in a community resource centre in central Manchester with other voluntary and statutory agencies. The service is jointly commissioned by the Manchester Drug and Alcohol Strategy Team (DAST), NHS Manchester and CMFT.

The two drugs and alcohol specialist midwives are based in a shared office with other members of the MSMS team. The cross-fertilisation of knowledge and expertise is particularly beneficial in the frequent joint case planning and safeguarding assessments with substance misusing families. It also facilitates ongoing experiential learning for all team members.

Experience in working with women and families with substance misuse, domestic abuse and other complex social factors is essential to undertaking the specialist midwife role, as is knowledge of both the physiology and psychology of addiction. This includes the impact of drug and alcohol use in pregnancy and on the newborn baby, and how best to manage neonatal withdrawal if it occurs. Risk assessment

and correlating the multiple complexities involved are key components of the specialist midwife's role.

### **Access to care**

Women are referred to the drugs and alcohol specialist midwives from a variety of sources. These include:

- drug and alcohol services
- maternity services
- GPs
- mental health services
- gynaecology and termination of pregnancy services
- voluntary agencies such as Lifeline
- needle exchange services
- MASH (Manchester Action on Street Health), a sex workers' project
- Styal prison
- Homeless Families
- Greater Manchester Police
- probation services
- domestic abuse agencies
- friends and family members
- self-referral.

Access to MSMS is not considered problematic because the service has established referral pathways with the voluntary and statutory agencies across the city. The service is also well known to service users. However, it is acknowledged that some women who misuse substances may book late for a variety of reasons. These include:

- ambivalence about their pregnancy
- avoiding services
- chaotic lifestyle
- amenorrhoea associated with opiate misuse may lead to late confirmation of pregnancy

- other priorities competing with accessing healthcare, such as criminal justice, probation, addiction services.

### **Additional consultations**

The specialist midwives provide additional expertise, in-depth assessment and input over and above the usual antenatal care provided. The role is not one of providing regular antenatal care but of individual casework and leading on coordinating care and case planning. Women are encouraged to attend for routine maternity care and are referred for consultant care if indicated.

Following referral, each woman receives a pre-arranged home visit for an initial assessment, so that childcare is not an issue. The average time is 1 hour. Follow-up visits are planned according to need and may range from one to ten visits, with the average being four to five visits. Time is spent helping the woman identify and access services to meet her needs. The home visit also provides an opportunity for the midwife to assess the woman's home environment, atmosphere and family interactions. This is particularly important if there are concerns regarding child neglect and/or domestic abuse. An individual care plan is drawn up after the initial assessment and updated and amended accordingly, with the woman being central to the process.

A Common Assessment Framework checklist is completed with all women. Post-delivery contraception is discussed early on, and women and their partners are referred to the outreach sexual health nurse who will then make contact. Families are also offered a referral to ECLYPSE, the young people's service for drugs and alcohol, where one-to-one counselling, group work and family therapy is provided. The specialist midwives also do joint assessments with the family workers.

Ongoing history taking and discussion with women includes the following topics:

- initiating and sustaining change
- the importance of attending for antenatal care and keeping appointments
- whether it is a planned pregnancy and whether it is wanted
- funding a drug or alcohol habit
- prostitution and criminal activity

- family background and personal history (including sexual abuse)
- family member in prison
- previous and current domestic abuse or violence
- experience in the care system
- relationship with current partner
- identifying partner's drug or alcohol use
- relationship with the father of any other children in household
- safeguarding issues
- blood-borne viruses and sexually transmitted diseases with a risk of vertical transmission, including HIV
- management of methadone in pregnancy and labour, and when in hospital
- potential impact of substance misuse on the baby before and after birth, including neonatal withdrawal
- breastfeeding, nutrition, infant mental health and attachment
- referral to mental health, psychological services, parenting programmes and so on
- involvement with children's services and social worker if necessary.

The specialist midwives provide postnatal contact for an average of approximately 3 months, and on occasions for longer, depending on the specific circumstances. The contact can be a pre-arranged visit or by phone. This includes women whose babies have been taken into care. The exit plan forms part of the care plan and is regularly discussed with the woman.

### **Attendance**

Contact also takes place in the drug and alcohol treatment services (outpatient and inpatient), antenatal clinic and maternity wards. Texts are frequently used to remind women of appointments and to maintain contact should they be reluctant to access services. Women also text the specialist midwives to seek information and reassurance or to change the dates of appointments, and when they have been admitted to hospital.

## **Interfaces and links with other services**

MSMS service provision is firmly rooted in the sphere of public health and embraces all aspects of a vulnerable, socially excluded lifestyle. The service has a city-wide remit and broad responsibilities that include providing input to three maternity hospitals, four drug service bases, a sexual health project for sex workers (MASH), the regional inpatient detoxification unit and a local women's prison.

## **Training**

A wide range of training is provided to voluntary and statutory health and social care agencies and the team provides regular input to Salford and Manchester universities. Training is provided for many other agencies and healthcare professionals across Manchester. These include drug and alcohol services, social workers, student nurses and midwives, doctors, neonatal nurses, GPs and foster carers.

### **July 2012 update**

MSMS was re-configured in January 2012 to address the increasing number of referrals, particularly of women with mental health problems. The three Band 7 specialist midwives roles and responsibilities have been combined to include drugs, alcohol and mental health. A Band 8a midwife remains the Clinical Lead for HIV/sexual health, while the Band 6 secondment has since finished.

An updated alcohol training programme is currently in progress to ensure that a validated assessment tool (AUDIT-C) is integrated into antenatal screening.

A weekly joint psychiatric-obstetric clinic at St. Mary's has also been agreed and funding identified.

The rest of the service continues as detailed in this document.

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## **Services for women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English**

### ***St Mary's Hospital, Manchester***

St Mary's Hospital employs a midwife for asylum seekers and refugees with specific funding from the primary care trust, known as a 'refugee midwife'<sup>4</sup>. The post was set up in 2005 to meet needs arising from the extent of service use by asylum seekers and the findings of the 2004 Confidential Enquiry into Maternal and Child Health. The midwife works 30 hours per week and sees about 150 women a year in central Manchester. She is an experienced midwife and has worked in other specialist services, such as diabetes, and has had training from the Refugee Council along with standard equality and diversity training.

Refugees and asylum seekers are encouraged to attend community parentcraft classes, but they are not specific classes for refugees because of the diversity of cultural backgrounds among this group. Women who attend enjoy the classes because they are isolated and have a limited social network.

In line with NICE guidance, there is a risk assessment at booking to determine whether a woman needs to see an obstetrician. Refugees and asylum seekers will see an obstetrician for the same reasons as other women.

### **Access to care**

Services for asylum seekers and refugees are embedded in mainstream maternity services. Women are referred by community and hospital staff. The policy is that every woman is asked at booking if she is an asylum seeker or refugee. If appropriate, the community midwife will then ask if they may refer her to the refugee midwife. Although the bulk of referrals are from St Mary's, some come from neighbouring trusts for women who need specialist services, or from support

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<sup>4</sup> A range of job titles was considered. 'Refugee midwife' was chosen because it does not prejudge an individual woman's situation. This approach was based on the advice of Refugee Action.

agencies if the woman is moved into the area. Many of the women referred have booked late.

### **Additional consultations**

Community midwives provide general, team-based antenatal care. Standard antenatal care is supplemented by three to four appointments with the refugee midwife and a review before hospital discharge. If possible, appointments are made when women are scheduled to visit the hospital, for example after scans or visits to specialist obstetric clinics. This is often the best use of time for the woman, the midwife and translation services. Some appointments are held in GP surgeries. Women are also seen at home if necessary, especially if there are problems with housing and an assessment is needed.

Longer appointments are needed than in standard antenatal care, particularly early in the care pathway. A detailed social history is necessary and often shows the reasons for other problems such as depression and non-attendance. It is important to identify concerns with asylum applications, subsistence and accommodation, and essential baby equipment. Addressing these issues in the antenatal period prevents many postnatal crises and avoids unnecessary extensions to the postpartum hospital stay.

### **Interfaces and links with other services**

The refugee midwife coordinates her work with that of other services and spends time developing and maintaining networks. A monthly list of antenatal refugees is circulated to all clinical areas in maternity services. Safeguarding issues are discussed at the monthly neonatal meeting with specialist midwives, team leaders and the named midwife for child protection. The service also benefits from close working relationships with the antenatal clinic, triage unit, delivery suite, postnatal wards, community midwifery and specialist services for HIV, sickle cell, haematology, diabetes and social services. In addition to cultural groups, the midwife works with Refugee Action, Manchester Asylum Induction Team and charities that provide support to destitute asylum seekers.

## **Attendance**

All women are given the refugee midwife's mobile number so they can reschedule appointments or raise other concerns by phone or text. When necessary, women are contacted by phone to rearrange appointments via an interpreter to overcome literacy and language barriers.

The UK Border Agency provides a basic package of support for all asylum seekers and aims to make a decision on immigration status within 6 months of arrival. The women stay in asylum-seeker accommodation during that time and may be moved (dispersed) depending on local property providers and directions from the UK Border Agency. This has the potential to fragment antenatal care. All women are therefore requested to contact the refugee midwife if notified of dispersal. If it is reasonable, handheld notes are updated with relevant test results and an antenatal check undertaken. All women are told how to access maternity services in the dispersal area and, if necessary, the refugee midwife notifies the community or child protection midwife.

## **Other information**

The trust employs in-house interpreters to cover the main languages (French, Arabic and Asian languages), but the interpreters are only available until 4 p.m. For other languages, and out of hours, an agency is used for face-to-face and telephone translation.

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## ***The Royal Berkshire Hospital, Reading***

The Royal Berkshire Hospital employs a specialist midwife in social inclusion. Her role is to support women from black or minority ethnic groups and their families to ensure they have equal access to maternity services. She provides support to other midwives who are working with women from black or minority ethnic groups. She also works with local communities and existing networks for black or minority ethnic groups to promote maternity services and educate women on the benefits of early access to services.

The social inclusion midwife has her own caseload in the community and the majority of the women she cares for are from black or minority ethnic groups. She also has a more strategic role to develop and improve services within both the community and hospital settings.

Referral to the obstetrician is based on health need, and recent migrants and non-English speaking women are no more likely to see the consultant than other women.

### **Additional consultations**

Appointments are usually longer than in standard antenatal care; for example, the social inclusion midwife allows 20 minutes for a follow-up appointment, or 40 minutes if an interpreter has been booked.

Most antenatal care is provided by GP surgeries. However, some clinics are held in children's centres.

Vulnerable women may need extra appointments to deal with individual issues, such as financial advice, benefits or support with filling in forms.

### **Interfaces and links with other services**

The role involves informing women and healthcare professionals about the different services available. These may include support groups that offer advice on issues such as health and employment, mother and toddler groups for women from black or minority ethnic backgrounds, refugee support groups, swimming sessions for women only, information about how to request an interpreter and where to find information in different languages.

### **Training**

All staff have training on equality and diversity, and the specialist midwife facilitates workshops on cultural issues for midwives and maternity care assistants.

### **Other information**

Staff have access to interpreters for face- to-face or telephone interpreting. The interpreting service can provide interpreters for most languages and dialects. In addition, the maternity services have a link worker who can speak three languages (English plus two others) who works with Asian women.

The social inclusion midwife has developed a guide for healthcare professionals that lists all relevant services available in Reading. She can also provide information for midwives in a number of languages.

Urdu birth preparation classes have been set up in a children's centre and are being widely promoted in the community.

Working in collaboration with providers of courses in English for speakers of other languages, staff are hoping to start antenatal birth preparation classes in which English is taught, to prepare women for labour and the postnatal period and to aid integration into the community.

### **July 2012 update**

In addition to the detail above, two link workers have now been employed. They work closely together to help the social inclusion midwife maintain links with women in the community as well as in hospital.

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## ***King's College Hospital, London***

### **Access to care**

King's College Hospital does not have a dedicated service for recent migrants. Women are seen by the community midwives attached to their local GP surgery or children's centre, or by hospital-based midwives. By nature of their vulnerable status, these women tend to be referred to children's centre midwives who will give them additional appointments, visits and support. The area covered by King's College Hospital includes a hostel for asylum seekers in Dulwich, which provides initial accommodation before dispersal.

### **Additional consultations**

Recent migrants receive the same quality of care as other women. It is provided according to individual needs, and although their main care is from midwives, additional consultations and referrals are offered if appropriate.

For women who do not speak English and need an interpreter, more appointments may be needed to make sure everything has been covered. Midwives schedule longer appointments if an interpreter is present.

### **Attendance**

The main problem with working with refugees and asylum seekers is maintaining contact with them. Women who are placed in the hostel can be dispersed with little notice and it is difficult to find out where they have been sent. The midwives follow up these women if they stop attending appointments and will spend more time with them than with other women, but there is a limit to what can be done. The only information available is what is on the records and often the GP will have no more information. If the Home Office is involved it can be complicated because it is reluctant to give out information.

### **Interfaces and links with other services**

There is a weekly meeting with social workers and other healthcare professionals who work with pregnant women. There are no formal links with third sector agencies, but sometimes contact is made with domestic violence charities and on occasion with a charity that works with torture victims.

### **Other information**

Finding an interpreter for an appointment is not considered a problem, although if the woman speaks a less commonly spoken language or dialect, it can be difficult to find an interpreter. There have been problems with short-term cancellations by the interpreters or the wrong interpreter being sent. There can also be problems if assumptions are made about language; for instance when a French interpreter was booked but the woman spoke 'pidgin French'.

### **July 2012 update**

An audit of the service for refugees and recent migrants, looking at what happened to pregnant women who were temporarily housed in the local hostel in East Dulwich, identified that a number of women had been dispersed by the UK Borders Agency in very late pregnancy and were lost to follow-up. In response to these findings the hospital introduced some changes in order to meet the needs of these women, who are particularly vulnerable in health and social terms.

The children's centre midwife links with the hostel. She visits three times a week and therefore knows almost immediately of any new arrivals. Women in early pregnancy are linked quickly with the maternity services for booking and screening. Anyone in late pregnancy will be booked at the hostel by the children's centre midwife and she will continue to do the rest of their antenatal care unless there is a need to refer them to the obstetrician. The children's centre midwife will also see them for postnatal visits in the hostel.

The UK Borders Agency has agreed that if a woman is 36 weeks or more pregnant when she has her first appointment with them, they will not disperse her until the baby is 4 weeks old.

The staff providing this service report that these changes have brought about significant improvements with a small investment. They report that the children's centre midwife still has time for lots of other activities.

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## **Services for women younger than 20**

### ***Brighton and Mid-Sussex***

Brighton and Mid-Sussex employs a midwife for teenagers younger than 19 at delivery. The teenager pregnancy midwife was a community midwife and has a particular interest in working with teenagers. She is trained in child protection and has done a number of courses on antenatal care for teenagers. She works 4 days a week on the teenage programme. The programme has been running for 6 years.

There are two clinics dedicated to young pregnant women, one in an area with a high rate of teenage pregnancies and one at a city centre children's centre. The children's centre has proved to be a good location for antenatal classes because most women find it easy to get there. The clinic runs at the same time as the antenatal class. Antenatal classes are held weekly as drop-in sessions, and the clinic provides lunch and bus fares. Monthly labour ward visits are also arranged for teenage mothers. The teenage pregnancy midwife can be contacted by phone or text for advice 7 days a week from 8 a.m. to 8 p.m.

Teenagers younger than 15 are routinely referred to a consultant obstetrician. There are no obstetricians who specialise in working with teenagers.

The teenage pregnancy midwife also works with two dedicated teenage health visitors and two support workers. They work with young women under 18. There is also a re-integration officer who provides advice for teenage mothers aged up to 16 and a Connexions personal adviser for those aged 17–19. Referrals can also be made to three teenage pregnancy advisers who spend time with the teenagers at the beginning of pregnancy to help with decision making.

### **Access to care**

The programme is well publicised. Referrals are mainly from midwives; however, there are now more referrals from GPs, Connexions personal advisers and other youth groups.

### **Additional consultations**

On top of the standard care set out in the NICE guideline '[Antenatal care: routine care for the healthy pregnant woman](#)' (NICE clinical guideline 62, 2008), the teenage pregnancy midwife provides on average three to four extra visits as needed by the woman, or if the midwife feels they are needed. These additional visits are done at home or in a clinic.

### **Attendance**

Non-attendance can be a problem; teenagers are less likely to attend for antenatal care than older women. The teenage pregnancy service is very accessible, but the teenage pregnancy midwife does not book every young woman. However, between

them the community midwives and the teenage pregnancy midwife are usually successful in booking young women before 10 weeks.

If someone is not engaging with the service, the teenage pregnancy midwife will follow them up. Sometimes it may be because they have moved and do not know how to access the local clinic but sometimes it is because there are other issues in their lives preventing them coming to clinic. If there is a dedicated service for teenagers it is easy to follow them up, but they need texting to remind them and appointments often have to be rearranged.

### **Interfaces and links with other services**

The health visitors, midwife, reintegration officer and Connexions personal adviser meet every month. They also work with and meet staff from other agencies, including youth advisory centres, social workers, and housing and domestic violence groups.

### **July 2012 update**

The midwife for teenagers now works 5 days a week and the service has been running for a total of 8 years. Previously the midwife worked with two dedicated teenage health visitors and two support workers; she now works with teen lead teenage health visitors who work from the children's centres.

In addition to the clinic and antenatal classes provided, the service offers an accredited BTEC award antenatal course which runs every 10 weeks and is delivered by a local college, midwife and health visitor.

The working links between the teenage pregnancy midwife and the dedicated teenage health visitors, support worker and Connexions personal adviser are no longer in place. However, the teenage pregnancy midwife works with a life coach and the re-integration officer (for teenage mothers aged up to 17).

There are two teenage pregnancy advisers (previously there were three).

The health visitors, midwife, reintegration officer and Connexions personal adviser no longer meet every month. The midwife continues to work with and meet staff from other agencies, including youth advisory centres, social workers, and housing and domestic violence groups. They meet every 3 months.

**Attendance:** It is estimated that around 90% of pregnant teenagers are booked in to the teenage pregnancy service by the teenager midwife.

**Interfaces and links with other services:** The original model described above has been superseded by a new system. There is a Teenage Forum meeting every 8 weeks for all agencies who work with young parents. This includes representatives from housing, education and health services. The teenage pregnancy midwife also meets and works with other agencies from social work, domestic violence groups and youth advisory centres.

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## **Services for women experiencing domestic abuse**

### ***Nottingham CityCare Partnership (previously CitiHealth), NHS***

#### ***Nottingham***

Nottingham CityCare Partnership employs a domestic abuse nurse specialist as part of the safeguarding children team. The role is non-clinical and the nurse is available to give advice to all trust staff about domestic abuse.

Midwives are able to get support from the specialist nurse. She also provides signposting for appropriate referrals to women's aid, police and safeguarding children.

#### **Interfaces and links with other services**

The specialist nurse attends the Multi-Agency Risk Assessment Conference (MARAC), at which approximately 20 high-risk cases are identified every fortnight. She also coordinates with social care, women's aid, the Nottinghamshire Domestic Violence Forum, probation, women's safety officers and housing, and she spends one half-day a week with the police.

#### **Training**

The specialist nurse provides one day of domestic violence basic awareness training twice a month to all trust staff as well as a half-day session on the impact on children. She also delivers training to partner agencies, such as Nottingham University Hospitals Trust and the local safeguarding board.

The basic awareness training covers aspects of domestic abuse (physical, emotional, sexual, psychological and financial), vulnerable groups and barriers to disclosure, why women stay in abusive relationships, and attitudes and opinions of young people. The afternoon then focuses on 'asking the question', the Multi-Agency Risk Assessment Conference, using the risk assessment forms, safety plans and specialist services in the area. The 'impact on children' training focuses on the holistic impact on children of different ages, the evidence base, safeguarding children, links to child abuse and scenarios.

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## Services for all women with complex social factors

### *Imperial College Healthcare NHS Trust, London*

Maternity services at Imperial College Healthcare NHS Trust (ICHT) are provided through two of the trust's five hospitals in London: Queen Charlotte's and Chelsea Hospital, and St Mary's Hospital. Across the two sites, ICHT has around 9500 births per year, provides care for local communities in six primary care trusts and acts as a tertiary referral centre. There is a large amount of ethnic diversity across the local communities, with, in different areas, 30–47% of local populations born outside the UK. Levels of deprivation and children classed as living in poverty are 'significantly worse' than the average for England, as are levels of substance misuse, mental health concerns and violent crime. (Information from the 2009 Health Profiles at [www.apho.org.uk](http://www.apho.org.uk))

ICHT has five 'One to One Midwifery' teams, totalling 27 midwives, each holding individual caseloads of 34–36 women per year. The One to One midwives provide full antenatal, intrapartum and postnatal care for all women referred to them. Women are allocated a named midwife to provide continuity, emotional and social support, flexible, individualised care and robust multi-agency liaison.

The One to One midwives work in partnerships or small teams to provide all aspects of midwifery care, including a 24-hour on-call service for their clients. Women can choose to receive their care in community settings or at home if appropriate. If hospital care is indicated, the One to One midwives continue support for women, acting as their advocates and ensuring their care is coordinated.

#### **Access to care**

If social risk factors are identified in families receiving maternity care, enhanced service provision is offered through the One to One Caseload Midwifery service. Criteria for referral to the scheme include:

- domestic abuse
- mental health concerns – current mental health illness or past history (treated by a psychiatrist and/or community mental health team)
- safeguarding concerns

- parental substance misuse
- under 19 at booking (leading to referral to specialist 'Young Mum's Team')
- women who have been abused as children (see below for update)
- victims of rape or torture
- women who are homeless or asylum seeking (see below for update)
- women with complex or multiple social risk factors.

Women can be referred for One to One Midwifery care by GPs, health visitors, midwives and obstetricians, and referral can happen at any point in pregnancy, whenever concerns or risk factors are identified.

### **Attendance**

With a dedicated One to One midwife working autonomously and organising her own diary, care can be tailored to meet women's needs, and any missed appointments are followed up promptly and efficiently. The overall aim is that women are offered a more intensive, individualised programme of care that is as accessible as possible and provided by someone they know.

### **Interfaces and links with other services**

Potential risks to children are assessed, and either early intervention or safeguarding procedures initiated as appropriate. Multi-agency liaison is coordinated and followed up, ensuring that high quality perinatal care is provided and that longer-term plans are initiated and professionals fully briefed so that care continues effectively after discharge from midwifery.

In addition to statutory services, links are constantly being developed and strengthened with an array of third-sector agencies, both by the midwives themselves and by specialist staff within the trust.

### **Training**

The complexities and emotional demands of caring for a caseload of vulnerable women are widely acknowledged at ICHT and the One to One midwives are fully supported by managers and ICHT's consultant midwife for public health. Specialist midwives and a safeguarding lead on each site provide non-managerial support, case management advice, training and safeguarding supervision, with particular

forums dedicated to supporting the One to One Midwifery service and multi-agency working.

### **Other information**

This service means that a woman's care is provided by someone she comes to know and trust, giving her the opportunity to form a strong working relationship with a professional. In situations that are complex or distressing, women do not have to keep re-telling their stories (or choosing not to). Having a known point of contact is helpful to women who might otherwise find it difficult to engage with care or ask questions and discuss issues. The midwives also come to know their clients very well, which is invaluable in liaising and developing care plans with other agencies, particularly in complex social cases.

### **Audit**

Outcomes achieved through the One to One Midwifery service are monitored through a programme of continuous audit.

#### **July 2012 update**

This report previously stated that ICHT had five One to One Midwifery teams totalling 27 midwives, each holding individual caseloads of 34–36 women per year. The service now has three One to One Midwifery teams totalling 18 midwives, each holding individual caseloads of 32–35 women per year.

**Access to care:** Women who are travellers, asylum seekers and/or refugees are considered to meet the criteria for referral. Women who are homeless or have been abused as children no longer automatically meet the criteria for referral.

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### ***The Women's Wheel – providing information***

The Polyanna Project is a non-profit organisation that develops health and social resources with and for communities.

The project was originally commissioned to develop an information resource for women in Hackney within a framework aiming to reduce infant mortality. A CD-sized

wheel with eye-catching images on the cover was developed in consultation with local women and experts in the team: this rotates to reveal telephone numbers for helplines and services. Further projects have been commissioned, including three in Barking and Dagenham: a Women's Wheel and an evaluation of its effectiveness, and, as a result of the positive feedback, a Maternity Wheel.

The Barking and Dagenham project had a specific focus on:

- the importance of emerging communities having improved access to services
- domestic abuse and violence, in line with recommendations in the last Confidential Enquiry into Maternal and Child Health report, 'Saving mothers' lives – findings on the causes of maternal deaths and the care of pregnant women' (Lewis 2007).

The project engaged with the local community, thereby increasing awareness of local and national services. In addition, it highlighted gaps in awareness and increased understanding of available services. It was thought that designing a tool to address these gaps could help reduce inequalities and inequity in access and engagement with services.

The Barking and Dagenham project involved ten focus groups that were held in community forums and venues. The priority was to try to meet women across the borough who were representative of different ethnic groups and needs. In particular, the project focused on more vulnerable women, such as asylum seekers, women who did not speak English, teenagers and women fleeing domestic abuse.

The numbers and relevance of the services were discussed with all women and groups. There appeared to be particular gaps in awareness and understanding of services for sexual health and postnatal depression, and there were anxieties about confidentiality.

The Wheel contains both local and national numbers, because many women are not comfortable ringing local numbers.

The Wheel can inform someone about a service they did not know about or give 'permission' to ask for help, for example domestic abuse services. It engages women

and facilitates questions, interactions and information sharing. Women can refer to the Wheel, keep it and share it, so that the services can become increasingly well known and seen as 'for them'. It works as an instigator of conversation, highlighting and giving permission to acknowledge and seek assistance for needs arising from circumstances that may be stigmatised, such as teenage pregnancy, domestic abuse, disability and mental health problems.

The images on the Wheel are loosely representative of the community, with different ages and ethnicities included.

Telephone numbers for advice lines were selected through user consultation and professional advice. All the numbers were checked, with a series of follow-up calls to establish suitability based on:

- matching women's needs
- helpline or phone advice given
- good signposting to other services
- good quality of answer and answerphone, and consistent advice.

The Maternity Wheel developed for Barking, Havering and Redbridge University Hospitals NHS Trust is given out at booking and offered again in the postnatal period for all women. As a tool to initiate a conversation, this Wheel not only provides information for the women attending the clinic, but also for the midwives.

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### ***Hackney Maternity Helpline – providing information***

The Hackney Maternity Helpline is an innovative service that was set up to give women across Hackney direct access to an experienced Hackney midwife. The helpline opened in September 2007 with the following aims:

- to pilot a maternity phone line advice service
- to provide direct access to professional clinical advice
- to facilitate earlier access to maternity care.

The helpline is based at Homerton Hospital and is open 7 days a week, from 10 a.m. to 6 p.m. It is staffed by a full-time coordinating midwife and six part-time clinical midwives, each working on the helpline for 1 or 2 days per week. All helpline staff are experienced (band 7) midwives.

A telephone helpline database system was specifically commissioned, designed and built to capture details of calls taken and advice given. All calls are logged on this system. The database has a reporting function. Helpline midwives have access to the Homerton Hospital electronic records system, which means that they can access information about women already booked with Homerton and register women directly who have not yet presented for care.

Publicity business cards (printed in English, French, Turkish, Spanish, Portuguese and Vietnamese) and posters were distributed across the borough in locations including GP surgeries and community pharmacies, which give out the small card when they sell pregnancy testing kits or if pregnant women come to them with queries. The helpline number is clearly marked on the front of all handheld maternity records.

### **Training**

A protocol has been developed to ensure that all clinical advice provided through the helpline service is evidence-based and consistent. The Maternity Helpline Reference Guide was written specifically to assist helpline staff to deal effectively with calls, and is a resource incorporating protocols of Homerton Hospital and summaries of evidence-based guidelines such as NICE and other national and local guidelines. This is essential because, although all midwives working on the helpline have a broad knowledge of midwifery issues, their knowledge may differ depending on their experience and areas of expertise.

The helpline staff underwent specifically tailored training events delivered by the Terrence Higgins Trust and domestic abuse specialist organisations. The focus was on issues such as confidentiality and handling difficult emotional calls.

## **Audit**

From September 2007 to September 2008 the Hackney Maternity Helpline dealt with more than 7000 calls. The majority of calls related to clinical queries, although a number were also focused on social issues.

Data analysis was conducted on a 'typical' week of calls to the service. During the sampled week the Maternity Helpline dealt with 134 calls.

- The majority of calls (61%) were from pregnant or postnatal women, with 32% of calls from healthcare professionals (predominantly community midwives) and 5% from pregnant or postnatal women's friends or family. Two per cent of calls were outgoing calls in response to previous calls made to the helpline.
- Of the 56 clinical queries received by the helpline during the sampled week, in more than two-thirds (38) of cases the midwives were able to offer advice to the caller that was sufficient to deal with their query.
- Just over half of calls resulted in callers being referred or directed to other services or professionals.
- More than a quarter of calls (27%) resulted in blood results being provided for healthcare professionals (predominantly community midwives), suggesting that the helpline may be an important resource for midwives and other professionals, giving them easy access to information about their clients.

By May 2010 the helpline was dealing with 600–900 calls each month. This includes calls initiated by helpline midwives to as many Hackney mothers as possible the day after discharge, offering support and advice on breastfeeding if wanted.

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## ***Centering Pregnancy at Kings College Hospital NHS Trust – a flexible model of care***

Centering Pregnancy is a new model of care practised in more than 200 sites in North America, which is being piloted at Kings College Hospital NHS Trust. A feasibility study is being conducted to assess whether:

- it can be successfully transferred to the UK NHS maternity system

- women find this model of care acceptable
- midwives and other stakeholders find it acceptable to provide antenatal care in groups.

In Centering Pregnancy, women receive all their antenatal care in groups of 8–12 women with a similar due date. Partners are invited to four of the sessions. Each session lasts 2 hours. There are nine sessions, reflecting NICE guidance on the schedule of care, with a reunion meeting 1 month after the birth. The group size is stable to promote trust and there are two named midwives providing continuity of carer.

Women complete self-care activities, including testing their urine, estimating blood pressure and calculating gestation. Abdominal palpation is conducted at the edge of the circle on a mat on the floor. The care provided is the same as in 'traditional' one-to-one care and women are invited to attend for additional assessments if they have particular needs. Hospital maternity notes have been adapted for the women in the project to encourage partnership working, self efficacy and involvement.

An important element of the model is the social support, friendships and motivation facilitated by meeting women regularly in a similar situation. The social philosophy is encouraged by providing healthy snacks and attractive name tags. The sessions are held in the morning, afternoon and evening and the women are provided with all the dates for their whole pregnancy. The sessions are based in the community, children's centres, GP surgeries and the hospital.

Women and their partners have an opportunity to discuss pregnancy, birth and early parenthood. A facilitative leadership style is used and each session has an overall plan but they are not 'classes'. Attention is paid to core content but emphasis may vary according to the women's needs. The key is that each session is designed around what the women want to discuss and share with each other, rather than what the midwife feels women need to know. Women are invited to share their experiences, and perspectives gleaned from the plethora of material available from the media and professional sites such as NHS Choices and the NICE website.

There are seven groups in the pilot, the last one being to amalgamate all the learning. One group was for teenage women. The women attending have all been English speaking, with a diverse range of demographic characteristics. The women have a longer consultation time and the more confident women lead initially with questions and points of view, but this encompasses most of the women as the sessions progress. Women benefit from a shared experience with women going through the same stage of pregnancy together. Midwives report that women who would not normally attend traditional antenatal classes benefited from the wisdom of the other women. Women attend because it is their antenatal care but also benefit from a longer consultation time and the trusting relationships that develop.

There is an ongoing evaluation of care. At each session the women record in the 'choices and discussion' sheet what has been discussed. There is then a formal evaluation questionnaire at 36 weeks and another when the baby is about 1 month old, at the reunion meeting. The midwives complete a reflection sheet after each session.

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## **Other resources to support learning**

The following versions of NICE clinical guideline 110 are available from

[www.nice.org.uk/guidance/CG110](http://www.nice.org.uk/guidance/CG110):

- The NICE guideline – all the recommendations.
- A quick reference guide – a summary of the recommendations for healthcare professionals and patient pathway algorithms.
- 'Understanding NICE guidance' – information for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

The recommendations from this guideline have been incorporated into a NICE pathway, available from <http://pathways.nice.org.uk/pathways/pregnancy-and-complex-social-factors>

## **Implementation tools**

NICE has developed tools to help organisations implement this guideline, available from [www.nice.org.uk/guidance/CG110](http://www.nice.org.uk/guidance/CG110)

- Slide set – highlights the key messages from the guideline.
- A costing statement – details of the likely costs and savings when the cost impact of the guideline is not considered to be significant.
- Data collection tools and baseline assessment tool – for monitoring local practice.
- Guide to resources – signposts to practical resources to help those who are responsible for implementing the recommendations.

## **Related NICE guidance**

[NICE quick guide to maternity care](#). This provides a summary of all the guidance available from NICE relating to maternity care for all pregnant women.

[Alcohol use disorders: preventing harmful drinking](#) NICE public health guidance 24 (2010). Available from [www.nice.org.uk/guidance/PH24](http://www.nice.org.uk/guidance/PH24)

[Alcohol-use disorders: physical complications](#) NICE clinical guideline 100 (2010) Available from [www.nice.org.uk/guidance/CG100](http://www.nice.org.uk/guidance/CG100)

[When to suspect child maltreatment](#) NICE clinical guideline 89 (2009) Available from [www.nice.org.uk/guidance/CG89](http://www.nice.org.uk/guidance/CG89)

[Interventions to reduce substance misuse among vulnerable young people](#) NICE public health guidance 4 (2007). Available from [www.nice.org.uk/guidance/PH4](http://www.nice.org.uk/guidance/PH4)

[Brief interventions and referral for smoking cessation](#) NICE public health guidance 1 (2006). Available from [www.nice.org.uk/guidance/PH1](http://www.nice.org.uk/guidance/PH1)

## **Reference**

Lewis G (2007) Saving mothers' lives – reviewing maternal deaths to make motherhood safer 2003–2005. The seventh report on confidential enquiries into

maternal deaths in the United Kingdom. London: The Confidential Enquiry into Maternal and Child Health (CEMACH)

Confidential Enquiry into Maternal and Child Health (2004). Why Mothers Die 2000 - 2002: the Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. London: RCOG Press

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