

Guidelines for Maternity Services Getting it Right for Every Mother and Child

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1. Introduction

The contribution that maternity services make to a woman's experience of pregnancy and childbirth will have a far reaching impact on her own and her children's future health and wellbeing. Pregnancy offers a window of opportunity for service providers to make a positive difference to outcomes for a woman and her baby* through early assessment, early support and early intervention.

Maternity services are the providers of a universal programme of health care which should ensure a robust assessment of obstetric, medical and social health and wellbeing. This universal programme includes screening, health improvement and health promotion, with maternity providers having a key role in ensuring that additional help and support are in place at the earliest stages in pregnancy, when required. This early intervention may offset the development or escalation of more complex needs and risks if it provides a coordinated, appropriate and timely response from all services working with children and families.

These guidelines were first developed in 2011 to offer a standardised and quality assured method of assessment and documentation across NHS Highland maternity services that support the use of the Scottish Woman Held Maternity Record (SWHMR), *GIRFEC*, Keeping Childbirth Natural and Dynamic (KCND) (Scottish Government (SG) 2007) programme and Pathways for Maternity Care (NHS Quality Improvement Scotland (QIS) 2009). They acknowledge the necessity for flexibility to meet individual and local needs and requirements.

Using the Getting it right for every child (*GIRFEC*) approach developed through the Highland Practice Model should ensure this response happens and it is the method that all services and agencies, who work with children and families, including those who work within adult services, should be implementing across Scotland (SG 2012).

This is the third version of the guidelines. The Planning for Fairness process has been applied to these guidelines to ensure equality and diversity.

* **baby** includes an unborn baby during the antenatal and intranatal periods.
(Midwives rules and standards, Nursing & Midwifery Council. 2012)

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2. Scope of the Guidelines

These guidelines will be useful to all those delivering maternity care, particularly midwives who undertake assessment of risk and need within a health and social context. They make reference to national and local policy and guidance that support best practice and includes local resources that are available to staff within Highland.

3. Objectives of the Guidelines

These guidelines have been developed to ensure:

- Maternity services play a key role in assessment and support of health and wellbeing during pregnancy and the early postnatal period in order to reduce inequalities in health.
- The principles and values of the Highland Practice Model (*GIRFEC*) are embedded in the delivery of maternity services.
- The potential impact of parental health and wellbeing is considered in respect of the parents' and children's welfare in both the short and long term.
- Staff are signposted to appropriate resources and guidance available to support them in their role.
- Recognition that women and their families should be included in the process of assessment of health and wellbeing with their views and opinions valued and considered, and that a proportionate and appropriate response is given.

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4. Tackling Health Inequalities through Public Health Practice

Inequalities in health arise because of inequalities in society and the conditions into which babies are born and how they are cared for and nurtured will have a direct impact on their future health and wellbeing. Disadvantage is often evident before birth and accumulates throughout life therefore action to reduce health inequalities must begin at the earliest stages (Department of Health 2010).

While a focus on vulnerable and disadvantaged families is crucial when planning services, the health gradient will only reduce if robust universal services provide the correct level of assessment, support and intervention. The strength of maternity services is that they offer all pregnant women and new mothers evidence based and quality standards of care based on principles that have their foundations in guidance from across the UK, developed into locally agreed policies and protocols.

Maternity statistics demonstrate an increasing and changing population of childbearing women, which poses challenges for midwives who are often at the forefront of maternity service delivery. Public health indicators such as deprivation, lifestyle factors and complex social issues make delivering services even more challenging in order to meet the needs of families.

However, maternity services have the potential to contribute significantly to the health of the nation by focusing on the opportunities that adopting a public health approach can bring. Midwives in particular have a major role in delivering health messages and identifying risk factors through promoting wellbeing, self-care and behaviour change approaches. These include identifying women who may need additional support with issues such as smoking, substance use, domestic abuse, mental health, poverty and access to services.

A key component in providing the correct level of support is the ability to identify risk and need and ensure appropriate, individualised care is provided within a scale and intensity that is proportionate to the level of risk, need or disadvantage. Partnership working within multidisciplinary and multiagency teams and services provides an opportunity to deliver truly client focused individualised care. Awareness of the circumstances and communities in which women and families live and the ability to recognise factors which may make them especially vulnerable are crucial to delivering effective care.

Developing an understanding of the different roles and responsibilities within a multiagency arena through joint training and working should ensure that practitioners are confident to engage with other services and agencies. Ensuring every child has the best start in life puts midwives at the centre of public health policy.

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5. Getting it right for every child – GIRFEC

GIRFEC is a programme of change across Scotland which provides practitioners with principles and practice models that enable them to focus on improving outcomes for all children. *GIRFEC* supports and builds on good practice delivered by universal services, with a shift in focus from intervening when a crisis occurs towards prevention, early support and early intervention (SG 2012). The *GIRFEC* approach delivered in Highland is known as the Highland Practice Model and all staff should be familiar with it.

The principles of *GIRFEC* describe provision of coordinated help for children and families to ensure that their health, wellbeing and development are not compromised by any delay in response, but provided in a timely manner, proportionate to their needs. Providing the correct level of support before problems escalate requires that all agencies work together to ensure Scotland's children get the best start in life.

Services to babies and their families are delivered through universal health services and most families will only require a core programme of care, delivered by the maternity team and later from health visitors (HVs) and GPs. Some babies and families may require additional help from within health services, for example the community paediatric team. Others will require coordinated support from another agency or service such as social work, who will work closely with the health team.

5.1 The Highland Practice Model

- In order to achieve their potential and best outcomes, every child needs to be safe, healthy, achieving, nurtured, active, respected and responsible and included (SHANARI). These **Wellbeing Indicators** form part of the Practice Model and have been identified from extensive research into child development, as areas which can make a positive difference to a child's life. They should be used as an aid for practitioners to identify when additional support may be required.
- If potential concerns are identified after considering the Wellbeing Indicators, the **My World Triangle** assessment tool provides an ecological model to enable practitioners to reflect on the whole world in which the child lives. It can assist practitioners to consider if any of the three domains that make up the assessment: 'How I grow and develop', 'What I need from people who look after me' and 'My Wider World' are likely to impact on wellbeing and development. This should enable practitioners undertaking assessment to focus on the areas and actions required to ensure best outcomes for all children.
- The use of the Wellbeing Indicators and the My World Triangle offers practitioners across all agencies and services the same assessment framework to facilitate a faster response to need by the use of a common language and process. *GIRFEC* places the importance of understanding risk within a framework that makes communication between practitioners more easily understood and therefore concerns can be acted on more quickly. The Practice Model acts as a communication tool, is outcomes focused and promotes partnership working.

Highland Children's Services Practice Guidance - Getting it right for every child addresses the models, principles and practice in greater detail. It should be familiar to all staff and is currently being updated <http://www.forhighlandschildren.org/5-practiceguidance/>

The full day training on the Highland Practice Model should be a requirement of all staff who have direct contact with children and families (specific contact workforce) including adult services. http://www.forhighlandschildren.org/3-icstraining/1-childprotection/index_55_2471785802.pdf

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6. Getting it Right in Maternity Services

The premise of *GIRFEC* is focused on the needs of a child; however within a maternity context the approach can be used as a model which provides the same principles and tools that can reflect the needs and risks to a woman and her baby. Therefore, early assessment during pregnancy can identify when a woman may require additional support to enable her and her baby to achieve the best health and wellbeing outcomes. Moreover, assessment and provision of support networks that promote health and wellbeing is core to the role of the midwife and is an important outcome of maternity care.

Identifying the need for early intervention is important when planning care and can often prevent escalation or deterioration of a current situation. Early intervention is described as:

- Early in the life of a child or unborn child
- Early in the spectrum of complexity
- Early in the life of a crisis

The Highland Practice Model requires that each child should have a plan which considers their health and wellbeing. Within universal health services this plan is developed by the named person who is responsible for delivering a service to the child. The aim in Scotland through the **Pathways for Maternity Care** (NHS QIS 2009) and the **Refreshed Framework for Maternity Care** (SG 2011a) is for each pregnant woman to have a named midwife who helps plan and coordinate care for the woman and her baby in partnership with the wider maternity team as required, and records the details of this in the SWHMR. The named midwife in Highland is able to undertake a named person role if required during pregnancy and develop an individual **Antenatal plan: additional support for mother and unborn baby** where additional needs are identified and this has been practice for many years now. Some of the smaller midwifery teams may have the midwifery team leader as the named midwife.

The named midwife is responsible for undertaking risk assessment at each contact and ensuring each woman follows the correct pathway of care, working closely with the wider team: obstetrician, the woman's GP and HV as appropriate.

When considering if additional support may be required to support wellbeing, the named midwife should consider the adaptation of the 5 key *GIRFEC* questions to help decision making. These are:

- What is getting in the way of this woman or baby's wellbeing?
- Do I have all the information I need to help this woman or baby?
- What can I do now to help this woman or baby?
- What can my service do to help?
- What help, if any, may be needed from others?

If any concerns are raised by any other agency or service that has contact with the mother, which may have the potential to affect the wellbeing of her and her baby, these should be shared with the named midwife. The midwife may need to discuss these concerns with the local Child Protection Advisor (CPA) and share these concerns as appropriate with social work. The **Interagency Guidelines to Protect Children and Young People in Highland**, (Highland Child Protection Committee 2013) must be followed

http://www.forhighlandchildren.org/2-childprotection/publications_90_2374507699.pdf

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The assessment of risk and need may identify that it is necessary to deliver additional or intensive support to a woman and baby through other disciplines within health or through a coordinated multiagency approach. Risk is dynamic and may change throughout the pregnancy and postnatal period

The need for additional support and early intervention from a Community Early Years Practitioner should be managed through an assessment based on the Highland Practice Model and shared with the Practice Lead Early Years who manages the service when early intervention is deemed appropriate. In other more complex situations the midwife will need to direct her concerns to social work or the local Family Team social work manager – now called the Practice Lead Care and Protection. The Family Teams form the operational structure within the new Care and Learning Service, Highland Council.

An **Antenatal Plan: additional support for mother and unborn baby** will assist the named midwife to undertake a thorough assessment of risks and needs for the mother and her baby who are identified as having additional or intensive needs. All midwifery teams should have access to the form which can also be downloaded from <http://www.forhighlandschildren.org/4-icspublication/>

If a multiagency Childs Plan is required the midwife will contribute to this plan, which is coordinated by an identified Lead Professional, which may or may not be the midwife. The named midwife will continue to provide her/his core role and function to support health and wellbeing in pregnancy based on assessment of risk and need. If assessment identifies that there are risks of significant harm then formal Child Protection Procedures must be followed.

7. Maternity Care

The aim of maternity care is to ensure the best outcomes for all mothers and babies. The most effective way to achieve this is through a process of continuous risk assessment and practice grounded in consistent, evidence based information and advice to ensure a high quality of care.

There are many policies, standards and guidelines that are available to support staff and enable them to undertake assessment of obstetric and medical risk in pregnancy. However, the Confidential Enquiry into Maternal and Child Health (CEMACH) in 2007 provided evidence that adverse pregnancy outcomes were often linked to vulnerability and social exclusion. **Mothers and babies: reducing risk through audits and confidential enquiries across the UK** (MBRRACE – UK) has now taken over this function of triennial reporting and issues such as access to care and mental health are still a feature in poorer outcomes <https://www.npeu.ox.ac.uk/mbrpace-uk/reports>

Therefore, the wider public health and social determinants of health must be recognised as just as important as medical or obstetric risk when planning care. Women who are vulnerable or with socially complex lives are far less likely to seek antenatal care early. They are less likely to stay in contact with maternity services unless they are designed to meet their specific need, which often requires flexibility to deliver services in a different way. Ensuring that appropriate support is provided may be achieved through developing opportunities that support multidisciplinary and multiagency working.

Many women may be in touch with other health providers including their GP, HV, addictions or mental health services and it is important that these health providers ensure close working with the woman's named midwife. There may also be contact with other agencies and services both before and during pregnancy which may include local authority and voluntary organisations. It is therefore important that maternity care providers use the contacts they have with other services innovatively to facilitate joint working, using opportunistic contacts to undertake maternity care and deliver health messages that support best practice and improve outcomes.

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7.1 Pre-pregnancy Care

Although maternity services do not always have an opportunity to be involved in pre-pregnancy care for women in their first pregnancy, they can influence future pregnancy planning through providing contraceptive and family planning advice. This is particularly important for women with complex social needs who may view their own health and wellbeing, including their sexual health, as low on their priorities.

The importance of brief intervention and behaviour change approaches that tackle lifestyle issues should be introduced pre-pregnancy. These include:

- Smoking
- Alcohol
- Medication and drug use
- Nutrition and exercise: including folic acid and other vitamin supplementation, maternal weight
- Dental health
- Sexual health and contraception
- Health screening and surveillance
- Pre-existing medical conditions: including diabetes, mental health conditions, epilepsy, cardiac

Opportunities to raise these issues should occur preferably before pregnancies are planned and should form part of general health and wellbeing discussions that begin with school age children around sexual health and relationships, and continue into all contacts with health professionals in primary care. Midwives should work in collaboration with education and voluntary sector colleagues to contribute to these agendas in schools, early year's settings and within youth services.

Mental health and wellbeing is an important area to address pre-pregnancy, particularly when there is a personal or family history of serious psychiatric disorders. A woman contemplating pregnancy with a mental health issue such as bipolar or schizophrenia or previous postnatal psychosis should have an opportunity to discuss her history and any medication with her GP and referral to the mental health team should be considered prior to conception to ensure she is very clear about what the proposed plan of care for her is likely to be. Many women will just stop their medication on finding out they are pregnant which can lead to a serious mental health crisis.

The **Perinatal Mental Health: Good Practice Guidelines** (NHS Highland 2008) should assist staff when working with women with mental health issues.

<http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Perinatal%20Mental%20Health%20Good%20Practice%20Guidelines.pdf>

or http://www.forhighlandschildren.org/4-icspublication/index_18_3666806153.pdf

Other important issues where a request for additional advice or services to women may include:

- Housing
- Income maximisation or money advice
- Social support and relationships

Early booking for antenatal care should be promoted to ensure women have an opportunity to make an informed choice of the full range of screening options and are offered the correct pathway of maternity care. The Scottish Government target is: ***At least 80% of pregnant women in each Scottish Index of Multiple Deprivation (SIMD) quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breastfeeding rates and other important health behaviours.***

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7.2 Antenatal Care

Pregnancy is often the first time in a woman's life that she will enter into a system of regular contact with health staff and it offers an ideal opportunity to involve women and their families in their personal health and wellbeing, engage them in health improvement and promotion, and support behaviour changes that can improve their future health beyond pregnancy.

- The **Pathways for Maternity Care** (NHS QIS 2009) provide a guide to enable practitioners to undertake risk assessment at recommended contact times through pregnancy, birth and postnatally. They offer general guidance for maternity staff around assessment of obstetric, medical and social risk to mother and baby, and support the use of the SWHMR.
- The **Refreshed Framework for Maternity Care in Scotland** (SG 2011a) now embraces a broader public health focus in addressing health inequalities through the use of strengths or assets based approach. The Refreshed Framework complements the original and should be used alongside it.

The antenatal booking appointment in particular forms the basis of a therapeutic relationship between the woman and her named midwife which will continue throughout the pregnancy. A **Pathway of Care for Vulnerable Families 0-3** (SG 2011b) reinforces the important role of routine universal contacts with women and provides examples of criteria for identifying woman and families who may require additional support and in particular those who may be more vulnerable. A diary insert has been developed that staff should make reference to (Appendix 1).

Although many women and families are seen at clinics in the community, home visiting should occur more routinely for those with intensive or complex needs to ensure a robust assessment of their situation and allow more time for discussion and planning appropriate care.

Providing information to women about screening, surveillance and health promotion in pregnancy is essential and **Highland's Information Trail** should be used to ensure a standardised, quality assured approach across Highland. It is updated annually (HC & NHS Highland, 2014). It contains a list of resources that families should have access to as required and is updated annually.

<http://intranet.nhsh.scot.nhs.uk/Org/CorpServ/PublicHealth/Lists/Announcements/DispForm.aspx?ID=49>

http://www.forhighlandschildren.org/4-icspublication/index_124_1837371241.pdf

7.3 Risk Assessment

Assessment of risk and need is fundamental when planning care and maternity services are well placed to identify those families that may require additional or intensive support to enable them to meet their optimal health and wellbeing needs.

The process of assessment begins at booking and midwives will follow the **Revised procedure for the communication and handover of health and social information between midwife and health visitor** (NHSH/HC 2014) to ensure that joint working and information sharing occurs within the wider maternity team at the earliest stages in pregnancy. If any additional needs are identified at any stage during pregnancy these concerns must be discussed with the woman's GP and the HV as early as possible so that care can be planned effectively well before the baby is born.

http://www.forhighlandschildren.org/4-icspublication/index_126_3619633817.pdf

or

<http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/The%20Communication%20and%20Handover%20of%20Health%20and%20Social%20Information%20Between%20Midwife%20and%20Health%20Visitor.pdf>

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7.3.1. Antenatal Plan

Requests for resources from another agency or service can be made through the **Antenatal Plan: additional support for mother and unborn baby**, which replaces the need for the different request forms used across agencies (Appendix 2). The **Antenatal Plan** does not contain any confidential health information and therefore makes sharing the health professional's assessment of additional or intensive social need with another agency more straightforward. Assessment begins at booking however it may take several contacts and time to gather further information before a full picture can be established of those needs. Where possible this should be in place by 18 weeks. The **Antenatal Plan** should be shared with the woman's GP, HV and obstetrician and can be used to populate a **multiagency Child's Plan** if needed

Missed appointments are an important indicator of engagement with services and if a woman does not attend an appointment, good practice would suggest that this should always be followed up by her named midwife. A woman may have just forgotten, but missed appointments may indicate that her plan of care may need to be reviewed or adapted and she may have additional needs. The chronology if used should be kept in the mother's summary record by the midwife and details shared as appropriate. A copy should be sent to the HV at handover, together with the completed handover records.

If an antenatal mother is missing from known address, the midwife should discuss with the CPA who will assist with a decision to complete the missing from known address checklist and whether a Missing Family Alert is required to inform staff in other areas.

8. Child Protection

Any concerns around risk and need identified at any stage during pregnancy, must be communicated with the local CPA and if required a child concern form should be completed and shared with social work as detailed in the **Interagency Guidelines to Protect Children and Young People in Highland** (Highland Child Protection Committee, 2013).

It is important that effective communication with the wider maternity team (GP, obstetrician, HV) and social work is maintained at all stages in pregnancy, and a prebirth planning meeting must take place where there are any issues of concern, to ensure all partners supporting a coordinated plan for the baby are involved and included. When a case of potential significant harm to a baby is identified at any stage in pregnancy, immediate Child Protection Procedures must be followed.

- A Child Protection Plan meeting should take place **no later** than 28 weeks of pregnancy or as soon as possible from the concern being raised, and certainly within 21 days of the concern (SG 2010).
- All partners to the plan should be included in the meeting and agreement can be made at any stage of pregnancy or following birth for the baby to go on the Child Protection Register, if deemed necessary.
- All decisions and actions must be clearly documented in the woman's medical notes held in the maternity base where she will deliver. If a woman is transferred to another unit for delivery this information must be communicated to the delivering unit as a matter of urgency.
- At the time of delivery the midwife in charge should contact the appropriate social work team within the Family Team or the emergency team out with office hours to inform them of the birth. The named community midwife must also be informed of delivery as soon as is practically possible.

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Practitioners should remember that having a child's name on the Child Protection Register does not offer it any protection unless they continue surveillance and act appropriately by following child protection procedures and liaising closely with the CPA and social work. Staff must ensure that they are clear about their roles and responsibilities and always act within their professional codes of conduct which support their practice.

When a decision has been made to remove a child to a place of safety at birth as detailed in a Child Protection Order:

- this must be clearly documented in the medical notes and the woman will require to be delivered at a unit that will facilitate this (Raigmore for North Highland).
- The midwife in charge of the delivery must inform social work immediately and also inform the named community midwife, who will continue to provide support to the mother.

For those women whose babies will not go home with them due to Child Protection Orders or chosen adoption, professionals should continue to offer the same high standard of care to women and treat them with dignity and respect.

Training around child protection and the Highland Practice Model is available for all staff across agencies and a minimum attendance every 3 years is a requirement to support best practice. Details can be found on the For Highlands Children site <http://www.forhighlandschildren.org/3-icstraining/1-childprotection/>

9. Continuing Support, Postnatal Care

Close liaison and effective handover with the family's HV and GP must be maintained throughout pregnancy and the postnatal period to ensure appropriate provision of care is maintained and sources of further help and support are sought following birth.

Opportunities to deliver early support and intervention to a woman in pregnancy should mean that by the time her baby is born, she should have experienced a high quality joined up service to support, enable and empower her transition into motherhood. The importance of investment in the early years particularly for the most vulnerable through working creatively with partners in other agencies is key to improving outcomes. The impact that pregnancy and the early years can have on outcomes for women and their families is documented in The Early Years Framework (Scottish Government 2008) and through the national development of the Early Years Collaborative <http://www.scotland.gov.uk/Topics/People/Young-People/early-years/early-years-collaborative>

Advice around lifestyle factors and general health and wellbeing should continue following birth and particular importance should be placed on support and advice around attachment and parenting. The implications of poor quality attachment relationships with adult carers on infant mental health are becoming more widely understood. **Infant Mental Health (prebirth – 3 years): Best Practice Guidelines** (Highland 2012) are available to support staff to facilitate positive attachments http://www.forhighlandschildren.org/4-icspublication/index_56_3923857013.pdf or [http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Infant%20Mental%20Health%20\(prebirth%20%203%20years\)%20Best%20Practice%20Guidelines%20North%20Highland.pdf](http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Infant%20Mental%20Health%20(prebirth%20%203%20years)%20Best%20Practice%20Guidelines%20North%20Highland.pdf)

Other resources include the GIRFEC pregnancy wheel, the magazine bag and Before Words which are all issued to pregnant women in Highland as per the Highland Information Trail.

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The universal provision of care is handed over to the HV at around 10 days following birth and he/she should be fully informed of any additional / intensive needs the baby and family may have by the named midwife. Hopefully the HV will have met the mother before her baby is delivered which is particularly important for those women who have additional/intensive needs identified in pregnancy by the midwife.

HVs deliver a universal service to children and families in line with local and national policy that supports the recommendations of Health for all Children (Hall 4 – Hall & Elliman, 2003) and the Hall 4 guidance produced by the Scottish Executive in 2005. Hall 4 recommended the allocation of Health Plan Indicators (HPIs) to determine future contact and support required for the child based on assessment of need. This is captured within the Child Health Surveillance Programme (CHSP), ISD Scotland.

HVs are well placed to work with partners across agencies and services to ensure children and families receive the correct level of support to enable children to reach their full potential. They can identify when children are in need of further help or protection and share their concerns and assessments with social care colleagues within their Family Team.

The Hall 4 schedule is currently under review.

10. Supporting Parents

In order to support the important role that parenting has on future outcomes for children, many staff across agencies in Highland have been trained to deliver different types of parenting support. The investment in parenting support can ensure staff are able to inform parents of the benefits of practical things they can do to promote the bond with their infant, such as baby massage and affectionate communication.

The focus on redesign of parenting preparation has been under discussion for some time and local and national work is continually being developed. In conjunction with partners across Highland through a local Supporting Parents Improvement Group, a Supporting Parents Framework has been developed based on the National Parenting Framework and all staff should be familiar with this. http://www.forhighlandschildren.org/4-icspublication/index_132_3013325563.pdf

This Framework will form the basis of development of local parenting plans for ages 0 – 18years. Mapping of current provision and services against the Framework is currently being undertaken.

The Scottish Antenatal Parent Education Pack has been developed by NHS Health Scotland to assist those delivering antenatal parent education and contains a variety of activities and discussion topics for use in pregnancy.

<http://www.maternal-and-early-years.org.uk/the-scottish-antenatal-education-pack>

All maternity bases have these packs and staff are required to understand the use of motivational interviewing and behaviour change principles that facilitate self-motivation to make positive health and wellbeing choices in order to develop this work more effectively.

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11. Conclusion

The early experiences that a child has will shape its future health and wellbeing, Maternity services that focus on a social model of care firmly embedded in the wider community where women and their families live will help to achieve better outcomes for children and families. This will require working that focuses on building partnerships that cross conventional care boundaries but yet respect and understand each other's unique roles and area of expertise.

Multiagency assessment, planning and delivering care requires a clear vision for services with effective leadership that supports frontline staff. This will enable the interface of maternity services with other agencies or services particularly with the new Family Team structures in the Care and Learning Service, Highland Council which is important if health inequalities are to be tackled.

Families will judge the experiences of maternity health care provision as a platform for future engagement with services. Hopefully theirs will be a positive experience and even when health or social problems may become evident through this journey, families should feel that they have been engaged in decisions and processes, and informed and involved in their care. Therefore maternity services play an important role in ensuring that those early contacts and assessments which they undertake support the provision of services within the Highland Practice Model (*GIRFEC*) approach.

Maternity practitioners work within an environment that understands the importance of assessment of risk and need and *GIRFEC* provides health staff with the same practice models and tools as our partners in the local authority and third sector (voluntary and private) when assessing and planning care within a health and social context. This approach will help to ensure that effective early intervention and support is provided in an attempt to offset the often inter-generational factors that continue to undermine the health and wellbeing of children and families every day.

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Guidelines for Maternity Services Getting it Right for Every Mother & Child

Appendix 1

A Pathway of Care for Vulnerable Families: Conception - 3

The Scottish Government developed this section and has sought permission for it to be included in the Pathways for Maternity Care.¹ It is intended as a resource to be used alongside clinical judgement to support women, children and families who may have an identified additional need.

Purpose

There is no fixed definition of 'vulnerability'. The impact that a risk or potential risk factor has on an individual pregnant woman, child or family is dependent on their own life circumstances. Risks rarely exist in isolation, and vary in impact, on outcomes, at different ages and stages across the life course. This tool is to support a common approach to reducing health inequalities in the very early years, conception to age 3. It is not intended as a checklist, but rather an aide memoire to help support clinical practice and judgement when assessing the needs of a pregnant woman, child or family.

The Named Person²

Most children and young people will get all the help and support they need from their families, the universal services of education and health, and the provision available to everyone within their neighbourhoods and communities. Even so, at various times in their childhood and adolescence, many children and young people will need some extra help that can be provided from universal services. Through children and families knowing who to contact, their access to help is made easier. This is an essential feature of a child centred approach to early intervention.

If the child's needs require help from more than one agency, as part of early intervention, the Named Person will take on the role of Lead Professional as a direct progression from the existing support set out in the single agency child's plan, provided this is compatible with their core responsibilities and area of expertise.

1. NHS Quality Improvement Scotland. Pathways for maternity care. 2009 [cited 2011 Feb 11]; Available from: [www.nhshealthquality.org/nhsqis/files/Final%20KCND%20pathway\[1\].pdf](http://www.nhshealthquality.org/nhsqis/files/Final%20KCND%20pathway[1].pdf)
2. The Scottish Government. GIRFEC practice briefings [online]. 2010 [cited 2011 Feb 10]; Available from: [www.scotland.gov.uk/Topics/People/Young-People/children's services/girfec/publications/practice briefings](http://www.scotland.gov.uk/Topics/People/Young-People/children's%20services/girfec/publications/practice%20briefings) NICE (2010): Pregnancy and complex social factors. London: NICE
3. NICE (2010): Pregnancy and complex social factors. London: NICE

Examples of High Risk Groups³

- Women misusing substances (drugs and/or alcohol)
- Women experiencing domestic abuse
- Women under 20 years
- Women who are recent migrants, asylum seekers or refugees, or have difficulty reading or speaking English

Principles

Getting it right for every child (GIRFEC)

- What is getting in the way of this child or young person's well-being?
- Do I have all the information I need to help this child or young person?
- What can I do now to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?
- Remember to keep mother and baby in mind.

Inequalities sensitive practice

- Be aware of how social circumstances (poverty, disability, domestic abuse) impact on health and health behaviours (smoking, alcohol and drug use)
- Sensitive enquiry into life circumstances
- Empathise- demonstrate this in language and behaviour
- Identify woman's strengths and risks with the woman
- Be aware of health literacy- use teach back

Strengths (examples)

- Social networks
- Support/relationship
- Sense of humour/personality
- Motivation

Risks (examples)

- Not in supportive relationship
- Own experience- e.g. abuse
- Depressed or vulnerable emotionally
- Poverty
- Learning difficulty /disability

Guidelines for Maternity Services Getting it Right for Every Mother & Child

Examples of criteria used in maternity services for identifying some of the most vulnerable women and families⁴

Substance Misuse

- Alcohol and/or drug misuse in woman and/or partner in last 12 months

Blood Borne Virus

- HIV + woman and /or with a known HIV + partner

Vulnerable Women

- Significant or current mental health issues (such as bipolar disorder or schizophrenia) impacting on their ability to parent a child and that may lead to child protection issues
- Late booker (over 20 weeks) with additional concerns +/- concealed pregnancy
- Women disengaged from mainstream maternity services (such as recurrent defaulter, or women with difficulties registering with a GP)
- Complex under 16's
- Unaccompanied asylum seeking children
- Mother in care (under 16)
- Gender based violence and/or abuse associated with child protection issues
- Vulnerable adult (eg learning disability that may lead to difficulty with ability to parent a child and child protection issues)
- Involvement in sex trade/forced prostitution
- Women who conceived in difficult circumstances and/or as a result of rape
- Mother leaving looked after services (16 0 Or over) or working with leaving care services

Child Protection Concerns

- Women who have or whose partners have current and/or past involvement with criminal justice system involving child protection issues (eg schedule 1 offence)
- Current or previously identified child protection issues (including children previously in care or on Child Protection Register)

Asylum Seeker/Refugee

- Disclosure of female genital mutilation (FGM)
- Failed or destitute asylum seekers or illegal entrants
- Women who have been trafficked to the UK
- Women who have been victims of torture/imprisonment
- Asylum seekers or refugee with any of the above issues

Others to consider

- Homeless families with any of the above issues
- Teenage pregnancy with any of the above

Examples of criteria for identifying children and families potentially requiring additional support from public health nursing services

Early Postnatal Additional Needs

- Postnatal depression
- First time parents
- Mothers recovering from a difficult delivery
- New babies up to 8 weeks of age
- All children in neonatal unit until completion of SOGS assessment
- Breastfeeding mothers depending on need
- Families with 2 or more children depending on need

Vulnerable Families

- Families new to area
- Children with isolated, unsupported partner
- Previous history of child bereavement
- Serious illness or parent/child
- Children/parents with complex needs
- Children whose emotional, psychological needs
- Children experiencing a crisis likely to result in a breakdown of care arrangements
- Significant life events, eg. bereavement/homelessness
- Children with disabilities including communication disorders

- Children with complex care needs, chronic ill health or terminal illness
- Children with emotional, behavioural, development or mental health issues
- Families with literacy issues
- Children isolated from services due to geography, resources or parenting capacity
- Children whose development may be affected by a succession of carers
- Specific behavioural problems e.g. sleep difficulties
- Obesity and/or other weight issues
- Children in families where there is poor hygiene
- Children involved in contact/residence disputes
- Failure to thrive/developmental delay

Child Protection concerns

- Children on child protection register
- Children recently removed from the child protection register
- Children subject to supervision requirement
- Chronology indicating high mobility
- Chronology failed health appointments
- Chronology frequent no access
- Looked after and accommodated children
- Children experiencing a crisis likely to result in breakdown of care arrangements

Others to consider

- Parents who self-refer for additional support
- Young carers

4. NHS Greater Glasgow and Clyde Women's and Children's Directorate. Special needs in pregnancy: referral criteria [unpublished internal document]. NHS Greater Glasgow and Clyde, [no date]

Appendix 2

Flowchart for Antenatal Plan

