

Pregnancy and complex social factors

A model for service provision for pregnant women with complex social factors

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Introduction

The NICE guideline 'Antenatal care: routine care for the healthy pregnant woman' ([NICE clinical guideline 62](#)) outlines the care that women should be offered during pregnancy. However, pregnant women with complex social factors may have additional needs. This guideline sets out what healthcare professionals as individuals, and antenatal services as a whole, can do to address these needs and improve pregnancy outcomes in this group of women.

The guideline has been developed in collaboration with the Social Care Institute for Excellence. It 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 will be of relevance to professionals working in social services and education/childcare settings, for example school nurses, substance misuse service workers, reception centre workers and domestic abuse support workers.

The guideline applies to all pregnant women with complex social factors and contains a number of recommendations on standards of care for this population as a whole. However, four groups of women were identified as exemplars:

- women who misuse substances (alcohol and/or drugs)
- women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English
- young women aged under 20
- women who experience domestic abuse.

Because there are differences in the barriers to care and particular needs of these four groups, specific recommendations have been made for each group.

The guideline describes how access to care can be improved, how contact with antenatal carers can be maintained, the additional support and consultations that are required and the additional information that should be offered to pregnant women with complex social factors.

Specific issues that are addressed in the guideline include:

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- the most appropriate healthcare setting for antenatal care provision
 - practice models for overcoming barriers and facilitating access, including access to interpreting services and all necessary care
 - ways of communicating information to women so that they can make appropriate choices
 - optimisation of resources.

In addition to the recommendations in this guideline, the principles of woman-centred care and informed decision making outlined in 'Antenatal care' ([NICE clinical guideline 62](#)), specifically recommendations on the provision of antenatal information and individualised care, are of particular relevance to women with complex social factors.

Woman-centred care

This guideline offers best practice advice on the care of pregnant women with complex social factors.

Women should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman in relation to her care and that of her baby should be sought and respected at all times.

Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If women do not have the capacity to make decisions, healthcare professionals should do not have the capacity to make decisions, healthcare professionals should follow the [Department of Health's advice on consent](#) and the [code of practice that accompanies the Mental Capacity Act](#). In Wales, healthcare professionals should follow [advice on consent from the Welsh Government](#).

If the woman is under 16, healthcare professionals should follow the guidelines in the Department of Health's ['Seeking consent: working with children'](#).

Good communication between healthcare professionals and women is essential. It should be supported by evidence-based, written information tailored to the woman's needs. Treatment and care, and the information women are given about it, should be culturally appropriate. It should also be accessible to women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English.

If the woman agrees, partners and relevant family members should have the opportunity to be involved in decisions about treatment and care.

Partners and relevant family members should also be given the information and support they need.

Key priorities for implementation

General recommendations

The recommendations in this section apply to all pregnant women covered in this guideline.

Service organisation

- In order to inform mapping of their local population to guide service provision, commissioners should ensure that the following are recorded:
 - The number of women presenting for antenatal care with any complex social factor^[1].
 - The number of women within each complex social factor grouping identified locally.
- Commissioners should ensure that the following are recorded separately for each complex social factor grouping:
 - The number of women who:
 - ◇ attend for booking by 10, 12⁺⁶ and 20 weeks.
 - ◇ attend for the recommended number of antenatal appointments, in line with national guidance^[2].
 - ◇ experience, or have babies who experience, mortality or significant morbidity^[3].
 - The number of appointments each woman attends.
 - The number of scheduled appointments each woman does not attend.
- Commissioners should ensure that women with complex social factors presenting for antenatal care are asked about their satisfaction with the services provided; and the women's responses are:
 - recorded and monitored
 - used to guide service development.

Care provision

- Consider initiating a multi-agency needs assessment, including safeguarding issues^[4], so that the woman has a coordinated care plan.
- Respect the woman's right to confidentiality and sensitively discuss her fears in a non-judgemental manner.
- Tell the woman why and when information about her pregnancy may need to be shared with other agencies.

Information and support for women

- For women who do not have a booking appointment at the first contact with any healthcare professional:
 - discuss the need for antenatal care
 - offer the woman a booking appointment in the first trimester, ideally before 10 weeks if she wishes to continue the pregnancy, **or** offer referral to sexual health services if she is considering termination of the pregnancy.
- In order to facilitate discussion of sensitive issues, provide each woman with a one-to-one consultation, without her partner, a family member or a legal guardian present, on at least one occasion.

Pregnant women who misuse substances (alcohol and/or drugs)

Service organisation

- Healthcare commissioners and those responsible for the organisation of local antenatal services should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example:
 - jointly developing care plans across agencies
 - including information about opiate replacement therapy in care plans
 - co-locating services
 - offering women information about the services provided by other agencies.

Training for healthcare staff

- Healthcare professionals should be given training on the social and psychological needs of women who misuse substances.
- Healthcare staff and non-clinical staff such as receptionists should be given training on how to communicate sensitively with women who misuse substances.

Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English

Service organisation

- Those responsible for the organisation of local antenatal services should provide information about pregnancy and antenatal services, including how to find and use antenatal services, in a variety of:
 - formats, such as posters, notices, leaflets, photographs, drawings/diagrams, online video clips, audio clips and DVDs
 - settings, including pharmacies, community centres, faith groups and centres, GP surgeries, family planning clinics, children's centres, reception centres and hostels
 - languages.

Young pregnant women aged under 20

Service organisation

- Commissioners should consider commissioning a specialist antenatal service for young women aged under 20, using a flexible model of care tailored to the needs of the local population. Components may include:
 - antenatal care and education in peer groups in a variety of settings, such as GP surgeries, children's centres and schools
 - antenatal education in peer groups offered at the same time as antenatal appointments and at the same location, such as a 'one-stop shop' (where a range of services can be accessed at the same time).

Pregnant women who experience domestic abuse

Service organisation

- Commissioners and those responsible for the organisation of local antenatal services should ensure that a local protocol is written, which:
 - is developed jointly with social care providers, the police and third-sector agencies by a healthcare professional with expertise in the care of women experiencing domestic abuse.
 - includes:
 - ◇ clear referral pathways that set out the information and care that should be offered to women
 - ◇ the latest government guidance on responding to domestic abuse^[1]
 - ◇ sources of support for women, including addresses and telephone numbers, such as social services, the police, support groups and women's refuges
 - ◇ safety information for women
 - ◇ plans for follow-up care, such as additional appointments or referral to a domestic abuse support worker
 - ◇ obtaining a telephone number that is agreed with the woman and on which it is safe to contact her
 - ◇ contact details of other people who should be told that the woman is experiencing domestic abuse, including her GP.

^[1] Examples of complex social factors in pregnancy include: poverty; homelessness; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; domestic abuse. Complex social factors may vary, in both type and prevalence, across different local populations.

^[2] See 'Antenatal care' ([NICE clinical guideline 62](#)).

^[3] Significant morbidity is morbidity that has a lasting impact on either the woman or the child.

^[4] For example, using the [Common Assessment Framework](#).

^[5] [Department of Health](#) (2005) Responding to domestic abuse. A handbook for healthcare professionals. London: Department of Health.

1 Guidance

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

In this guideline the following definitions are used.

- Domestic abuse: an incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. It can also include forced marriage, female genital mutilation and 'honour violence'.
- Recent migrants: women who moved to the UK within the previous 12 months.
- Substance misuse (alcohol and/or drugs): regular use of recreational drugs, misuse of over-the-counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile substances (such as solvents or inhalants) to an extent whereby physical dependence or harm is a risk to the woman and/or her unborn baby.

1.1 General recommendations

The recommendations in this section apply to all pregnant women covered in this guideline.

Service organisation

1.1.1 In order to inform mapping of their local population to guide service provision, commissioners should ensure that the following are recorded:

- The number of women presenting for antenatal care with any complex social factor^[6].
- The number of women within each complex social factor grouping identified locally.

1.1.2 Commissioners should ensure that the following are recorded separately for each complex social factor grouping:

- The number of women who:

- attend for booking by 10, 12⁺⁶ and 20 weeks.
 - attend for the recommended number of antenatal appointments, in line with national guidance^[7].
 - experience, or have babies who experience, mortality or significant morbidity^[8].
- The number of appointments each woman attends.
 - The number of scheduled appointments each woman does not attend.

1.1.3 Commissioners should ensure that women with complex social factors presenting for antenatal care are asked about their satisfaction with the services provided; and the women's responses are:

- recorded and monitored
- used to guide service development.

1.1.4 Commissioners should involve women and their families in determining local needs and how these might be met.

1.1.5 Those responsible for the organisation of local maternity services should enable women to take a copy of their hand-held maternity notes when moving from one area or hospital to another.

Training for healthcare staff

1.1.6 Healthcare professionals should be given training on multi-agency needs assessment^[9] and national guidelines on information sharing^[10].

Care provision

1.1.7 Consider initiating a multi-agency needs assessment, including safeguarding issues^[10], so that the woman has a coordinated care plan.

1.1.8 Respect the woman's right to confidentiality and sensitively discuss her fears in a non-judgemental manner.

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- 1.1.9 Tell the woman why and when information about her pregnancy may need to be shared with other agencies.
- 1.1.10 Ensure that the hand-held maternity notes contain a full record of care received and the results of all antenatal tests.

Information and support for women

- 1.1.11 For women who do not have a booking appointment at the first contact with any healthcare professional:
- discuss the need for antenatal care
 - offer the woman a booking appointment in the first trimester, ideally before 10 weeks if she wishes to continue the pregnancy, **or** offer referral to sexual health services if she is considering termination of the pregnancy.
- 1.1.12 At the first contact and at the booking appointment, ask the woman to tell her healthcare professional if her address changes, and ensure that she has a telephone number for this purpose.
- 1.1.13 At the booking appointment, give the woman a telephone number to enable her to contact a healthcare professional outside of normal working hours, for example the telephone number of the hospital triage contact, the labour ward or the birth centre.
- 1.1.14 In order to facilitate discussion of sensitive issues, provide each woman with a one-to-one consultation, without her partner, a family member or a legal guardian present, on at least one occasion.

1.2 Pregnant women who misuse substances (alcohol and/or drugs)

Pregnant women who misuse substances may be anxious about the attitudes of healthcare staff and the potential role of social services. They may also be overwhelmed by the involvement of multiple agencies. These women need supportive and coordinated care during pregnancy.

1.2.1 Work with social care professionals to overcome barriers to care for women who misuse substances. Particular attention should be paid to:

- integrating care from different services
- ensuring that the attitudes of staff do not prevent women from using services
- addressing women's fears about the involvement of children's services and potential removal of their child, by providing information tailored to their needs
- addressing women's feelings of guilt about their misuse of substances and the potential effects on their baby.

Service organisation

1.2.2 Healthcare commissioners and those responsible for providing local antenatal services should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example:

- jointly developing care plans across agencies
- including information about opiate replacement therapy in care plans
- co-locating services
- offering women information about the services provided by other agencies.

1.2.3 Consider ways of ensuring that, for each woman who misuses substances:

- progress is tracked through the relevant agencies involved in her care
- notes from the different agencies involved in her care are combined into a single document
- there is a coordinated care plan.

1.2.4 Offer the woman a named midwife or doctor who has specialised knowledge of, and experience in, the care of women who misuse substances, and provide a direct-line telephone number for the named midwife or doctor.

Training for healthcare staff

- 1.2.5 Healthcare professionals should be given training on the social and psychological needs of women who misuse substances.
- 1.2.6 Healthcare staff and non-clinical staff such as receptionists should be given training on how to communicate sensitively with women who misuse substances.

Information and support for women

- 1.2.7 The first time a woman who misuses substances discloses that she is pregnant, offer her referral to an appropriate substance misuse programme.
- 1.2.8 Use a variety of methods, for example text messages, to remind women of upcoming and missed appointments.
- 1.2.9 The named midwife or doctor should tell the woman about relevant additional services (such as drug and alcohol misuse support services) and encourage her to use them according to her individual needs.
- 1.2.10 Offer the woman information about the potential effects of substance misuse on her unborn baby, and what to expect when the baby is born, for example what medical care the baby may need, where he or she will be cared for and any potential involvement of social services.
- 1.2.11 Offer information about help with transportation to appointments if needed to support the woman's attendance.

1.3 Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English

Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English, may not make full use of antenatal care services. This may be

because of unfamiliarity with the health service or because they find it hard to communicate with healthcare staff.

1.3.1 Healthcare professionals should help support these women's uptake of antenatal care services by:

- using a variety of means to communicate with women
- telling women about antenatal care services and how to use them
- undertaking training in the specific needs of women in these groups.

Service organisation

1.3.2 Commissioners should monitor emergent local needs and plan and adjust services accordingly.

1.3.3 Healthcare professionals should ensure they have accurate information about a woman's current address and contact details during her pregnancy by working with local agencies that provide housing and other services for recent migrants, asylum seekers and refugees, such as asylum centres.

1.3.4 To allow sufficient time for interpretation, commissioners and those responsible for the organisation of local antenatal services should offer flexibility in the number and length of antenatal appointments when interpreting services are used, over and above the appointments outlined in national guidance^[6].

1.3.5 Those responsible for the organisation of local antenatal services should provide information about pregnancy and antenatal services, including how to find and use antenatal services, in a variety of:

- formats, such as posters, notices, leaflets, photographs, drawings/diagrams, online video clips, audio clips and DVDs
- settings, including pharmacies, community centres, faith groups and centres, GP surgeries, family planning clinics, children's centres, reception centres and hostels
- languages.

Training for healthcare staff

1.3.6 Healthcare professionals should be given training on:

- the specific health needs of women who are recent migrants, asylum seekers or refugees, such as needs arising from female genital mutilation or HIV
- the specific social, religious and psychological needs of women in these groups
- the most recent government policies on access and entitlement to care for recent migrants, asylum seekers and refugees^[1].

Information and support for women

1.3.7 Offer the woman information on access and entitlement to healthcare.

1.3.8 At the booking appointment discuss with the woman the importance of keeping her hand-held maternity record with her at all times.

1.3.9 Avoid making assumptions based on a woman's culture, ethnic origin or religious beliefs.

Communication with women who have difficulty reading or speaking English

1.3.10 Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman's family, her legal guardian or her partner) who can communicate with her in her preferred language.

1.3.11 When giving spoken information, ask the woman about her understanding of what she has been told to ensure she has understood it correctly.

1.4 Young pregnant women aged under 20

Young pregnant women aged under 20 may feel uncomfortable using antenatal care services in which the majority of service users are in older age groups. They may be reluctant to recognise their pregnancy or inhibited by embarrassment and fear of parental reaction. They may also have practical problems such as difficulty getting to and from antenatal appointments.

1.4.1 Healthcare professionals should encourage young women aged under 20 to use antenatal care services by:

- offering age-appropriate services
- being aware that the young woman may be dealing with other social problems
- offering information about help with transportation to and from appointments
- offering antenatal care for young women in the community
- providing opportunities for the partner/father of the baby to be involved in the young woman's antenatal care, with her agreement.

Service organisation

1.4.2 Commissioners should work in partnership with local education authorities and third-sector agencies to improve access to, and continuing contact with, antenatal care services for young women aged under 20.

1.4.3 Commissioners should consider commissioning a specialist antenatal service for young women aged under 20, using a flexible model of care tailored to the needs of the local population. Components may include:

- antenatal care and education in peer groups in a variety of settings, such as GP surgeries, children's centres and schools
- antenatal education in peer groups offered at the same time as antenatal appointments and at the same location, such as a 'one-stop shop' (where a range of services can be accessed at the same time).

1.4.4 Offer the young woman aged under 20 a named midwife, who should take responsibility for and provide the majority of her antenatal care, and provide a direct-line telephone number for the named midwife.

Training for healthcare staff

1.4.5 Healthcare professionals should be given training to ensure they are knowledgeable about safeguarding responsibilities for both the young woman

and her unborn baby, and the most recent government guidance on consent for examination or treatment^[12].

Information and support for women

- 1.4.6 Offer young women aged under 20 information that is suitable for their age – including information about care services, antenatal peer group education or drop-in sessions, housing benefit and other benefits – in a variety of formats.

1.5 Pregnant women who experience domestic abuse

A woman who is experiencing domestic abuse may have particular difficulties using antenatal care services: for example, the perpetrator of the abuse may try to prevent her from attending appointments. The woman may be afraid that disclosure of the abuse to a healthcare professional will worsen her situation, or anxious about the reaction of the healthcare professional.

- 1.5.1 Women who experience domestic abuse should be supported in their use of antenatal care services by:
- training healthcare professionals in the identification and care of women who experience domestic abuse
 - making available information and support tailored to women who experience or are suspected to be experiencing domestic abuse
 - providing a more flexible series of appointments if needed
 - addressing women's fears about the involvement of children's services by providing information tailored to their needs.

Service organisation

- 1.5.2 Commissioners and those responsible for the organisation of local antenatal services should ensure that local voluntary and statutory organisations that provide domestic abuse support services recognise the need to provide coordinated care and support for service users during pregnancy.

1.5.3 Commissioners and those responsible for the organisation of local antenatal services should ensure that a local protocol is written, which:

- is developed jointly with social care providers, the police and third-sector agencies by a healthcare professional with expertise in the care of women experiencing domestic abuse
- includes:
 - clear referral pathways that set out the information and care that should be offered to women
 - the latest government guidance on responding to domestic abuse^[13]
 - sources of support for women, including addresses and telephone numbers, such as social services, the police, support groups and women's refuges
 - safety information for women
 - plans for follow-up care, such as additional appointments or referral to a domestic abuse support worker
 - obtaining a telephone number that is agreed with the woman and on which it is safe to contact her
 - contact details of other people who should be told that the woman is experiencing domestic abuse, including her GP.

1.5.4 Commissioners and those responsible for the organisation of local antenatal services should provide for flexibility in the length and frequency of antenatal appointments, over and above those outlined in national guidance^[6] to allow more time for women to discuss the domestic abuse they are experiencing.

1.5.5 Offer the woman a named midwife, who should take responsibility for and provide the majority of her antenatal care.

Training for healthcare staff

- 1.5.6 Commissioners of healthcare services and social care services should consider commissioning joint training for health and social care professionals to facilitate greater understanding between the two agencies of each other's roles, and enable healthcare professionals to inform and reassure women who are apprehensive about the involvement of social services.
- 1.5.7 Healthcare professionals need to be alert to features suggesting domestic abuse and offer women the opportunity to disclose it in an environment in which the woman feels secure. Healthcare professionals should be given training on the care of women known or suspected to be experiencing domestic abuse that includes:
- local protocols
 - local resources for both the woman and the healthcare professional
 - features suggesting domestic abuse
 - how to discuss domestic abuse with women experiencing it
 - how to respond to disclosure of domestic abuse.

Information and support for women

- 1.5.8 Tell the woman that the information she discloses will be kept in a confidential record and will not be included in her hand-held record.
- 1.5.9 Offer the woman information about other agencies, including third-sector agencies, which provide support for women who experience domestic abuse.
- 1.5.10 Give the woman a credit card-sized information card that includes local and national helpline numbers.
- 1.5.11 Consider offering the woman referral to a domestic abuse support worker.

^[6] Examples of complex social factors in pregnancy include: poverty; homelessness; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or

understanding English; age under 20; domestic abuse. Complex social factors may vary, both in type and prevalence, across different local populations.

^[7] See 'Antenatal care' ([NICE clinical guideline 62](#)).

^[8] Significant morbidity is morbidity that has a lasting impact on either the woman or the child.

^[9] For example, using the [Common Assessment Framework](#).

^[10] [Department for Children, Schools and Families, and Communities and Local Government](#) (2008) Information sharing: guidance for practitioners and managers. London: Department for Children, Schools and Families, and Communities and Local Government.

^[11] See Department of Health and [Maternity Action](#).

^[12] See [Department of Health](#).

^[13] [Department of Health](#) (2005) Responding to domestic abuse: A handbook for healthcare professionals. London: Department of Health.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is [available](#).

How this guideline was developed

NICE commissioned the National Collaborating Centre for Women's and Children's Health to develop this guideline. The Centre established a guideline development group (see appendix A), which reviewed the evidence and developed the recommendations. An independent guideline review panel oversaw the development of the guideline (see appendix B).

There is more information about [how NICE clinical guidelines are developed](#) on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is [available](#).

3 Implementation

NICE has developed [tools](#) to help organisations implement this guidance.

4 Research recommendations

The Guideline Development Group (GDG) has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and antenatal care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see section 3).

4.1 Training for healthcare staff

What training should be provided to improve staff behaviour towards pregnant women with complex social factors?

Why this is important

The evidence reviewed suggests that women facing complex social problems are deterred from attending antenatal appointments, including booking appointments, because of the perceived negative attitude of healthcare staff, including non-clinical staff such as receptionists. It is expected that education and training for staff in order to help them understand the issues faced by women with complex social factors and how their own behaviour can affect these women will reduce negative behaviour and language. A number of training options currently exist that could be used in this context; however, which of these (if any) bring about the anticipated positive changes is not known. Given the resource implications of providing training across the NHS it is important to ascertain the most cost-effective way of providing this.

4.2 Effect of early booking on obstetric and neonatal outcomes

Does early booking (by 10 weeks, or 12⁺⁶ weeks) improve outcomes for pregnant women with complex social problems compared with later booking?

Why this is important

The NICE guideline on antenatal care (NICE clinical guideline 62) recommends that the booking appointment should ideally take place before 10 weeks and current policy^[14] supports booking by 12 weeks for all women. The main rationale behind these recommendations is to allow women to

participate in antenatal screening programmes for haemoglobinopathies and Down's syndrome in a timely fashion, to have their pregnancies accurately dated using ultrasound scan, and to develop a plan of care for the pregnancy which sets out the number of visits required and additional appointments that may need to be made.

Pregnant women with complex social factors are known to book later, on average, than other women and late booking is known to be associated with poor obstetric and neonatal outcomes^[6]. It seems likely that facilitating early booking for these women is even more important than for the general population of pregnant women. There is, however, no current evidence that putting measures in place to allow this to happen improves pregnancy outcomes for women with complex social factors and their babies.

4.3 How can different service models be assessed?

What data should be collected and how should they be collected, and shared, in order to assess the quality of different models of services?

Why this is important

There is a paucity of routinely collected data about the effectiveness of different models of care in relation to demography. Although mortality data are accurately reflected in reports published by the Centre for Maternal and Child Enquiries^[6], morbidity and pregnancy outcomes are not often linked back to pregnancies in women with complex social factors. Most research in the area of social complexity and pregnancy is qualitative, descriptive and non-comparative. In order to evaluate the financial and clinical effectiveness of specialised models of care there is a need for baseline data on these pregnancies and their outcomes in relation to specific models of care.

A national database of routinely collected pregnancy data is needed. The GDG is aware that a national maternity dataset is currently in development and it is hoped that this will ensure that data are collected in a similar format across England and Wales to allow for comparisons of different models of care.

4.4 Models of service provision

What models of service provision exist in the UK for the four populations addressed in this guideline who experience socially complex pregnancies (women who misuse substances,

women who are recent migrants, asylum seekers or refugees or who have difficulty reading or speaking English, young women aged under 20 and women who experience domestic abuse)? How do these models compare, both with each other and with standard care, in terms of outcomes?

Why this is important

The evidence reviewed by the GDG was poor in several respects. Many of the studies were conducted in other parts of the world, and it was not clear whether they would be applicable to the UK. Many of the interventions being studied were multifaceted, and it was not clear from the research which aspect of the intervention led to a change in outcome or whether it would lead to a similar change in the UK. Also, in some instances it was not clear whether a particular intervention, for example a specialist service for teenagers, made any difference to the outcomes being studied.

Developing a clear and detailed map of existing services in the UK for pregnant women with complex social factors, and the effectiveness of these services, would enable a benchmark of good practice to be set that local providers could adapt to suit their own populations and resources. A map of providers, their services and outcomes may also enable commissioners and providers to learn from each other, work together to develop joint services and share information in a way that would lead to continuous improvement in services for these groups of women.

4.5 Antenatal appointments for women who misuse substances

What methods help and encourage women who misuse substances to maintain contact with antenatal services/attend antenatal appointments? What additional consultations (if any) do women who misuse substances need, over and above the care described in the NICE guideline 'Antenatal care' (NICE clinical guideline 62)?

Why this is important

Women who misuse substances are known to have poorer obstetric and neonatal outcomes than other women. Late booking and poor attendance for antenatal care are known to be associated with poor outcomes and therefore it is important that measures are put in place to encourage these women to attend antenatal care on a regular basis. Some of the evidence examined by the

GDG suggested that some interventions could improve attendance for antenatal care, but this evidence was undermined by the use of self-selected comparison groups, so that the effect of the intervention was unclear.

In relation to additional consultations, the GDG was unable to identify any particular intervention that had a positive effect on outcomes, although there was low-quality evidence that additional support seemed to improve outcomes. Much of the evidence was from the US and there was a lack of high-quality UK data.

It seems likely that making it easier for these women to attend antenatal appointments and providing tailored care will improve outcomes, but at present it is not clear how this should be done.

^[14] [Department of Health](#) (2007) *Maternity matters: choice, access and continuity of care in a safe service*. London: Department of Health.

^[15] [Confidential Enquiry into Maternal and Child Health](#) (2007) *Saving mothers' lives: reviewing maternal deaths to make motherhood safer – 2003–2005*. London: Confidential Enquiry into Maternal and Child Health.

^[16] [Confidential Enquiry into Maternal and Child Health](#) (2009) *Perinatal mortality 2007*. London: Confidential Enquiry into Maternal and Child Health.

5 Other versions of this guideline

Full guideline

The full guideline, 'Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Women's and Children's Health and is available from our [website](#).

Information for the public

A summary for women, their partners and their families ('Information for the public') is [available](#).

We encourage NHS and voluntary sector organisations to use text from this document in their own information about the care of pregnant women with complex social factors.

6 Related NICE guidance

Published

- How to stop smoking in pregnancy and following childbirth. [NICE public health guidance 26](#) (2010).
- Alcohol-use disorders: clinical management. [NICE clinical guideline 100](#) (2010).
- Alcohol-use disorders: preventing harmful drinking. [NICE public health guidance 24](#) (2010).
- When to suspect child maltreatment. [NICE clinical guideline 89](#) (2009).
- Antenatal care: routine care for the healthy pregnant woman. [NICE clinical guideline 62](#) (2008).
- Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. [NICE public health guidance 11](#) (2008).
- Smoking cessation services. [NICE public health guidance 10](#) (2008).
- Community engagement to improve health. [NICE public health guidance 9](#) (2008).
- Behaviour change at population, community and individual levels. [NICE public health guidance 6](#) (2007).
- Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. [NICE public health intervention guidance 4](#) (2007).
- Drug misuse: opioid detoxification. [NICE clinical guideline 52](#) (2007).
- Drug misuse: psychosocial interventions. [NICE clinical guideline 51](#) (2007).
- Antenatal and postnatal mental health: clinical management and service guidance. [NICE clinical guideline 45](#) (2007).
- Brief interventions and referral for smoking cessation in primary care and other settings. [NICE public health intervention guidance 1](#) (2006).
- Looked after children and young people. [NICE public health guidance 28](#) (2010)

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

Appendix A: The Guideline Development Group and NICE project team

Guideline Development Group

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Stefanie Reken

Health Economist

Judy McBride

Editor

^[17] From June 2009

^[18] From December 2008

^[19] Until October 2009

^[20] Until 19 November 2008

^[21] From June 2009

Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

Dr John Hyslop (Chair)

Consultant Radiologist, Royal Cornwall Hospital NHS Trust

Mr Peter Gosling

Lay member

Mr Kieran Murphy

Health Economics and Reimbursement Manager, Johnson & Johnson Medical Devices & Diagnostics, UK

Dr Ash Paul

Medical Director, Bedfordshire Primary Care Trust

Professor Liam Smeeth

Professor of Clinical Epidemiology, London School of Hygiene & Tropical Medicine

Appendix C: The algorithms

The [full guideline](#) contains a care pathway and algorithms.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Women's and Children's Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

We have produced [information for the public](#) explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

Changes since publication

October 2012: minor maintenance

January 2012: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this 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 this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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