Homerton Healthcare
NHS Foundation Trust

Vulnerable Women Pathway

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Version Box

Version	Version Date	Author	Reason	Ratification
1.0	2017	Tamsin Bicknell - *Consultant Midwife Public Health and Safeguarding*	New Guideline	N/A
2.0	November 2020	Tamsin Bicknell - *Consultant Midwife Public Health and Named Midwife for Safeguarding* Lauren Ward – *GP Clinical Lead*	Triennial Review	Yes
3.0	July 2023	Tamsin Bicknell - *Consultant Midwife Public Health and Safeguarding*	Triennial Review	Yes
3.1	July 2024	Emma Yates – *Named Midwife for Safeguarding*	Changes needed to reflect service structure changes	No

Vulnerable Women Pathway

Women are defined as socially vulnerable in City and Hackney who are/have:

- Aged < 20yrs (unless family/other support available for woman).
- Difficulty speaking or understanding English (but not including all who have English as a second language) – this vulnerability may be mitigated by proper use of interpreting services, and if this is the sole vulnerability, client is unlikely to need ongoing input from the public health midwife
- Homeless or at risk of becoming homeless
- Use of substances and/or alcohol to an extent where physical dependence and/or harm to their health or that of their unborn baby is a risk
- Experiencing domestic violence/abuse (DVA)
- Experiencing or at risk of honour-based violence (HBV)/forced marriage
- Victim of human trafficking/modern slavery
- Recently arrived as a migrant (and/or with no recourse to public funds); asylum seeker, refugee (receiving refugee services), or undocumented
- Mental Health concerns including history of serious mental illness, current depression or anxiety disorder or history of post-natal depression or psychosis
- Have been identified by social care as having complex/high risk (previously called Tier 3) child protection issues, having been a Looked After Child (LAC) themselves or had previous children removed from their care
- A learning and/or physical disability (see Maternity and Early Years Learning Disability Pathway)
- Booked late for their pregnancy (in the absence of an acceptable reason), particularly after 20 weeks
- Female Genital Mutilation – self or family member
- History of concealment of pregnancy
- Unplanned pregnancy: London Measure of Unplanned Pregnancy (LMUP) score of 0-3 (this is completed as part of the booking history)
- Significant involvement with the Criminal Justice System, particularly those having been recently released from prison

Antenatal booking – who to refer to

- If identified as vulnerable from referral, refer directly to specialist/public health midwife, case triaged and booking arranged.
- This may be from self-referral/phone referral/GP referral
- If vulnerability identified at booking by community midwife/ANC midwife/obstetrician, use appendix 2 to assess whether to refer to specialist/public health midwife: use EPR ad hoc form.
- For all referrals to Public health/Safeguarding Midwives, the booking midwife must continue care until written/verbal confirmation of full handover (including that they have an appointment booked with the woman) is received from accepting midwife.
- When vulnerability identified safeguarding flag on EPR activated where appropriate (for example, an alert does not need to be raised regarding a non-English speaker).
- **Translation services should be used without fail** where needed. Appointments should be reorganised if interpretation not available. Family members/friends are not acceptable interpreters. If a woman declines translation, this should be confirmed via interpreter, without anyone else present.
- The trust lead nurse for contraception can offer postnatal contraception choices counselling to women antenatally whose pregnancies are unplanned (score 0-3 on the LMUP); the booking midwife will be alerted to offer this to the woman following booking.
- Referral and signposting to other agencies as required. This includes referral to MAT/Early Help for Universal Plus/Universal Partnership Plus (previously Tier 2) support through Children's Centres or other comparative local services.

Ongoing antenatal care

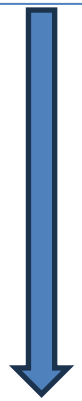
- Depending on vulnerability, care may be delivered by community/ANC midwife with support from specialist/public health midwife and regular safeguarding supervision.
- Public Health and Specialist Midwives will caseload only the most complex cases, ensuring they maintain a caseload number that allows them to give the highest quality care whilst also maintaining their other responsibilities.
  Appendix 1 outlines criteria for discussion with and referral to Public Health or Specialist Midwives.

On-going antenatal Care

- Contact made by specialist/public health midwife following receipt of referral.
- Client seen at home/children's centres/antenatal clinics/other settings e.g. community drug/alcohol treatment services.
- Routine antenatal care and specialist midwife input re vulnerability including appropriate liaison with other agencies.
- All safeguarding referrals to be clearly recorded on EPR/ ad hoc forms as well as direct referrals to local borough, Maternity Safeguarding Team to be copied into any referrals sent on huh-tr.maternitysafeguarding@nhs.net
- Contact can be made with the link obstetric consultant for vulnerable women should there be obstetric/medical complications and non-engagement.
- At each antenatal visit document any relevant safeguarding or vulnerability updates on specialist maternity care plan ad hoc form on EPR.
- For all cases in Areas A-G at least one antenatal visit should be in the home (unless unsafe to do so). There is flexibility to home visit those living out of area within reason.
- Notify safeguarding administrator for all complex/high risk cases to be added to weekly psychosocial meeting (see Terms of Reference for meeting, available on Trust intranet safeguarding children page) as part of maternity child protection supervision practice.
- All cases with any of the criteria on this pathway to be discussed at child protection supervision with a qualified supervisor as per policy, and information/actions documented in the Maternal Safeguarding Children ad hoc form on EPR. This ensures information is auditable and clearly identifiable on patient's record.
- Health visitor and GP to be notified of vulnerabilities by 24 weeks of pregnancy to facilitate 28/40 health visitor contact. The antenatal health visitor notification form should be used for this purpose (appendix 3).
- Cases should be discussed at GP link meetings where these take place to ensure notification and information sharing takes place in a timely manner.
- E-groups should be created for information sharing purposes. Allocated professionals in the multidisciplinary team should be added as they are identified.
- By 36 weeks midwife to ensure clear safeguarding plan for unborn is on EPR documentation tab using template available or on Specialist Maternity Care Plan.
- Consider Children's Social Care referral for women who disengage from antenatal care after following *Did Not Attend* policy.
- Consider referral to OCEAN midwife for Trauma Informed birth planning

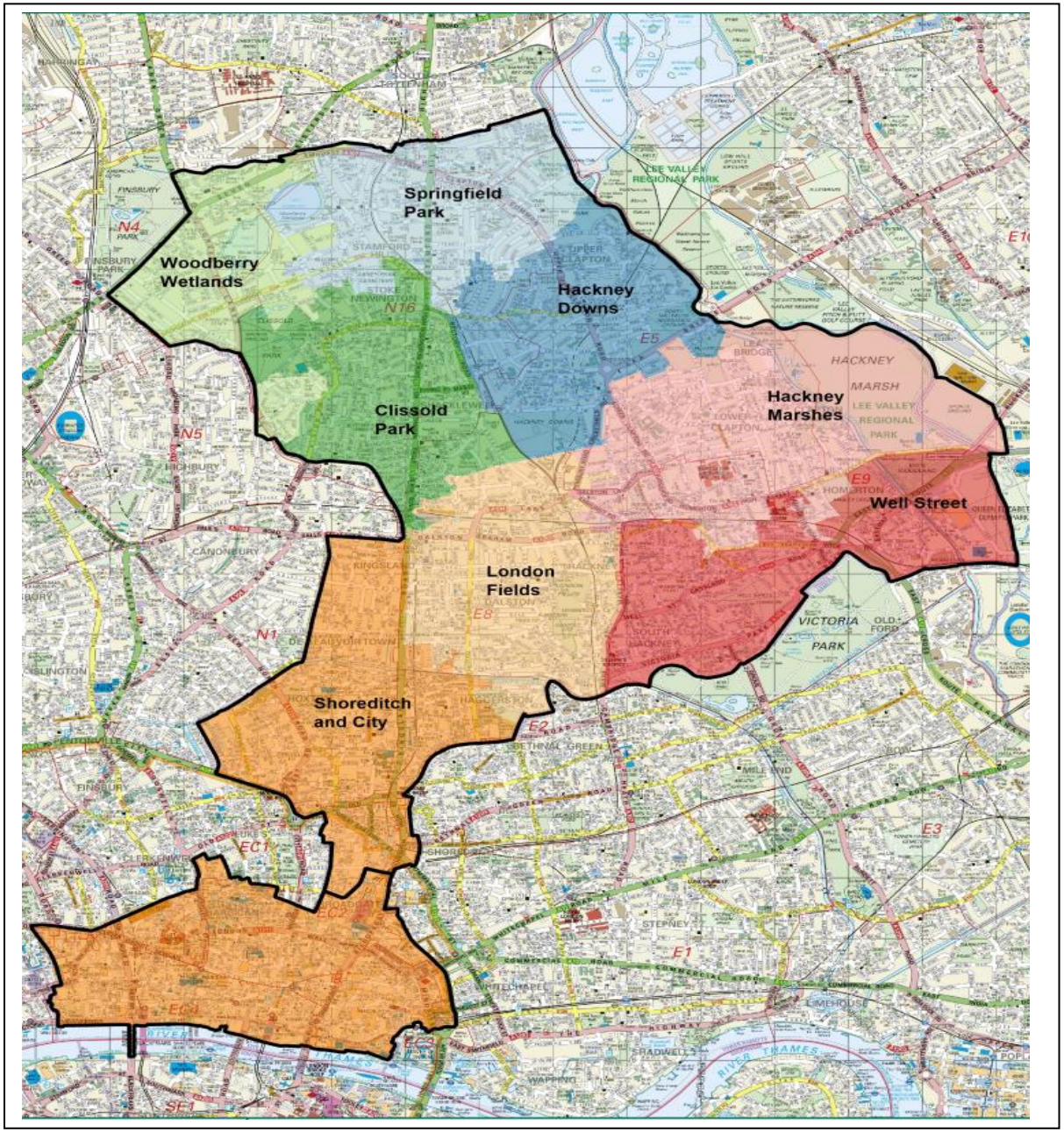
Delivery and hospital postnatal care

- Relevant professionals to be notified of admission/delivery as per plan and notification documented.
- Mental health, social care and other professional reviews/discharge planning to take place prior to baby's discharge home from hospital as required.
- Safeguarding/specialist care plans should be followed as documented at all times. Women should not be discharged against the instructions of such a plan, or instruction from a member of the maternity or Trust safeguarding teams, such as the public health midwife, specialist midwife, Named Midwife for Safeguarding or consultant midwife for public health and safeguarding.
- Special attention should be paid to the mental state of women whose babies have been removed from their care by the Local Authority/family court. If there is any deterioration or comments indicative of a suicide risk, immediate referral should be made to a mental health professional (usually the Homerton Psychological Medicine team) and discharge delayed until assessment and a plan for appropriate follow up care from the MDT has been completed. This should be considered irrespective of whether there are pre-existing mental health needs.
- As with all women, contraceptive choices should be discussed and the chosen method provided prior to discharge wherever possible. Where this is not possible, women can be advised of the dedicated postnatal contraception clinic, held at the Ivy Centre on Wednesday afternoons (no appointment necessary, further information on trust website).



Community postnatal Care

- Specialist and public health midwives provide/lead planned 28 days postnatal care (extended visiting) for in-area women whether they have delivered at Homerton or elsewhere, in partnership with community midwives, health visitors, community and acute mental health services (e.g. Mother and Baby Unit) and social care. In exceptional cases care can extend to 42 days; this is most likely to be helpful in cases where the baby has been taken into Local Authority Care and it is anticipated that the extra time will principally be used to monitor and support the woman's mental health following this bereavement. Care during the extended visiting period does not always need to be conducted face-to-face; other forms of communication may be employed as per the needs or wishes of the woman.
- For vulnerable women going home out of borough, information regarding vulnerabilities should be safely shared with the receiving hospital. The safeguarding information template should be used by the discharging team on the postnatal ward to include in the email as per STOW discharge process. If necessary further information can be shared via the Named Safeguarding Midwife at the receiving Trust – contact details for London units available on intranet.
- Transfer care (hand over) to health visitor when discharging family from midwifery care; via joint visit wherever possible.
- In addition to the automatic *discharge summary* which is sent to GPs for all women following delivery, the case loading midwife must consider writing a more detailed *discharge letter/email* to GP outlining any ongoing concerns or health needs and outcomes for particularly complex clients, especially those whose children have been removed from their care (as they will not routinely receive ongoing input from health visiting and on occasion may not engage well with postnatal midwifery care).



Public Health Midwives by Area

Woodberry Wetlands/ Clissold Park – 07423797189

Springfield Park – 07824461654

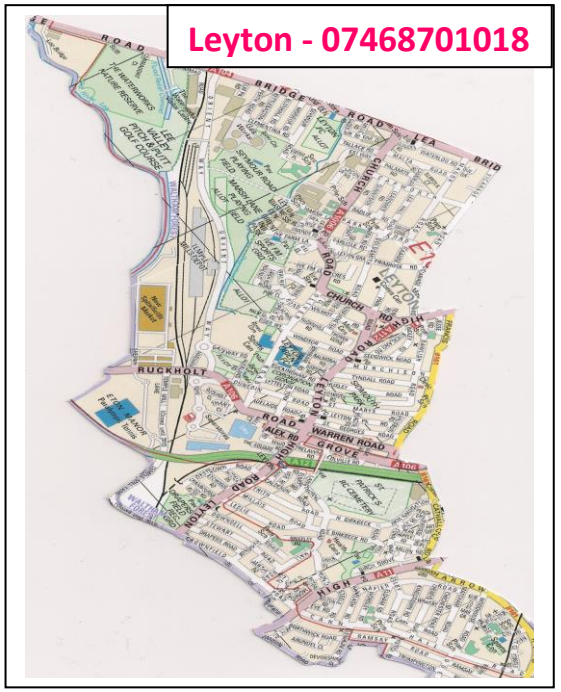
Hackney Downs – 0777195623

Hackney Marshes – 07776451101

Well Street – 07771975266

London Fields – 07771975266/ 07824461677

Shoreditch Park and City - 07824461677



Midwives Caring for Vulnerable Women Homerton University Hospital July 2024

Named Midwife for Safeguarding
07789618354

Operational Lead for Maternity Safeguarding. First Line for advice or supervision, escalation, and senior support in complex cases; doesn't hold a caseload but can triage referrals. Able to facilitate contact with Safeguarding Midwives across London and send Maternity Alerts via named midwives. Responsible for safeguarding training/ policy, MARAC contact. Contact for Maternity Psychosocial meeting.

Consultant Midwife for Public Health and Safeguarding 07919538357

Strategic Lead for Safeguarding. Can support with escalation and advice when Named Midwife not available.

Specialist Safeguarding Midwife for Out of Area Women
07825 546304

Caseloads vulnerable women booked for care at HUH who do not live in City and Hackney or Leyton areas. Assists Named Midwife with safeguarding enquiries, supervision, and training

Specialist Midwife for Perinatal Mental Health
07776391178

Caseloads women who are inpatient on MBU, adult psychiatric wards or have very high risk complex mental health conditions. Drives Froward Perinatal Mental Health agenda and training and supports staff

Specialist Maternal Mental Health/ OCEAN Midwife

Supports with Trauma Informed Care Training/ Birth Reframing Clinic. Link for OCEAN service. Supports midwives around Trauma informed Birth Planning and group work.

Public Health Midwives/ Team Leaders (see previous page for contact details)

Caseload most complex women within their Neighbourhood. Provides Support and supervision for team midwives. May joint caseload or provide liaison for less complex women

Specialist Midwife for Substance and Alcohol Misuse
07876863165/ 07825733325

Caseloads the most complex women affected by substance or alcohol misuse booked at HUH. May joint caseload or provide liaison for less complex cases. Co-facilitates weekly ORBIT support group and supports staff/ provides training

Homerton University Hospital: Referral criteria for Public Health and Specialist Midwives

	Green (Low) Criteria	Amber (Moderate) Criteria	Red (High) Criteria
	• Unsupported (please consider voluntary orgs for support). • Unplanned pregnancy (explore relationship with partner/father of baby, offer antenatal discussion with contraception lead nurse, monitor for other complexities or difficulty bonding with pregnancy. Ensure provision of chosen contraception prior to discharge from hospital after birth where appropriate).	• Non-engagement with antenatal care (consider disguised compliance) • DNAs appointments (follow policy) • Surrogate pregnancy (see guideline) surrogate parents will need full social assessment to ensure baby is going into a safe environment • Planning to relinquish baby for adoption	• • Concerns about parenting capacity • Concealed pregnancy – why? • Unbooked at delivery • Surrogate pregnancy with suspicions of coercion into surrogacy
Mental health problems	• Historical depression and not currently on medication • Emotional antenatally i.e. low mood or tearful, with no history of depression or mental health – (please consider support from 'Bump Buddies', Maternity Mates' &/or 'Birth Companions' in addition to following guidance re PHQ-9 and GAD-7 assessment). • Emotional postnatally i.e. low mood or tearful, with no history of depression or mental health – (please consider voluntary orgs for support in addition to using postnatal scales for anxiety and depression and sharing concerns with health visitor).	• Anxiety impacting on daily living • Diagnosed and controlled OCD • Body dysmorphia / Eating disorder • Post-traumatic stress disorder (PTSD) • Partner has a severe mental health illness • Severe tokophobia	• Previous puerperal psychosis • Diagnosed with a psychotic disorder (schizophrenia, schizoaffective disorder, bipolar disorder). • Currently uncontrolled Obsessive-Compulsive Disorder (OCD) • Severe Anxiety or depression • Personality disorders • Suicide risk related to new or persistent expressions of incompetency as a mother or estrangement from the infant, new thoughts or acts of violent self-harm or recent significant change in mental state / emergence of new symptoms
Social Services involve	• Reports history of social care involvement with her own family when she was a child – explore whether has	• The woman or her partner themselves were Looked After Children (in care) • Victim of previous sexual abuse / sexual exploitation – who is perpetrator? Is risk	• A previous child that was subject to child in need plan or a child protection plan

	any emotional needs around this and transition to parenthood	current? Offer referral to Positive Birth After Sexual Trauma (PBAST) clinic with Consultant Midwife for Public Health & Safeguarding	• The woman or her partner have children that have been removed from their care
Domestic abuse	• Previous domestic abuse, now with a new partner (which you have verified) with no current abuse. No risk from previous perpetrator	• Current emotional abuse without fear or escalation • Historical abuse from previous partner but still has contact	• Current domestic abuse • Separated from abusive partner but still at risk/in fear • Case discussed at Multi-Agency Risk Assessment (MARAC) • Forced marriage/honour-based violence
Teenage pregnancy	• Low risk 19-year-old with a planned/wanted pregnancy and supported i.e. married or has a partner of an appropriate age to theirs.	• Unwanted/unplanned teenage pregnancy but supported • Socially isolated and teenage pregnancy	• Socially high risk teenager (in care, on child protection or child in need plan, child sexual exploitation risk, mental health problems etc
Comprehension difficulties	• Little or no English **– interpretation services should <u>always</u> be used.** Appointments should be rescheduled if no translation support available.	• Little or no English and declines interpretation services (may mask vulnerabilities). **Midwife should confirm via interpretation services <u>whilst alone with woman</u> that she does not want translation services.** • Physical disability that may impact on parenting – focus should be on asking whether there is any support we can offer without assuming incapability	• Any diagnosed or suspected learning disability that might impact on parenting (use pathway)
Housing	• General housing issues, please direct to local housing department or voluntary organisations for support with accessing rights (Shelter, Crisis)	• 'Hidden homeless' i.e. sofa-surfing/staying with friends/relatives/religious organisation acquaintances • At risk of eviction or homelessness • Living in complex needs hostel	• Street homeless • Staying with strangers (i.e. met on the street etc) • Living in refuge/shelter accommodation
Drugs/ Alcohol	• Cannabis use - perform a toxicology (offer referral to smoking cessation) if positive liaise with Substance Misuse Midwife	• History of addiction and currently abstinent	• Current drugs or alcohol misuse, whether known to drug services or not • Partner misuses substances/alcohol
Criminal/ Forensic		• Historical minor offending behaviour, convictions or police involvement	• Concerns regarding trafficking /modern day slavery • Recent offending behaviour, convictions or police involvement on tag or probation • Gang involvement – known or suspected

RED	Please refer to Public Health or Specialist Midwife, or if postnatal and going out of area, liaise with local safeguarding midwifery team to handover (see contact list on intranet)
1 Amber	Please liaise with Public Health or Specialist Midwife
2 or more Ambers	Please refer to Public Health or Specialist Midwife
GREEN	Mainstream Midwife with regular safeguarding supervision and GP shared care

This list is not exhaustive. Please liaise with the team regarding any queries

Homerton Healthcare
NHS Foundation Trust

Vulnerable Women Pathway

Signature Page

These guidelines have been signed off by the Maternity Risk Management Group

Signed: _____ Date: 21/7/23

Signed by Director of Midwifery

Signed: _____ Date: 21.07.23

Signed by Clinical Director/Lead