



Homeless pregnancy toolkit



City of Westminster

St Mungo's
Ending homelessness
Rebuilding lives

Why have we developed this toolkit?

We have developed this toolkit to:

- Improve health and development outcomes for babies born to homeless women;
- Improve outcomes for pregnant homeless women including supporting and empowering women to have a degree of choice and decision making over their pregnancy;
- Implement current good practice in working with pregnant women who have complex social needs;
- Promote equitable quality of service and consistency of approach for all pregnant homeless women including women in hostels, vulnerably housed and rough-sleeping;
- Provide increased support and guidance to staff working with homeless pregnant women;
- To capture data on outcomes in order to further develop good practice in this area.

What are the needs of pregnant women and their babies?

At the current time we have no robust data on the incidence of pregnancy in homeless women (both hostel based and rough sleeping women) or outcomes for babies or mothers. Flowing from this, evidence for what works well to increase positive outcomes for babies and mothers during pregnancy and in the peri-natal period is not currently recorded and women can receive care and support that varies considerably.

Gestation is a period where the rapidly growing foetus is vulnerable to maternal stress, poor nutrition and the impact of alcohol and drugs which can have a life long impact for the child. Homeless families are over-represented in Serious Case Reviews.

Many homeless women have experienced a history of adversity¹ which can impact upon the woman's lifestyle, motivation, ability to engage with services, make changes and parenting capacity. Vulnerable and socially excluded women (which can include women who are homeless) are at increased risk of maternal death². Pregnancy is a time of increased vulnerability for homeless women

as there is an increased risk of physical harm, financial and sexual exploitation. Woman may have previous pregnancies which have resulted in children being removed from their care. This can result in reluctance to engage with services, anxiety, experiencing feelings of shame and isolation which can sometimes result in increased substance misuse. Many homeless women (78% of hostel based women) have diagnosed mental health conditions³ and pregnancy and the peri-natal period can impact upon maternal mental health.

Women with complex social needs will require support and input from different agencies in order to fully meet needs of the unborn and mother. Robust and well co-ordinated multi-agency working is key to securing positive outcomes for both. Women can find the involvement of different agencies difficult and therefore a lead professional (from any discipline) who keyworks with the woman and co-ordinates services can be very beneficial at promoting engagement, facilitating change and co-ordinating other agency activity to identify and manage risk. Homeless women may have experienced previous significant trauma and may find it re-traumatises them to repeatedly disclose difficult life events. A lead professional can obtain consent from the woman to share sensitive information to other professionals who need the information to avoid repeated disclosure. Pregnant

¹ All Babies Count: spotlight on homelessness – an unstable start. Sally Hogg, Alice Haynes, Tessa Baradon and Chris Cuthbert. NSPCC 2015.

² Saving Mothers Lives – Reviewing maternal deaths to make motherhood safer: 2006-2008 (2011) British Journal of Obstetrics and Gynaecology, vol 118, S.I.

³ St Mungo's Broadway Client Needs Survey 2015.

women may move around frequently due to lifestyle or housing need and it is essential that information is handed over promptly and accurately to successive workers.

Recent Migrant women

Recent migrant women may experience poorer baseline health compared with settled women and are over represented in maternal deaths⁴. Women may have become pregnant as a result of sexual violence during their journey to the UK or whilst here and may have additional support needs for this.

Women may have been trafficked into or within the UK and workers should be alert to this and use the National Referral Mechanism if trafficking is suspected to ensure women receive the right support:

<http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism>

Recent migrant women may be unaware (and misinformed) of their entitlements to healthcare during pregnancy and should be informed that it is expected that women receive maternity care (includes ante, birth and post natal care) in the UK to care for both baby and mother:

In some countries, routine universal healthcare is not provided and pregnant women will only consult with a health care professional if there is a problem. Professionals should explain to all women that healthcare is routinely provided as standard to all pregnant women and their babies to avoid causing alarm and set out the expectation that women should engage with services.

Survivors of female genital mutilation/cutting should be referred to specialist services for obstetric care and emotional support.

Domestic abuse can start or escalate during pregnancy, migrant women who are dependent upon their partner to remain in the UK are particularly vulnerable. Women in this situation should be referred for immigration advice with a view to making

an application to settle in the UK under the domestic violence concession <https://www.gov.uk/government/publications/application-for-benefits-for-visa-holder-domestic-violence>

Charging for maternity care

All persons are entitled to 'immediately necessary treatment' which includes maternity care, irrespective of their status in the UK⁵. Women who are not ordinarily resident or covered by an exception (see below) are deemed 'chargeable' for maternity care. The NHS has no discretion over whether or not to issue an invoice to someone who is chargeable.

Being chargeable should not result in maternity care being delayed or refused.

Charges for healthcare are at 150% of tariff costs and typically for maternity services, most trusts do not invoice for itemised services but for a package of care, a typical price for standard maternity care (e.g. non caesarean delivery) is around £4,000.

People who are 'ordinarily resident' in the UK (e.g. here lawfully and 'settled' for a period of 6 months) are eligible for free NHS care. There are exceptions to 'ordinarily resident' rules which cover refused asylum seekers receiving section 4 or section 95 support, women who are recognised victims of trafficking and children in the care of the local authority.

Because the rules on charging are complicated, sometimes invoices are issued in error and this should be checked with Maternity Action (see page 4).

It is important that women who have received an invoice speak to the Overseas Charging department of the hospital trust and that workers support them to do this. It is good practice, although not mandatory for trusts to work with people to negotiate affordable repayment plans. If there is a debt of over £500, it is mandatory for the health trust to inform UK Visas and Immigration. Such a

⁴ Saving Mothers Lives – Reviewing maternal deaths to make motherhood safer: 2006-2008 (2011) British Journal of Obstetrics and Gynaecology, vol 118, S.1.

⁵ Guidance on implementing the overseas visitor hospital charging regulations 2015. Department of Health 2015.

debt will adversely affect the individuals right to settle which is why it is vital to engage with the trust to attempt to reschedule and settle the debt. Women could be referred on for debt advice from a specialist organisation.

Workers can contact Maternity Action for advice on maternity charging www.maternityaction.org.uk, Advice Line **0845 600 8533** and consult the very helpful section on rights for women from overseas⁶.

Helpful factsheets for pregnant women with no recourse to public funds can be found at www.maternityaction.org.uk as well as a protocol for workers.

Promoting autonomy over fertility

As part of discussions on physical and mental health and wellbeing, workers should speak to clients regularly about sexual health and support them to access healthcare services, information and advice including contraception. Short acting methods of contraception (e.g. combined oral contraceptive pill, condoms) are likely to be unreliable for women who have complex lifestyles. Long-acting reversible contraception such as an implant or intra-uterine device may be more suitable.

Many clients may have had experiences such as childhood sexual abuse which may affect their motivation to acknowledge and deal with sexual health needs. Such clients may require extra support and motivation e.g. accompanying to clinic appointments and opportunity to de-brief afterwards. Workers should not make the assumption that clients who are involved in prostitution won't require support around sexual health and contraceptive needs. Clients can feel that due to their lifestyle that they are unlikely to get pregnant and therefore don't need to use contraception. It is important to tell women that fertility can fluctuate and that changes in lifestyle (e.g. starting on an opioid substitute) can rapidly change fertility.

Refusal to use or allow access to contraception can be an abusive strategy in relationships

where there is domestic abuse. Workers can ask women if they feel they are able to make choices about when they have sex, if they are able to use the method of contraception that they want and if they have a choice over whether they become pregnant or not.

Supportive discussions around what to do about pregnancy

Women who traditionally present later in pregnancy for ante-natal care include younger women (age under 24), women with chaotic lifestyles, including those with irregular menstrual cycles due to opiate use, poor nutrition and other factors. This may result in a delay in women becoming aware they are pregnant. Women who think they may be pregnant should be supported to access over the counter tests which could be provided by services.

Once pregnancy is confirmed, workers should offer neutral acknowledgement. Good questions include *"how do you feel about being pregnant?"* *"are you happy with the news?"*. Previous experiences of pregnancy may impact upon the woman's feelings and *"what happened when you have been pregnant before?"* is a good question to begin to explore this.

Women who have previously had children removed from their care may be very anxious about what may happen with this pregnancy. Because of this, these women may tell professionals that they are pregnant quite early in the pregnancy because they are anxious to find out what the plan will be for this baby. However, some women in this situation may present late in pregnancy due to fear of involvement of services. By regularly talking to women about sexual health and contraception, clients can feel more comfortable about disclosing pregnancy earlier and having open discussions about their feelings about it.

Women who fear not being allowed to care for their babies after birth may not engage in pre-natal care and feel that they are too scared to form an emotional attachment to their unborn child. In women who misuse

⁶ <http://www.maternityaction.org.uk/advice-2/mums-dads-scenarios/3-women-from-abroad/entitlement-to-free-nhs-maternity-care-for-women-from-abroad/>

substances, this can result in an increase in use due to feelings of guilt.

Rough sleeping women may become less visible and accessible during pregnancy e.g. may not be rough sleeping and go to a squat or sleep in a car due to it offering greater physical protection. Outreach workers should be alert to this and be inquisitive about women of childbearing age that are not in their usual location.

Workers encountering rough sleeping women could hand her information about pregnancy services in the local area. For Westminster see http://www.westminsterhhcp.org/westminster_tools_info_sheets.htm.

Consideration should be given to speaking to the woman on her own and verbalising information as she may be unable to read written information.

Workers should explain to women who disclose pregnancy that they have a choice about whether or not they decide to continue with the pregnancy or not and that the woman will receive appropriate support whatever her decision is.

Women are entitled to receive neutral support around whether or not to continue a pregnancy and it is acknowledged that a workers own views and experiences may impact upon workers ability to offer unbiased support. If workers identify any difficulties in being able to provide neutral support, they should raise this with their local management who can make alternative arrangements for supporting the client during this time.

Women who chose to terminate their pregnancy should be offered emotional support during and afterwards. This could include increased support from an existing worker or accessing specialised support from an appropriate organisation or therapeutic support via GP or in-house psychotherapy service.

Women accessing a first trimester medical termination of pregnancy may require additional practical and emotional support to attend the two clinic appointments and to access a pregnancy test three weeks later to confirm that the procedure was successful.

Support after miscarriage

Homeless women can be at an increased risk of miscarrying and stillbirth. Women (and their partner if appropriate) should be offered appropriate support. This need could be met by a specialist organisation or by a trusted worker offering emotional support if appropriate. Workers should be alert to women being subject to bullying by peers and other residents in this situation and should monitor and be ready to respond as appropriate.

Promoting good choices in pregnancy

Midwifery services and access to services

Pregnancy is usually a time of renewed hope where motivation to make positive changes is experienced by many women, including women who are homeless and have complex social needs.

NICE Guidelines⁷ specify that women with complex social needs should be booked with a midwife by 10 weeks. A suitable worker should be identified who can offer to accompany the woman to the booking appointment if this is what she wants. The worker can provide advocacy, emotional support to the woman and also help to explain anything that the woman did not understand after the appointment.

Midwifery services consist of community based midwives who provide a generalist service to the majority of pregnant women. Homeless women will usually benefit from a more intensive service that is provided by specialist midwives who have additional training, skills and experience in the areas of safeguarding, homelessness, substance misuse and domestic abuse. Specialist midwives will

⁷ NICE Guidance CG110 – Pregnancy and Complex Social Factors – A Model for Service Provision for Pregnant Women with Complex Social Factors 2010 <https://www.nice.org.uk/guidance/cg110/evidence/cg110-pregnancy-and-complex-social-factors-full-guideline3>

have a smaller caseload that they can work with more intensely. Specialist midwives bring considerable value due to enhanced relevant knowledge, multi agency working and experience of building effective relationships with women with complex needs. Sometimes, specialist midwives work in conjunction with community midwives to provide advice and support on cases which do not need the full specialist service.

For hostel based women, they will normally be registered with a GP and a booking appointment with a midwife can be booked via the GP surgery. If women are taking any medication, a medication review should be booked with the GP to see if any changes are indicated.

For women who are rough sleeping, or women who don't use their bedspace or are at high risk of abandoning, these women should be directly referred to midwifery.

To make a self/direct referral for a pregnant woman go to the Maternity Services part of the local hospital website. Workers referring should include as much detail as possible for ways to contact the woman including usual locations, contact details for workers she engages with, mobile phone number (including whose number it is and any risks associated with that) and details of day centres used. The worker should follow up the referral by contacting the Named Midwife for Safeguarding at the hospital and giving them brief details of the referral and if there are any current health or safeguarding concerns.

Midwifery support during pregnancy

If a pregnant woman is experiencing 'red flag symptoms'⁸ including:

- Spotting or bleeding
- Constant vomiting
- High temperature
- Painful urination
- Leaking fluid
- Persistent severe headache
- Pelvic pain
- Contractions or cramps

- Chest pain (particularly migrant women who frequently have undiagnosed cardiac problems)
- Sudden, sharp or continuing abdominal pain
- Swelling in face, hands or legs
- Blurred vision, spots in front of eyes
- Itching, especially on hands and feet
- Baby's movements slow down or patterns change
- Self harm / suicidal thoughts

She should attend at the Obstetric Triage Unit (daytimes) or Labour Ward/A&E (24hrs). Workers should be aware that pregnant women can deteriorate rapidly if unwell.

Workers can contact the on-call Supervisor of Midwives who has a public protection and clinical remit if advice is needed. Every hospital will also have a Named Midwife for Safeguarding who professionals can contact for advice. Contact via hospital switchboard.

Substance Misuse

Women who misuse substances may already be engaged with appropriate services and knowledge of pregnancy should be shared by the woman as soon as possible. Pregnant women not already using such services should be referred as soon as possible after confirmation of pregnancy, most services will have a fast-track assessment procedure for pregnant women. Many women will be motivated by pregnancy to enter treatment services who were previously ambivalent about change.

Substance use can change during pregnancy and patterns of usage can include reduction or withdrawal, withdrawal and binging and increase in use. These changes can result in a high level of physical stress to the foetus which can increase the risk of miscarriage. Early involvement of substance misuse specialists to stabilise and maintain are critical for improving outcomes for babies.

Where involved, the substance misuse service will be an important part of the multi agency team to identify risk, minimise harm and promote positive change. Consideration should be given to suitable in-patient options where treatment or risk would be

⁸ <https://www.tommys.org/pregnancy-information>

too difficult to manage in the community. Different substances have the potential to impact differentially during sensitive time periods for development of different organ systems. Specialists should consider providing information to pregnant women so that they can understand specific risks and take an active role in managing risk to their unborn baby.

Discharge plans may need to take into account possible treatment for neo-natal abstinence and withdrawal.

Identifying other needs

A lead professional should be identified to work with the woman to conduct a needs assessment for the pregnant woman and unborn baby. This should be done in early pregnancy and updated regularly. Later assessments could be done in conjunction with the Common Assessment Framework (CAF) process. An assessment should take account of strengths, identified risk, what services are already working with the family unit and what needs are unmet. Unmet needs could include:

- Smoking cessation (Speak to Midwife, NHS pregnancy stop smoking advice line on **0300 123 1044**)
- Access to mental health treatment and support
- Exiting prostitution support
- Healthy Start (vouchers for milk, fruit, vegetables and vitamins for some women <http://www.healthystart.nhs.uk/>)
- Preparing to parent – ante natal classes from around 30 weeks – speak to midwife about local classes. Contact local Family Centre (previously known as children's centres, the website of the local authority will have a list of centres on the Health and Social Care, Children's pages) for details of parenting classes.
- Domestic abuse support – a national organisation such as Women's Aid will be able to signpost to local organisations www.womensaid.org.uk **0808 200 0247**

- Support during delivery – homeless women may be less likely to have someone to be with them during delivery as they may be estranged from family. Trained birth companions are available to support women during delivery and provide emotional support during this time see Birth Companions <http://www.birthcompanions.org.uk/> or Doula UK <https://doula.org.uk/>

A useful checklist is available at <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/to-do-list-pregnant.aspx#close> which is a good starting point.

Young pregnant women aged under 19 can be referred to the Family Nurse Partnership who can provide enhanced support to the woman up to the child being two years. Women should be referred before 28 weeks gestation <https://www.westminster.gov.uk/family-nurse-partnership>

Lead professional can be of assistance in helping the woman to keep a diary of appointments and tasks to be completed as well as contact details of professionals. Some women will require prompting to remember appointments and assistance and support to attend including arranging travel to the appointment.

Identifying and managing risk

Individual services may have risk assessments that should be reviewed as soon as they become aware that a client is pregnant. Workers should also consider how pregnancy can change risk and include this where possible in existing risk assessments to plan work that manages risk. Risks which can change during pregnancy can include:

- Domestic abuse (many victims report DA starting or escalating in pregnancy) and workers should try to speak to women on their own where possible
- Financial exploitation (pregnant women can be sent out to beg)

- Sexual exploitation (sex buyers may pay more for sex with a pregnant woman)
- Substance misuse (due to guilt some women may increase use)
- Physical vulnerability
- Mental health (can worsen due to pregnancy or the need to reduce or stop some medications).

Risk assessment and planning should be done in conjunction with the pregnant woman and partner wherever possible in order to agree actions and work together to reduce risk. Workers should be clear with the woman that information may be shared with other agencies in order to build up a clear picture of strengths, risks and actions needed to reduce risk.

For a pregnant woman that is homeless, it is very likely that the unborn child and family will have additional needs which need to be identified and met. A lead professional should be identified to complete a Common Assessment Framework (CAF) Pre-Assessment Checklist⁹ and complete the full CAF documentation if indicated by the Checklist. The CAF process is designed to identify additional needs of the child relating to:

1. Their growth and development
2. Additional educational requirements
3. Family and environmental issues and any specific needs of the parent/carer

Safeguarding referrals

Professionals should discuss safeguarding concerns with the pregnant woman as soon as they are identified. Professionals should follow their organisations safeguarding adults at risk and safeguarding children's policy and procedures and if the threshold for referral to statutory services is met (either with or without consent), should make referrals to children's social care and adult social care or the local MASH (Multi Agency Safeguarding Hub) as necessary. There are separate routes for a referral to safeguarding children and safeguarding adults services at the Local Authority.

Safeguarding children referral

Discussions with the pregnant woman and her partner should make it clear:

- What the concerns are;
- What the potential for harm is;
- What needs to change and when it needs to change;
- That the family will be supported to make changes and the timetable for change is based on the child's needs and stage of development, not the adults.

People in some groups can hold beliefs that children can be removed by authorities purely because of the parents ethnicity or because mother is on replacement prescribing in the absence of safeguarding concerns. Professionals should therefore be clear that concerns relate to actual risk and are not based purely on the adult's belonging to a certain ethnic group or because of lifestyle factors.

Safeguarding adults who have care and support needs

The Care Act 2014 sets out that safeguarding duties apply to an adult who:

- Has needs for care and support whether or not the local authority is meeting any of those needs and
- Is experiencing or at risk of abuse or neglect and
- As a result of those care and support needs is unable to protect themselves from either the risk of or the experience of abuse or neglect.

Professionals working with homeless pregnant women should consider these criteria and make a referral for the woman if the criteria is met.

⁹ <http://www.protectingchildren.org.uk/cp-system/child-in-need/caf>

Information to include on referrals:

Professionals making safeguarding referrals to statutory services should be clear:

- What the current risks are that have been identified;
- Provide a brief summary of work done to date to address risk and nature of your agencies involvement;
- What agencies are already involved with the person/couple/family;
- What interventions you feel are needed to reduce risk;
- Your overall assessment of the level of risk.

Referrals should be made as soon as concerns arise. For unborn children, there may be a delay between referral and allocation for assessment by a social worker. During this time, professionals involved should continue to work together to regularly review risk to both children and adults in conjunction with the family unit and work with the family to identify and implement interventions to reduce risk. Should risk increase, new information should be fed into the previous referral by contacting the Duty Worker.

Pregnancy and housing

A pregnant woman or a person with whom she resides or might reasonably be expected to reside (s.189(1)(a) Housing Act 1996) is in a priority need for accommodation.

Pregnant women who are street homeless or staying in other non-stable living arrangements should present at the local housing options for assessment and advice. Women should take along proof of pregnancy (e.g. Form Mat B1 which is available from a midwife) if at all possible. Workers should consider accompanying women to present at housing options to provide support and advocacy.

For women in hostel accommodation, this accommodation will generally be assessed to be suitable until around seven months gestation and the Local Authority will accept a duty to provide other accommodation after this time. This may include providing temporary

accommodation, which could include a bed and breakfast. A pregnant woman should not be accommodated in B&B unless no other accommodation is available. A pregnant woman should not be accommodated in a B&B for longer than six weeks¹⁰.

For hostel based women, they will require a Notice to Quit, stating that their current accommodation is no longer suitable by seven months. Workers should explain well ahead to women that this notice is necessary to comply with legal requirements and is needed to assist them to obtain more suitable accommodation and is not a negative judgment about them being pregnant.

If the plan is for the baby to be removed from the woman's care at birth and for her to return to hostel accommodation, discussions should be had with the woman and the staff team about the suitability of returning to her current hostel. Some women have reported that they experience bullying from other residents after returning to their hostel following birth and this risk should be balanced against the trauma that a woman may experience in having to settle in a new environment after a very difficult life event.

Support and navigation of systems

Homeless women may find it difficult and overwhelming to manage multiple appointments and relationships with different professionals. Appointing a lead professional to co-ordinate services and agency activity and keywork with the pregnant woman can be key to promoting engagement and helping the woman feel more in control.

The lead professional can be from any discipline but ideally should be someone with whom the woman has already forged a good working relationship with (in the absence of this, where the woman has indicated that they are willing to work closely with, such as a specialist midwife), has a good understanding of the nature of the work of other professionals in the team, has good knowledge about safeguarding processes and has some experience of multi agency working.

¹⁰ Homelessness (Suitability of Accommodation) (England) Order 2003

Lead professional activities could include:

- Keeping an up to date record of professionals involved, names, roles, contact numbers and appointment details and explaining and clarifying this for the pregnant woman as necessary;
- Reminding the woman about appointments and chasing and assisting the woman to re-book missed appointments;
- Doing regular needs and risk assessments in conjunction with the woman and other professionals to identify unmet needs and risk;
- Acting as a single point of contact for updates and information sharing.

Pregnant women and the family unit may require some extra support to understand processes (such as statutory safeguarding processes, legal proceedings and parenting assessments). The lead professional can work with the relevant specialist (e.g. social worker, solicitor) to increase and promote understanding, knowledge and engagement.

Women can sometimes feel embarrassed to ask professionals questions and therefore workers should be proactive in checking that women understand information that has been provided to them. In order to meaningfully participate in keeping them and their baby safe, women need to understand what is going to happen and when. Understanding and processing of information can be impaired if the woman is experiencing stress, so workers should give thought to ensuring that the language used is appropriate and may need to be explained again on another occasion.

Planning for delivery

Where an unborn child is subject to a Child Protection Plan, Core Group professionals should work with the woman and partner well ahead of delivery to develop a plan that safely manages risks. The plan will be led by Children's Social Care and Midwifery. Where Children's Social Care are not involved, the plan will be led by Midwifery.

Late pregnancy can be an emotionally difficult time for pregnant women and it is preferable that plans (even if not very detailed) are discussed and set out as early as possible so that the parents have time to process any feelings related to this.

Plans can include:

- Where the baby is to be born;
- How the woman will get to the hospital;
- Arrangements for any other children;
- Who will be notified that labour has started;
- Who will be present at delivery – consider volunteer companions if no family or partner available;
- What will happen when baby is delivered;
- What additional needs are the baby expected to have when born (e.g. neo-natal withdrawal and abstinence treatment);
- What are the discharge plans and who will be involved in reviewing them;
- Will baby be in mother's care at discharge;
- Where will mother and baby be discharged to;
- What involvement will the mother's partner have;
- What is the contingency plan and when will it be invoked.

Due to substance misuse or substitute prescribing, birth may occur earlier than expected and it will be necessary to factor this into plans.

If the plan is for the Local Authority to apply for a Care Order at birth, the usual procedure is to give parents a Letter before Proceedings by week 24 of gestation. At this point, parents

will be eligible for non-means tested legal advice and representation. Parents should be supported to ensure that they separately instruct solicitors as soon as possible.

After birth, parents may be involved in parenting assessments. Children's Social Care will be the lead agency for making arrangements for where and how these will be carried out. It is important that parents are given information, in a way that they can easily understand about how the assessment will be undertaken, who will be involved, how and when feedback will be provided, how long the process will take and what their expectations are. It is necessary to identify any learning disability that the parents may have that may impact upon their ability to fairly participate in any assessment.

Support needs of the parents should also be assessed and identified during this time as unmet parental need can impact negatively upon other work being done to safeguard the child and improve parenting.

Support post delivery

The woman's support needs will need to be re-assessed post delivery.

Where the plan is for mother to care for her baby after it is born, this may be in a supported environment e.g. mother and baby rehabilitation project or foster placement. There should be a clear plan of support for baby and mother with expectations set out. There is likely to be a parenting assessment during this period (which may also include the woman's partner). Workers who are working with mother at this time should ensure that she understands what is happening, when it is happening, what her expectations are and the responsibilities of different workers. A named worker should also work with mother to help her identify any extra support or information that she needs in order to allow the best chance of success.

In some circumstances, women may be living more independently with their baby e.g. in their own tenancy or in temporary accommodation pending own tenancy. It is important that one professional carries out

a thorough risk assessment of the needs of the adults and baby in order to ensure that unmet needs are met and that risks are identified and managed. This could be achieved by completion of a Common Assessment Framework (CAF) see www.protectingchildren.org.uk/cp-system/child-in-need/caf

Where the plan is for the baby and mother to be separated after delivery, plans should be made for where the woman will live afterwards. Although returning to a familiar environment may be beneficial, some women who have returned to the same hostel where they were pregnant have reported that they have experienced bullying from other residents. This risk should be highlighted to women wishing to return to the same hostel and work done with the women to identify other suitable options that she may choose from.

During pregnancy, safeguarding and care proceedings, women will have attended many different meetings and had their time filled with lots of appointments with different professionals. Although women often find this overwhelming and difficult to manage at the time, women can struggle to cope when they suddenly have no appointments and no workers involved when their children are removed from their care – “*everyone's clients to no-ones clients*”. During pregnancy, many women report that they enjoy some of the positive, nurturing attention that they receive from professionals. This may be a factor in why some women will become pregnant again quickly despite the trauma of having a child removed from their care. Needs assessment should also include a review of the woman's contraceptive requirements and supporting her to access services and information.

Prior to other services disengaging with the woman, a new needs assessment should take place to plan for this change and ensure that ongoing support needs are met, including emotional or therapeutic support to deal with the loss of children.

Mental Health in the peri-natal period

Workers should be alert to the possibility of a deterioration in mental health in the peri-natal period and all workers engaging with the woman should make routine enquiries with her regarding mental wellbeing post delivery. Sudden onset of poor mental health and/or a rapid deterioration are red flag symptoms that require referral to the Perinatal Mental Health Team.

Capturing and recording data and outcomes

– what works?

What doesn't?

As women and families will transition to other services as their needs and risks change, it can be difficult to track outcomes and capture data on the effectiveness of different interventions.

To capture this data and inform future service delivery, services should consider:

- How incidence of pregnancy, data on continuation/termination of pregnancy, births, interventions and outcomes are recorded for clients within their service (e.g. CHAIN and client data recording systems) and how this data can be used to inform planning of future services;
- At discharge from service or referral on, routinely recording a simple set of outcomes which can be recorded as anonymised data and used to inform future practice within that service and also the wider sector;
- Providing the woman with opportunities to feedback about what they feel has worked well/less well for them;
- Obtaining consent and contact details from the woman/family to contact them after discharge at agreed points (e.g. six months, one year) to obtain data on current situation;
- Appointing a designated person within each organisation to collect, review and analyse data on pregnancy and outcomes for trends, evaluation of current work, planning and development of future services both within their organisation and in the wider practice area.

Please send any updates or suggested revisions for this toolkit to Jennifer.Cirone@mungos.org

Resources

Care Proceedings – Legal	
<p>Parents are eligible for non-means tested legal advice and representation once the Local Authority have issued a Letter Before Proceedings. This letter normally lists some local solicitors who specialise in Public Law (care proceedings work) but parents can instruct any other solicitor. You can look for solicitors using the Law Society website – area of law ‘family and relationships’ and then refine search ‘children’. Check individual firms to see if they have experience in care proceedings. Each parent should be separately legally represented.</p> <p>http://solicitors.lawsociety.org.uk/</p>	
Care Proceedings – Information and emotional support for birth parents	
After Adoption	<p>Birth Ties service for parents whose children are at risk of removal or have been adopted, includes phone advice and counselling service 0800 840 2020 http://www.afteradoption.org.uk/our-services/your-child-being-adopted</p>
Family Rights Group	<p>http://www.frg.org.uk/ 0808 801 0366 advice and information for families where Children’s Social Care are involved. Professionals may find the factsheets very helpful for increasing their own knowledge of law and procedure. Has a Young Parents Project http://www.frg.org.uk/involving-families/our-projects/young-parents-project offering tailored advice and support to young parents.</p>
PAC UK	<p>http://pac-uk.org/ provide support to all involved in adoption and permanency including birth parents – First Family service http://www.pac-uk.org/firstfamily/ which includes telephone advice and support and some support groups in North London.</p>
Pause	<p>http://www.pause.org.uk/ works with women who have had at least one child removed from their care and are at risk of further removals. Intensive work to help women address underlying problems whilst taking a break from pregnancy and care proceedings.</p>
Family Centres (previously known as children’s centres):	
<p>Family centres are an excellent source of support for vulnerable families including parenting classes and ante-natal group.</p>	
Hammersmith & Fulham	<p>http://www.lbhf.gov.uk/Directory/Education_and_Learning/Pre-Schools/Childrens_centres/192653_Childrens_centres.asp#0</p>
Kensington & Chelsea	<p>https://www.rbkc.gov.uk/family-information-service/family-information-service</p>
Westminster	<p>https://www.westminster.gov.uk/childrens-centres</p>
Common Assessment Framework	
<p>Common Assessment Framework (CAF) is a very useful tool to assess children’s needs. You can find out more about CAF here:</p> <p>http://www.protectingchildren.org.uk/cp-system/child-in-need/caf</p>	
Westminster	<p>https://www.westminster.gov.uk/ecaf-westminster</p>

Domestic Abuse

Pregnancy is a time when domestic abuse can start or escalate. All workers should screen during the ante-natal period and risk assess and signpost or refer on as necessary.

Angelou Project	http://angelou.org/ Angelou is a partnership of nine specialist organisations that have come together to support women and girls experiencing domestic or sexual violence and harmful practices across Westminster, Hammersmith & Fulham and Kensington & Chelsea.
National Centre for Domestic Violence	For help getting injunctions www.ncdv.org.uk 0800 970 2070
Women's Aid	www.womensaid.org.uk 24 hour helpline 0808 200 0247
Domestic violence concession	Domestic abuse can start or escalate during pregnancy, migrant women who are dependent upon their partner to remain in the UK are particularly vulnerable. Women in this situation should be referred for immigration advice with a view to making an application to settle in the UK under the domestic violence concession https://www.gov.uk/government/publications/application-for-benefits-for-visa-holder-domestic-violence

Family Nurse Partnership

Voluntary program offered to young mothers (under 19 years) having their first baby. Provides support to the family until the child's 2nd birthday. Refer by 28 weeks gestation

<https://www.westminster.gov.uk/family-nurse-partnership>

Healthcare for homeless people

Westminster	There are two dedicated services for homeless health care in Westminster: Great Chapel Street Medical Centre Tel: 020 7437 9360 Email: Info@greatchapelst.org.uk http://www.greatchapelst.org.uk/ Cardinal Hume Medical Centre Tel: 020 7222 1602 Email: info@cardinalhumecentre.org.uk https://www.cardinalhumecentre.org.uk/need-help/surgery/ Pregnant rough sleepers should be added to their weekly nursing outreach shifts to be targeted on the street – email: m.radcliffe@nhs.net
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Healthy Start

Free vitamins, milk, fruit and vegetables for pregnant women (after 10 weeks) in receipt of certain benefits – check eligibility online <http://www.healthystart.nhs.uk/>

Homeless Outreach Services

Hammersmith & Fulham	TeamOutreachH&F@mungos.org
Kensington & Chelsea	Street Population Outreach Team 020 7341 5210
Westminster	https://www.westminster.gov.uk/rough-sleeping-helpline

Housing

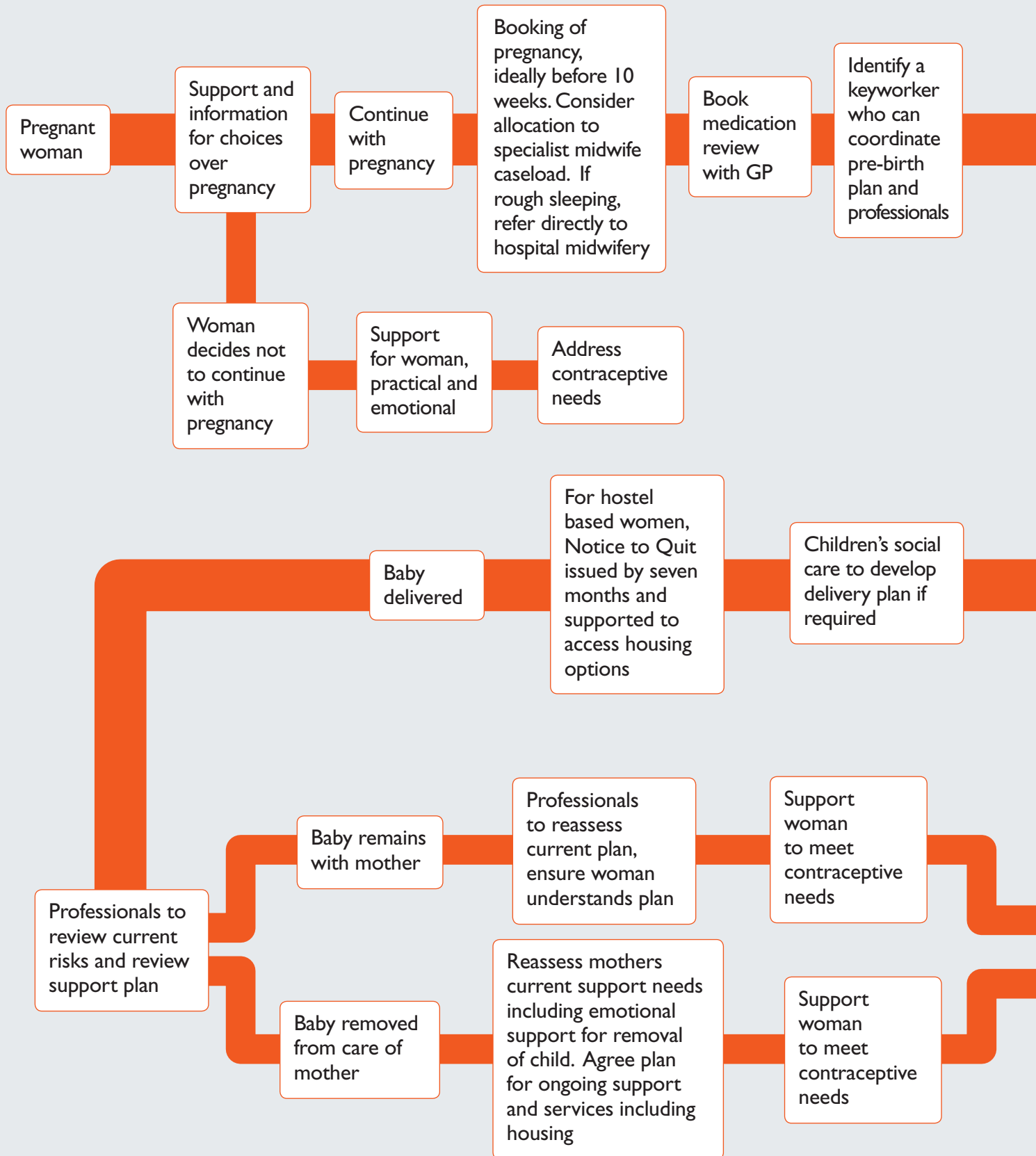
Hammersmith & Fulham	http://www.lbhf.gov.uk/Directory/Housing/homepage.asp H&F Advice 0845 313 3935
Kensington & Chelsea	https://www.rbkc.gov.uk/housing/housing Homelessness Team 020 7361 3982
Westminster	https://www.westminster.gov.uk/housing-options-westminster Housing Options: 020 7641 1000

Immigration/NRPF:	
Westminster Information Sheet	http://www.westminsterhhcp.org/westminster_tools_info_sheets.htm
Praxis	http://www.praxis.org.uk/ 020 7729 7985 Also host a Doctors of the World Clinic for families and pregnant women twice monthly.
Project 17	http://www.project17.org.uk/ 07963 509 044 – Advocacy service for destitute migrant families with children aged under 18 to access support under Section 17 of the Children Act 1989.
NRPF Network	http://www.nrpfnetwork.org.uk/Pages/Home.aspx good resource for professionals.
Learning Difficulties	
WTPN – Working Together Parenting Network	Resources for professionals working with parents with learning difficulties including parenting assessments http://bristol.ac.uk/sps/wtpn
Legal	
Care Proceedings – see ‘Care Proceedings’	
General – Phone legal advice is available on a number of topics if meet Legal Aid eligibility criteria – https://www.gov.uk/civil-legal-advice	
Just for Kids Law – Advocacy, support and assistance for young people including a Young Parent Youth Advocacy Service for parents aged 16-25 http://www.justforkidslaw.org/	
Shelter provide specialist housing advice and have a phone helpline and some drop in sessions http://england.shelter.org.uk/get_advice 0344 5151540	
Law Centres are good sources of free advice on a range of legal matters including housing:	
Hammersmith & Fulham	http://hflawcentre.org.uk/ 020 3080 0330
Kensington & Chelsea	http://www.nklc.co.uk/ 020 8969 7473
Westminster	http://www.londonlawcentre.org.uk/ 020 7734 4067
Maternity Services and Midwifery	
Booking of pregnancy	For hostel based women who are registered with a GP should be made via the GP surgery. Women who have complex social needs should be booked before 10 weeks if possible.
Rough sleeping or women not registered with a GP	Should be referred directly to midwifery services. Following referral a follow up call should be made to the Named Midwife for Safeguarding confirming the referral and highlighting any current health or safeguarding concerns.
Chelsea & Westminster Hospital	Supervisor of Midwives 0844 822 2888 and ask for pager number 813408. Maternity Unit 020 3315 7841 Ante-natal referral form http://www.chelwest.nhs.uk/services/womens-health-services/maternity-obstetrics/antenatal-self-referral-form
Guys & St Thomas’	http://www.guysandstthomas.nhs.uk/our-services/maternity/overview.aspx Labour Ward 020 7188 2973 Ante-Natal Day Assessment Unit 020 7188 1722 / 1723.
St Mary’s Imperial College	https://www.imperial.nhs.uk/our-services/maternity-and-obstetrics/referrals Advice Mon to Fri 10.00 to 18.00 020 3312 6135, emergency care call the consultant obstetrician or registrar on-call through the hospital switchboard, or delivery suite directly Queen Charlotte’s and Chelsea Hospital delivery suite: 020 3313 3025 or 020 3313 5167, St Mary’s Hospital delivery suite: 020 3312 1060.
University College London Hospitals	https://www.uclh.nhs.uk/OurServices/ServiceA-Z/WH/MAT/Pages/Home.aspx Supervisor of Midwives via switchboard on 020 3456 7890. Direct referrals https://www.uclh.nhs.uk/OurServices/ServiceA-Z/WH/MAT/Pages/refer.aspx

Entitlement including recent migrants:	All persons are entitled to free 'immediately necessary treatment' which includes maternity care, irrespective of their immigration status in the UK. Women who are not ordinarily resident or covered by an exception (see main toolkit document) may be charged for maternity care, but care cannot be withheld or delayed if chargeable. The criteria for charging for maternity care is complicated and women can contact Maternity Action to see if they should have been issued an invoice http://www.maternityaction.org.uk/ Helpline no 0845 600 8533 .
Specialist debt advice	Women whose immigration status is at risk due to debt incurred for maternity care should be referred for specialist debt advice Money Advice https://www.moneyadviceservice.org.uk/en National Debtline 0808 8084000 Stepchange http://www.stepchange.org/
Specialist obstetric services for women who are survivors of FGM/Cutting	http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/List%20of%20FGM%20Clinics%20Mar%2014%20FINAL.pdf
Support organisations for survivors of FGM/C	http://whfs.org.uk/index.php/what-we-do/fgm/fgm-c-resources-and-links
Maternity Action	http://www.maternityaction.org.uk/wp/lots of information for women and professionals on rights and entitlements
NICE Guidance	Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors CGI 10 https://www.nice.org.uk/guidance/cg110
Tommys	Excellent source of pregnancy related advice for professionals and patients https://www.tommys.org/
Birth companions	Homeless women, especially recent migrants may have no-one to be present with them at birth. Birth Companions http://www.birthcompanions.org.uk/ and Doula UK https://doula.org.uk/ may be able to assist with provision of someone to accompany the woman during delivery.
Mental Health	
Hammersmith & Fulham	http://www.wlmht.nhs.uk/services/gp-information/service-directory-gps/services-in-hammersmith-fulham/adult-services-in-hammersmith-fulham/
Kensington & Chelsea	Central & North West London NHS http://www.cnwl.nhs.uk/services/mental-health-services/
Westminster	Central & North West London NHS http://www.cnwl.nhs.uk/services/mental-health-services/ Good service directory for service users http://www.go4mental-health.com/servicedirectory/index.php?page=home.php Mental Health Pathways for rough sleepers and hostel residents in Westminster http://westminsterhhcp.org/Resources/Mental%20Health%20pathways%20in%20Westminster.pdf
Miscarriage support	
Miscarriage Association Helpline	01924 200 799 http://www.miscarriageassociation.org.uk/support/
Prostitution and trafficked women	
National referral mechanism	http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism
Exiting prostitution support	NIA http://www.niaendingviolence.org.uk/ 0207 683 1270

SWISH – Sex Workers into Sexual Health	http://www.swishproject.org.uk/ sexual health and case management for anyone involved in sex working
Tamar	providing emotional and practical support to women involved in sex working in Westminster; particularly trafficked women http://www.tamarwestminster.org/
Sexual Health	
Services covering the TriBorough http://www.clch.nhs.uk/services/sexual-health.aspx	
Sexual Violence	
Angelou Project	http://angelou.org/ Angelou is a partnership of nine specialist organisations that have come together to support women and girls experiencing domestic or sexual violence and harmful practices across Westminster, Hammersmith & Fulham and Kensington & Chelsea.
The Havens	http://www.thehavens.org.uk/ one stop centres of co-ordinated support and care for those who have experienced sexual assault and rape.
Smoking Cessation	
Midwives and Health Visitors can give advice and details of local services. NHS pregnancy stop smoking advice line can also provide details of local support 0300 123 1044 .	
Substance Misuse	
Tri-borough Service Wellbeing Cloud	three.boroughs@turning-point.co.uk Hammersmith & Fulham 020 8746 0303 Kensington & Chelsea 020 8960 5599 Westminster 020 7437 3523
Safeguarding Adults at Risk	
TriBorough website: http://www.peoplefirstinfo.org.uk/	
Hammersmith & Fulham	h&fadvice.care@lbhf.gov.uk 0845 313 3935
Kensington & Chelsea	Tel: 020 7361 3013 (9am to 5pm) Tel: 020 7373 2227 (out-of-office-hours) Fax: 020 7368 0228 (office hours only) Secure Email: socialservices@rbkc.gov.uk.cjism.net Email: socialservices@rbkc.gov.uk
Westminster	safeguardingadults@westminster.gov.uk 0845 313 3935
Safeguarding Children	
Tri-Borough Local Safeguarding Children Board https://www.rbkc.gov.uk/subsites/lscb/aboutus.aspx	
Hammersmith & Fulham	familyservices@lbhf.gov.uk Tel: 020 8753 6600
Kensington & Chelsea	socialservices@rbkc.gov.uk Tel: 020 7361 3013
Westminster	accesstochildrenservices@westminster.gov.uk Tel: 020 7641 4000
Sure Start Maternity Grant	
£500 grant for women having their first child and in receipt of certain benefits, check eligibility online https://www.gov.uk/sure-start-maternity-grant/overview	

Quick reference action timeline for supporting pregnant homeless women



Pregnant woman, keyworker and other professionals to draw up list of contacts of professionals if needed and pre-birth plan

Pre-birth work could include:

- engagement of substance misuse services
- smoking cessation
- mental health services
- exiting prostitution
- healthy start vouchers
- domestic abuse support / referral to MARAC
- engagement with children's centre / parenting classes

Referral to children's social care if unborn experiencing / likely to experience significant harm (may not be allocated for assessment until approx. 20 weeks)

Refer pregnant woman to Adult Safeguarding if criteria met

For women referred to children's social care, it is usual for assessment to happen at around 20-24 weeks and if the plan is for application for a care order at birth, a letter before proceedings should be issued by 24 weeks. Woman should be supported to access legal representation

Identify ongoing needs and risks – all professionals, can include:

- domestic abuse
 - financial exploitation
 - sexual exploitation
 - substance misuse
 - physical vulnerability
 - mental health
- Consider referral for pregnant woman to adult social care for assessment as appropriate

If no significant harm threshold met, consider Common Assessment Framework (CAF) identify appropriate lead professional

Record keeping – what has worked, what hasn't

St Mungo's, Fifth Floor, 3 Thomas More Square, London E1W 1YW
Tel: 020 3856 6000 **Fax:** 020 3856 6001
Email: info@mungos.org
www.mungos.org

St Mungo Community Housing Association, a company limited by guarantee
Charity No. 1149085 • Company No. 8225808 (England and Wales) • Housing Association No. LH0279

St Mungo's
Ending homelessness
Rebuilding lives