HSC Public Health Agency

HSC Health and Social Care

Women who do not present, or present late for antenatal care

Guidance for Multiprofessional Health and Social Care Staff

Version 1
Issue Date: August 2023
Review Date: August 2025

1.0 INTRODUCTION

This guidance was developed as a recommendation from two Case Management Reviews (CMR) completed by the Safeguarding Board of Northern Ireland in 2022: Renata and Duke. Regional learning was identified regarding women who do not present or present for antenatal care late in pregnancy. The Duke CMR recommended that health and social care professionals are given clear guidance on how to contact local maternity services in each area, if they are concerned that a pregnant woman has not accessed antenatal care. The Renata CMR recommended the development of multi-professional guidance to assist staff in the assessment and potential management of such women, to support consistent risk assessment, and to make it congruent with safeguarding procedures.

This guidance is complimentary to existing clinical and safeguarding guidance:

- Antenatal care. Rationale and impact. (NICE, 2021)
- Female Genital Mutilation Safeguarding Pathway and Risk Assessment (SBNI, 2020)
- Guidance for the Safeguarding Process Prior to and Immediately After the Birth of a Baby Where There May be Risks of Significant Harm (HSCB, 2015)
- Notification of Children/Families assessed as being at potential risk and their whereabouts remain unknown (HSCB, 2016)
- Pregnancy and complex social factors: a model for service provisions for pregnant women with complex social factors (NICE, 2010)
- Regional Core Child Protection Policy and Procedures (SBNI, 2017)
- Understanding the Needs of Children in Northern Ireland (DoH, 2011)
- Working Arrangements for the Welfare and Safeguarding of Unaccompanied and Separated Children and Young People (HSCB, 2018)
- Working Arrangements for the Welfare and Safeguarding of Child Victims and Potential Child Victims of Human Trafficking and Modern Slavery (HSCB, PSNI, 2018)
- Working Arrangements for The Welfare and Protection of Adult Victims and Potential Victims of Human Trafficking and Modern Slavery (Doj, PSNI, HSCB, 2018)
- Local Trust policy relating to antenatal screening programme for infectious diseases in pregnancy

NB: Acknowledgement is given to the WHSCT who had developed guidance for midwives which has significantly informed this regional policy.

2.0 SCOPE

This guidance is for all Health and Social Care professional staff, including General Practitioners (GP), who are involved with women in the antenatal period (and with their partners). It applies to women who do not present for antenatal care at all, or present after 14 weeks gestation and to all pregnant women or pregnant young girls under the age of 18 years[1].

While the focus of this guidance is around optimal clinical care and safeguarding children, there may be a requirement to initiate adult safeguarding procedures in respect of a pregnant woman over the age of 18 years. The process is not described in the scope of this document.

Practitioners should follow local Trust/GP arrangements for communication between professionals.

3.0 AIM

Ensure early identification and response to the health and social needs of pregnant women who do not present for antenatal care or present after 14 weeks gestation.

- Assist professionals to ensure appropriate and timely care for pregnant women which meets best practice standards.
- Ensure early identification and response to support needs or potential safeguarding concerns for the unborn baby.

4.0 DEFINITIONS

Definitions will aid the understanding of the various circumstances when a woman, may not present at all, or present late, promote the consistent use of language by professionals and assist in informing clinical and safeguarding risk assessment.

Late Presentation of Pregnancy: When a woman does not inform a health professional of pregnancy until 14 weeks or over.

Concealed Pregnancy: A concealed pregnancy is when a woman or girl knows she is pregnant but does not tell any health professional; or when she tells another professional but conceals the fact that she is not accessing antenatal care; or when a pregnant woman tells another person and they conceal the fact from all health agencies.

Denied Pregnancy: A denied pregnancy is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant.

1 For the purpose of this guidance the term 'woman' will be used for all pregnancies except where there are particular considerations/processes for girls under the age of 18 years.

Free birth/Unassisted birth: The practice of women intentionally birthing their baby without a doctor, midwife or other trained health professional in attendance.

Transfer of antenatal care: When a woman has accessed regular maternity care in another area during this ongoing pregnancy and has 'transferred' to another unit, or decides on a home birth, for the remainder of the pregnancy.

Born Before Arrival: When a woman who has every intention of either having a hospital or planned home delivery and has engaged with maternity services in the planning of either, but where the birth of the baby has happened so rapidly that the woman either does not make it to the hospital setting/ place of birth or in the case of a planned home birth the midwife does not arrive at the home to support and witness the delivery.

5.0 RATIONALE FOR ENSURING WOMEN PRESENT/BOOK EARLY FOR ANTENATAL CARE

The optimal time for women to access maternity services is in the first trimester of pregnancy (up to 12 weeks gestation). It is recommended that the majority of women will have had their first booking appointment with a midwife by the 10th completed week of pregnancy. The optimal time to perform a dating scan is between 11 weeks 2 days and 14 weeks 1 day. Booking appointments and dating scans are health-screening tools to determine the maternal history and facilitate assessments of the woman's medical, physical, emotional, mental health and socioeconomic needs during her pregnancy**.** It can also be an optimal time to educate in health promotion and offer necessary additional support to the mother from a multi-professional perspective. It is recommended that all screening investigations at booking should be completed at 10 weeks in pregnancy. This aims to provide timely information and improve pregnancy outcomes when planning the pathway of care for the woman and her baby(s). (NICE 2021).

Presenting late is known to be associated with poorer obstetric and neonatal outcomes. These women often have complex social issues.

Confidential Enquiry into Maternal Deaths and Morbidity, includes surveillance data on women who died during or up to one year after pregnancy between 2016 and 2018 in the UK. Delayed access to antenatal care ('late booking') has been linked to increased mortality and morbidity for mother and baby. The Confidential Enquiry into Maternal Deaths in the UK (2007) found that 17% of the women who died from Direct or Indirect causes presented for maternity care after 22 weeks gestation, had missed >4 routine antenatal visits or didn't seek care at all.

MBRRACE-UK/PMRT (2022) report that late presentation or not having presented at all was a commonly identified issue in the cases reviewed (24%). However, the proportion of pregnancy outcomes for which this issue was relevant was unchanged from the previous report at 4%. It is unclear from the information available why late presentation or not having presented at all was so common; this may have been a consequence of access to services or at least a perceived inability to access services as a result of changes due to the [Covid-19] pandemic.

Initiation of the Perinatal Mental Health Pathway should commence at the first contact with primary care and subsequent antenatal appointments to ensure early and appropriate support for women.

The optimum time for enrolment onto the Family Nurse Partnership for eligible girls/women is before 16 weeks gestation and no later than 28 weeks gestation.

The antenatal contact by a health visitor should occur after 28 weeks gestation but earlier where pre-birth risk assessment has been initiated or other need identified that requires intervention.

Where there are potential safeguarding children concerns requiring multiagency care planning, a referral to children's social services should be made as soon as the pregnancy is known and before 18 weeks gestation (HSCB, 2015).

6.0 FACTORS INFLUENCING LATE BOOKING

The CMACE (2011) evidence shows that non-attendees at antenatal visits are likely to fall into one of the following categories:

- Incorrect contact details
- Ethnic minority groups (including members of the travelling community)
- Able to speak little or no English
- Under 16 years of age
- Woman experiencing domestic abuse
- Substance misuse (drugs/alcohol)
- Poverty
- Homeless
- Asylum Seekers or those with immigration issues that may mean they do not want to reveal their status
- Women with disabilities
- Multiparous women with short inter-pregnancy intervals (including women who have experienced a neonatal death)
- Current or previous safeguarding issues

Other reasons:

- Miscarriage/baby delivered/born before arrival
- Current in-patient
- Relocated out of area to another jurisdiction/ transient families
- Conception following rape including incestuous paternity
- Ambiguous paternity/paternity outside of a stable relationship
- Religious or cultural practices/disapproval
- Mental health issues
- Poor social network
- Maternal choice: anti medical intervention/ desire for 'natural', free or unassisted birth.
- Service/capacity issues within maternity services
- Concealed or denied pregnancy
- Women who have been trafficked or exploited

7.0 PREVENTATIVE ACTIONS

Preventative actions will depend on individual circumstances and assessed need. Any professional who becomes aware that a woman has not presented for antenatal care after 14 weeks gestation, should ascertain the reason why (see risk assessment below), explain why antenatal care is important and encourage attendance at their general practitioner (GP), self-booking or referral for antenatal care in line with Trust policy. Where the professional only has contact with the partner, the same explanation should be given to that service user.

Where it is within their remit, the professional should ensure that actions to support the woman to do so are initiated and potential barriers minimised for example, giving information about services by signposting them to the Trust website for maternity services, assisting with transport or communication needs.

Where a pregnant woman presents at hospital for any reason, the relevant professional must make arrangements for a midwifery/obstetric review to ascertain the gestation before the woman leaves the department. If the woman is found to be less than 20 weeks gestation, the professional should forward written correspondence to Trust maternity services (either an acute or community midwife depending on Trust arrangements) where the woman resides. Contact details are available on each Trust website/intranet. A copy should be forwarded to the GP. If the woman is found to be 20 weeks or greater, the professional should verbally liaise with Trust maternity services (as above) where the woman resides and follow up with written correspondence. A copy should be forwarded to the GP. A midwife will then make arrangements as per section 9 of this guidance. If the woman does not consent to the referral to maternity services, the professional should seek advise from their line manager to agree further action.

Where the professional in a community setting has ongoing contact with the woman, they should liaise with the community midwifery team leader/midwifery lead. Contact details are available on each Trust website/intranet. There will be occasions where the professional is having ongoing contact with the partner/significant other and this action may be appropriate. They should seek advice from their line manager/professional safeguarding lead to agree the next action.

Professionals should ensure that they have up to date demographic and contact details for the woman and, with consent, an alternative contact number.

At any stage, where the woman has not presented for antenatal care and immediate clinical or safeguarding actions are required, the professional should liaise with the GP, midwife (and obstetrician where relevant), health visitor, other professionals who may be involved and, where relevant, make a referral to children's social services. Where possible consent should be obtained. If the woman declines and the professional remains concerned, they should discuss with their line manager and professional safeguarding lead, where available, in the first instance. Advice may also be sought from children's social services. Contact details are available on each Trust website/intranet.

8.0 RISK ASSESSMENT

A holistic view should be considered when identifying a woman as having not booked at all , or booking late for antenatal care. The reason for not presenting or presenting late must be ascertained to ensure any clinical and social risks are identified and actions initiated to mitigate these. Not presenting at all, or late presentation is not always a safeguarding concern. There are situations where women appear to have been unaware of their pregnancy until late in pregnancy or at the unexpected arrival of a baby but adjust quickly and can parent safely and effectively with or without support. Women have the right to make their own birth choices. These in themselves are not automatically a cause for concern.

Engaging women and their partners is integral to effective assessment and intervention. Where women have experienced adversity, a trauma-informed response is required. Women with communication, language or disability needs will require a response to meet their individual needs. In order to come to an informed assessment, it is important to be aware of disguised compliance where women or their partners appear to co-operate with professionals in order to allay concerns and stop professional engagement. The practitioner should maintain professional curiosity and employ respectful challenge to information provided by the woman/family. The practitioner should consider communication styles using probing questions to ensure that a full clinical and psychosocial history is obtained.

Fully exploring the reason for not presenting or late presentation will be a key factor in determining the potential safeguarding risk to the unborn baby or new-born baby. This may require a multiagency approach including referral to children's social services. The woman or new-born baby may need support or the new-born baby may need protection. Risk assessment will include identifying any potential impact on parenting of the baby and include the assessment of historical information in the context of current circumstances.

Professionals deciding on what level of support or onward referral should be made, should take account of all factors of the UNOCINI Threshold of Need guidance: https://www.health-ni.gov.uk/publications/thresholds-need-model. Factors to consider relate to the woman, the father and the woman's current partner or any other relevant person.

The following list are the main reasons why a referral to Children's social services must be made. There must be potential risk or impact on the current unborn/newborn baby:

- Any type of abuse has occurred, or is likely to occur, to a young person under the age of 18 years
- A previous child in the family has died due to unascertained causes but safeguarding concerns had been considered
- A young person has conceived under the age of 13 years
- Human/child trafficking/exploitation
- Concerns about domestic violence/abuse in either the present, or in the previous relationship(s) of either parent
- Significant parental mental health issues or learning disability
- Significant parental alcohol/substance misuse
- Significant current/historical parental criminal history/imprisonment in particular convictions against a child or for violent, sexual or domestic abuse offences
- Missing person
- On female genital mutilation risk assessment, there is a concern that a female child is likely to undergo female genital mutilation in the future
- Denying previous or current social services involvement where there is potential risk to the unborn/new-born baby
- Previous social services involvement resulting in children subject to child protection or looked after procedures
- The woman indicates that adoption or fostering (including private fostering) is being considered.
- Any other concern that may initiate a pre- birth risk assessment process led by children's social services

9.0 CLINICAL ACTIONS FOR MIDWIVES/MATERNITY STAFF/ GENERAL PRACTITIONERS

General Practitioners (GP)

Where a GP makes a referral for antenatal care, they should do so as soon as the pregnancy is confirmed. The referral letter should include all relevant physical, emotional and social information relating to the woman, where relevant. Where a GP becomes aware that the woman has not attended a booking appointment they should consider all available information to inform their desicion and initiate actions required. This will include liaising with the midwife and health visitor.

Midwives

Presenting between 14 -20 weeks gestation

The midwife must organise a dating scan, if not offered on the same day as the booking appointment, within three working days of the woman booking/presenting where possible. The midwife should perform an abdominal palpation, ask the woman if she reports any fetal movement patterns and consider auscultation of fetal heart if appropriate. This will provide an assessment for all woman who may or may not be sure of dates as findings may suggest a more/less advanced gestation. The midwife should record all findings in the Maternity Hand-Held Record (MHHR)/electronic maternity record.

Presenting later than 20 weeks gestation

The midwife must organise a dating scan, if not offered at the booking appointment, at the next available clinic (within three working days where possible). The midwife must perform an abdominal palpation, fundal height measurements as per NICE guidance, for an approximate gestation, auscultation of fetal heart and determine if woman reports fetal movement patterns. The midwife should record all findings as late presentation/booking in the MHHR/electronic maternity record. The midwife will apply the protocol for antenatal screening bloods pathway accordingly (Appendix 1). Trusts should follow their late-booker care plan where available.

All late presentations

Ascertain why the presentation did not occur prior to 14 weeks. The midwife must check NIECR/ Encompass electronic record to determine, if the pregnancy was confirmed in a timely manner which should have enabled an earlier appointment being arranged by maternity services. This will inform the assessment as the late booking is not attributable to the woman.

At booking, all routine investigations (bloods and urine) must be obtained as per Trust/regional antenatal screening guidance. If booking bloods have not been taken at the optimum time of 10 weeks then additional pathways may need to be considered depending on gestation (see Appendix 1). If the woman has transferred from outside Northern Ireland (NI) Rubella screening may still be required as it is still mandatory in NI. If official hospital laboratory printed copies of booking bloods are present in the woman's MHHR (provided by previous Health Care Trust), these can be regarded as sufficient for medical referencing. If printed copies are not available, then all booking bloods must be repeated with informed consent. If woman is 20 weeks gestation or more please refer to Appendix 1.

The midwife should discuss women, where relevant, who present after 14 weeks with the line manager, obstetrician and SCNS where clinical or safeguarding concerns exist. They will liaise with the GP, health visitor/family nurse and any other relevant professional and follow up in writing according to Trust/GP arrangements.

10.0 SAFEGUARDING ACTIONS

Any professional who has a safeguarding concern should discuss/seek advice from their line manager/ safeguarding lead and gather information (including that relating to the partner) to inform their decision on next actions. This may involve discussion with the GP, obstetrician, midwife, health visitor/ family nurse and any other relevant professional involved, including those in the area where the woman previously resided if she has moved home. The professional should check NIECR/Encompass electronic record to ascertain if family are currently known to children's social services. Absence of information relating to previous or current social services involvement or difficulty accessing NIECR/ Encompass electronic record should not delay or deter appropriate action. The professional should contact chlidren's social services Gateway Team (or the Regional Emergency Social Work Service out of normal hours) to make relevant enquiries.

Where there is a concern that the woman may be missing and known to social services', meeting the criteria within the Notification of Children/Families assessed as being at potential risk and their whereabouts remain unknown (HSCB, 2016), the professional should make telephone contact with children's social services Gateway Team (or the Regional Emergency Social Work Service out of normal hours) or the Safeguarding Children Nurse Specialist (where this is in keeping with Trust policy) to check the missing persons database.

Safeguarding is a dynamic process and new information should inform ongoing assessment and action. Professionals who have ongoing contact with patients/clients, should have processes in place to enquire and record if their health or social circumstances have changed.

Any professional who makes an assessment that the threshold for referral to social services has been reached should take the following action.

If the family are already known, the referrer should discuss with the social work case co-ordinator and follow up in writing. A copy should be retained in the patient/client/professional records. In the case of MHHR, consideration must be given to where the copy is stored. Trusts should have a process for the use of repository files where information cannot be stored in the MHHR. The MHHR should include a reference that additional information is stored elsewhere. The full roll out of the Encompass electronic record will negate the need for repository files.

Where the family are not currently known to social services, two situations need considered.

For a family support referral; the referrer must seek consent from the woman and make the referral in writing using a UNOCINI referral form. In the case of a young person under the age of 18, consent from the person with parental responsibility may be required depending on the age, understanding and consent of the young person.

For a child protection referral; the referrer must make the referral by telephone to the children's social services Gateway Team (or the Regional Emergency Social Work Service out of normal hours) and follow up in writing using a UNOCINI referral form within 24 hours. Consent is not required but the referrer should inform the woman that the referral has been made unless to do so would increase the risk for her, the unborn baby or any other children.

A copy of the UNOCINI referral form should be retained in the patient/client/professional records. In the case of MHHR, consideration must be given to where the copy is stored. Trusts should have a process for the use of repository files where information cannot be stored in the MHHR. The MHHR should include a reference that a referral has been made. The full roll out of the Encompass electronic record will negate the need for repository files.

Depending on the reason for referral, it may be important/required that information is shared with others involved in the care of the family including the GP and obstetrician. Verbal communication may need followed up in writing according to local information sharing arrangements.

Once social services receive the referral, they will make a decision on what level of intervention is required, if any, including use of the UNOCINI Thresholds of Intervention guidance (DOH, 2010, link unavailable).

This may include initiating a pre-birth risk assessment as per Guidance for the Safeguarding Process Prior to and Immediately After the Birth of a Baby Where There May be Risks of Significant Harm (HSCB, 2015). This process should commence as soon as possible after the referral to allow for effective planning. Depending on the stage of pregnancy and level of concern, the child protection process may be initiated. All professionals should contribute to the process but social services are the lead agency. This does not negate the need for other professionals to communicate with each other. Health visitors should undertake their antenatal visits earlier than 28 weeks gestation to inform the process and agree interventions.

Any additional concerns about a woman over 18 that meets the criteria for an adult safeguarding concern should be referred in line with the regional Adult Safeguarding Operational Procedures (HSCB, 2015).

11.0 ONGOING ATTENDANCE AT ANTENATAL CARE

Trust midwifery services should have a process in place for monitoring and addressing missed antenatal appointments and communicate this to others who may need to be aware for example the GP. They should also ensure that there is a mechanism for enquiring and recording any changes in the woman's health or social circumstances.

APPENDIX 1

LATE BOOKING BLOODS

For women presenting either: for booking ≥ 20 weeks; unbooked admission ≥ 20 weeks; unbooked in labour/delivered.

Obtain informed consent and document in MHHR.

1. Send bloods for HIV, hepatitis B, syphilis and rubella screening, in **one yellow/red topped** bottle.
2. Use the Regional Virus Laboratory (RVL) "late booker form" available in Maternity Unit.

NON-URGENT

Booking ≥ 20 wks gestation, unbooked admission ≥20 wks

1. Complete RVL "late booker form" ticking **routine** (not in labour) box.
2. Separate from NIBTS booking samples and send to RVL using routine sample transport system.

Positive result

1. Trust informed via generic email.
2. Arrange review within 10 working days.
3. Follow regional guidelines.
4. Refer to specialist services as required (GUM/hepatology/RJMS)

Negative result

1. Woman informed at next A/N visit.
2. Result recorded on NIMATS.
3. Result inserted into MHHR

HIV - emergency drugs pack held in local Unit to be used on advice from GUM and RJMS neonatologist.

Syphilis - treatment for mother and baby as per regional guidance.

Hepatitis B - vaccinate baby within 24 hours (4 hours preferable)

URGENT

Admitted: unbooked in labour; delivery likely within 48 hours; or delivered

1. Send sample within 1 hour of admission to ward.
2. Complete RVL "late booker form" ticking **URGENT** box and provide contact details.
3. Phone Micro BMS on call to alert that sample is being sent and urgency of sample (details on form).
4. Use correct transport packaging.
5. Organise taxi/arrange for sample to be taken **immediately** from maternity unit to RVL

1. Positive results phoned to named contact person on form by RVL.
2. Negative results available via Lablinks.
3. Follow up if no results by 4 hours.

Positive results

Immediately inform:

Liaise with manager and consultant obstetrician on call.

- Advise the woman of result and implications for care for her and baby.

Follow regional guidelines for positive HIV and syphilis results and local guidance for positive hepatitis B result. (→ see HIV / Syphilis / Hepatitis B box)

CONTACT DETAILS

RVH GUM consultant in hours: 96151034/51033/51036; out of hours: 90240503

RJMS neonatologist in hours: 96156591; out of hours: 96150570

Duty Virologist 07889086946 or Out of Hours 02890240503 ask for MICRO BMS

REFERENCES

NB: Some guidance and reports will be updated or supercede those referenced in the document. The relevant websites should be accessed for the most up to date version.

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- **DOJ, PSNI, HSCB (2018) Working Arrangements for the Welfare and Safeguarding of Child Victims and Potential Child Victims of Human Trafficking and Modern Slavery.**
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- **HSCB (2015) Adult Safeguarding Operational Procedures.**
  Adult Safeguarding: Prevention and Protection in Partnership key documents (health-ni.gov.uk)
- **HSCB (2015) Guidance for the Safeguarding Process Prior to and Immediately After the Birth of a Baby Where There May be Risks of Significant Harm**
  https://hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/UNOCINI-Guidance-for-the-Safeguarding-Process-Prior-To-and-Immediately-After-The-Birth-Of-A-Baby-Where-There-May-Be-Risks-of-Significant-Harm-January-2016.pdf
- **HSCB (2016) Notification of Children/Families assessed as being at potential risk and their whereabouts remain unknown (link unavailable).**

- **HSCB (2018) Working Arrangements for The Welfare and Protection of Adult Victims and Potential Victims of Human Trafficking and Modern Slavery.**
  adult-working-arrangements-2018.pdf (justice-ni.gov.uk)
- **HSCB (2018) Working Arrangements for the Welfare and Safeguarding of Unaccompanied and Separted Children and Young People.**
  Working Arrangements for the Welfare and Safeguarding of Unaccompanied and Separated Children and Young People (health-ni.gov.uk).
- **MBRRACE-UK (2020) Saving Lives, Improving Mother's Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18.**
  https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10_ONLINE_VERSION_1404.pdf
- **MBRRACE-UK (2021) Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19.**
  Confidential Enquiry into Maternal Deaths | NPEU > MBRRACE-UK (ox.ac.uk)
- **MBRRACE/PMRT (2022) Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool Fourth Annual Report.**
  National Perinatal Mortality Review Tool: Learning from Standardised Review when Babies Die: 4th annual report
- **NICE (2010) Pregnancy and complex social factors: a model for service provisions for pregnant woman with complex social factors.**
  https://www.nice.org.uk/guidance/cg110/chapter/1-guidance
- **NICE (2019) NICE Clinical Guideline 62. Antenatal care for uncomplicated pregnancies.**
  https://www.nice.org.uk/guidance/cg62
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- **PHA (2015) Communication Pathway for Midwives, Health Visitors, Family Nurse Partnership Nurses and School Nurses (Link unavailable)**
- **SBNI(2017) Core Child Protection Policy and Procedures.**
  Safeguarding Board for Northern Ireland Procedures Manual (proceduresonline.com)
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