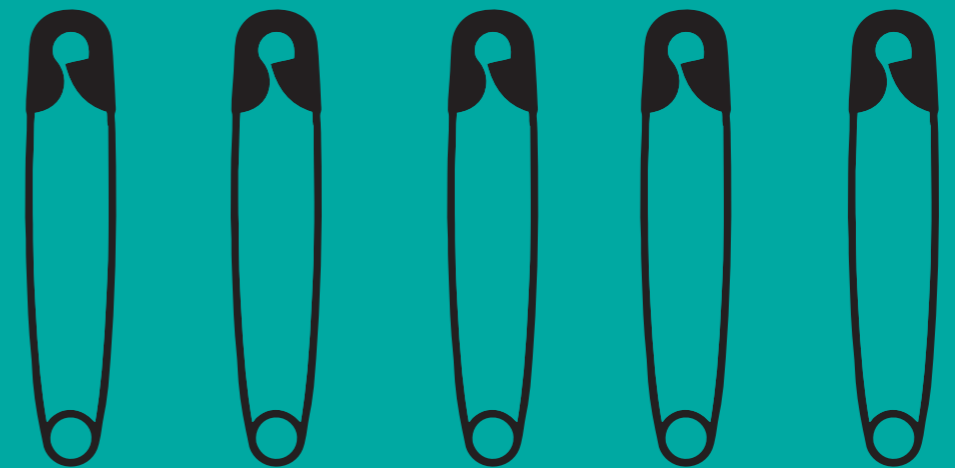


# BIRTH AND NEWBORN Clinical Pathway Group



## EXECUTIVE SUMMARY

The Birth and Newborn Clinical Pathway Group ask commissioners to focus on 3 areas when commissioning maternity services, whilst continuing to use the current core maternity pathway:

- Pre-conception care which optimises the health of all women 15- 45 years, regardless of intention to conceive (more than 50% of pregnancies are unplanned)
- Improving the quality of the initial maternity assessment appointment (social and medical needs, risks, preferences, leading to a plan for pregnancy)
- Planning and provision of post-natal care

**The group developed standards and metrics for these three areas, which have been placed with the Advancing Quality Alliance (AQuA). Commissioners and providers are asked to use them to aid commissioning and evidence-based service provision.**

## INTRODUCTION

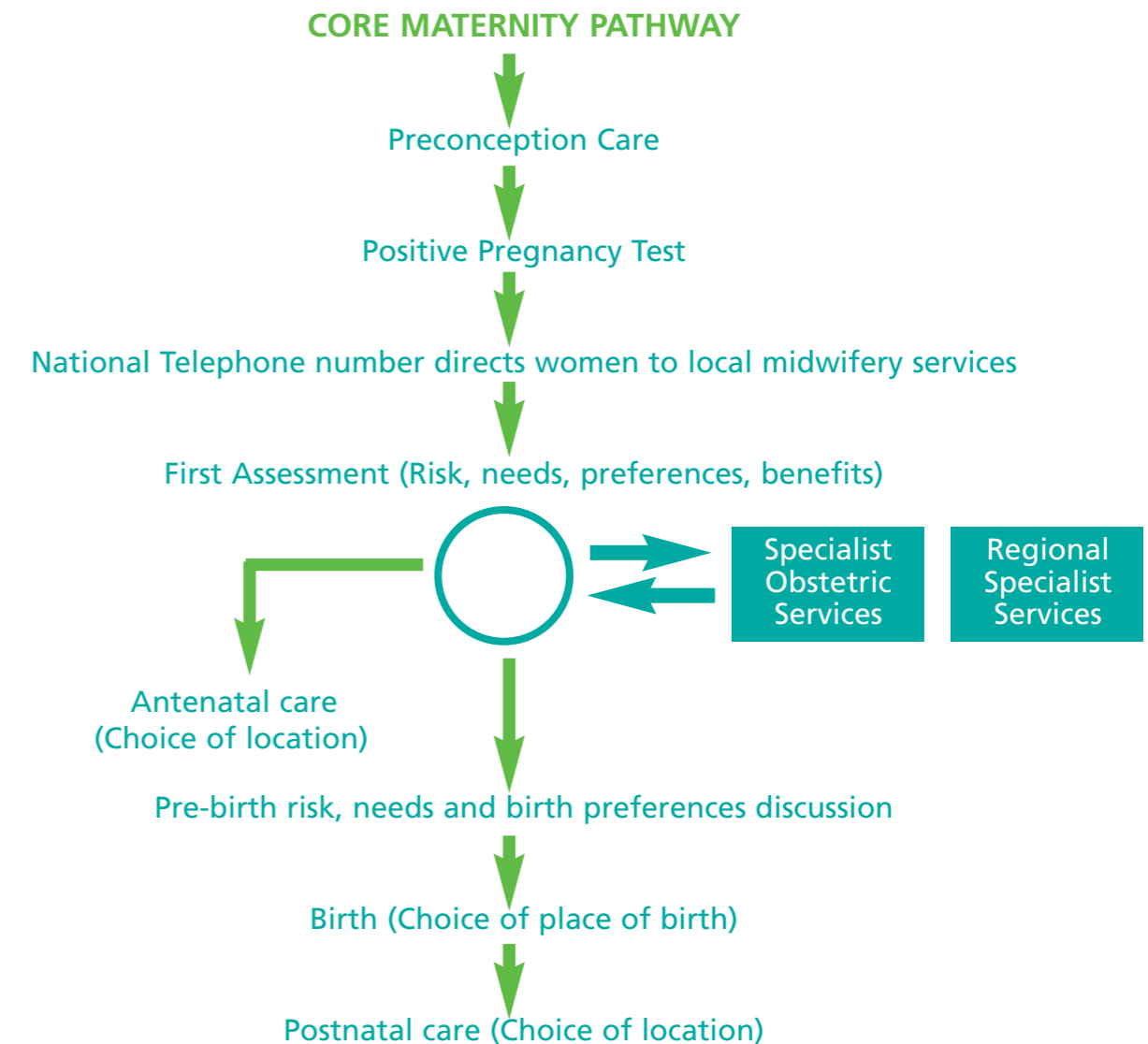
The Birth and Newborn Clinical Pathway Group is a group of 26 clinicians from all over the North West of England. They were put forward as members of the group by their own organisations at the invitation of NHS Northwest. The group's collective clinical expertise spans 349 years of NHS service and had the remit to identify areas of work within maternity and newborn services that needed improvement, independent of ongoing national policy drives. The group was marshalled by the Chair, David Rowlands and Deputy Chair Leanne Bricker, with Chief Executive Sponsorship from Sheena Cumiskey.

Through its membership, the group spanned the expertise of midwifery, obstetrics, gynaecology, neonates, children's centres, pharmacy, laboratory services, mental health, commissioning, public health and primary care. The group was supported by two NHS Northwest clinical leadership fellows, Ted Adams (Registrar in Obstetrics & Gynaecology, Mersey region) and Jill Cooper (Midwife, East Lancashire Hospitals NHS Trust)

### Our starting point

The core maternity pathway (summarised in figure 1) devised in Healthier Horizons is the general model which should be used throughout the Northwest as an ideal pathway to deliver woman-centred and midwife-delivered maternity care. We make no apologies for continuing with its basic premise that birth is on the whole a normal process and that deviation from the core pathway and away from normality should be minimised. There always remain some women who are at a higher risk, either due to previous medical or other conditions, or due to the effect of their pregnancy. These women will require additional care and the pathway allows for women to access specialist services when needed while still receiving core care from midwives known to them.

birth is on the whole a normal process and deviation from the core pathway and away from normality should be minimised.



**FIGURE 1: THE CORE MATERNITY PATHWAY**

The CPG membership was, and remains, acutely aware of other regional and national initiatives concurrently taking place in maternity services. These included Maternity Matters implementation, a wealth of NICE guidance, Kings Fund **Safer**

**Births**, NHS Institute **Promoting Normal Birth and Reducing Caesarean Sections** initiative. We continued to support these ongoing initiatives, but then identified areas that need further support.

## PRIORITISING AREAS FOR FURTHER SUPPORT



The group focussed on three areas of pathway provision which were currently overlooked or were of uncertain quality and had the potential to improve outcomes if quality was systemically improved;

- **Provision area 1** Pre-conception care within the context of optimising the health of all women 15- 45 years, regardless of intention to conceive (more than 50% of pregnancies are unplanned)
- **Provision area 2** Improving the quality of the initial maternity assessment appointment (social and medical needs, risks, preferences leading to a plan for pregnancy)
- **Provision area 3** Improving the planning and provision of post-natal care so that women's satisfaction is increased and outcomes are improved through best value services.

Guidance already published by the National Institute of Health and Clinical Excellence, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Nursing and Midwifery Council was examined for potential influence on provision areas. Documents and guidance produced by relevant third sector organisations such as Diabetes UK, Change for People, Epilepsy Action, and The National Childbirth Trust were also used in order to include and maintain a service user influence. Relevant research documents and reviews from the Cochrane Database and Confidential Enquiries into maternal and child health were also accessed.

The CPG needed to produce a method of measuring attainment of the standards. The clinical metrics were taken from national guidance where available and then "regionalised" by the clinical expertise on the CPG. The metrics are therefore firmly rooted in realistic clinical practice. The CPG and others throughout the North West had input into the final metrics produced. If the standards are to be used, it is essential that those commissioning maternity services have a feasible and SMART way of measuring their efficacy. In some cases the point of measurement will not be within the same service as the point of clinical activity. For example the metric describing the care of diabetic woman who wants to become pregnant suggests that at maternity care 'booking-in', their HBA1c (a measure of diabetic control) should be in the "good" range.

This figure will be measured in maternity care, but more strongly influenced by the previous three months of diabetes care.

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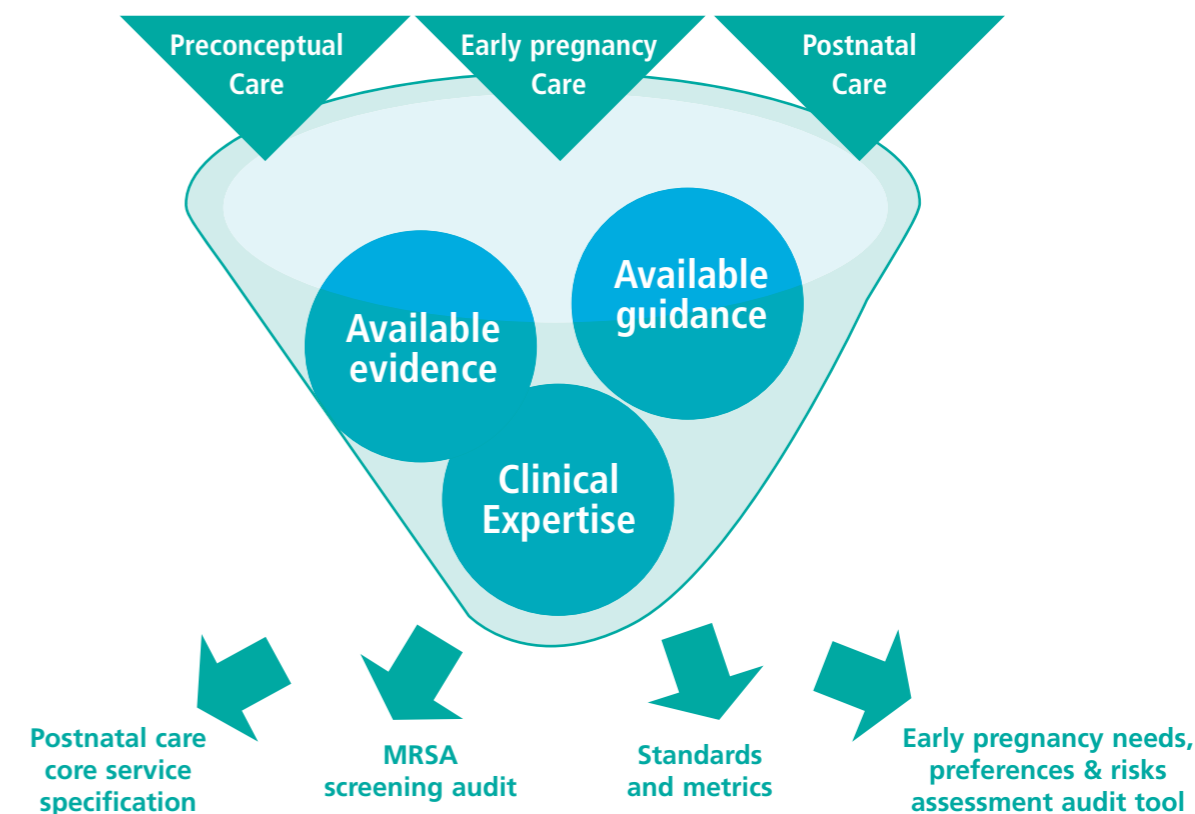


FIGURE 2 THE BIRTH AND NEWBORN CLINICAL EXPERTISE FUNNEL

As the three care provision areas were explored and developed into standards and metrics to support commissioners, 'funnel vision' highlighted areas where some systems issues needed to be addressed if quality was to be improved and prevention and productivity opportunities utilised. See figure 2. These were identified later in the CPG work and for these issues we can currently only provide an interim report on progress.

- Systems issue 1 Undertaking a regional clinical and cost-effectiveness audit of MRSA screening in maternity care

- Systems issue 2 Developing a Northwest postnatal core service specification
- Systems issue 3 Improving information sharing agreements between children's centres and maternity services
- Systems issue 4 Joining up ongoing work across the region on a social needs assessment to be used at the first maternity assessment appointment

## IMPROVING QUALITY OF CARE PROVISION AND OPTIMISING OUTCOMES

### Provision area 1 - Pre-conception care

- Nationally and regionally, there is little evidence of pre-conceptual care being delivered as an entity in itself within primary or secondary health care services, and no inclusion in commissioning or service planning. There is however, consistent evidence from The Confidential Enquiries into Maternal and Child Health and other reports which tells us that care for high risk women and

vulnerable groups is often not planned or appropriate. If women enter pregnancy in optimum health, no matter what their underlying social and medical needs might be, there is a stronger foundation for a pregnancy which is as healthy as possible. The CPG felt that gathering information in this area was of key importance.

### Provision area 2- Early pregnancy care

The CPG felt that it was important to look at the quality of early pregnancy care, rather than focus solely on attaining the Early Access to Maternity Care indicator (where all women should be booked for maternity care before they reach 12 weeks, 6 days gestation). Ensuring that women and families have consistent care and information on which to base their choices is a key factor in early pregnancy. A detailed social needs, risks and preferences assessment is a vital part of this process and the

CPG felt that examining this in detail would provide a valuable basis for the provision of maternity care. There is currently a protracted state of waiting for a national assessment tool, so the CPG felt it important to offer an audit tool for providers to use. The availability of measures to allow comparability of the quality of the assessment will help commissioners and providers understand the cause of variability and ensure that a desire to meet the indicator does not inadvertently reduce the quality of the assessment.

<p><b>What's needed</b></p> <p>Pre-conception care within the context of optimising the health of all women 15- 45 years, regardless of intention to conceive (more than 50% of pregnancies are unplanned)</p>	<p><b>What preconceptual care delivered by optimising female health looks like when its working really well</b></p>	<p><b>What's needed</b></p> <p>Improving the quality of the initial maternity assessment appointment (social and medical needs, risks, preferences leading to a plan for pregnancy)</p>	<p><b>What early pregnancy care looks like when its working really well</b></p>
<p><b>Measures of success</b></p> <p>Standards and metrics have been developed by the pathway group and are available from AQUA</p>	<p>Jane is 38 and has two teenage daughters, Amy (16) and Jemima (14). Jemima was diagnosed with Insulin dependent diabetes when she was 9. She currently attends the regional children's hospital for yearly checkups and also her General Practitioner and practice nurse in between the hospital visits. Jemima goes to the practice nurse for a diabetes check. Jemima mentions her new boyfriend, Paul who is a year older than her. The practice nurse encourages Jemima to discuss with her mum that she is sexually active. Jemima isn't keen to and the practice nurse suggests that she might want to see the GP or go to the family planning clinic for a chat about contraception. Jemima doesn't get round to it, but is at the hospital next month. Her diabetes is well controlled, but the Consultant there also mentions contraception and reminds Jemima about NHS Choices website. Jemima goes online when she's at home and finds her nearest sexual health centre. She attends there and is given some contraception and advice about some of the issues around getting pregnant and diabetes. The doctor at the clinic suggests that when its time for Jemima to start planning a family (which she hopes is a few more years yet) she should speak to her general practitioner before getting pregnant. She reminds Jemima to get more contraception before her current method runs out from the clinic or from her GP. 4 years later Jemima missed her contraception appointment and went on holiday after her A-levels with Paul. She misses her next period and finds that she is pregnant. Because of the regular talks with the sexual health doctors, her GP and the diabetes consultant, she remembers that she needs to see the consultant at the maternity hospital as soon as possible because of her diabetes. She makes contact with her midwife who refers her promptly to the antenatal clinic. She is seen well before 12+6 weeks, her HBA1C levels show that her diabetes has been well controlled around the time of conception, and a plan for pregnancy and her diabetes is made.</p>	<p><b>Measures of success</b></p> <p>The quality of the initial maternity assessment appointment (social and medical needs, risks, preferences leading to a plan for pregnancy) shows no variability between providers of maternity services, with the proportion of assessments that meet the quality standard being as good as the best within the region.</p>	<p>Saira attends her first midwife appointment at a local Children's Centre. Because she was given an information pack (and offered a choice of which language this information was in) when her pregnancy was confirmed she feels confident about what is going to happen and knows she can ask for the help of a link worker if she needs to.</p>
<p><b>What commissioners need to do</b></p> <p>Commission primary care health and wellbeing providers to deliver services that improve the health of all women 15-45years so that any conception occurs against a background of optimal female health.</p> <p>Commission maternity care providers to measure at the point of first contact with maternity services, and report on the levels of optimal health achieved once primary care services are delivering the above health improvement services.</p>		<p><b>What commissioners need to do</b></p> <p>Specify the use of the audit proforma (located at AQUA) within the quality schedule for maternity services contracts and monitor improvement.</p>	<p>The midwife asks lots of questions which Saira was prepared for from reading the information pack. These questions are not just about her health but also about her family, housing and support. Saira is 19 and has recently arrived in England to live with her husband. The midwife asks Saira if she would like to register with the Children's Centre and arranges for a family support worker to contact her at home. The Centre provides courses and groups for expectant parents, those wanting to improve their English and smoking cessation (for Saira's husband).</p>
<p><b>Any potential for quality or productivity gain</b></p> <p>If a woman should become pregnant whilst in the most optimal state of health possible for her, this increases the likelihood of a straightforward pregnancy. For example women with diabetes who maintain good control over their blood glucose levels have a reduced likelihood of congenital malformations occurring in the early fetal development period and hence a reduction in the need for specialist fetal medicine referrals. Good control during pregnancy reduces the likelihood of unscheduled attendances for maternity care and reduces the need for special care of the baby when it is born.</p> <p>Maintaining a normal weight in adulthood minimises the likelihood of developing weight related complications in pregnancy and makes it more straightforward to monitor the growth of the developing baby using clinical skills rather than attending for regular ultrasound growth monitoring. This reduces the number of attendances for complications of pregnancy and for ultrasound.</p>		<p><b>Any potential for quality or productivity gain</b></p> <p>A family context assessment approach to maternity care planning enables opportunistic signposting to other services and reduces the future risks to the family, for example reducing the risk of exposure to second hand smoke. There are also medium term gains to be made in connecting women at risk of social isolation into existing community support systems. This lessens the risk of antenatal and postnatal depression and promotes community interaction making it more likely that women can secure resources such as improving language skills, employment and training which keeps children out of poverty. In turn there is a longer term gain in these children have improved life chances and are more likely to be economically independent and emotionally resilient, thus reducing future use of health and social care and welfare systems (this is well evidenced in the USA in the Family Nurse Partnership model).</p>	<p>As a consequence of this early input Saira and her husband are well prepared for labour, birth and parenting. Saira has made some good friends locally who also have small babies and her husband has been able to stop smoking. This is a great foundation for their future family life.</p>

### Provision area 3 - Postnatal care and planning.

Postnatal care availability has decreased in the last decade, with the number of face-to-face visits between care giver and new mum declining. This is of concern when linked with demographic changes including isolated families, growing unemployment and greater pressure on other services. The CPG felt that identifying the minimum requirements for

postnatal care would provide a firm foundation for care in the North West and also lead to better multi-agency working, especially when women and families are moving from maternity care to child health services.

## OPTIMISING THE PREVENTATIVE POTENTIAL AND IMPROVING THE PRODUCTIVITY OF SERVICES

- **Systems issue 1** Clinical and cost-effectiveness audit of MRSA screening in maternity care

Current guidelines covering MRSA screening in maternity services are difficult to interpret. Neighbouring trusts may have different screening regimes and treatment options. The CPG felt that investigating the screening regimes, colonisation and bacteraemia rates and treatment regimes would firstly give an understanding of the prevalence of MRSA within the North West and secondly provide an opportunity to consider whether MRSA screening in a low risk population is appropriate and cost-effective.

Currently data from all regional Trusts is being collected, this will be analysed and recommendations made as to the future of MRSA screening in the region with a view to developing new guidance for MRSA screening in this population which is clinically effective and financially beneficial.

- **Systems issue 2** Developing a Northwest postnatal core service specification

Whilst we recognise the need for change in service provision, we are determined that services remain woman and family-centred. With the continued reduction in postnatal care from maternity services, it was felt that it would be useful to establish a minimum care standard which could be used as a foundation across the region for all women. Again using published evidence and clinical expertise, the North West Postnatal Plan has been produced, along with standards and metrics for its use.

- **Systems issue 3** Improving information sharing agreements between children's centres and maternity services

It is of prime importance that services provide joined-up care for new and existing families. Currently Children's Centres (key to family support as children grow), are left out of the loop in terms of being given information on births and pregnancies. The CPG is looking at how this information can be best shared in a suitable confidential manner, with permission from the families involved. It is also essential that maternity services become an integral part of health services co-ordinating with other health priorities, for example mental health and children's services, long-term conditions and public health promotion.

- **Systems issue 4** Joining up ongoing work across the region on a social needs assessment to be used at the first maternity assessment appointment.

It is recognised that this is an important element of maternity care. However, as a result of other initiatives, Trusts are already developing their own Social Needs Assessment framework for use within their services. The CPG has been able to connect those Trusts and enable them to share their working and difficulties.

It is also essential that maternity services become an integral part of health services co-ordinating with other health priorities,

What's needed	What postnatal care looks like when its working really well
<p>Improving the planning and provision of post-natal care so that women's satisfaction is increased and outcomes are improved through best value services.</p>	<p>Tania gives birth to her second baby Katy three days after her expected date. She has a quick labour and a normal birth and wants to go home as soon as possible the same day. Before she leaves the birth centre a midwife explains the pattern of postnatal care that Tania can expect—her first visit at home the following day, the heelprick or bloodspot test at her local Children's Centre and then her last midwifery appointment at the post natal clinic, again at the Children's Centre.</p>
<p><b>Measures of success</b></p> <p>The postnatal core service specification is utilised to specify the core minimum postnatal midwifery care in all contracts with maternity providers.</p>	<p>The midwife gives Tania and her partner Greg some written information about how to get support and advice if they are worried at any time. She also explains the warning signs that would tell them that either Tania or Katy needed to be seen sooner than arranged (such as heavy bleeding for Tania). Tania is a little worried as she didn't continue breastfeeding very long with her first baby, Martin as she had very sore nipples and wants to breastfeed Katy for longer. Tania accepts a referral to the local breastfeeding peer supporters' network and is also given their phone number.</p>
<p><b>What commissioners need to do</b></p> <p>The CPG recommends the use of the North West Postnatal Plan as a baseline for the contracted provision of postnatal care throughout the region together with exemplary multi-agency working. Contracts also need to specify a range of 'individualised' 'add-on' care provision for those who are identified at greater need.</p>	<p>The three of them also discuss how Katy might behave over the next 24 hours in terms of sleeping, feeding, pooing and weeing so that Tania and Greg feel confident.</p>
<p><b>Any potential for quality or productivity gain</b></p> <p>Quality is improved because a clinic setting commitment enables midwifery and support staff personnel to be allocated to that and no other duty; in effect this means that an appointment at a community clinic is less likely to be affected by needs to attend a home birth or urgent breastfeeding problem.</p> <p>Productivity is improved through a reduction in community midwifery time and mileage spent travelling to homes of women who are recovering well and babies who are developing well in the postnatal period, and a reduction in the number of wasted visits when well women have prioritised going out for shopping, school pick-up etc over waiting at home for a midwifery visit. These savings may not be cash releasing but do extend the capacity of community midwifery services to provide more tailored home support to women and families who are more vulnerable to a poor recovery or difficulties with early parenting.</p> <p>Additionally provision of some elements of postnatal care makes signposting and access to the parenting support services provided by children's centres much easier for families.</p>	<p>The midwife gives the couple some written information on the local immunisation programme, the health visiting service, and Children's Centre. As Tania and Greg only moved to the area recently they are not registered with the Children's Centre and the midwife gets their consent to notify the Centre of the birth.</p> <p>Once home all goes well, although Tania requests an extra home visit on the third day due to passing a large blood clot. She is reassured by the midwife that this is normal.</p> <p>Tania and Greg meet their health visitor and Children's Centre support worker before they move on from maternity services and feel well supported.</p>

**THESE FOUR SYSTEMS ISSUES AND POTENTIAL OUTCOMES ARE SHOWN BELOW (FIGURE 3) .**

	INNOVATION	PRODUCTIVITY	PREVENTION	QUALITY
<b>Systems Issue</b>	Local audit shows that 50% of maternity services are sharing info but only 38% children's centres are receiving it	MRSA screening (national HCAI prevention guidance) effectiveness in maternity care	Postnatal care variable and provision much maligned by women	Absence of tool to monitor quality of needs and risk assessment in early pregnancy
<b>Evidence</b>	Information sharing enables earliest intervention & parenting support	WHO principles of effective screening programme not met. Clinicians view is little/no gain.	NICE Guidance HCC Maternity Survey	NICE Guidance gives 14 required elements of assessment
<b>Who needs to be engaged</b>	Maternity Services Caldicott Guardians LA registrars of births Child Health	HCAI leads in trusts Commissioners CNO DH	Commissioners Maternity Services General Practice Health Visiting Services	Commissioners Providers
<b>Champions</b>	Directors Children's Services	Consultant Obstetricians Midwives	Commissioners AQuA	Maternity Services AQuA
<b>Potential</b>	CCs undertake parenting needs assessment with all families in pregnancy. Plans are in place for vulnerable families well in advance of baby's birth.	£12.50 is saved for every test not done. Currently 100 tests are performed to pick up MRSA colonisation in one woman.	Healthy women have clear offer for care. Resource freed to re-direct to families with identified/ emergent need.	Inadequacies in assessment are addressed and early pregnancy outcomes optimised.

**RECOMMENDATIONS**

Standards, metrics and audit tools to support commissioner and providers in achieving these five recommendations are available from the Advancing Quality Alliance (AQuA).

**Preconception care**

The CPG recommends the specification and establishment of pre-conceptual care for women with long-term conditions and for those wishing to attain optimum health prior to conception. This will mostly be achieved outside maternity services (apart from very specialist medical conditions) but measured during pregnancy.

**Postnatal planning**

The CPG recommends the use of the North West Postnatal Plan as a baseline for the provision of clinically relevant and cost-effective postnatal care throughout the region. Through commissioning arrangements, exemplary multi-agency working at the service provision level should be expected.

**Early Pregnancy needs and risks social and medical assessment**

Quality early pregnancy care is the aim, with choice and a detailed needs, risks and preferences assessment at its heart. Ongoing assessment of the quality of the assessment should be monitored by specifying use of the audit tool provided by the CPG.

**Information sharing to improve targeted universalism and earliest intervention**

Introductions to local authority children's centres by maternity services should be commissioned. Suggestions on how best to do this are available from AQuA.

**MRSA testing in selective populations of pregnant women**

There appears to be an opportunity across the northwest to eliminate the costs associated with routine selective MRSA testing in the pregnant population by ceasing this practice. Commissioners and providers should discuss the benefits and any potential risks associated with ceasing to perform MRSA screening. This will have an immediate effect on the amount of resource spent on laboratory tests, and will have a productivity gain as the clinical staff resource used for testing can be re-directed to provide additional support for vulnerable women in the antenatal period. Figures obtained so far indicate that just under 10% of women giving birth in the North West Region each year meet the threshold for being screened for MRSA. 1.83% of those screened test positive for colonisation (i.e. 100 women are tested and only 1 is MRSA positive). Each test costs around £12.50 to complete, taking into account laboratory testing and staff time. For large maternity units, cost of MRSA screening in maternity services per annum (for completing the screening test only) is likely to cost in the region of £12,000. The costs associated with midwifery time to discuss screening with women are not cash releasing savings as women are likely to be accessing midwifery care anyway (usually for pre-operative tests and discussion) but this time could be better utilised in offering the families the opportunity to ask questions and be well prepared for their planned procedure and the discharge process thereafter.

There appears to be an opportunity across the northwest to eliminate the costs associated with routine selective MRSA testing in the pregnant population



WHAT WE DID	AREA OF IMPROVEMENT		
	PRE-CONCEPTION	CARE IN EARLY PREGNANCY	PLANNING & PROVISION OF POSTNATAL CARE
<b>Rationale (why did it need to be improved?)</b>	<ul style="list-style-type: none"> <li>Prevention part of QIPP agenda (i.e. stop health problems getting worse in pregnancy).</li> <li>Help all health professionals understand their impact on pregnancy.</li> <li>Tap into a population more motivated to change their existing health behaviours.</li> </ul>	<ul style="list-style-type: none"> <li>Quality part of QIPP agenda (i.e. improve "intelligent" ways of using NICE guidelines) in as efficient ways as possible.</li> <li>Focus on public health interventions.</li> <li>Focus on maximising medical improvement of pre-existing conditions by referral to a properly qualified person.</li> </ul>	<ul style="list-style-type: none"> <li>Innovation and Productivity part of QIPP agenda (i.e. define how best postnatal care is delivered and who should deliver it).</li> <li>Involve other (non NHS) agencies as necessary.</li> <li>Improve inter-agency communications to stop duplication across public sector.</li> </ul>
<b>Example of standard</b>	All women seeking pregnancy and fertility advice before pregnancy should be counselled about weight gain and sensible eating during pregnancy.	Women should not smoke in pregnancy and those they live with should take appropriate measures to ensure they live in a smoke free home.	Women and families need to be encouraged to self-care where suitable, and be signposted to relevant services when this is not suitable.
<b>Example of metric</b>	All health care providers ensured that they had standard advice about healthy eating and weight gain during pregnancy for women seeking advice.	90% of women who smoke in pregnancy or live with those who smoke were given information on smoking cessation services and were offered referral, after discussion on the implication of smoking/being subjected to passive smoking during pregnancy.	90% of women and families were given written or pictorial guidance (in a suitable language) on when and how to seek further advice (this must include factors relevant to both mother and baby).  90% of women and families were given information about postnatal and neonatal changes in the first few weeks following birth. This should be individualised where possible, for example to discuss care of sutures, recovery from caesarean section.
<b>Super metric for each area</b>	Expectation of a drop in the perinatal mortality rate.	Consistent care across the region.	Evidence of joined up working across all services.
<b>Cost effectiveness</b>	Women with pre-existing medical problems that are well managed decrease the likelihood of their baby needing admission to neonatal intensive care at a cost of approx £840/day.	Fewer missed appointments. Targeted care packages.	Reduced duplication across health and social care by information sharing. Care given by appropriate staff.
<b>Area of service that will effect change</b>	Primary care, long term conditions management, paediatrics, community child health, charities in the main, with expert help from some obstetricians and other specialist.	Maternity services.	Maternity services, neonatology, health visiting, children's centres, local authority.

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