Women, pregnancy, and additional support:

A trauma informed pathway of care

Maternity Services
NHS North Highland / Highland Council Care and Learning

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http://www.nhshighland.scot.nhs.uk/Pages/YourRights.aspx

Date	Author	Change
01/06/22	Claire MacPhee	Appendix 3 added Support and care for Gypsy/travellers
01/10/24	Claire MacPhee	Full review undertaken with wide expert consultation; Title changed to Women, pregnancy, and additional support: A trauma informed pathway of care. Links updated and graphics added. Section on concealed pregnancy added. A/N planning meeting timings changed to by 22 weeks. Literature search undertaken and references updated to reflect updated local Girfec and child protection changes.

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1. Introduction

The early identification of factors which may place an infant at risk, during pregnancy and/or the postnatal period is crucial for a proactive prevention strategy for the protection of vulnerable children including unborn babies. Good working relationships with all families help ensure that they get the right help at the right time and early provision of safe, effective family centred care helps in securing positive outcomes for children (Critchley 2018).

Work with all families can be enhanced by taking a *Trauma Informed* approach by building **trusting** relationships based on **choice** and **collaboration** whilst empowering families with a sense of **control** and **safety** (Scottish Government 2023). Particular focus should be given to including fathers in processes as they are often underrepresented in assessments and care planning (Cusworth & Whincup 2024).

2. Scope and Purpose

The purpose of this protocol is to ensure standardised timely and proportionate care is received by all pregnant women and their families in need of additional support across North Highland. It aims to provide clear guidance for staff around roles and responsibilities and expected timescales for those who may need multi agency support. The guidance within should be applied in combination with the National Child Protection Guidance for Scotland, (Scottish Government 2021) Getting it right for every child and young person in Highland: Interagency Practice Guidance & Child Protection Procedures, (Highland Child Protection Committee 2024) and follow the framework of family centred care with the needs of the unborn/child at the centre, National Practice Model Getting it right for every child (GIRFEC) (Scottish Government 2022).

This guidance was developed using best practice from both national and local guidance. Consultation was undertaken widely with relevant staff and all agencies involved with supporting pregnant women who need additional support across North Highland.

It has been designed to include a quick reference guide that can be printed or stored to be used as an aid memoire and check list.

Whilst we use the term ‘women’/‘woman’ throughout this document to preserve women-centred language we acknowledge that it is not only those who identify as women who require access to maternity services. The actions included within this pathway are underpinned by services being respectful and responsive to the individual needs of all women and birthing people.

3. Supervision

The purpose of supervision is to enhance professional development and safe practice. It minimises risk to the service user and practitioner. The line management structure should facilitate supervision for all staff. Caseload supervision relating to child protection in North Highland is facilitated by local Child Protection Advisors (The Highland Council 2024). Caseload supervision for families benefiting from additional support in general will be supported by Team Leaders.

	4. North Highland Vulnerable Pregnancy Pathway quick reference guide	Check box
Booking to 16 Weeks **Primary Midwife**	Carries out Wellbeing HPI assessment (**see appendix 2**) on ALL pregnant women, as per Highland Child Protection & GIRFEC Guidance 2024 and Electronic Maternity Notes (Badgernet) This should be shared with the HV/FNP if Additional HPI	
	Allocate Health Plan Indicator (HPI) as Core or Additional.	
	Refer to Additional Services if appropriate, with consent.	
	If the situation is socially complex and the unborn baby is considered at risk of significant harm: • Discuss with your team leader and Child Protection Advisor Health (CPA); Contact the Advice and Guidance line 01463 705828 or email childprotectionadvice@highland.gov.uk . • Notify Social Work via Practice Lead for Care & Protection without delay by telephone Numbers available here, follow this up with Child Concern Form (CCF) as soon as possible. This should prompt assessment by social work if required. • Any concern for older children within the household/family should also be considered and shared. • A decision to hold an Interagency referral discussion (IRD) may be actioned if certain criteria are met, CPA's Health will advise on this. Commence single agency plan as soon as possible: • A/N Plan with mother, copy to partners of the plan in line with information sharing procedures. • Chronology of Significant Events	
By 22 weeks	For all women with **an additional HPI** primary midwife should consider convening an Antenatal Plan Meeting with parent/s and partner agencies involved in the plan. The CPA (Health) may be able offer support for this meeting. (see appendix 5 for agenda example)	
	Following shared assessment of risks and needs at the A/N Planning Meeting a decision is made to carry out further assessment and or/ proceed to Pre Birth (Initial) Child Protection Planning Meeting (CPPM) or to continue with single agency (health) care via A/N plan. Minutes of this meeting and outcome should be uploaded to the badgernet record.	
	If Pre-birth CPPM is required, the allocated Social Worker will be appointed as lead professional and coordinate any further multi-agency assessment and planning.	
	Where interagency disagreement exists the Dispute Resolution should be followed.	
22-28weeks	If required, a Pre-birth CPPM should be coordinated and convened by SW within 28 calendar days of the concern being raised and always no later than 28 Weeks gestation. The meeting will gain either a unanimous or majority decision from professionals based on shared assessment and available information at this meeting to place unborn name on Child Protection Register if deemed at risk of significant harm. If decision is made to register the unborn, any need for application of a Child Protection Order (CPO) should form part of the discussion at this meeting and be included on the Child Protection Plan. If CPO is to be sought at birth, a decision should be made regarding where the newborn is taken after delivery. It should not be assumed that the baby will go to SCBU. Any need for supervision of the parents must be discussed and will be the responsibility of the Lead Professional to organise.	
	If the unborn baby is deemed at risk of significant harm and is placed on the child protection register social work will automatically assume the role of lead professional and arrange core group meetings as per child protection guidance. The multi-agency unborn child protection plan is updated as agreed with parents and relevant professionals. This Plan must stipulate who is responsible for notifying the birth of the child and what steps need to be taken at that point (e.g. referral to the Principal Reporter).	
	It is the Named Midwife's responsibility to ensure the Maternity Alert Form is completed at the initial CPPM and filed in the hospital maternal notes. Any plans for CSO/CPO, supervised contact or information relevant to Hospital Maternity Staff should be recorded on the Maternity Alert Form by the **Primary/Named midwife.**	

<table>
<tr><td></td><td>If unborn baby not deemed at risk of significant harm following Child Protection Planning Meeting:
• A/N plan is updated
• The lead professional agreed
• Core group Meetings arranged for around 4 weeks' time whilst continuing appropriate liaison with partners to plan.
• Any subsequent concerns/changes to current situation should always be discussed with Team Leader/CPA/Social Work</td><td></td></tr>
<tr><td>Post Birth</td><td>If an unborn baby is placed on the Child Protection Register or has an Unborn Childs Plan and there is a concern whether the baby can be discharged home safely a pre-discharge child protection planning meeting must be organised.
This is the role of the Lead Professional who will liaise with maternity staff, family members and partners to the plan, to agree arrangements for the care of the newborn following discharge from hospital. This meeting must be chaired by a QARO, Principal Officer or in some exceptional circumstances a Service Manager/Strategic Lead for CP. If it is not deemed safe, the chair must be explicit as to the legal measures that would be taken to ensure the safety of the child. The meeting should also consider any other children living in that household. NB: Where an Initial CPPM has been held and agreement regarding the suitability of discharge has been reached, a pre-discharge meeting to consider the plan and agree actions are still relevant and suitable to meet the child's needs should be convened. Where multi-agency partners are unable to agree on the discharge process or decisions, this should be escalated using established procedures</td><td></td></tr>
<tr><td></td><td>If a CPO is sought at birth and is served then the baby will be taken to a place of safety as agreed at CPPM, details of which will be available to hospital staff on the Child Protection Maternity Alert Form filed in the Hospital Notes. Any loss of a child whether through bereavement or removal by local authority is traumatic for parents consideration should be given for psychological support of the parents and vigilance around Perinatal mental health risk assessment.</td><td></td></tr>
<tr><td>Late booker/ Concealed Pregnancy</td><td>If a woman presents after 20 weeks AND there is considered a potential risk of significant harm discussion with SW should not be delayed. A summary of concerns should be conveyed via the telephone and followed up with CCF. Complete the A/N plan and share as soon as possible.</td><td></td></tr>
</table>

6. North Highland VP Pathway Components

6.1 National Practice Model – Getting it right for every child (GIRFEC)

Full guidance can be accessed here

The practice model has been designed to ensure that assessment information about children and young people (including unborn/new-born babies) is recorded in a consistent way by all professionals. This helps provide a shared understanding of needs and clarifies how best to address concerns. The model and the tools which support it can be used by workers in adult and children's services and in single or multi service/agency contexts.

The Practice Model Within Highland has an integrated service delivery structure the main components being:

The Well-being Indicators: An assessment to identify strength and pressures around the 7 wellbeing indicators **Safe, Healthy, Achieving, Nurtured, Active, Respected and Included** helping identify any concerns, record, share information and take appropriate action.

The Five Questions:

1. What is getting in the way of this child' wellbeing?
2. Do I have all the information I need to help this child?
3. What can I do now to help this child?
4. What can my agency do to help this child?
5. What additional help, if any, may be needed from other agencies?

The My World Triangle: to organise information around three areas *How I grow and develop*, *What I need form the people who look after me*, *My wider world*. When necessary, used to gather more information about the strengths and pressures in the child's world, additional specialist assessments may be appropriate.

The Resilience Matrix: helps analyse information and evaluate risks using two dimensions of vulnerability and resilience alongside adversity and protective environment. This tool helps analyse the strengths and pressures in a child's world by working towards strengthening or undermining factors which boost or compromise the child's resilience and protection.

An Antenatal Plan identifies the actions necessary to address the mother's needs to support her and her unborn baby. It assists practitioners to focus on analysis and outcomes within set timescales and with clear arrangements for monitoring and review. This plan is the unborn babies equivalent of the child's plan and reflects need to consider the unborn baby within the context of its mother. Named midwives are responsible for completing this in collaboration with the mother.

A Child's Plan is a personalised non-statutory plan which should offer a simple planning, assessment and decision-making process which leads to the right help, at the right time. The Child's Plan is achieved through collaboration with the family and child and should reflect the voice of the child or the unborn. The family and services around the child are called the partners to the plan. A core group of significant family members and professionals is identified, including the child if appropriate. Unborn babies will only require a child's plan if they require a multiagency child protection plan.

A Multi-agency Child protection plan is required when a Child or unborn is believed to be at actual or potential risk of harm and will be incorporated and prioritised within the child's plan where the criteria for placing a child's name on the register are met. This will ensure a single plan of action and meeting structure regardless of the number of processes a child might be involved in.

These components should be used proportionately to identify and meet the unborn/new-born needs and:

- be developed in collaboration and consultation with the child and their family
- link actions to intended reduction or elimination of risk
- be current and consider the child's short-, medium- and long-term outcomes
- clearly state who is responsible for each action
- include a named lead professional
- include named key contributors (the Core Group)
- include detailed contingencies
- consider the sensitive direct involvement of children and/or their views

6.2 HPI Well Being Assessment (SHANARI)

Timely support starts with early universal assessment, all pregnant women should have an HPI wellbeing assessment completed by around 16 weeks. If they are assessed by the midwife as *additional* a copy must be securely sent to the named HV/FNP. This is an assessment which looks at the wider aspects of wellbeing that contribute to a healthy mother and baby. Both strength and pressures are identified assisting in early allocation of help when needed and strengthening self-efficacy and resilience. The 7 wellbeing indicators **Safe, Healthy, Achieving, Nurtured, Active, Respected and Included,** a helpful aid memoire for midwives has been developed and can be accessed here. Crib sheet WBA.pdf (scot.nhs.uk)
This assessment can be used to support a request for service within health such as community early years worker and will aid further analysis and completion of the A/N plan should assistance be required from Social Work.

6.3 Inter-agency Referral Decision (IRD)

Inter-agency referral discussion is a formal process of information sharing, assessment, analysis and decision making following a reported concern. The decision to hold an IRD can be made by either of the agency decision makers of Health, Police or Social Work.
IRD's for unborn babies in Highland will happen in the following circumstances:
- Where a pregnant woman has been the victim of domestic abuse
- Where a pregnant woman, the father of the baby or the pregnant woman's partner are known to be schedule 1 offender(s)
- Where either the pregnant woman, her partner or the father of the baby have a significant criminal history including for domestic abuse.

A pre-birth CPPM may the outcome of the inter-agency discussion.

6.4 Electronic Maternity Notes (Badgernet)

Badgernet is the electronic notes system developed by System C hosted on Microsoft's azure platform which allows healthcare professionals to record and view on in real-time at the point of care both in the community and acute settings.
Women can also view their notes using a pc/tablet or smartphone and access leaflets recommended by their by midwife.
Until new Girfec processes are fully tested, some paperwork still currently requires to be scanned into BN,
- The HPI wellbeing assessment
- The A/N Plan
- The maternity Alert forms
- Child concern forms

It is important that they are named and dated to ensure the correct version is quickly found at point of care. Work is ongoing with Clevermed to reduce and eliminate the need to add these paper documents.
There are several SOPs and guidance on how to use the social pathway on NHSH Badgernet intranet site contained within the Social Folder here

6.5 HPI (Health Plan Indicator)

The HPI indicates the level of service required by the woman/family/child and is assessed as core or additional. The heath visitor/public health nurse is responsible for allocation of the HPI. The maternity team can assist in this process by ensuring early communication and care planning for those families with complexity or identified vulnerabilities. The allocation of the HPI requires a structured approach to assessment, this approach ties in with the appropriate, proportionate and timely interventions approach.

Any information around allocation of the HPI should be shared with HV/FNP/PHN. The following are ***examples*** of HPI allocation:

Additional: · Domestic abuse · Previous or current history depression/mood disorders · Severe enduring mental health issues · Previous or current child protection issues · Woman or partner in criminal justice system · Teenage parents · English as a second language · Asylum seeker or refugee · Poor literacy/learning difficulties · Poor social networks, isolation · Family breakdown · Previous history of loss- child or other · Substance use previous or current-either parent/partner · Poverty/deprivation · Housing difficulties/at risk of being homeless · Significant parental stress · Congenital anomalies or chronically sick baby · Health issues that impact on parenting ability · Premature/low birth weight baby · Mothers recovering from a difficult birth

Core: · No risk factors or additional needs identified during ongoing risk assessment · Women and maternity team agree with proposed plan of care· Good understanding of local support agencies· Proactive in managing health and wellbeing · Good network of social support – family/friends

6.6 Chronology of Significant Events

Each agency involved with a child/unborn and their family should collate key information into a **single agency chronology** from the point of notification of pregnancy. Chronologies are a key part, of the assessment / management of risk. All significant events or changes in circumstance should be noted within the chronology. If required a **multi-agency chronology** would be constructed by the Lead Professional in consultation with the person taking on named person responsibilities. Information should be collated from services involved with the child/family and combined into an integrated chronology. Ideally, this should be held electronically and shared with all relevant persons, in accordance with applicable legislation and agencies' information sharing guidance and protocol.

A more comprehensive guide by the care inspectorate updated 2017 which includes good practice examples is available here

6.7 Practice Lead for Care and Protection

Family Teams are made up of Health and Social Care Practitioners with experience of Child Protection. Each team is supported by Practice Leads with responsibilities for Care & Protection (Child Protection), School Years and Early Years. The practice Leads for care and protection should be contacted when there is a concern regarding potential abuse or neglect for an unborn/new-born child. Health professionals should share information about any concerns arising from their observations with their line manager, Child Protection Advisor and Practice Lead for Care and Protection, as appropriate, and/or the police.

Contact details for **Practice leads** for **care and protection** across North Highland can be found here

6.8 Child Protection Advisor Health

The Child Protection Advisor is the Designated Person for Health. The Child Protection Advisor is a specialist health professional who will support, advise and guide all personnel through the HCPC processes, including the roles and responsibilities of health professionals. They will:

- Advise on referrals to social work, record keeping, training relevant to post, HCPC Guidelines
- Take part in Inter-agency Referral Discussions regarding health information, interpretation and assessment of children with Child Protection concerns.
- Ensure appropriate attendance at Child Protection Plan Meeting, and other relevant meetings.
- Assist with providing information and preparing reports for child's plans as appropriate for the purpose of assessment and investigations
- Initiate and disseminate and follow up Missing Family Alerts.

• Support through legal processes and in consultation with the Central Legal Office as appropriate.
• Supervise practice, and peer review as appropriate.
• Undertake learning reviews and Quality Assurance.

Contact the Advice and Guidance line 01463 705828 or email childprotectionadvice@highland.gov.uk

6.9 Antenatal (A/N) Plan

A crib sheet guidance on completing the A/N plan can be accessed here Crib sheet AN plan.pdf (scot.nhs.uk)

The A/N Plan is an *our world triangle* assessment and should be used to analyse information gathered and formulate a plan with clear actions and responsibilities articulated. It should be used for mothers with an additional HPI who need multiagency support. It should be written in collaboration with the women and her support network, it supports sharing of information with colleagues (predominately social work) when requesting additional input from services. It encompasses the following components:

• Page 1 - Demographic detail and reasons for the plan.
• Page 2 - Assessment, Analysis, any planning undertaken, or actions required.
• Page 3 - Single agency chronology.

If social work colleagues become involved in the care of a pregnant woman, they assume the role of Lead Professional and will use the A/N plan to inform the multiagency unborn child protection plan. When sending by secure email to SW a copy should be sent to the named HV/FNP and GP. A copy should be saved within the electronic maternity record (Badgernet) for maternity service colleagues to view. It is important to date and name this file appropriately as per relevant SOP.

6.10 Information Sharing Procedures

Healthcare staff have a duty to share information when an unborn baby, child or young person may be at risk of significant harm. This will always override a professional or agency requirement to keep information confidential. Information should be disclosed only for the purpose of protecting children and young people and therefore should be relevant and proportionate and shared promptly and effectively when necessary. Staff should seek advice if they are not confident about sharing information from their local Child Protection Advisor. The Information commissioners office has a useful code of practice guidance as well as a sharing information to safeguard children guidance. Both the Scottish national child protection guidance (Scottish Government 2021) and local Getting it Right for Every Child & Young Person in Highland: Interagency Practice Guidance & Child Protection Procedures (Highland Council 2024) have extensive chapters on best practice around information sharing. A summary of the guiding principles are below:

- The wellbeing of a child is of central importance when making decisions to lawfully share information with or about them.
- Children have a right to express their views and have them considered when decisions are made about what should happen to them. Implementation of Article 12 requires recognition of, and respect for, non-verbal forms of communication including play, body language, facial expressions, drawing and painting, through which very young children demonstrate understanding, choices and preferences
- The reasons why information needs to be shared and actions taken should be communicated openly and honestly with children and, where appropriate, their families.

- In general, information will normally only be shared with the consent of the child (depending on age and maturity). However, where there is a risk to a child's wellbeing, consent should not be sought, and relevant information should be shared with other individuals or agencies as appropriate.
- At all times, information shared should be relevant, necessary and proportionate to the circumstances of the child, and limited to those who need to know.
- When gathering information about possible risks to a child, information should be sought from all relevant sources, including services that may be involved with other family members. Relevant historical information should also be considered.
- When information is shared, a record should be made of when it was shared, with whom, for what purpose, in what form and whether it was disclosed with or without informed consent. Similarly, any decision not to share information and the rationale should also be recorded.
- Agencies should provide clear guidance for practitioners on sharing information for example, the GMC guidance on Protecting Children and Young People. This should include advice on sharing information about adults who may pose a risk to children, dealing with disputes over information-sharing and clear policies on whistle-blowing.
- It is not necessary to seek consent when there is legislative requirement to share information; for example, when making a referral to the Children's Reporter, or the prevention and detection of crime.

6.11 Risk of Significant Harm

Significant harm is a complex matter, subject to professional judgement based on multiagency assessment of the circumstances of the child and their family. **Professional judgement**, substantiated by the assessment of individual cases or by research evidence, is that the child is likely to suffer ill-treatment or the impairment of health or development as a result of physical, emotional, or sexual abuse or neglect.
Significant harm is **not** of a minor, transient or superficial nature. It can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time. It is essential to consider the impact (or potential impact) on the child takes priority and not simply the alleged abusive behaviour.
Harm means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered because of seeing or hearing the ill treatment of another. In this context, ‟development‟ can mean physical, intellectual, emotional, social or behavioural development and ‟health‟ can mean physical or mental health. Whether the harm suffered, or likely to be suffered, by a child or young person is **significant** is determined by comparing the child's health and development with what might be reasonably expected of a similar child.

There are no absolute criteria for judging what constitutes significant harm. In assessing the severity of ill treatment or future ill treatment, it may be important to take account of: the degree and extent of physical harm; the duration and frequency of abuse and neglect; the extent of premeditation; and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm results from an accumulation of significant events, both acute and long-standing, that interrupt, change or damage the child's physical and psychological development.
To understand and identify significant harm, it is necessary to consider:
• the child's experience, needs and feelings as far as they are known. When a child talks about maltreatment, this may prompt a request for Interagency Referral Discussion (IRD). The child's disclosure is not a pre-requisite
• the child's development in context, including additional needs such as a medical condition, communication impairment or disability, that may affect the child's health, wellbeing, vulnerability and care needs
• what has happened, meaning the nature and degree of the actual or likely harm, in terms of abuse or failures to provide care and protection
• parental or carer responses to concern as far as they are known

• past occurrence, frequency or patterns in the occurrence of harm
• immediate risk of harm and cause of this risk
• impact/potential impact on the child's health and development
• degree of professional confidence in the information that either the abuse has occurred and is likely to be repeated, or that the child is at risk of harm
• capacity of the parents or carers to protect and care for the child
• the context of risk within the child's culture, family network and wider world
• interaction between known risks and known strengths, complicating or protective factors in the child's world
• the presence of premeditation, threat, coercion or sadism
• the probability of recurrence or persistence of harm or risk of harm

6.12 Child Concern Form

Child concern forms should be used to record and share concerns about a child or unborn baby. If you are concerned that there is risk of **significant harm** a telephone call should be made first to the relevant Practice Lead for Care and Protection to discuss your concerns or if in immediate danger telephone the police. Child concern forms can also be used to share information that causes concern but has not reached the threshold of significant harm. Following discussion with the Named Person or Lead Professional and where requested, significant information may be recorded on the Standard Child Concern Form which is forwarded securely to the Named Person or Lead Professional.

6.13 Antenatal Planning Meeting

- **Purpose:** to gather multi professional information to ensure that a robust risk assessment takes place, ensuring families get the right support as early as possible and a plan of care (A/N plan) is developed in partnership with the parents. These meetings also allow discussion on whether to proceed to a pre-birth child protection planning meeting. The dynamic nature of risk dictates that as new information becomes available any decisions or previous plans made require ongoing review.
- **Who Requires one** Any woman allocated an additional HPI despite meeting threshold for SW referral or not should be considered for a A/N planning meeting. Risk indicators such as young mums and FNP clients, PNIMH issues, domestic abuse, substance use and learning disability always require multi professional assessment and serious consideration should be given to holding an A/N planning meeting.
- **Convened by:** The primary midwife caring for the woman or allocated buddy midwife in their absence. Child Protection Advisor (Health) are available to support midwives around agendas, guidance etc..
- **Chair:** A chairperson should be agreed prior to the meeting this should be either the primary or buddy midwife or Child Protection Advisor.
- **Timings:** Meetings to take place by 24 weeks to allow for timely organising of CPPM's and processes, if necessary.
- **Invitees:** Any appropriate professionals relevant to the woman and family including third sector should be invited, eg social workers, Police, Health Visitor/FNP, CEYP, Psychiatrist, CPN, GP, Housing, Obstetrician, specialist midwives. Parents should always be invited unless there is a significant risk around doing so and this should be discussed with CPA, e.g. Domestic abuse or risk of absconding.
- **Recording:** The Time and date of the meeting should be clearly documented on Badgernet under the Antenatal management plan. Meeting notes should be taken, and any actions recorded on the wellbeing assessment or A/N plan. Good practice would be to allocate a note taker who isn't chairing the meeting.

- **Where:** These meetings should be face to face where possible with links to technology for agencies if they are held virtually thought should be given to ensure that parents have the technology and face to face support and confidentiality in the setting location.

Prior to meeting: See Appendix 5 for Example agenda

1. Aim to hold as soon as possible after the wellbeing/HPI assessment and always before 24 weeks
2. Allocate **chair** (Primary/buddy midwife/Team lead or CPA) and **note taker** roles.
3. Book suitable room if face to face.
4. If being held remotely the meeting must be arranged on a secure platform such as Microsoft TEAMS. Ensure parents have access to required technology and the necessary support and a confidential setting to attend digital meeting.

During the meeting:

1) Chair Introduces purpose of the meeting and outlines the agenda (see above) Those present are respectfully reminded of the client's right to confidentiality within the bounds of inter-agency working.
2) Round table introductions of names and roles if required.
3) Agree on roles and note taker, (note taker should not be chair)
4) Set ground rules
5) Information sharing from each agency and parents around
    - What is working well
    - Where is there need for extra support
    - What the risk factors would be for the unborn or new baby -ie what is it we are concerned about
6) Summary of information sharing and discussions – next steps
7) Agree Actions/ Tasks for moving forward including any dates arrangements for further meetings. Consider:
    - Is there a need for an initial pre-birth child protection plan meeting? If so articulate specific reasons and who will take over as lead professional.
    - Is a Social work risk assessment required.
    - Is it sufficient to continue with the A/N plan only either single or multi agency?
8) Close meeting and arrangements for further meetings

After the meeting:

1. Ensure the discussions, outcome of the meeting and all agreed actions are recorded within the electronic maternity record (badgernet) on the A/N plan. Outline assessment, analysis & actions on the A/N plan. This updated copy of the plan should be shared with all parties including the parents.
2. Circulate minutes and agreed actions to all members in attendance.

6.14 Partner Agencies

Partner agencies include Highland Council, Police Scotland, NHS Highland and any relevant Third Sector Agencies working with a family.

6.15 Pre-Birth (Initial) Child Protection Planning Meeting (CPPM)

The purpose of a pre-birth CPPM is to decide whether serious professional concerns exist about the likelihood of harm through abuse or neglect of an unborn child when they are born. The pre-birth CPPM should take place within 28 calendar days of the concern being raised and always before 28 weeks

pregnancy or, in the case of late notification of pregnancy, as soon as possible from the concern being raised but always within 21 calendar days of the concern being raised. There may be exceptions to this where the pregnancy is in the very early stages. However, concerns may still be sufficient to warrant an inter-agency assessment. The participants need to prepare an inter-agency plan in advance of the child's birth. They will also need to consider actions that may be required at birth, including:

- whether it is safe for the child to go home at birth;
- whether supervised access is required between the parents and the child at/or after birth and who will provide this if needed;
- whether the child's name should be placed on the Child Protection Register. It should be noted that as the Register is not regulated by statute, an unborn child can be placed on the Register. Where an unborn child is felt to require a Child Protection Plan, their name should be placed on the Register. If the child is registered the Child Protection Plan must stipulate who is responsible for notifying the birth of the child and what steps need to be taken at that point (e.g. referral to the Principal Reporter). Legal measures such as referral to the Reporter and application for a CPO can only be made at birth
- Discharge arrangements: Where a child is subject to a child protection investigation or already on the child protection register (including pre-birth) and there is concern whether the child can be discharged home safely, it is imperative that a further child protection planning meeting is convened to determine if the partners agree that it is safe for the child to go home. This meeting must be chaired by a QARO, Principal Officer or in some exceptional circumstances a Service Manager/Strategic Lead for CP. The purpose of this meeting is to agree arrangements for the care of the child following discharge from hospital. This should include consideration of the role and level of involvement of community-based supports. Where the decision of this meeting is that the child would be at risk of significant harm by being discharged to the care of their parent/s, the Child Protection Plan should be amended to reflect this, and proportionate action should be taken to keep the child safe.

Reviews of pre-birth CPPMs. A review may be held within three months of the previous CPPM. There should be latitude for professional judgement about the most appropriate timing post-birth. This does not preclude an earlier review where changes to the child's living situation are enough to remove or significantly reduce risks. Careful consideration is required about early decisions to remove a baby's name from the register, for example by ensuring that necessary supports are in place.
Named midwives are responsible for ensuring that information from the pre-birth CPPMs and any review meetings is written in a Maternity Alert form to ensure maternity staff have the relevant information in a timely manner.

6.16 Dispute Resolution

When a practitioner wishes to raise an issue about the process, or disagrees with CPPM decisions, communication and concerns should be channelled through their agency line management. If a parent or carer wishes to challenge the decisions of the CPPM, there are clear processes set out in the decision letter. If the complaint is about a specific practitioner, they should follow the relevant agency's complaints procedures. Children and young people should have access to guidance that they can understand about how to challenge a decision or make a complaint from any of the practitioners with whom they have contact.

6.17 Child Protection Register

The Child Protection Register provides a record of children who require a multi-agency plan to reduce the risk of significant harm. A child may be placed on the register if there are reasonable grounds to believe or suspect that a child has suffered or will suffer significant harm from abuse or neglect, and that a Child Protection Plan is needed to protect and support the child. When placing a child on the register, it is not necessary to identify a category of registration relating to the primary type of abuse and neglect. The local

authority should ensure the child's name and details are entered on the register, as well as record the areas of concern identified. The local authority should inform the child's parents or carers verbally and in writing about the information held on the register and who has access to it. In Highland Council, this responsibility lies with the Care and protection Service.
All partner agencies are encouraged to use the Register.
The Register has no legal status but provides a central point of enquiry for any professional staff who are concerned about a child. The Child Protection Register is maintained on the Council CareFirst management information system. The Keeper of the Register in North Highland is the Principal Officer (Social Care) who can be contacted at: cpadmin@highland.gov.uk
All practitioners should notify the keepers of local registers of any changes to details relating to children named on the register. If a Compulsory Supervision Order is likely to be required to meet the child's needs for protection, guidance, treatment or control, or to ensure compliance, then a referral must be made to the Principal Reporter to allow consideration as to whether a children's hearing should be arranged.

6.18 Child Protection Order (CPO)

A Child Protection order is an emergency legal measure which aims to protect children and young people who are at risk of significant harm and is applied for when there is an urgent need for protective action. It authorises the applicant to remove a child from circumstances in which he or she is at risk or retain him or her in a place of safety. The Loss of a child, either by miscarriage, stillbirth and neonatal death or by the child being taken into care increases vulnerability to mental illness for the mother and she should receive additional monitoring and support (Saving Lives, 2015). The reasons for decisions to apply for the order should be clearly recorded. A child protection order may also specify conditions (e.g. medical examination) attached to the order. The following information should be ascertained when a CPO is planned or applied for and documented clearly on the maternity alert form and updated if any changes are made by the named midwife.

- Specific conditions of the order
- Is the mother allowed contact with her baby prior to CPO being served?
- If supervised contact required detail who and where? Social work are responsible for arranging this.
- What arrangements if SW unavailable?
- If baby needs to go to SCBU are foster parents allowed/encouraged to visit if no contact is allowed with birth mother?

6.19 Named Person Role/Service

The Named Person is a point of contact for children, families and professionals for information sharing, advice and assistance, when required. The Named Person has an important role in coordinating additional help for children within universal services.
The named midwife will assume the named person *service* for a pregnant woman, working in partnership with the allocated Health Visitor. Health visitors are the named person from birth until the child enters education.

6.20 Lead Professional Role

The Lead Professional is the person who co-ordinates the assessment, actions and review of the Unborn/Child's Plan. The Lead Professional will not do all the work with the child and family. Neither does he or she replace other staff who have specific roles or who are carrying out direct work or specialist assessments.

The choice of the role of Lead Professional for a particular child will be influenced by: the kind of help the child or family needs, complexity of the child's circumstances and plan, previous contact or a good relationship with the child statutory responsibilities to co-ordinate work with the child or family.
A Registered Social Worker will always be the lead professional for:
- Children including Unborns who have multi-disciplinary child protection plans
- Looked after children
- Looked after and accommodated children

6.21 Core Group

The core group will be confirmed at the Child Protection Plan Meeting and will involve the:
Lead professional; Named Person Key professionals, directly involved with the child/ren and family, from health, care & learning, adult services, third sector, forces welfare, police, and housing services as appropriate; Where possible, parent/s and/or carer/s.
The Lead Professional or line manager will normally be responsible for chairing the core group, and ensuring it is recorded.
The record of core group meetings must be completed on the standard format. This should be signed by the Chair of the core group and the Practice Lead for Care and Protection.
The core group record should be distributed to child/ren, parent/s and carer/s, all professionals attending, and a copy should also be forwarded to the Practice Lead for Care and Protection, and Quality Assurance Reviewing Officer.
The first core group after the Child Protection Plan Meeting will take place within 15 working days of registration, but child protection activity and the progression of actions agreed in the child protection plan must begin immediately and not wait until after the core group is convened.
Core group members must:
- agree the detailed actions to be carried out to implement the child protection plan and ensure that risk will be reduced, and the wellbeing of the child promoted;
- agree the focus of work and how it is to be evaluated;
- identify the tasks of the parents and who will support them;
- coordinate the contacts the professionals have with the child and family to ensure this is proportionate and effective;
- agree how information about assessment, help, progress and further risk will be shared;
- agree appropriate timescales for all tasks
- agree how the work of those not present at the meeting will be included in the evaluation of progress, the meeting of need, or reduction of risk;
- agree the recommendations to be made to subsequent Child Protection Plan Meetings.

The core group, and its individual members, have an on-going responsibility to consider whether referral to the Children's Reporter is required, where voluntary engagement with the parents/carers/child is not able to address the assessed risks and needs. It is recommended that dates for a further two core groups should be set after the Child Protection Plan Meeting, and that these dates should be no more than one calendar month apart.

6.22 Unborn Multi-agency Child's Protection Plan

This is a multiagency plan of action managed and reviewed through a single meeting structure led by a Lead Professional from social work with specified actions to reduce risk. They are required where evidence suggests that an unborn baby is at risk of significant harm. It will be informed by the A/N plan and should set out in detail:
- The perceived risks and needs;
- What is required to reduce these risks and meet those needs; and

- Who is expected to take any tasks forward including parents/carers
- The agreed outcomes for the unborn/newborn baby;
- Key people involved and their responsibilities, including the Lead Professional and named practitioners
- Timescales
- Supports and resources required (in particular, access to specialist assistance)
- The longer terms needs of the baby
- The process of monitoring and review
- Any contingency plans.
- Any compulsory Measures of Supervision

Responsibility is shared for the Child Protection Plan. Each person involved should be clearly identified, and their role and responsibilities set out. Any interventions should be proportionate and clearly linked to a desired outcome for the child. Progress can only be meaningfully measured if the action or activity has had a positive impact on the baby. Participants should receive a copy of the agreed Child Protection Plan **within ten calendar days** of the CPPM. If a child protection order is to be sought at birth, it should be made clear where the new-born is taken after delivery. It should not be assumed that the baby will go to SCBU. Any need for supervision of the parents must be discussed and will be the responsibility of the Lead Professional to organise.

6.23 Maternity Alert Form

This purpose of this form is to alert Hospital Staff within the maternity unit of any Child Protection Concerns and required actions when an unborn baby is placed on the Child Protection Register or when a Child Protection Order may be sought at birth. It is the named midwife's responsibility to complete a maternity alert form as soon as possible and on a timely basis following a child protection planning meeting when an unborn baby's name is placed on the child protection register. It is the named midwives' responsibly to ensure following core group meetings that this is kept updated. It can be accessed here Child Protection Maternity Alert.pdf (scot.nhs.uk)

6.24 Decision Letter

A decision letter outlines the outcome and required actions of the pre-birth CPPM; it is compiled by Social Work and sent to the core group members.

6.25 Core Group Meetings

A core group meeting will take place two weeks after a child protection planning meeting if the unborn baby's name is placed on the child protection register and monthly thereafter, with subsequent Child Protection Plan Meetings normally reviewed after 3 months and then 6 monthly thereafter if registration is continued. Changes in the child's circumstances or legal status may require any scheduled meeting to be brought forward.

6.26 Concealed/Denied Pregnancy and Birth

A **concealed pregnancy** is when a pregnant woman knows she is pregnant but does not tell anyone or those who are told conceal the pregnancy from agencies. It may be identified late in pregnancy, during labour or following delivery. A **denied pregnancy** is when the 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. There is no definitive definition of **late presentation** but for the purposes of this guidance is considered over 20 competed weeks of pregnancy.
Both require a sensitive and thorough assessment, analysis, and plans of care to consider the medical, physical, emotional, mental health and socioeconomic needs of the woman. Staff should be alert to any safeguarding concerns as late presentation or concealed/denied pregnancy is a known risk factor for poorer outcomes. The reason for concealment/denial will be a key factor in determining any risk of significant harm to the unborn baby/infant. Staff should initiate information gathering from relevant professionals/agencies and seek support from child protection advisors and line managers if unsure of whether to initiate a social work referral and CCF. Consider a referral for mental health assessment.
If a woman arrives at the hospital CMU or at home in labour or following an unassisted delivery where a booking has not been made the emergency duty team must be informed.

7 Additional Support Services

7.1 Child Protection Resources

Highland Child Protection Committee Website www.hcpc.scot

7.2 Substance Use Recovery Services

Highland Drug and Alcohol Recovery Directory of Services
Women, Pregnancy and Substance Use: Good practice Guidelines

7.3 Learning Disability

Guidelines for Practitioners working with pregnant women and mothers with learning disabilities
Refreshed Scottish good practice guidelines for supporting parents with a learning disability
IRISS insights evidence summary 37 Parents with Learning Disabilities
NHS Highland Learning Disability Services

7.4 FNP

Contact FNP@Highlnad.gov.uk
Webpage on NHS Highland

7.5 Smoking Cessation

Smoking and Pregnancy page on NHS Highland

7.6 Violence Against Women

Support Services for women in Highland
Domestic Abuse: Pregnancy and the Early Years

7.7 Housing

Highland Councils Housing options – Help and advice

7.8 Financial Help

Highland Money worries leaflet and app
Highland Council welfare Support Team can be contacted on **0800 090 1004 or** welfare.support@highland.gov.uk

7.9 Foodbanks

https://www.blythswood.org/foodbank-addresses
https://www.trusselltrust.org/get-help/find-a-foodbank/

7.10 Employment/Education

Adult Education Opportunities and help
Job Centre Plus 08001690190

7.11 Mental Health Services

Perinatal and infant mental health NHS Highland
Birth Trauma Association
Community mental health teams providing psychiatric, addiction and learning disability services

7.12 Refugee Immigration/English as Second Language

Scottish Refugee council
Highland Multicultural Friends
Migrant help

7.13 Community Early Years Workers

Midwives and social workers can request Community Early Year Practitioner (CEYP) input using the GIRFEC practice model, in the pregnancy and post-natal period by emailing Health Visitors. The support offered uses the Solihull approach to help parents manage any pressures and promotes responsive care giving. CEYPs work in health visiting teams and are available to support parents or care givers at home or as part of a group. Requests for CEYP input can be made directly to the appropriate Health Visiting teams generic email boxes which can be accessed here: Health Visiting Services within The Highland Council | Health visitor services | The Highland Council

7.14 Resources including links Third sector support agencies

Local Information System Scotland signposting/social prescribing
Resources and ideas for parents and early years staff
Highland Information Trail

7.15 Support and care for gypsy travellers

The term 'Gypsy/Travellers' refers to distinct groups – such as Roma, Romany Gypsies, Scottish and Irish Travellers – who consider the travelling lifestyle part of their ethnic identity.' (Scottish Government 2017 policies)
Gypsy / Travellers are more likely to have long-term health problems or disability than any other ethnic group. They also have lower than average life expectancy and higher infant mortality. They face numerous barriers to good health, including discrimination and marginalisation as well as often poor living conditions and limited educational attainment. (NES TURAS Course)
Further information on how the Scottish Government is tackling these inequalities can be found in the improving the lives of Scotland's gypsy travellers strategy Scottish Government. The strategy details a specific action for *improving Gypsy/Traveller access to maternal and child health services, including, offering dedicated income maximisation services to Gypsy/Traveller mums.* Training for professionals in understanding local income maximisation services can be undertaken through TURAS
Gypsy / Travellers overall will require the same support as other pregnant women through universal services. However, due to the significant health inequalities that the community faces, some pregnant

women may need some extra support. This support will be more effective at tackling some of the inequalities and risks the women face when good relationships based on trust, respect, understanding and person-centred care are established. More information on how Children's Services can support Gypsy / Traveller communities can be found in the guide for professionals working with Gypsies and Travellers

The following good practice has been identified through research and projects with the Gypsy / Traveller community such as the Mums-Matter-Report produced in Fife:

- Gain and maintain trust
- Be reliable and consistent
- Also gaining the trust and building relationships with the wider family is crucial – particularly the women closest to the pregnant woman. Gypsy / Travellers have very close families with trusted intermediaries within the community
- Encourage and assist pregnant women to register with a local GP and Dentist in locality they will be living during pregnancy and birth https://www.healthliteracyplace.org.uk/toolkit/access-to-healthcare/
- Understanding the culture of the Gypsy / Traveller community is vital to good care. The raising awareness of gypsy traveller communities TURAS course is a good place to start in understanding some of the culturally important issues. Also, the Roads From The Past YouTube video is really useful.
- Understanding the barriers to services Gypsy / Travellers face – due to a number of factors such as GP Registration processes, difficulties in navigating the NHS, poor literacy, stigma and discrimination. Gypsy / Traveller people, especially travelling families, tend to use emergency services such as A&E rather than any structured approach to healthcare, due to previous poor experiences. This leads to disrupted health provision and makes preventative care very difficult to administer.

Gypsy / Travellers in Highland live in several different types of accommodation across the locality. There are four official Traveller sites in North Highland, but also many the community now living in settled 'bricks and mortar' accommodation and still strongly identify themselves as Gypsy / Travellers.

The Highland Council Housing teams work closely with both the communities living on the official Gypsy / Traveller sites and with those more transient communities at negotiated stopping places/roadside camps. Local contacts and support for professionals and the communities can be found at:

Help for Gypsies and Travellers | Help for Gypsies and Travellers | The Highland Council

Unauthorised roadside camps | Unauthorised roadside camps | The Highland Council

Other local support includes the Public Health Team who have a member of their Health Improvement Team working closely with the local Gypsy / Traveller communities. There are other relevant Health Improvement courses available and resources that support working with Gypsy / Traveller communities.

There are several dedicated National Third Sector organisations that can also support working with Gypsy / Traveller communities including the following:

https://www.mecopp.org.uk/

Friends, Families and Travellers (gypsy-traveller.org)

7 Supporting Local Guidance -available on links below

Policies & Guidance - Highland Child Protection Committee (hcpc.scot)

Highland Council information for staff health page

NHS Highland maternity guidance page

- Getting it right for every child and young person in Highland: Interagency Practice Guidance & Child Protection procedures 2024
- Women Pregnancy and substance use: good practice guidelines
- Domestic Abuse pregnancy and the early years
- Guidelines for supporting pregnant teenager and their partners
- Guidelines for practitioners working with pregnant women and new mothers with learning disabilities
- Policy for child not brought to appointments
- Policy on Management of Bruising and Injuries in Non-Mobile Children
- PROTOCOL FOR PREGNANCY AND BIRTH NOTIFICATIONS RE KNOWN SEX OFFENDERS
- The Communication and Handover of Health and Social Information Between Midwife and Health Visitor
- Responding to those at risk of forced marriage in Highland
- Responding to Female Genital Mutilation in Highland
- Infant Mental Health Guidelines pre-birth – 3 years
- Highland Information Trail

9 Supporting National Guidance

- A pathway of care for vulnerable families 0-3
- Universal Health visiting pathway Scotland
- The Best Start: 5-year plan for maternity and neonatal care
- Transforming Psychological Trauma
- National guidance for child protection in Scotland
- Getting our priorities right: children affected by parental substance misuse
- Nice Clinical Guidance 110: Pregnancy and complex social factors
- Getting it right for every child
- Making it easier: a health literacy action plan 2017-2025

10 Training

Training available for staff providing support to vulnerable women and families:

- **Highland Child Protection Committee Training Page**
- **Violence against Women Partnership Training Page**
- **Health Promotion/Health behaviour change**
- **NES essential Perinatal and infant Mental Health e-Learning (7 PNIMH Modules on Turas: Introduction, assessment, stigma, interventions, pharmacological interventions, risk in the perinatal period and keeping baby in mind)**
- **Highland Practice Model Training is now accessed as "Introduction to Child Protection" via CALA website a voucher is required from CP training team**
- **NES Public Protection learning site includes adult support and protection and child protection.**
- **Children affected by Parental Substance misuse, What makes a good Chronology, Understanding the child's plan, Introduction to child exploitation e-learning modules are all free and accessible via CALA**
- **NES national trauma training programme a suite of training resources available on Turas ranging from informed, skilled, enhanced, specialist to leaders.**
- **Health Literacy Tools and Techniques**
-

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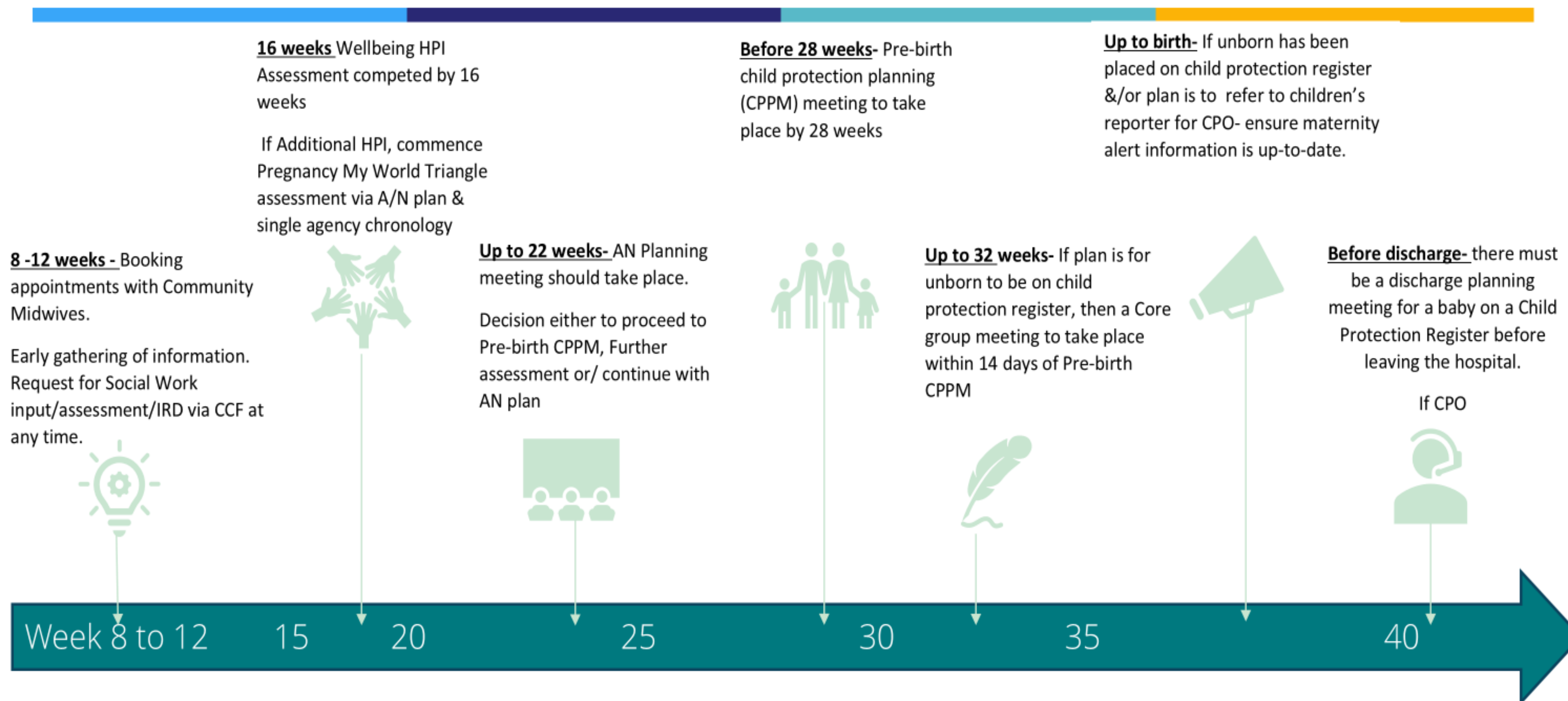
Appendix 1

Women, Pregnancy and Additional Support Timeline



Principles for Good Practice:

- Early assessment & early support increase the likelihood of good outcomes .
- Good assessments & effective plans and achievable timescales require early multi-agency involvement and robust planning.
- **Timescales** – all decisions, plans & intervention should be informed by thorough timely assessment and analysis; to reflect levels of risk and need, this includes decision to convene an Interagency Referral Discussion (IRD) or a Pre-birth Child protection Planning Meeting.

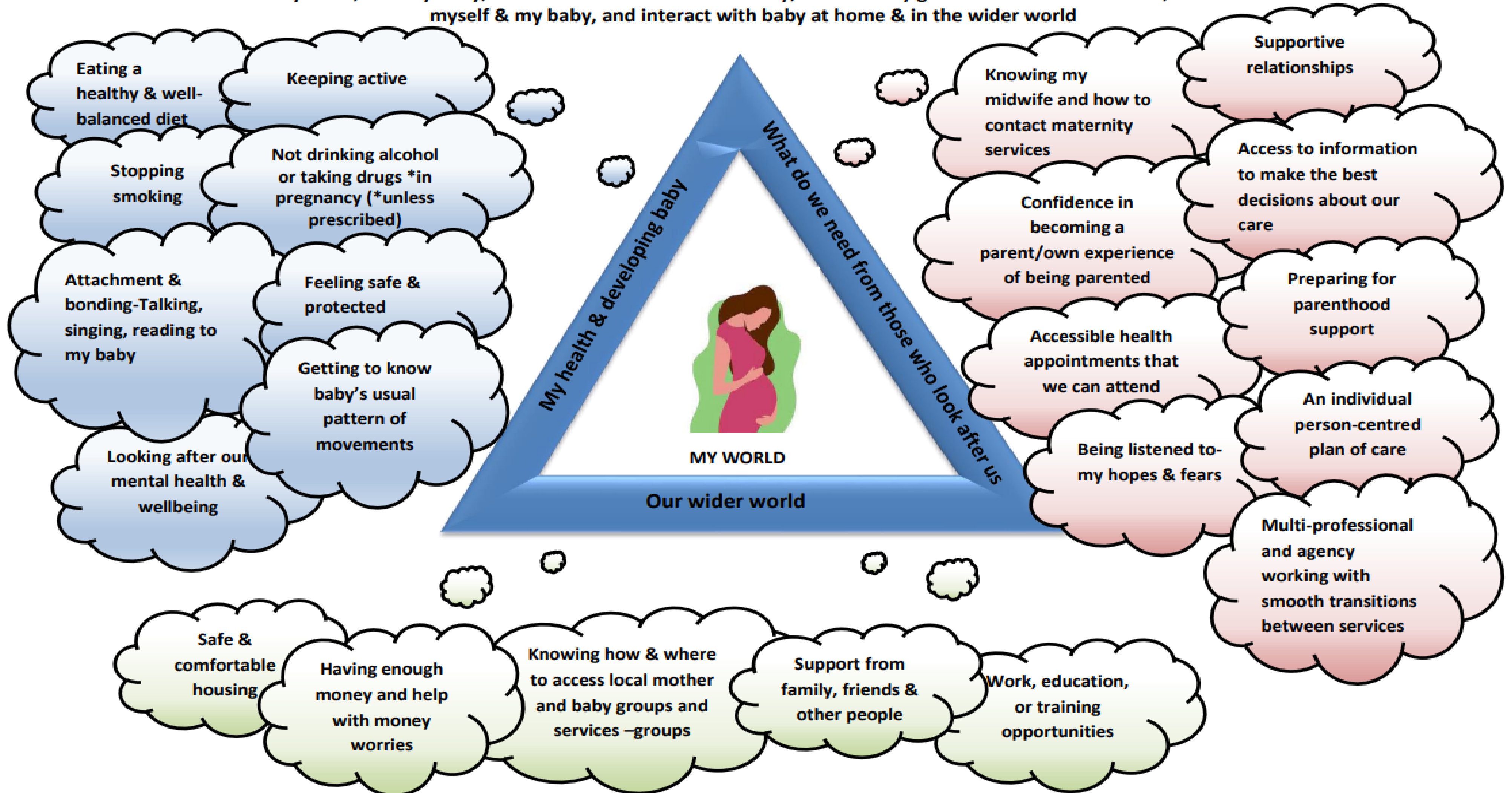
Appendix 2

A/N HPI Wellbeing Assessment

Aim to assess all pregnant women from 16 weeks to allocate as Core or Additional Health Plan Indicator. Can be populated using answers to questions posed at booking back at base or used to facilitate face to face assessment for women with more complex needs.

Safe	• Housing • Finances • Domestic Violence/FGM • Social Work/Child Protection
Healthy	• Pregnancy health • Physical Health • Mental Health • Diet • Smoking • Alcohol/Drugs • Developing baby
Achieving	• Employment • Education • Learning Disability • Preparation for Parenthood
Nurtured	• Feelings towards Pregnancy • Experience of being parented • Experienced Adversity in Childhood, e.g., care experienced, survivor of child physical/sexual abuse/neglect, • Support network • Any family Loss/Bereavement
Active	• Physical disabilities • Enduring health problem • Wellbeing
Responsibility & Respected	• Communication Difficulties • Criminal Justice involvement • Feels involved in decision making
Included	• Anything getting in the way of being included in society such as? • Young parents • Gypsy traveller • Recent immigrant • New to area, lack of support network

Appendix 3



Multi professional single agency A/N Plan

My World Triangle

Assessment/request for service

Date of Assessment:			**Mothers Name:**	
EDD/Gestation:			**DOB & CHI:**	
Address:				
Phone Number:				

Significant others include everyone who lives in the house any siblings or half siblings

Name	**Relationship to mother**	**Age**	**Same Address**

Professionals Involved

Role	**Name**	**Email**	**Telephone Number**
Named Midwife			
Health Visitor			
Obstetrician			
GP			
Social Worker			
Early Years Worker			
CPA			

Brief outline of reason for A/N plan

My World Triangle Assessment
My health and developing baby
What I need from those who look after us
Our Wider World
ANALYSIS (include mothers view of plan & information sharing discussions)
PLANNING AND ACTIONS

Maternity Services Single Agency Chronology			
Date/Gest	**Incident event**	**Where seen/source of information**	**Any follow up and signature**

Completed By:		**Date:**	
Signature:			

Copy sent to:					
☐	Social Worker	☐	GP	☐	CPA
☐	HV/FNP	☐	Obstetrician	☐	Other

A/N Planning meeting AGENDA

Name/Chi:
Date/Time:
Venue:

1. **Purpose of meeting and agree roles, notetaker.**

2. **Introductions**

3. **Ground Rules**

4. **Information sharing, risk factors (if any) and discussion of what is working well and any need for extra support**

5. **Summary of discussions and next steps**

6. **Agree actions**
    - **Pre-birth initial CPPM?**
    - **Social work risk assessment?**
    - **Agree Lead Professional**
    - **A/N multi professional plan or multi agency unborn child's plan**

7. **Close meeting and further arrangements.**