Gloucestershire

PRE-BIRTH MULTI-AGENCY PROTOCOL 2019

Gloucestershire Constabulary

NHS Gloucestershire Clinical Commissioning Group

Gloucestershire County Council

Contents

Introduction

Pre-birth and pregnancy can have a significant impact for all children and their parents. Research has shown that pre-birth harm can have a critical and life changing impact on a developing child. This is evidenced in the impact of Adverse Childhood Experiences see: www.actionaces.org.

In Gloucestershire, we are determined to work together to make a positive difference to pre-birth outcomes for children in this county. We aim to identify those babies most at risk and to effectively provide support services to parents to safeguard babies.

- The most positive outcomes are achieved if identification and preventative action is taken during the pre-birth period.
- This early warning system can only operate effectively if there is an agreed interagency commitment and interventions from Early Help and Child Protection services.
- Professionals need to work with the whole family; mother, father and partner to assess and manage the response to high levels of potential risks to the unborn child.

As prescribed in Working Together (2018), the key agencies in the identification and intervention of potential Pre-birth harm are Children's Services, Maternity Services; Primary Care Services; Adult Mental Health; Community Drug and Alcohol Services; Glos DA support, Probation; Police and Learning Disability Services. "Local authorities, with their partners, should develop and publish local protocols for assessment".

This includes the publication of an unborn baby protocol. (Working Together 2018).

This guidance is specifically designed to assist in identifying those unborns most at risk and promote effective sharing of information and multi-agency working. The guidance will support professionals in constructing meaningful risk assessments and plans.
Where required, advocates and or language communication interpreters must be made available to the parents throughout the process.

This guidance aims to:

- Clarify what is meant by Pre-birth Child & Family assessments and the circumstances in which they should be used.
- Set out the procedures for unborn and pre-birth assessment.
- Provide a framework for unborn and pre-birth assessment.
- Clarify decision-making regarding thresholds of intervention;
- Clarify the timeline of provision of resources/meetings.
- Set out a clear meeting structure.
- Avoid delay and improve the protection of the unborn child.
- Enable expectant parents, partners and their families to be clear from the outset about the process that will be followed and the responsibilities of all those involved.
- Ensure that professionals are clear about their roles and responsibilities and that a holistic approach is taken from the outset.

Referral Stage

Any professional who becomes aware that a woman is pregnant and has cause to be concerned that the new-born baby may be at risk of significant harm (and/or the parents and partners would require significant levels of support to care for the child), should make a referral to the Children Services as soon as possible irrespective of the time of pregnancy.

Professionals must inform the prospective parents of the referral and gain consent where possible. An exception to this would be if informing the parents might place the unborn baby or the mother at greater risk. Working Together 2018 sets out the parameters for gaining consent. The safety of unborn is of paramount importance and where there is a conflict the safety of the unborn should be prioritised. (Working Together 2018).

The unborn will be recorded on Gloucestershire Children's Social Care electronic system - ICS under the name of 'Unborn' with mother's family name as the surname and will be linked in the social network with mother, father, partner and any other existing family members.

Working Together 2018 states 'it is good practice to have a discussion with parents where possible and ensures that consent has been agreed. However, if there are concerns that are potentially significant harm then no consent is required. In addition, in line with Working Together 2018, consent should not preclude a referral where professionals have concerns'.

An unborn must be referred if any of the following factors are present:

- There is significant domestic violence or escalation during pregnancy and/ or honour based violence.
- A parent has significant mental health difficulties/diagnosis. S/he may be subject to an enhanced Care Programme Approach (CPA).
- A parent has moderate or severe learning disabilities which have been assessed as likely to impact on parenting
- A parent is a current looked after child.
- Previously the parent has had children removed.
- A parent who is a former looked after child and is assessed as having additional vulnerabilities. (Although it is accepted that not all former looked after children will be referred, it is essential that they are supported and any vulnerabilities are identified and appropriate support is offered). The question to ask is what I would do if this was my child or my child's partner/ex-partner who is pregnant?
- A parent misuses substance/s that will have a significant impact on the health and development of the baby.
- A parent (mother, partner, father) has had a child previously removed from their care or has a child voluntarily accommodated under Section 20 of the Children Act 1989.
- A parent of 18 years and also 16 years and under where there are concerns about sexual exploitation, trafficking or abuse and vulnerabilities.
- A parent is previously suspected of complex illness.

- A parent is suspected of being involved in a forced marriage.
- A parent has been subject to Female Genital Mutilation. (FGM).
- A parent is suspected of being a victim or involved in spirit possession or witchcraft.
- A parent of whatever age, is suspected or known to have been the victim of grooming and/or sexual exploitation and the putative father is unknown or known to be the one who groomed them.
- A parent is a victim or involved in honour based violence.
- Incest is suspected.
- If a parent is/may attempt to move authorities and/or attempts to avoid professionals.
- A parent/relative or associate is someone who may present a risk to children, or has previously harmed a child (this would include issues such as a violent history, significant criminal history, sexual offences against adults or children etc.).
- The baby once born will be living with or having contact with someone who may present a risk to children (see above).
- A sibling is subject to a Child Protection Plan.
- There are significant concerns about the home conditions, such that the baby may suffer physical neglect.
- One or both parents' behaviour or circumstances during pregnancy indicates that they will be unlikely to protect or care for their baby appropriately, e.g. living a chaotic lifestyle with no home base, significant emotional instability and/or lack of preparation/awareness of the impact of becoming a parent.
- Late booking for maternity care with an inadequate explanation.

When a pregnancy is discontinued whether through termination or miscarriage, consideration of referral to Children's Services should be made if there are any remaining safeguarding concerns relating to another child.

This list is not exhaustive and if a professional is in doubt about making a referral, s/he should always seek advice. While there is an imperative to safeguard unborn, risks assessments should be proportionate.

All referrers are required to complete a Referral Form and email the Multi-Agency Safeguarding Hub (MASH/Front Door).
https://www.gscb.org.uk/i-work-with-children-young-people-and-parents/front-door-services/

Gloucestershire MASH
Children's Social Care
Gloucestershire County Council
Shire Hall
Westgate Street, Gloucester GL1 2TG

This referral will progress through MASH to determine threshold for support and/or for a pre-birth assessment being met and started. The MASH evaluation will consider whether the need for support can be delivered either through early help or social work intervention.

The benefit of clear information from the referrer will assist in determining thresholds, it being important that the expected date of delivery (EDD) is obtained from the referrer at the point of referral, with the details of the biological father of the child and if different the partner of the mother.

Pre-Birth Implementation Partnership Group

To improve pre-birth practice, a partnership group will oversee the progress and implementation of this work. The group will not discuss individual 'unborns' but rather provide an overview of pre-birth work, challenge and support good practice in respect of all aspects of this pre-birth work in Gloucestershire.

The group will review systems that are working well and identify and follow up with appropriate action where there are challenges in the system. Relevant themes will be shared with the GSCP for the wider partnership to agree how these can be improved upon.

Where there are disagreements between professionals, the escalation policy will be the mechanism to resolve or escalate concerns.

This group will meet 4 weekly initially to provide an overview of all pre-birth work to ensure safeguarding practices are reviewed in line with this guidance.

The Panel members include:
Chair - Head of Service from Children's Social Care.

This is not exhaustive other professionals/organisations will be added by the Group.

- Lead Safeguarding Midwife
- GP Representative
- Lead Safeguarding Nurse (Trust to be decided).
- Health Visitor Liaison – Gloucestershire Care Services
- FDAC Service Manager
- Early Help Team Manager
- Team Manager - Adoption service.
- CP Chair/IRO Team Manager
- Business Support
- Health commissioners

Minutes and recommendations from the meetings will be shared with senior leaders in respective agencies to embed change and improve practice on pre-birth. For the first 6 months these meetings will take place on a monthly basis and reviewed by the group. If the group agrees that regularity of meetings should change they can agree this within the group. If the representative is not able to attend they will send a representative in order to ensure that work is progressed.

Guidance for Pre-Birth Process

Pre-Birth Assessments must be completed and considered as a separate piece of work from assessments that may have been written for siblings of the expected baby.

Referral to MASH

- A referral can be made at any point once the pregnancy is confirmed (referrals can be made before the 12-week scan – see flow chart for details);
- If the referral identifies concerns regarding a baby being relinquished for adoption, this will be passed immediately to the social worker involved (see Relinquished for Adoption Procedure);
- Where a parent has had previous children removed in the last 24 months this will be passed immediately to the relevant social work team who has been involved with the family previously;
- Pre-birth Assessment will be commenced immediately, covering aspects of parental capacity and written within the context of the assessment potentially presented in court. The social worker must seek parental consent to share the pre-birth Assessment with midwifery colleagues as this will assist discussions relating to risks and analysis of need for support; where consent has not been approved, the social worker information should be shared if it is in the interest of safeguarding the unborn. This is especially significant in communication between the midwife and the social worker.
- To support parents' preparation and learning, the social worker should consider Early Help family work involvement, perhaps including use of the Virtual Doll; a link should be made with the midwife wherever possible;
- The Pre-birth Assessment should explore the potential for the development of a nurturing relationship with the unborn and look for anticipation and positive representation of the unborn by the parents.

It will be important to explore parental understanding of secure attachment and the importance of developing this.

Timescale Guidelines

Although these guidelines set out timescales following work with Early Help Partnerships, it is important to remember that safeguarding processes for the unborn should always prioritise the safety and well-being of the unborn, mother, father/partner – as well as taking account of timescales the needs of unborn, parent/father/ partner should be prioritised.

Early Help Partnership (1 – 12 Weeks).

It is important that unborn and new born children have the best opportunity to have their needs met at the earliest and at the lowest level in the Levels of Intervention document. Where a referral is made to MASH there should be evidence that interventions have been attempted within the Early Help Partnership.

Routine Antenatal Care

The care that women should be offered during pregnancy is outlined in NICE clinical guideline 62 (Antenatal care for uncomplicated pregnancies 2008) However, pregnant women with complex social factors may need additional support to use antenatal care services.

Midwifery services undertake a universal vulnerability Screening pre-birth this may include an ACES based inquiry to determine whether the pregnant mother would benefit from additional support (www.actionaces.org).

The Gloucestershire Hospitals Trust Policy on antenatal care A2002 requires all women to be given the opportunity to discuss sensitive issues and disclose problems. All women should be seen on their own at least once during their pregnancy, with a qualified interpreter when required to ask personal questions about concerns, including the risk of Domestic Abuse. The midwife should also undertake at least one visit in the home.

During the antenatal consultation Midwives, will obtain information from the mother (and father/partner if present) and record this in the booking forms and the women's hand held patient notes, or a confidential outside folder if more appropriate.

At the same time the midwife will review the medical records of any past pregnancies and the information held by the GP and will incorporate this information when completing the universal screening checklist to identify any vulnerabilities.

Midwives should exercise professional curiosity when conducting antenatal consultations. Midwives should consider the risks identified and if these warrant further investigation/discussion, referral should be made as necessary and a clear management plan to be put in place to address identified risks. Where risks are unknown or unclear– these should be raised with MASH.

Midwives are expected to consider whether the risk assessment and if these are prevalent and warrant a discussion, referral should be made as necessary and a clear management plan to be put in place to address identified risks.

When a risk is identified during the risk assessment at each antenatal visit, the midwife undertaking the examination will refer the woman to the consultant obstetrician for review and further management plan. If the risk identified is urgent direct contact will be made to the Triage / on-call obstetrician and the woman will be admitted to hospital.

Women who are managed on the high risk pathway should maintain the minimum schedule of appointments with their named community midwife to ensure consistency and coordination of care.

At 36 weeks a risk assessment must be undertaken, to ensure booked place of birth is still appropriate. When a risk factor is identified that will impact on the intrapartum or postnatal periods, a management plan should be recorded.

This should be easily accessible to all health professionals who may be involved with an individual's care provision. Clear documentation of all contact should be recorded in the Maternity Health Care Records recording as well as attempts to make contact and give antenatal care will assist in supporting the pregnant woman.

The midwifery department will notify the GP and the Health Visiting Service that the woman is pregnant and is in the care of the midwifery service. The completed checklist is used to document any concerns and share these with the GP and Health Visitor. If

additional information is held by either the GP or Health Visitor receipt of the checklist will act as a trigger to inform the midwife of any further relevant information.

The midwife service will seek relevant information from relevant health services such as the GP and Health Visiting Service and children's social care where vulnerability factors have been identified.

Where the pregnancy is identified within Social Care or Primary Health Care, consideration of any known or potential risk will be shared as relevant with Midwifery Services, Gloucestershire Children's Social Care or Primary Health Care Service based on information sharing guidance outlined in Working Together 2018.

Vulnerable Women: Pregnancy and Complex Social Factors

The Trust guideline on Vulnerable Women: Pregnancy and complex social factors M114 describes how access to care can be improved and how, contact with antenatal carers can be maintained, the additional support and consultations that are required and the additional information that should be offered to pregnant women with complex social factors.

Examples of complex social factors include:

- Substance misuse
- Recent arrival as a migrant
- Asylum seeker or refugee status
- Difficulty speaking or understanding English
- Age under 20 (Trust criteria for extra support for teen pregnancy is under 18 at conception)
- Domestic abuse
- Homelessness
- Learning disability
- Poor mental health – self or partner

Assessment of the living situation focuses on domestic abuse and the outcome of the discussion must be documented. In known domestic abuse cases women should as standard practice have the opportunity to be seen alone at key points throughout the pregnancy to discuss concerns

Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors NiCE Clinical guideline [CG110] September 2010
Pregnant women who experience domestic abuse
A woman who is experiencing domestic abuse may have particular difficulties using antenatal care services: for example, the perpetrator of the abuse may try to prevent her from attending appointments.
The woman may be afraid that disclosure of the abuse to a healthcare professional will worsen her situation, or anxious about the reaction of the healthcare professional.
Women who experience domestic abuse should be supported in their use of antenatal care services by:
training healthcare professionals in the identification and care of women who experience domestic abuse
making available information and support tailored to women who experience or are suspected to be experiencing domestic abuse
providing a more flexible series of appointments if needed
addressing women's fears about the involvement of children's services
by providing information tailored to their needs https://www.nice.org.uk/guidance/cg110

Saving Lives, Improving Mothers' Care
Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16
MBRRACE November 2018

Improving care of women with mental health problems
In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications (such as alcohol or substance misuse or interpersonal violence), and should prompt renewed attempts at engagement, diagnosis and care co-ordination

Mental health services should work to minimise barriers to care for women in pregnancy and the postnatal period, recognising the need for lowered thresholds and direct access for maternity and primary care professionals.
Assessments should always include a review of previous history and always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour

Improving care of women from vulnerable groups
Professionals need to be alert to the symptoms or signs of domestic abuse and women should be given the opportunity to disclose domestic abuse in an environment in which they feel secure
Services should develop or adapt clear protocols and methods for sharing information, both within and between agencies, about people at risk of, experiencing, or perpetrating domestic violence and abuse.

and plan care for themselves and their unborn baby. This is not only with midwives, but with other members of the multidisciplinary team where appropriate, refer to Gloucestershire Hospitals Trust A1114 Vulnerable Women: Pregnancy and Complex Social Factors and A2151 Trust Domestic Abuse Safeguarding Policy.

The Gloucestershire Hospitals Trust Guidance on antenatal care provision recommends that Women should be seen at least once alone with a qualified interpreter when required to ask personal questions about concerns, including the risk of Domestic Abuse. The midwife should also undertake at least one visit in the home.

Midwifery services can undertake a pre-birth vulnerability Screening Tool including ACES to determine whether the pregnant mother would benefit from support. This support can be identified through a "My Plan" supported by the early help partnerships. www.actionaces.org.

If the "My Plan" is not be deemed sufficient to meet the identified need or there are additional needs and circumstances, an early help assessment and a "My Plan +" can be established for the mother, father/partner of the unborn. See Levels of intervention document from GSCP.
https://www.gloucestershire.gov.uk/media/2100844/gloucestershire-revised-loi-guidance-v6-feb-2020.pdf

At this stage, the Midwifery services are the most appropriate service to support mother, father/partner and unborn. The Health Visitor and Community Social worker will offer services to assess support for positive parenting as required and needed by mother/father/partner.

The Community Social Worker should support the development of "My Plan" and work with other partners to access relevant services in line with the identified needs. If necessary, an assessment will be carried out to inform the "My Plan".

Where there are safeguarding concerns. (12 weeks onwards).

The "My Plan" supported by Early Help partnerships or the "My Plan +" supported by Early Help practitioners may be deemed sufficient to provide optimum support for the unborn. However, if required a referral for a social work Pre-Birth assessment can be made.

When considering a referral for social work intervention this should evidence the work that has been undertaken by the midwife, the early help partnerships and / or by families first. It is expected that a "My Plan" accompanies the referral to MASH even if there are immediate safeguarding concerns. The My Plan and the work carried out with the parent should accompany the referral.

This should be part of a continuum of services to support the unborn. Some of this work may continue to be delivered as part of social work intervention either under a Child in Need or Child Protection plan whilst a pre-birth assessment is carried out.

There are three fundamental questions when deciding whether a pre-birth assessment is required:

- Is it likely the new-born baby will be safe in the care of this parent/ partners?
- Is there a realistic prospect of this parents/partner being able to provide adequate care throughout childhood?
- Have Children's Services' involvement previously identified that a new baby would be at risk; and evidence provided by a new assessment as to what has changed, if anything.

Parents who are children in care or care leavers

It is vital that planning for an unborn baby and their parents is aligned and the most appropriate professionals are involved in early decision making regarding potential risk and vulnerabilities, and support that parent/partners will need to care for their unborn baby at home. Contact should be made with leaving care worker to develop risk and vulnerability assessment.

To assist social workers and leaving care workers for the parents a 'risk and vulnerability' matrix has been designed to help analyse factors present to determine the most appropriate course of action. (See attached in tools).

Allocated workers for the parents need to work in conjunction with professionals who have a key responsibility for the unborn baby - for example Midwife. The rationale for decision making and support provided needs to be clearly recorded on the parent's case file.

Where concerns relate to the father who at the time is unknown, advice needs to be sought from the MASH as to where this information is held. In addition, if there are details that are not known, advice should be sought from MASH.

Pre-birth Assessment

Guidance on the Assessment

An assessment is not an exact science, but can be made as thorough as possible if it includes the following three elements:

- What research tells us about risk factors?
- What do we know about the history of mother/father/partner – if there were historical concerns, what has changed since then?
- What practice experience tells us about how parents may respond, circumstances?

- The practitioners' professional knowledge of this family (taking into consideration history).
- The practitioner should make use of tools, techniques to gather information, develop assessments and recommendations based on evidence, likelihood and impact of risk.

The content of a Pre-birth Child & Family Assessment will be formed by collating factual evidence, looking at relationships between parent/s and partners, between parents/partners and the child (whether born or unborn) and looking at how previous history shapes current experiences in the context of parents/partner circumstances.

This is consistent with the Framework for Assessment of Children in Need and their Families and should be applied in conjunction with the assessment tools below to inform the assessment.

The Pre-Birth Assessment must be completed in line with the contact and referral timescales. The Pre-Birth Assessment should be completed within 12-week timescale. However, if there are safeguarding needs and risks identified during assessment, then appropriate intervention must be taken. For example, a safety plan should be in place in the interim while the Pre-Birth Assessment is being progressed.

The Pre-Birth Assessment will inform planning – for example, Early Help Partnership, Child in Need and Child Protection. All assessments should commence under S.17 with the assessment completed within 12 weeks of pregnancy. The use of a multi-agency chronology is an effective way to see what is happening as it helps identify patterns and issues.

Throughout the Pre-birth Assessment, consideration should be given to as to whether the criterion for an s47 investigation is met. If so, the Team Manager needs to authorise and convene a strategy discussion with Police, Health and any other relevant partners at any point in the process.

If a s47 investigation is not appropriate, then the Pre-birth Assessment should continue to its conclusion and the needs of the unborn baby determined at that time.

The main purpose of a Pre-birth assessment is to identify:

- What the needs of and risks to the new-born child may be.
- Whether the parent/s has/have appropriate capacity to recognise these and is willing and able to engage and work with professionals so that the identified risks, addressed to safeguard the unborn child.
- What support the parents may need.
- What support is available in the wider family and community, a genogram and ecomap should be used to make assessments.
- What plan is required to ensure the needs are met and risks addressed.

Once the concerns have been assessed, identified and discussed with parents, the Team Manager will be responsible for determining which pathway the case planning takes.

- If there are no ongoing concerns, then the family would close to children's social care with appropriate links to other services signposted as appropriate or agreed on going support from Early Help Partnerships
- The family may require ongoing support, then Children in Need procedures will be followed and a Family Plan formulated;

- Where the threshold is met for an Initial Child Protection Case Conference, then an S. 47/Strategy Discussion will be undertaken and a clear rationale for the Conference recorded.
- An Initial Child Protection Conference will be held in respect of Unborn to support mother/father/partner.
- The outcome of the assessment will be communicated in writing to all professionals involved with the family.

Supporting Parental Engagement

There are many reasons why expectant mothers and fathers may fail to engage with the assessment, some of which relate to the factors outlined above. For example, a parent suffering from mental health problems may be reluctant to attend appointments or be compliant with medication. It is extremely important that all professionals involved with the family work together and ensure parental non-engagement does not become the reason for delaying the assessment and making multi-agency plans and contingency plans for the birth of the baby. Any assessment started from the point of referral must be completed by 12 weeks.

Pre-birth Initial Child Protection Conferences

There should be no delay in booking a Pre-birth Conference to ensure an appropriate protection plan is in place prior to the baby's birth as soon as the threshold for a Pre-birth Conference has been met.

Initial Child Protection Conference held (where CP concerns are present)

- If the unborn is to be the subject of a Child Protection Plan, the family must be made aware that care proceedings are likely if there is no significant change in the level of concern by the time the baby is born. This must be made clear, both at the Initial Child Protection Conference and within the Child Protection Plan;
- The social worker must ensure a contingency plan is in place, in case the baby is born early. This must be known to parents, midwife, GP, HV and other professionals, as appropriate, including the Emergency Duty Team in case action is required out of hours;
- A Safety Plan must be completed alongside the Child Protection Plan to ensure any eventuality is considered;
- If a child or children are the subject of a Child Protection Plan and their mother is pregnant, there may be occasions when it would be good practice to hold a combined Initial Child Protection Conference and Review Child Protection Conference.

In planning the Initial Child Protection Conference, the social worker should immediately discuss with the chairperson the possibility of bringing forward the Review Child Protection Conference for the other child/ren to ensure effective planning.

Where this does not happen, the Review Child Protection Conference for the new-born would normally be arranged to coincide with the next Review Child Protection Conference for the older child/ren;

If the mother or father is a Child in Care, then joint planning needs to be completed to ensure the needs of the unborn / new baby and the mother or father are supported.

- Where there is any suggestion that the baby will not be living with parents, potential kinship options should be identified, prioritised and viability assessments undertaken.

Potential carers should be referred to the Kinship Team without delay; Family Group Conference should be considered at the earliest stage to ensure that all support available within the family/community is mobilised for the mother/father/ partner.

- Social worker will liaise closely with the Community Midwife and arrange Core Group meetings to review progress with the plan and preparation for the baby's arrival at four week intervals;
- If the threshold has been met using Gloucestershire threshold document with the agreement of the team manager, the social worker will book a Legal Planning Meeting. This will determine whether the Public Law Outline is required (see Care and Supervision Proceedings and the Public Law Outline Procedure);

Child Protection Plan

If a decision is made that the baby needs to be the subject of a Child Protection Plan. The plan must be outlined to commence prior to the birth of the baby. It is critical to use this time to assess the capacity of the prospective parents and their extended families to meet the needs of the Unborn Baby, both now and once it is born. Any Public Law Outline process may require additional active assessment, possibly by external assessors, during this phase of intervention.

Pre-birth Review Child Protection Conference

The first Review Conference should take place within three months of the date of the Pre-birth Initial Child Protection Conference. It is important that the parents' capacity to change and reduce risk factors for the unborn baby is considered carefully at this conference. In addition, the social worker and partners should work together to ensure and evidence that the mother, father/ partners have appropriate and robust support to address their needs and maximize the opportunity to care for their baby when born.

Core Group

The first core group meeting will be designated a pre-birth planning meeting as well as addressing the Child Protection Plan. All essential professionals and the prospective parents should attend unless the Chair makes the decision that in case of domestic violence the perpetrator should not be present at the meeting. For women under the age of 18 an advocate, parent, carer or IRO may attend to support the young woman. A written plan will be constructed.

This must consider:

- Parental strength and abilities. What experience does the parent have of parenting – either as a child and/or of child care looking after babies?
- What support is available to the parents in their communities, what community support network is available to them?
- If previously children have been removed, what has changed since then and what support have the parents received since the removal?
- Practical arrangements for mother and baby-including post-natal ward monitoring
- Who will inform the Social Worker of the birth?
- Plans for out of hours/emergency birth
- Contact arrangements with parents and other family members
- Discharge plans and support package-including out of area

as relevant e.g. if discharging to extended family or friends address for any period or specialist setting
- Management of parental non-co-operation
- Arrangements for legal proceedings/ removal
- Parental attitudes to the plans Health and safety issues
- Ongoing assessment of parents
- Agreed roles and responsibilities of social workers and/or leaving care workers if either of the parents are a child in care or a care leaver.

All subsequent Core Group/Pre-Birth Planning meetings should incorporate the above plan in its discussion and decisions. The plan should ensure that parents have the support they need in the community. For example, parenting classes, use of Family Drug and Alcoholic Court services if they have substance misuse needs and domestic violence support needs. If they do not attend Gloucestershire Domestic Abuse Support Services, then they have the support on a one to one basis as part of the Child Protection Plan.

Legal Planning

In cases where it has been agreed by a Head of Service that a Legal Planning Meeting should be undertaken and the Public Law Outline framework instigated, this should be started following the Pre-Birth Child Protection Conference.

However, if the baby is due within three months from the referral and the level of concerns are identified at the referral stage the Head of Service should be alerted for a Legal Planning Meeting to be convened earlier where the threshold for Legal Planning is met.

This will also trigger the instigation of the best care plan for the baby including what is best for them in the short, medium and long term. All plans should prioritise the support needs for mother/father/partner to ensure that the unborn's interest is paramount and permanency has been addressed in the planning processes.

If PLO or legal action is being progressed a Permanency Planning Meeting should be booked. Please see the Permanency Planning Procedures for further information. The Jones model will be used for Legal Planning Meetings.

Legal Planning

- Social worker should obtain Head of Service agreement for Public Law Outline, and where agreed, this should be progressed through a request for a Legal Planning Meeting;
- A decision must be made about progressing any positive kinship viability assessments to full assessment;
- Where a child is to be looked after at birth, a decision will be made about whether it would be appropriate to undertake concurrent planning (see Fostering for Adoption and Concurrent Planning Procedure).

Possible Outcomes:

- Possible outcomes when the baby is born include:
  - Baby relinquished for adoption;
  - Baby remains with Parents;
  - Baby remains with parents with close support of their extended family;
  - Section 20 agreed – child becomes Looked After in agreement with parents;
  - Care Proceedings, with or without concurrent planning.

Late Bookings and Concealed Pregnancy

For the purposes of this guidance, late booking is defined as relating to women who present to maternity services after 24 weeks of pregnancy and/or who are referred to Children's Social Care after this point. There will be women who were not aware that they are pregnant as well as some women who may have concealed their pregnancy.

There are many reasons why women may not have engaged with ante-natal services or concealed her pregnancy. They may not be aware of their pregnancy, some of which may result in heightened risk to the child.
Some of the indicators of risk and vulnerability are as follows:

- Previous concealed pregnancy;
- Previous children removed from the mother's care;
- Fear that the baby will be taken away;
- History of substance misuse;
- Mental health difficulties;
- Learning disability;
- Domestic violence and abuse and interpersonal relationship problems;
- Previous childhood experiences/poor parenting/sexual abuse;
- Poor relationships with health professionals / not registering with a GP.

N.B. This list is not exhaustive.

In situations where there are issues of late booking and concealed pregnancy, late referral or other identified immediate risk of significant harm, it is extremely important that careful consideration is given to the reason for concealment.

In addition, assessments should address potential risks to the child and convening a Strategy Meeting as a matter of urgency if required.

Any plan arising from a Strategy Meeting should decide on the following:

- Timescales for completion of a Pre-Birth Assessment which is should be carried out as soon as the pregnancy is deemed to be viable and not beyond 12 weeks.
- Convening a Legal Planning Meeting to consider legal options.
- Contingency planning undertaken to look at alternative care and which will include a Permanency Planning Meeting if PLO or Care Proceedings are instigated;

Birth and Discharge Planning

If the unborn baby is the subject of Child Protection and/or Public Law Outline, a Birth Plan should be written and implemented.

The purpose of the plan is to ensure the baby's protection and welfare at and immediately after birth so that all members of the hospital team are aware of the plans and actions expected.

The hospital midwife must inform the allocated social worker of the birth of the baby where agreed within the discharge plan and there must be close communication between all agencies around the time of labour and birth, with the allocated Social Worker informing the allocated/duty lawyer where legal action is planned. If the mother is a child in care, then their social worker needs to be informed of the birth.

The discharge planning meeting must take place within the day after birth. Where birth has taken place out of hours or at the weekend, then the Emergency Duty Team (EDT) will represent Children's Social Care.

The Social Worker must ensure that all information about the post birth plan and discharge planning has been shared with EDT and midwife from the time that the decision to instigate the pre-birth process was made. It is essential that these records are up to date on the electronic system if the baby is born before term.

The Social Worker must make sure that all relevant agencies are invited to the discharge planning meeting. (See for Discharge Plan information below).

The plan should address:

- How long the baby will stay in hospital;
- Level of Supervision required.
- How long the hospital will keep the mother on the ward;
- The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed to the e.g. parental substance misuse;
- The plan should include the risk of potential abduction of the baby from the hospital particularly where the plan is to remove the baby at birth;
- The plan for contact between mother, father, partner, extended family and the baby whilst in hospital. Consideration to be given to the supervision of Contact - for example whether contact supervisors need to be employed;
- Consideration of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; medication being taken by the mother which is contraindicated in relation to breastfeeding;
- To plan for the baby upon discharge, where alternative care has been agreed, e.g. discharge to extended family members; mother and baby foster placement; foster care and supported accommodation;
- The Social Worker may need to seek a legal order to protect and safeguard the new born baby and there will need to be a discussion with the hospital to agree the child remaining on the ward until this has been resolved in the court.
- The court order may not be immediately available; however, the social worker and the hospital must agree the best plan in the safety and interest of the new born baby. (A paper copy of the legal document

may not be available to the social worker. The social worker must have identification document and follow the discharge from hospital process in the tools section of this document). The discharge from hospital process should be followed swiftly and should not delay progressing care for the baby).

- Contingency plans should also be in place in the event of a sudden change in circumstances;
- The Children's Emergency Duty Team (Out of Hours Service) should have all discharge information as soon as it is agreed. A written discharge plan will be agreed between the hospital and the social worker and uploaded onto the child's file.

The social worker should ensure that the contingency plan/discharge plan/safety plans are kept updated in preparation for the birth. A specific Birth Plan must be compiled.

Midwifery Services recommend that a date for the discharge planning meeting is arranged prior to the baby being born as this prevents delay in the baby being discharged and increases the likelihood of professionals being able to attend.

These decisions will be guided by the level of intervention from the relevant pathways being Child in Need, Child subject to a Child Protection Plan and or subject to Public Law Outline procedures. https://www.gscb.org.uk/media/13088/gloucestershire-revised-loi-guidance-version-21-060217.pdf

Therapeutic Support to the Mother and Father and/or if the Baby is to be separated at Birth

In cases where the baby has been removed at birth and the plan is adoption, it is essential that the mother/father/partner is signposted for therapeutic support, including bereavement work to support their emotional wellbeing. Consideration should be given to taking photographs of the new-born baby with its birth parents to assist with permanency planning for the child.

Concurrent planning: (30 weeks onwards)

The appropriateness of concurrent planning should be considered at specific points – after the Pre-birth Assessment, and at the Initial Child Protection Case Conference. The 30/31 weeks' stage is an ideal time for a final decision on this matter.

Relinquished for adoption

Early involvement is essential. The aim of the work with the parent(s) who remain committed to relinquishing responsibility is for the expected child to be placed with an adoptive family as quickly as possible.

This can be achieved within 6 months, or sooner, after the child's birth, if all necessary steps are taken early enough. What is known is that the earlier a child is placed with their permanent carers, the better the chances are that they will form secure attachments. (See Relinquished for Adoption Procedure).

Escalation Policy

If after following the protocol flowchart, a professional still has concerns about the appropriateness of the response from any agency, they should consider using the escalation policy. They should contact their manager or named safeguarding lead professional who if necessary will guide them through the relevant resolution policy. (See GSCP Escalation Policy)

Gloucestershire Pre-Birth Protocol - Process

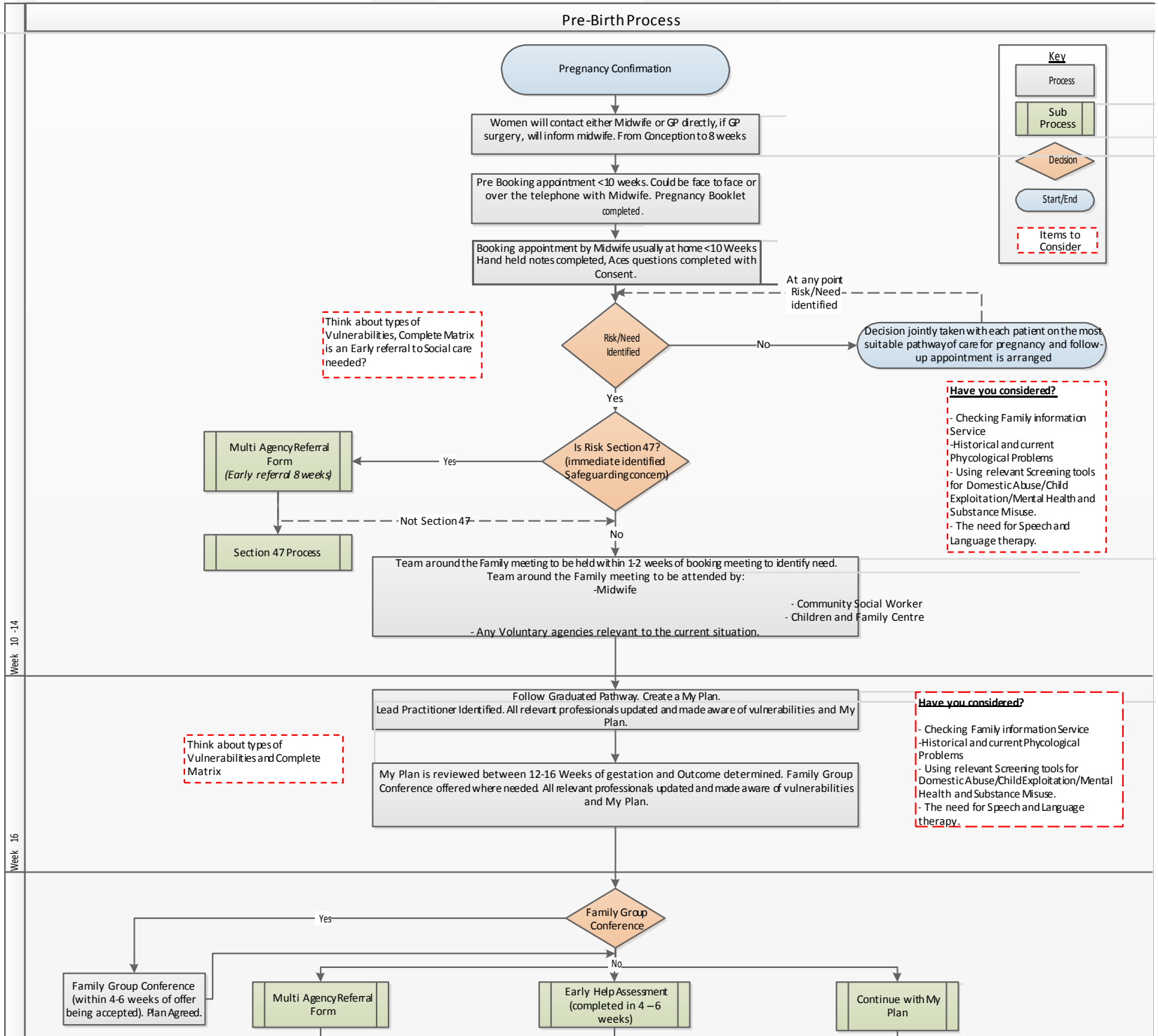
Gloucestershire Pre-Birth Protocol - Process

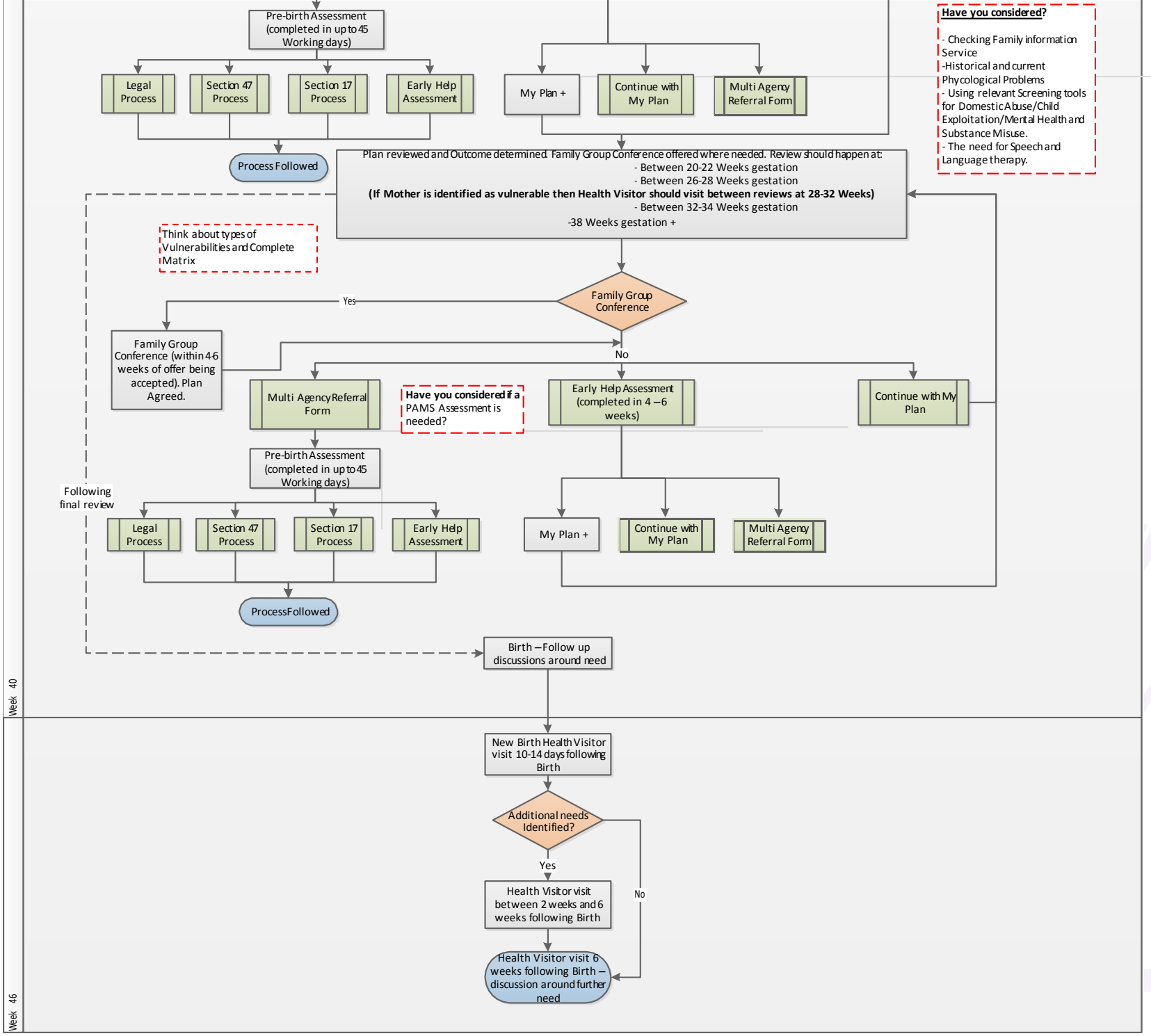
An unborn must be referred to Social Care if any of the following factors/ vulnerabilities are present:
This list is not exhaustive and if a professional is in doubt about making a referral, s/he should always seek advice.

- There is significant domestic violence or escalation during pregnancy and/or honour based violence.
- A parent has significant mental health difficulties/diagnosis. S/he may be subject to an enhanced Care Programme Approach (CP A).
- A parent has moderate or severe learning disabilities.
- A parent is a current looked after child.
- A parent who is former looked after child and is assessed as having additional vulnerabilities. The Local Authority should ask the question.
- A parent misuses substance/s that will have a significant impact on the health and development of the baby.
- A parent has had a child previously removed from their care or has a child voluntarily accommodated under Section 20 of the Children Act 1989.
- A parent of 18 years and under where there are concerns about sexual exploitation, trafficking or abuse and vulnerabilities.
- A parent is previously suspected of complex illness.
- A parent is suspected of being involved in a forced marriage.
- A parent is suspected of being a victim or involved in spirit possession or witchcraft.
- A parent whatever age is suspected or known to have been the victim of grooming and/or sexual exploitation and the putative father is unknown or known to be the one who groomed them.
- A parent is a victim or involved in honour based violence.
- Incest is suspected.
- If a parent is/may attempt to move authorities and/or attempts to avoid professionals.
- A parent/relative or associate is someone who may present a risk to children, or has previously harmed a child (this would include issues such as a violent history, significant criminal history, sexual offences against adults or children etc.).
- The baby once born will be living with or having contact with someone who may present a risk to children (see above).
- A sibling is subject to a Child Protection Plan.
- There are significant concerns about the home conditions, such that the baby may suffer physical neglect.
- One or both parents' behavior or circumstances during pregnancy indicates that they will be unlikely to protect or care for their baby appropriately, e.g. living a chaotic lifestyle with no home base, significant emotional instability and/or lack of preparation/awareness of the impact of becoming a parent.
- Late booking for maternity care with an inadequate explanation

All referrers are required to complete a **Referral Form** and **email the Multi-Agency Safeguarding Hub (MASH/Front Door).**

Working Together 2018 states '*it is good practice to have a discussion with parents where possible and ensure that consent has been agreed. However, if there are concerns that are potentially significant harm then no consent is required. In addition, in line with Working Together 2018, consent should not preclude a referral where professionals have concerns'.*


Pre-Birth Process
Pregnancy Confirmation
Women will contact either Midwife or GP directly, if GP surgery, will inform midwife. From Conception to 8 weeks
Pre Booking appointment <10 weeks. Could be face to face or over the telephone with Midwife. Pregnancy Booklet completed.
Booking appointment by Midwife usually at home <10 Weeks Hand held notes completed, Aces questions completed with Consent.
Key
Process
Sub Process
Decision
Start/End
Items to Consider
At any point Risk/Need identified
Think about types of Vulnerabilities, Complete Matrix is an Early referral to Social care needed?
Risk/Need Identified
No
Decision jointly taken with each patient on the most suitable pathway of care for pregnancy and follow-up appointment is arranged
Yes
Have you considered?
- Checking Family information Service
-Historical and current Phycological Problems
- Using relevant Screening tools for Domestic Abuse/Child Exploitation/Mental Health and Substance Misuse.
- The need for Speech and Language therapy.
Is Risk Section 47? (immediate identified Safeguarding concern)
Yes
Multi Agency Referral Form (Early referral 8 weeks)
Not Section 47
No
Section 47 Process
Team around the Family meeting to be held within 1-2 weeks of booking meeting to identify need.
Team around the Family meeting to be attended by:
-Midwife
- Community Social Worker
- Children and Family Centre
- Any Voluntary agencies relevant to the current situation.
Week 10 -14
Follow Graduated Pathway. Create a My Plan.
Lead Practitioner Identified. All relevant professionals updated and made aware of vulnerabilities and My Plan.
Think about types of Vulnerabilities and Complete Matrix
My Plan is reviewed between 12-16 Weeks of gestation and Outcome determined. Family Group Conference offered where needed. All relevant professionals updated and made aware of vulnerabilities and My Plan.
Have you considered?
- Checking Family information Service
-Historical and current Phycological Problems
- Using relevant Screening tools for Domestic Abuse/Child Exploitation/Mental Health and Substance Misuse.
- The need for Speech and Language therapy.
Week 16
Family Group Conference
Yes
No
Family Group Conference (within 4-6 weeks of offer being accepted). Plan Agreed.
Multi Agency Referral Form
Early Help Assessment (completed in 4 – 6 weeks)
Continue with My Plan


Pre-birth Assessment (completed in up to 45 Working days)
Legal Process
Section 47 Process
Section 17 Process
Early Help Assessment
My Plan +
Continue with My Plan
Multi Agency Referral Form
Have you considered?
- Checking Family information Service
-Historical and current Phycological Problems
- Using relevant Screening tools for Domestic Abuse/Child Exploitation/Mental Health and Substance Misuse.
- The need for Speech and Language therapy.
Process Followed
Plan reviewed and Outcome determined. Family Group Conference offered where needed. Review should happen at:
- Between 20-22 Weeks gestation
- Between 26-28 Weeks gestation
(If Mother is identified as vulnerable then Health Visitor should visit between reviews at 28-32 Weeks)
- Between 32-34 Weeks gestation
-38 Weeks gestation +
Think about types of Vulnerabilities and Complete Matrix
Family Group Conference
Yes
No
Family Group Conference (within 4-6 weeks of offer being accepted). Plan Agreed.
Multi Agency Referral Form
Have you considered if a PAMS Assessment is needed?
Early Help Assessment (completed in 4 – 6 weeks)
Continue with My Plan
Pre-birth Assessment (completed in up to 45 Working days)
Following final review
Legal Process
Section 47 Process
Section 17 Process
Early Help Assessment
My Plan +
Continue with My Plan
Multi Agency Referral Form
Process Followed
Birth – Follow up discussions around need
Week 40
New Birth Health Visitor visit 10-14 days following Birth
Additional needs Identified?
Yes
No
Health Visitor visit between 2 weeks and 6 weeks following Birth
Health Visitor visit 6 weeks following Birth – discussion around further need
Week 46

Tools and resources

Contents:

For universal use

For use when relevant/appropriate

TOOL 1. Pre-Birth Assessment Guidance for completion of the Pre-Birth Child & Family Assessment

1) Introduction

This Guidance is designed to help professionals to carefully consider a range of themes and to consider issues that have potential for having a significant negative impact on the child when completing a Pre-birth Child & Family Assessment. However, a robust pre-birth process will also always consider areas of strengths within the mother, father and wider family. Professionals work with parents and families in partnership for the child to remain in the community whenever possible using creative and supportive approaches to do so.

The Template to use is the Child & Family Assessment but with an unborn baby this will result in a Pre-birth Child & family Assessment following this guidance to inform the relevant domains

The word "parent" should be interpreted as appropriate to mean the mother and father, the mother's partner, anyone with parental responsibility and anyone else who has or is likely to have day to day care of the child. It is crucial to involve everyone who is a potential parent or carer in the assessment.

2) General Guidance

Antenatal care begins as soon as the pregnancy has been confirmed and midwives continue care in the postnatal period for at least 10 days following birth. Booking appointment with the community midwife takes place usually between 8-12 weeks' gestation. It is at this consultation that the midwife can assist women in their choices for childbirth and ensure they are informed of all the options available to them. National Institute for Health and Care Excellence provides guidelines for uncomplicated pregnancies. For further details go to: https://www.nice.org.uk/Guidance/CG62

Women are given choices in early pregnancy of lead professional and place of birth:

- Midwife-led care (MLC) means the midwife is the lead professional. All antenatal care would be conducted in the community. Women would have the choice of giving birth in the hospital under MLC or at home with midwives in attendance.
- Consultant led care is offered to women who have recognised complications. Women at a higher risk of complication or those who choose to see the consultant team. These pregnancies require additional surveillance both pre-birth and in labour. Care is shared between the community midwife, a hospital consultant team consisting of midwives and doctors specialising

in care of women at high risk of complications. Delivery of the baby will usually take place in the hospital.

Discussions take place with the most appropriate professionals to lead care in pregnancy and support decisions concerning place of birth.

The booking consultation is a time for collection of information and an opportunity for the midwife and mother to plan her care in pregnancy. It is an ideal time for the midwife to assess health and social needs of families and to consider packages of care and support suitable for individual needs.

Antenatal appointments are arranged to suit the individual clinical needs of the mothers and the initial choices may change if complications of pregnancy arise. A collaborative approach between all health professionals is encouraged with direct midwife referral to obstetrician being available always.

In the case of home births all postnatal care is provided in the home by the community midwife. For births in one of the midwifery led birth centres postnatal care other than that in the immediate post-partum period is provided by midwives in the community only. Following birth on the central Delivery suite at Gloucestershire Royal, or for those requiring a longer stay accommodation is provided on the post-natal ward.

Women go home within a few hours of birth in the Birth Centres, but generally 12-48 hours are the more normal lengths of stay on maternity wards the post-natal wards and in Stroud Maternity. On transfer home care is undertaken by the community midwife for at least 10 days following the birth. Care can be extended to up to 28 days if a clinical or social need is identified. Liaison between the Health Visitor attached to the GP's surgery and community midwife usually takes place during the antenatal period with some Health Visitors contacting the mother in pregnancy. Following the birth of the baby most Health Visitors arrange a primary visit at 10 days postnatal, which coincides well with the handover of care from the midwives.

Partners play an important role during pregnancy

It is important that all agencies involved in pre-and post-birth assessment and support, fully consider the significant role of partners and wider family members in the care of the baby even if the parents are not living together and where possible involve them in the assessment. This should include the father's attitude towards the pregnancy, the mother and new born child and his thoughts, feelings and expectations about becoming a parent.

Information should also be gathered about partners who are not the biological father at the earliest opportunity to ensure any risk factors can be identified.

A failure to do so may mean that practitioners are not able to accurately assess what mothers and other family members might be saying about the father's role, the contribution which they may make to the care of the baby and support of the mother, or the risks which they might present to them. Background Police and other checks should be made at an early stage on relevant cases to ascertain any potential risk factors.

Involving fathers in a positive way is important in ensuring a comprehensive assessment can be carried out and any possible risks fully considered.

3) Information Required from Midwife / Health Professional as Part of a Pre-Birth Risk Assessment

This section could be completed by an appropriate Health Professional and sent to the Social Worker to assist in the completion of the Pre-birth Child & Family Assessment. The central question is whether there is anything in the medical and obstetric history that seems likely to have a significant negative impact on the child? And if so, what?

Medical and Obstetric issues and age of mother

- Are there any aspects of any of the following items that seem likely to have a significant negative impact on the child? If so, what, and how?
- Feelings of mother about being pregnant?
- Feelings of partner / putative father about the pregnancy?
- Dietary intake - and related issues?
- Medicines or drugs - whether prescribed - taken before or during pregnancy?
- Alcohol consumption?
- Smoking?
- Previous obstetric history?
- Miscarriages and terminations?
- Chronic or acute medical conditions or surgical history?
- Mental Health - especially depression and self-harming?
- Prematurity

4) Assessment of Parents and Potential Risks to Child

This section will be completed by the Social Worker - but they will draw on help from a range of other professionals regarding some aspects of it.

Partners

Partners make a significant impact may be a positive or negative influence and play an important role during pregnancy and after.

It is important to include as a minimum, name, date of birth, address where different from the mother's, relationship to the baby and GP details. Where adult services i.e. mental health, substance misuse, are involved contact details of professionals and consent to contact should be sought.

Where consent to contact services has not been given but the risk to the mother has been identified as potentially high, professionals should consult their named or specialist safeguarding lead and consideration must be given to sharing information in the best interest of the child.

Care should be taken when assessing risks to babies whose parents are themselves children. Attention should be given to:

- evaluating the quality and quantity of support that will be available within the family and extended family
- the needs of the parent(s) and how these will be met
- the context and circumstances in which the baby was conceived
- the wishes and feelings of the child who is to be a parent.

1. Relationships
- History of being parented?
- Being a parent previously and experience of that?
- History of relationships of adults?
- Status?
- Positives and negatives?
- Violence?
- Who will be main carer for the baby?
- What are the expectations of the parents re each other re parenting?

Is there anything regarding "relationships" that seems likely to have a significant negative impact on the child? If so, what?

2. Abilities
- Physical?
- Emotional? (including self-control);
- Intellectual?
- Knowledge and understanding re children and child care?
- Knowledge and understanding of concerns / this assessment?

Is there anything regarding "abilities" that seems likely to have a significant negative impact on the child? If so, what?

3. Social history
- Parenting
- Experience of being parented, including care episodes?
- Experiences as a child? And as an adolescent?
- Negative cultural influences for example FGM?
- Education?
- Employment?

Is there anything regarding "social history" that seems likely to have a significant negative impact on the child? If so, mother, father or other significant adult/s in the child's life?

4. Behaviour
- Violence to partner?
- Violence to others?
- Violence to any child?
- Violence to pets?
- Drug misuse?
- Alcohol misuse?
- Criminal convictions?
- Chaotic (or inappropriate) life style?

Is there anything regarding "behaviour" that seems likely to have a significant negative impact on the child? If so, what?

If drugs or alcohol are a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

5. Circumstances
- Unemployment / employment?
- Debt?
- Inadequate housing / homelessness?
- Criminality?
- Court Orders?
- Social isolation?

Is there anything regarding "circumstances" that seems likely to have a significant negative impact on the child? If so, what?

6. Home conditions

Chaotic?
- Health risks / insanitary / dangerous?
- Over-crowded?
- Other Risks
- Adults

Is there anything regarding "home conditions" that seems likely to have a significant negative impact on the child? If so, what?

7. Mental Health

- Mental illness – this should include current and previous mental illness? Also include medication and hospital admission. How relevant is this to current situation?
- Personality disorder? Also include medication and hospital admission. How relevant is this to current situation?
- Any other emotional/behavioural issues? Also include medication and hospital admission. How relevant is this to current situation?

Is there anything regarding "mental health" that seems likely to have a significant negative impact on the child? If so, what?

If mental health is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

8. Learning Disability

Is there anything regarding "learning disability" that seems likely to have a significant negative impact on the child? If so, what?

If learning disability is likely to be a significant issue, more detailed PAMS Assessment (A PAMs Assessment is a risk Assessment designed to identify potential risks to the child (for example, neglect, physical emotion abuse or impact of domestic violence and substance misuse on the child) Assessment should be sought from professionals with relevant expertise in undertaking this type of assessment.

9. Communication

- English not spoken or understood?
- Deafness or blindness
- Speech impairment?
- Cultural issues

Is there anything regarding "communication" that seems likely to have a significant negative impact on the child? If so, what?

If communication is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

10. Support

- From extended family?
- From friends?
- From professionals?
- From other sources?

Is there anything regarding "support" that seems likely to have a significant negative impact on the child? If so, what?

Is support likely to be available over a meaningful time-scale?

Is it likely to enable change?

Will it effectively address any immediate concerns?

11. History of being responsible for children

- Convictions re offences against children?
- CP Registration?
- CP concerns - and previous assessments?
- Court findings?
- Care proceedings? Children removed?
- Current health status of other children?

Is there anything regarding "history of being responsible for children" that seems likely to have a significant negative impact on the child? If so, what?

If so also consider the following:

- Category and level of abuse;
- Ages and genders of children;
- What happened?
- Why did it happen?

- Is responsibility appropriately accepted?
- What do previous risk assessments say? Take a fresh look at these - including assessments re non-abusing parents;
- What is the parent's understanding of the impact of their behaviour on the Child?
- What is different about now?

12. History of abuse as a child
- Convictions - especially of members of extended family?
- CP Registration?
- CP concerns
- Court findings?
- Previous assessments?

Is there anything regarding "history of abuse" that seems likely to have a significant negative impact on the child? If so, what?

13. Attitude to professional involvement.
- Access to Health Services E.g. G.P registration, up-to date immunizations, access to education Previously - in any context?
- Currently - regarding this assessment?
- Currently - regarding any other professionals?

Is there anything re "attitudes to professional involvement" that seems likely to have a significant negative impact on the child? If so, what?

14. Attitudes and beliefs re convictions or findings (or suspicions or allegations)
- Understood and accepted
- Issues addressed? Responsibility accepted?
- Is there anything regarding "attitudes and beliefs" that seems likely to have a significant negative impact on the child? If so, what?

It may be appropriate to consult with the Police or other professionals with appropriate expertise.

15. Attitudes to child
- In general,
- Re specific issues? Eg discipline, behaviour?

Is there anything regarding "attitudes to child" that seems likely to have a significant negative impact on the child? If so, what?

16. Dependency on partner
- Choice between partner and child?
- Role of child in parent's relationship?
- Level and appropriateness of dependency?

Is there anything regarding "dependency on partner" that seems likely to have a significant negative impact on the child? If so, what?

17. Ability to identify and appropriately respond to risks?
Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what?

18. Ability to understand and meet needs of baby
Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what?

It may be appropriate to consult with Health professionals re this section.

19. Ability to understand and meet needs throughout childhood
Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what?

It will usually be appropriate to consult with relevant Health professionals re this section.

20. Ability and willingness to address issues identified in this assessment

- Violent behaviour?
- Drug misuse?
- Alcohol misuse?
- Mental health problems?
- Reluctance to work with professionals?
- Disguised compliance?
- Poor skills or lack of knowledge?
- Criminality?
- Poor family relationships?
- Issues from childhood?
- Poor personal Care?
- Chaotic lifestyle?

Is there anything regarding "ability and willingness to address issues" that seems likely to have a significant negative impact on the child? If so, what?

It will usually be appropriate to consult with other professionals re this section.

21. Any other issues that have potential to adversely affect or benefit the child.
E.g. one or more parent aged under 16? Context and circumstances of conception?

22. Planning for the future

- Realistic and appropriate?

Overall Risk Assessment Analysis and Conclusions (with) Recommended Actions with Timescales

a. Concerns identified;

b. Strengths or mitigating factors identified;

c. Is there a risk of significant harm for this baby?
It is crucial to clarify the nature of any risk - of what? From whom? In what circumstances? etc. - and to be clear how effective any strengths or mitigating factors are likely to be;

d. Will this risk arise:

- Before the baby is born?
- At or immediately following the birth?
- Whilst still a baby (up to 1 year old)?
- As a toddler? or pre-school? or as an older child?

If there is a risk that the child's needs may not be appropriately met.

e. What changes should ideally be made to optimise well-being of child?
If there is a risk of significant harm to the child.

f. What changes must be made to ensure safety and an acceptable level of care for child?

g. How motivated are the parents to make changes?

h. How capable are the parents to make changes? What is the potential for success and history of making change as assessed by professionals?

TOOL 2. Pre-Birth Implementation Group

Purpose of Group

- Systemic Panel to implement revised Protocol and Pre-birth work in Gloucestershire
- Implement changes in the systems/ agencies and sharing information in line with Working Together 2018.
- Appropriate challenge and support of Pre-birth work within and between agencies.
- Use Data analysis to evaluate the new process to understand the impact of the revised protocol and update/ challenge when necessary
- Work together with partners, commissioning and early to support parent/s and partners in the community to successfully parent their new born. This may include the commissioning of new services post birth.
- Drive Resources to support community based post birth assessment informed by Early Help Plans and Pre-birth Assessment to support mothers/fathers and partners to remain within their own community as the preference to residential and foster care based provision for post birth assessment.

TOOL 3. Out of Hours Births

Whilst mother may go into labour during working hours, it is more likely that the baby will be born outside of these, during the evening, in the early hours of the morning, at the weekend or on a bank holiday.

Therefore, it will be necessary for the responsible social worker to ensure the following:

- All relevant information and paperwork, including the Discharge Plan has been sent to the Out of Hours Team and the midwife has been involved. If accommodation is by consent, Out of Hours Team will need to visit (if the birth does take place outside of normal office hours) to ensure that the mother is still consenting to this plan and that the Section 20 paperwork and form giving consent are signed by the parent(s) prior to the accommodation of the baby;
- Out of Hours Team must be notified of the contact arrangements following separation for example if baby is separated following birth to another appropriate area, Out of Hours Team must be informed as to who will supervise the contact. This may be a family member if assessed as appropriate. Where there is an agreed plan to separate the mother and baby at birth, a Social Worker must visit to check this consent;
- The responsible social worker must notify the Legal Team at the point information is received informing Social Care that mother has gone into labour. The responsible worker will need to ensure that the legal team are updated and an application for Interim Care Order is made at the earliest opportunity. Where the baby is born out of hours, this must be actioned on the next working day.

TOOL 4. Birth Plan/Hospital discharge Plan

The purpose of the plan is to ensure the baby's protection and welfare at and immediately after birth so that all members of the hospital team are aware of the plans and actions expected.

The plan should address:

- How long the baby will stay in hospital and supervision;
- How long the hospital will keep the mother on the ward;
- The arrangements for the immediate protection of the baby if it is considered that there are serious risks, for example, parental substance misuse;
- Any risk of abduction of the baby from the hospital, particularly where the plan is to remove the baby at birth;
- The plan for contact between mother, father, extended family and the baby whilst in hospital and whether supervision/Contact Supervisors required.
- Discussion with health colleagues of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; mother's current medication;
- To plan for the baby upon discharge, where alternative care is planned, e.g. discharge to extended family members; mother and baby foster placement; foster care, supported accommodation;
- Contingency plans should also be in place in the event of a sudden change in circumstances and the Emergency Duty Team should also be notified of the Birth Plan.

2. Discharge planning meetings

The following agencies must be invited to attend discharge planning meetings (to be arranged by staff within the hospital) and should be represented for the meeting to proceed. When the meeting relates to concerns of significant harm/child protection concerns CSC will chair the meeting.

- Children's Social Care Team Manager /Social Worker
- Paediatric Consultant (or specialist registrar with consultant's consent).
- Named community midwife, team leader or safeguarding specialist midwife?
- Acute Named Nurse/Midwife Safeguarding Children
- Other relevant hospital staff involved in the care of the child/family
- Health Visitor if there is a child under 5
- Other agencies may need to be involved in cases and attendance should be considered such as, School Nurse, Police, Mental Health Colleagues, Learning Disability colleagues.

When a child that is subject to a child protection plan is admitted with a medical condition (unrelated to ongoing child protection concerns) a teleconference on discharge between a senior doctor and allocated social worker must occur.

3. Timing of Discharge Planning Meeting

When it is agreed that a Discharge Planning meeting should be held this should be convened if possible, at least 24 hours prior to discharge to allow for appropriate arrangements to be made to support or safeguard the child or young person.

4. The discharge planning meeting must fully document and include:

- An agreed multi-agency discharge plan which will set out arrangements for the care and safety of the child following discharge from hospital into the community and will include actions; timescales and responsibility for actions.
- Details of the child's GP. If they are not registered this must be organised before the child leaves hospital. This may not occur out of hours but a GP should be identified and the child should be registered on the first working day after child leaves hospital.
- Additional medical investigations requested including timescales for completion
- Documentation of any legal orders arising from the admission (with copies filed if available)
- Agreement about what information should be shared with parents/ carers and other professionals, e.g. school staff, and how and when this information will be shared.
- Any further meetings required or other review dates.

A copy of the Discharge Planning meeting must be placed in the child's medical notes.

TOOL 5. Discharge Planning Meeting Agenda

1. Introductions and purpose of meeting.

2. Professionals attending and apologies.

3. Clarify name, DOB, address, ethnicity of child and significant family members including other children.

4. Agency updates in relation to pre-birth, birth and post birth considerations during hospital stay.

5. Discharge plans to include:

- When and to whom baby is to be discharged to
- Reasons why this is the proposed plan
- Is parental consent required to implement this plan? If not detail how consent will be dispensed with.
- Consideration of the baby's development and if there are specific medical needs which need to be addressed, including how these will be addressed.
- Who will transfer/transport baby and/or parent/s to proposed address?
- What equipment is required and who will provide this e.g. car seat, clothing, and feeding equipment.
- Who and when will parent/s be informed of discharge plan.
- Consider any equality and diversity issues in relation to baby and the family and how these may impact on implementation of plan.
- Contingency plans

5. Consideration of support needs for other siblings, parent/s and significant family members, including how and who will provide this.

6. Where the baby is to be separated from parent/s consider contact arrangements with parents and any siblings following discharge.

7. Consider information to be shared or withheld from parent/s and the reasons for this.

8. Arrangements to inform (including who and when);

- The community midwife
- The health visitor

9. Proposed multi agency visiting arrangements following discharge 10. Dates for review of arrangements

Safeguarding Birth Plan and Discharge Template

This form is to be completed for all unborn babies who are;

- Subject to a child protection plan
- Subject to a pre-birth assessment (Children's Social Care)
- Subject to pre-proceedings processes (Children's Social Care)

1. Summary of safeguarding plan	
Unborn baby (state family name)	Care First Reference
EDD	Ethnicity
Delete as applicable: • Baby to remain with mother but there are safeguarding concerns • Baby to be separated from mother following birth • Baby to be separated from mother following discharge	
2. Family Information	
Mothers name	Date of birth
Home address	
Putative Father's name	Date of birth
Home address	
Will the putative Father have parental responsibility (i.e. married to Mother or likely to be named on birth certificate)	Yes/No
Are there any barriers to communication e.g. language understanding	
Are there any specific observation, assessment or support needs for the mother during birth or the post-natal period?	
Are there any other children that need considering within this plan? (please detail names, ages, and nature of concern/consideration)	

Agreed birthing partner's name and status
Person(s) who are to be excluded from the maternity unit and reasons why
Names(s) and status of any person(s) who may have access to the maternity unit but whose conduct and behaviour may pose difficulties. State why:
NB: Any difficult or disruptive behaviour within the hospital will automatically involve the hospital's security and police and those persons will be removed as per hospital policy.

3. Health and social care professionals	
Name of Hospital and birthing unit	
Named Midwife Team Contact details	
Named Health Visitor Contact details	
GP/Practice Contact Details	
Named Social Worker Team Contact details	
Team Manager Contact details	
EDS contact details	
Child Protection Plan	Yes/No
Category (tick as applicable) Physical ☐ Sexual ☐ Neglect ☐ Emotional ☐	
Date of CP Plan	
Pre-birth assessment completed?	Yes/No
Recommendations of completed pre-birth assessment	
Public Law Outline meeting?	Yes/No and date

Outcome of PLO	
Professionals to be notified – including EDS if required	
On admission to hospital NAME	CONTACT DETAILS
Following birth NAME	CONTACT DETAILS

4. Contact following birth within Hospital		
For Mother		
Is supervised contact required?		Yes/No
Date of discussion with Named Midwife for Safeguarding		
Outcome of discussion. If contact is to be supervised, please detail the: • level of supervision required • who will supervise • reason why contact is to be supervised		
For putative Father		
Is supervision required?		Yes/No
Date of discussion with Named Midwife for Safeguarding		
Outcome of discussion. If contact is to be supervised, please detail the: • level of supervision required • who will supervise • reason why contact is to be supervised		

Contact for any other person (detail names and relationship)		
Is supervision required?		Yes/No
Date of discussion with Named Midwife for Safeguarding		
Outcome of discussion. If contact is to be supervised, please detail the: level of supervision required who will supervise reason why contact is to be supervised		
5. The Safeguarding Plan		
Is the child to be separated from the mother following birth?		Yes/No
If yes		
On delivery suite following birth and transferred to a designated place of safety		Yes/No
On discharge from post-natal ward		Yes/No
Are there any concerns about the mother's capacity to consent to the plan? E.g. mental health issues, learning disability, due to mother's young age?	Yes (detail)/No	
Is the plan agreed by the mother?		Yes/No
Is the plan agreed by the Father?		Yes/No
Evidence of and date of Agreement NB: Consent can be withdrawn at any time by any person with parental responsibility		
Where the plan is not agreed or consent is withdrawn detail the contingency plan to safeguard the child upon birth. Please include the names of professionals who will be enacting the contingency plan.		
State how lawful authority for the plan will be obtained:		

Police Powers of Protection	Yes/No
Emergency Protection Order	Yes/No
Interim Care Order application	Yes/No
6. Discharge Planning	
Is a Discharge Planning Meeting required?	Yes/No
Detail the date of the meeting and who will participate:	
Arrangements for discharge	
Is the baby to be discharged from hospital to an alternative carer?	Yes/No
If yes:	

To foster carer?	Yes/No
Is the foster carers address to remain confidential?	Yes/No
Address of F/C (if confidential please ensure this is not shared with parents/ carers)	
Discharge to others carers? Please state:	Yes/No
Name	
Relationship to child	
Address	
If baby and/or mother are being discharged to another area have maternity services been informed? If not when will this happen?	Yes/No
Where mother and baby are to be discharged to home address, detail any action and support required, including who is to provides these and the timescales for doing so.	
Any other issues to be noted	

6. Distribution of notes	
Date plan given to:	
Midwife	
Named midwife for safeguarding	
Health Visitor	
Others (please state)	
Date when plan shared with Mother	
Date when plan shared with putative Father	
If plan not shared with parent/s state reason why	
Date copy signed by Social Worker	

Discharge Planning Protocol: Discharge of Children and Young People from Acute Hospital Settings - Multi-Agency Guidance
This guidance has been developed to support multi-agency staff to make appropriate arrangements to ensure the safe discharge and transfer of children and young people where there are safeguarding concerns, from acute hospital settings. This guidance applies to children already known to have safeguarding concerns prior to admission and children in whom a safeguarding concern arises during admission.

TOOL 6. Discharge Planning For Babies – Children In Care Status

1. Introduction

In Gloucestershire, we are committed to ensuring that all children who leave hospital to have a safe destination that has been planned by professionals and in consultation with parents and carers. As there has been in increase in the numbers of children in care it is vital that professionals have:

- A common understanding about what it means for a child to be in care
- A clear understanding of their own contribution to safeguarding and promoting the health of Children in Care
- A clear understanding of the roles and responsibilities of other professionals involved

This guidance is the agreed protocol for children in care to leave hospital. The guidance includes a circumstances and safe practice approaches but does not include all eventualities.

All staff in hospital and working with the new born must be aware of the issues around consent and parental responsibility (PR) for individual children and this should be documented and should be checked before each episode of care.

Staff should feel confident in challenging decisions that they feel are not in the best interests of the child and where necessary follow Gloucestershire's professional challenge (escalation) guidance.

2. Purpose

- To improve the understanding for staff involved in the care of vulnerable babies who are in care or who are being discharged from GHNHST into care, including the implications for the provision of health care.
- To improve the understanding of processes involved during health care delivery in a hospital setting and on discharge.
- To ensure a smooth transition when babies move into foster care or parent and baby placements.
- To improve the knowledge and skills of Foster Carers in the care of babies.
- To ensure clear lines of communication between partners in hospital, social workers, family first and community health services.

3. Parental/Responsibility and consent

Birth parent(s) retain PR (shared with the local authority if a Care Order is in place) unless a baby is placed for adoption (under a Placement Order) when PR is shared with prospective adopters. Once the Adoption Order is complete, the child is no longer looked after and adoptive parents will hold full PR.

Foster carers do not have PR but consent for some interventions can be 'delegated' to the carers via a Delegation of Authority form which is discussed and agreed with the birth parent/s and which they sign. Foster carers are expected to give one copy

to their GP and take a copy for health appointments.

4. Information Sharing

All children in care babies are entitled to the same level of confidentiality as other babies – hospital staff should not include third party information (particularly foster carers) personal information within the child's clinical record for confidentially section of the child's health records.

Key contacts form should be filled if, when born, the baby will be subject to care proceedings from birth/hospital. Information sharing protocols should be used in line with Working Together 2018 for babies subject to care proceedings from hospital/birth.

Guidance for Staff when babies are Discharged into Care.

Health colleagues should be aware that some Foster Carers, particularly those who are newly approved may only have attended very basic training. Staff should ensure that carers are given any necessary advice and information before discharge, particularly in relation to infants with complex medical needs. This should be agreed at the discharge planning meeting and includes family members who will be caring for the baby on discharge.

The foster carers may be providing a 'Fostering to Adopt' or 'Early Permanence' placement that is adopters who are approved to care for the infant as foster carers awaiting the application of the Placement Order. In these cases the carers may had very little training or recent experience of caring for babies. Hospital staff should treat these carers as though they were first time parents unless there is evidence to suggest otherwise.

Discharge/Placement Planning Meeting

This is a multi-agency meeting convened to discuss the child's needs, plans for placement and whether foster carers need any additional support, information or training to care for the child safely.

The discharge planning meeting should be convened at the earliest opportunity (see discharge planning meeting section) to ensure that a clear plan is agreed.

As well as the Foster Carer/s, it is good practice for this meeting to be attended by the baby's fostering social workers along with the relevant hospital staff to ensure that consistent messages are given about the needs of the child and their carers.

The foster carer should be given a copy of the placement plan, which will detail where the child is to be discharged and to whom. This should be signed by the child's Social Worker. The Foster Carer should ensure that they take this along with their photo ID badge to show the hospital staff when the child is being handed over for discharge. If hospital staff have concerns regarding the ability of the Foster Carer to provide safe, evidence based care, they should in the first instance contact the child's Social Worker. All Foster Carers also have a supervising Social Worker who should also be made aware of any difficulties.

Good Communication at all times

It is essential that there is good communication between the midwife, ward staff, foster carers or connected cares, fostering social workers, baby's social worker and the parent's social worker (if there is one) in order to develop safe plans for when the baby is discharged from hospital. Failure to do this can have considerable impact on the safeguarding of the baby.

TOOL 7. Child Protection Concerns – actions for Staff in Acute Hospitals

Children with known safeguarding concerns may be admitted to hospital with an acute medical or surgical problem, or for a planned period of observation or intervention, or they may be admitted due to further safeguarding concerns. Other children will be admitted to hospital and during their stay safeguarding concerns may arise.

Where there are new safeguarding concerns, the child should be referred to Children's Social Care (CSC) and the child should not be discharged without a discharge planning meeting or the agreement of the allocated social worker or the emergency duty team and, where appropriate, other multi-agency partners such as the Police. If a child is already known to CSC with ongoing child protection or safeguarding concerns, there must be a discussion with the allocated social worker or emergency duty team and appropriate plans made prior to discharge (which may include a discharge planning meeting).

The Named Nurse for Safeguarding Children for the NHS Trust where the child has been admitted must be informed and medical information should be sought from the previous NHS Trust(s) before discharge if they have been treated at another hospital. No child can be discharged or transferred from hospital, where there are child protections or safeguarding concerns without the permission of the responsible Consultant Paediatrician or Emergency Duty Consultant. This permission must be documented in the child's medical record.

Permission should only be provided once the Consultant confirms that there is a clear, agreed discharge plan in place and receives confirmation that the child is being discharged or transferred to a place of safety.

Discharge letters which detail the discharge plan should be copied, with the patient's/parent's/carer's knowledge, to the relevant health and social care children's professionals involved with the family, with clearly documented plans for further follow up or investigations. So far as possible, all investigations should be completed before discharge. If the child is discharged to an address other than their home address, or into the care of someone other than their parent, this must be clearly recorded in the child's records.

TOOL 8. Unborn Tracker for Social Workers

Name	EDD	Outcome and Date of Pre-birth Assessment	Strategy Meeting	ICPC Date	LPM Papers to be completed	Paperwork to issue	Social Worker

TOOL 9. Child in Need and Child Protection Plan

Child in Need Route	Child Protection Route
Where threshold is met for an ongoing role for Children's Services, a Pre-birth Assessment should be undertaken. It is very important that this assessment involves relevant multi-agency professionals directly in the assessment. The Team Manager should review the progress of the Pre-birth Assessment regularly throughout the process to be satisfied and determine whether other services or processes are required If a meeting is called the purpose of the meeting is to ensure that all professionals are aware of the same information and contribute to the developing picture of the prospective parents and their parenting capacity. It is ultimately the role of the Social Worker to determine the levels of risk involved in any Pre-birth Assessment, but there is an expectation that this is supported by non-judgmental, evidence-based information and advice from other professionals, especially those with an expertise in the areas of drug and alcohol; mental health and learning disability. The strengths identified by any health visitor and midwife during the assessment and other joint visits with the health specialist, and relevant agencies as appropriate If sufficient concerns emerge at any time during the assessment or from the Multi-Agency information sharing meeting, a Strategy Meeting should be requested from the relevant Team Manager within Children's Services to determine if an s47 Child Protection enquire should be commenced and pre-birth Child Protection Conference held. Any case of late presentation or referral may require immediate action, and may move straight to Child Protection or legal planning	Potential risks to the unborn child should be flagged up as early as possible to inform effective planning from a strategy meeting of the Pre-birth Assessment and subsequent s47 enquiry and pre-birth Initial Child Protection Conference, to gather information at an early stage including relevant Police checks including from overseas if the parent has come from another country. In cases where previous children have been removed from either parent and continue to be Looked After, or are a Care Leaver, the allocated Social Worker or Personal Advisor, must be invited to the Strategy Meeting to provide relevant background information and history. It is crucial to involve health visitors and midwifery in the strategy meeting to ensure full information is available to all agencies. In cases where care proceedings have been conducted by Gloucestershire, the social worker should contact the Legal Department to request a copy of and read the legal bundle from those proceedings. Any case of late presentation or referral may require immediate action, and may move straight to Child Protection or legal planning.

TOOL 10. Perinatal risk Indicators for referral to mental health services

Women with perinatal mental illness can rapidly deteriorate, so once concern has been raised, early assessment/advice should be sought. Late pregnancy and early puerperium have an increased risk of suicide

Perinatal Red Flags and Risk Indicators

- Recent significant changes in mental state or emergence of new symptoms.
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant.

Perinatal risk indicators (Antenatal and postnatally period)

- Women with a history of bipolar disorder, schizophrenia, severe depression, other psychotic disorder, or previous inpatient/crisis care should be referred to the perinatal team; this group is at increased risk of severe postpartum episodes.
- Women with a family history of a first degree relative with bipolar disorder or puerperal psychosis should be referred even if presenting with mild symptoms of mental disorder
- Antenatal presentation can be a predictor for post-natal episode of mental ill health; discuss all antenatal referrals with perinatal team.
- High risk period for is 1-10 days post-natal but the threshold should be lower for women up to 10 weeks postnatally
- Women who are presenting with uncharactersitic symptoms and marked changes to normal functioning. This can include symptoms of confusion and general perplexity.
- If partner, family, friends report significant change in presentation and acting out of character.
- Older professional women with depression who appear to be functioning at high level
- Women who present with anxiety/panic attacks or unusual or overvalued ideas (ideas that seem out of context or extreme)

For pregnant mums under 18 with non-urgent mental health concerns professionals can contact CYPS professional advice line 01452 894272 Mon-Fri 9am-5pm.

Consider asking the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing (The Whooley Questions):

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

Also consider asking about anxiety using the 2-item GAD scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge? (Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3)
- During the past month have you not been able to stop or control worrying? (Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3)

If a woman responds positively to either of the depression identification questions above or scores 3 or more on the anxiety GAD-2 scale, is at risk of developing a mental health problem, or there is clinical concern, consider:

- using the PHQ-9 scale for further assessment (as below)
- using the GAD-7 scale for further assessment (as below)
- Referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional.

Adapted from: Antenatal and postnatal mental health: clinical management and service guidance (2014 updated 2018) NICE guideline CG192 https://pathways.nice.org.uk/pathways/antenatal-and-postnatal-mental-health

Parental mental health

It is important that parents experiencing mental health disorders are given opportunity to talk about their experiences and to access the right care and support. A quick and useful tool to get parents talking about their mental health is the PHQ-9 and GAD-7 measuring depressive and anxiety based symptoms respectively. As with any other assessment, assessing mental health is a dynamic process and asking questions about how they are feeling and coping need to be repeated.

In the first instance, parents can talk to their GP about their mental health and can be referred to the mental health team who have nurses linked to the GP surgeries. If their condition is particularly serious or enduring, they can be referred on to more specialist services.

Let's talk is a service that can be accessed by a referral from a professional in contact with the family or parents can self-refer. The service offers a range of cognitive behavioural based therapies from guided self-help, psychoeducational courses (stress and anxiety, low mood and mindfulness), and a trauma programme to individual cognitive behavioural therapy for mild to moderate anxiety and depressive disorders. This covers: depression, anxiety, panic disorder, social anxiety, PTSD, OCD, phobias, generalised anxiety disorder and health anxiety.

Let's talk:0800 073 2200
https://www.talk2gether.nhs.uk/

https://www.talk2gether.nhs.uk/quick-self-assessment/

Foundation Trust
For Gloucestershire

IAPT Questionnaire 1
PHQ-9

Over the last 2 weeks, *on how many days* have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0		2	3
2 Feeling down, depressed or hopeless	0		2	3
3 Trouble falling or staying asleep, or sleeping too much	0		2	3
4 Feeling tired or having little energy	0		2	3
5 Poor appetite or overeating	0		2	3
6 Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0		2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0		2	3
8 Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0		2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0		2	3

A11 – PHQ-9 Total Score ____

IAPT Questionnaire 2
GAD-7

Wk..... Date.....

Over the last 2 weeks, *on how many days* have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0		2	3
2 Not being able to stop or control worrying	0		2	3
3 Worrying too much about different things	0		2	3
4 Trouble relaxing	0		2	3
5 Being so restless that it is hard to sit still	0		2	3
6 Becoming easily annoyed or irritable	0		2	3
7 Feeling afraid as if something awful might happen	0		2	3

A12 - GAD-7 Total Score ____

Tool 11. Risk and Vulnerability Matrix for unborn babies of children in care or care leavers

RED	3	AMBER	3	GREEN	3
There has been a previous unexplained death of a child whilst in the care of either parent		History of low mood or anxiety or low level substance / alcohol use (either parents)		All children in care or care leavers who are parents to be should be supported to engage with early intervention / preventative services through universal services.	
A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children					
A sibling to the unborn / baby is the subject of a child protection plan or is or has been looked after (voluntarily or via a court order)		Previous parental childhood experiences / experience of poor parenting /sexual abuse			
The parent is a child in care (under age of 18yrs)		Previous concealed pregnancy			
Domestic abuse is known to have occurred or there are concerns about the current parental relationship (control, coercion, emotional abuse etc)		Unstable housing, risk of eviction or temporary housing situation			
The degree of parental mental illness/ impairment, learning disability, physical disability, substance misuse is likely to have a significant impact on the baby's safety, care or development		Concern about lack of support network and / or isolation from family / friends / community.			
There are concerns about parental maturity and ability to self care and look after a child.		Stresses related to finances, work or lack of work, benefits			
The parent to be is under 13 years old		Disengagement or poor engagement with SW / LCW			
Any other concern exists that the baby may be likely to suffer significant harm including a parent previously suspected of fabricated or inducing illness in a child					
Parent not registered with GP with no intention of this					

RED	3	AMBER	3	GREEN	3
WHAT DO YOU NEED TO DO NOW?					
If one or more ticks then an automatic referral to social care needs to be made and a discussion with the midwife is needed	TOTAL	If one or two ticks then a discussion with the midwife is needed referencing the reason for concern as a minimum. If a more than two ticks present then a referral to CSC is needed	TOTAL	Discussion with midwife as a minimum.	
Decision making for unborn babies needs to be made in conjunction with a professional who has a professional responsibility for the unborn baby i.e. midwife or social worker / MASH					

Name of Young Person:

Completed by:

Date:

Gloucestershire Safeguarding Children Partnership

Email: gsce@gloucestershire.gov.uk