Hull Safeguarding Children Partnership

PROCEDURES AND GUIDANCE UNBORN PROCEDURES AND GUIDANCE (PRE-BIRTH PATHWAY)

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UNBORN PROCEDURES AND GUIDANCE (PRE-BIRTH PATHWAY)

SCOPE OF THIS CHAPTER

See also

The purpose of the unborn procedures and guidance is to help identify all babies who may require additional support as early as possible in their lives, and to ensure that appropriate and timely multi-agency services are put in place and delivered in an integrated manner.

Pathway diagram (see link in 2. Principles of the Pre-Birth Pathway)

Unborn Threshold of Need (see link in 5. Thresholds of Need in decision making)

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1. Guidance for all Agencies

All women who are, or suspect, that they may be pregnant should be advised to book in with Midwifery services at the earliest opportunity. This is usually between 8 to 10 weeks gestation.

The direct access booking line number is 01482 605304 or Text: 07825280822

Email - **hyp-tr.direct.access@nhs.net**

Further information can be found at **'I'm pregnant what's next'** which includes an online referral form.

The Midwife will be able to assist the woman in making informed choices about the care she receives, offer advice on the suitability of her choices and will be able to consider if there are any concerns for the unborn child.

Other professionals must not assume that the pregnant woman is known to Midwifery Services. If any agency becomes aware that a woman is pregnant then contact needs to be made with Midwifery for booking in at the earliest opportunity.

Evidence indicates that women who have additional vulnerability are less likely to access antenatal care or stay in regular contact with maternity services. Where vulnerability has been identified, providing antenatal services in a more flexible way may encourage women to attend more regularly and therefore receive appropriate care and referrals. For further information, please see **Pregnancy and Complex Social Factors, NICE guidelines CG110, (2010).**

If there are immediate concerns about an unborn child or an adult with care and support needs, existing safeguarding procedures need to be followed alongside encouragement to access maternity services.

2. Principles of the Pre-Birth Pathway

The **Pre Birth Pathway** has been developed and designed in partnership, in order to develop consistent Pre Birth Assessment practice, which identifies potential vulnerability early in pregnancy and provides a clear pathway through appropriate support services. The guidance takes into account findings from local Learning Lesson and Serious Case Reviews as well as local and national research into good practice.

The key principles of the Pre-Birth Pathway are:

- Practitioners 'think pregnancy, think midwife'.
- All practitioners 'think family'.
- Early Help and support is key.
- Midwives complete a Pre-Birth vulnerability Screening with all women at their booking appointment.

- Primary Care Networks (PCN) will be advised of the pregnancy, risks and vulnerabilities should be shared at the earliest opportunity.
- Timely and appropriate information sharing between services is crucial.
- All appropriate professionals should contribute to a Pre-Birth Assessment where one has been identified as being necessary.
- As needs are identified and assessed during pregnancy, there should be consideration to a 'step up or step down' approach so that children and families are supported by the most appropriate services.
- All agencies will ensure that their own procedures are in line with the pathway and that practitioners within their organisations are briefed in its use; and
- All staff to be aware that if at any point there is disagreement about the correct level of intervention reference should be made to the HSCP Escalation and Resolution Policy.

3. Identifying vulnerability

These guidelines follow the NICE Guidance **Ante Natal Care for Uncomplicated Pregnancies**, which outlines that pregnant women with complex social factors may require additional support, they set out what healthcare professionals, antenatal services, and other agencies can do to address the needs and improve pregnancy outcomes in this group of women.

In order to support decision making in relation to the assessment of complex social factors and vulnerability during pregnancy Hull University Teaching Hospitals NHS Trust (HUTH) midwifery services complete a vulnerability screening with every woman from the moment of booking, in order to begin to identify the most appropriate support and services available.

At the beginning of any intervention, it is important to identify whether the pregnant woman has any communication needs. At the earliest opportunity, access to translation or advocacy services should be considered.

Where multiple vulnerabilities are identified, with explicit consent, the woman would be referred to a specialist midwife for an enhanced level of midwifery care.

If a woman discloses substance misuse, severe mental health issues or a diagnosed learning disability, with consent the women will be referred to the specialist midwife.

The specialist midwife will assess the information and with consent refer to the appropriate agency to offer the relevant support. The specialist midwife will attend a monthly meeting with the substance misuse agency (Renew) and also with the Perinatal Mental Health Team.

The Vulnerability Screening is based partly on the 2010 NICE guidance – Pregnancy and Complex Social Factors, and also takes into consideration locally identified vulnerability factors.

Consideration should be made as part of the assessments for parents with Learning disabilities/difficulties, parental mental illness.

The following risk factors should alert professionals to consider a co-ordinated response. Where mothers, fathers, or partners or any other significant member of the household are identified with any of the following vulnerabilities:

- Drug and/or alcohol use.
- Mental Health Issues.
- Disabilities and difficulties – Learning and Physical.
- Domestic Abuse.
- Asylum Seeker / Refugee or Recent Migrant (less than 12 months) / Language Barrier.
- Homelessness – including living in temporary accommodation.
- Child/Adult Exploitation / Human trafficking.
- Female Genital Mutilation; (Part of a separate guideline).
- Honour Based Abuse / Forced marriage.
- Other children in the family open to Children's Social Care.
- Existing child or children not in the care of parents.
- Pregnant woman or partner is Looked After Child or has been child in care (21 years old or younger, or 25 years if in education).
- Mothers aged 19 years or under; with additional vulnerability factors identified.
- Late presentation / Denied / Concealed / unwanted pregnancy, and frequent attendance.
- Nonattendance or regular cancellation of appointments (both antenatal and postnatal).

Midwifery can revisit the vulnerability screening at any point in their contact with pregnant women and their families.

If at any stage, it becomes known that a pregnancy is no longer viable this information needs to be sensitively communicated in a timely manner to all involved agencies and consideration given to referral for access to bereavement support for parents as appropriate.

The antenatal booking summary reflects the application of the screening tool and is shared with the Health Visiting team and GP after the 12-week viability scan or after booking in the case of late presentation. Where multiple vulnerabilities are identified, women and their families may be suitable for enhanced health visiting services under the enhanced family support pathway, universal partnership plus or universal plus provision.

Any change in the assessment will be communicated with other agencies involved in supporting the parents / carers at the earliest opportunity.

All professionals who come into contact with pregnant women should consider the 'vulnerabilities' section and refer to appropriate services which may include EHASH.

Service charges in NHS for marginalised groups.

There are a cohort of women who may be subject to charges for maternity care. This issue has been raised by the National Child Mortality Database who co-authored an editorial published in the BMJ (2022) which warned that NHS charging for maternal care could contribute to health inequalities and neonatal and maternal mortality. The editorial explains the current system, whereby women who are not ordinarily resident in the UK are asked to pay for maternity care in advance. The authors highlight how this practice, and its inconsistent application across different NHS trusts, can exacerbate inequality of health outcomes for mothers from vulnerable groups – including those from black and minority ethnic backgrounds, low-income families and single mothers. (Read the full editorial in the BMJ: **Maternity charges in NHS widen health inequalities**.

These include ensuring that no one is denied access to care, careful identification of patients who meet the criteria for free care, and greater support for women who are charged.

4. Role of father's / invisible men / partners

'The involvement of prospective and new fathers in a child's life is extremely important for maximising the life-long wellbeing and outcomes of the child regardless of whether the father is resident or not' (**National service framework 2004**). It is important that all agencies involved in pre, and post birth assessment fully consider the role of fathers and the 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 unborn/newborn child and his thoughts, feelings and expectations about becoming a parent. Information should also be gathered about fathers and partners who are not the biological father at the earliest opportunity to ensure any risk factors can be identified. A careful assessment of the role that person has in relation to the woman and any other children in the household as well as their views about the future care of the baby should be undertaken. 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 present to them. Involving fathers or other males in the Pre-Birth Assessment is important if all strengths and risks are to be fully considered.

See: **The Child Safeguarding Practice review Panel: The Myth of Invisible Men**. Review of serious incidents involving babies under-one-year-old who have been harmed or killed by their fathers or other males in a caring role.

5. Thresholds of Need in decision making

The pre-birth pathway follows the HSCB **Threshold of Need Framework and Guidance** and describes 4 types of response to providing appropriate support to all children, young people and their families, including unborn children.

As families are assessed during pregnancy and support needs are identified, there should be consideration of a 'step up or step down' approach so children and families are supported by the most appropriate services.

6. Consent

Where it has been identified that a family may benefit from additional support services in the context of Universal, additional or Targeted Early Help, any referral should be completed with the explicit consent of the parents / carers.

Where concerns have been identified in relation to safeguarding of the unborn, these should be shared with prospective parent/s and consent obtained to refer to children's social care unless obtaining consent in itself may place the welfare of the unborn child at risk e.g., if there are concerns that the parent/s may move to avoid contact with agencies. For further information about consent, agencies should follow their own governance processes and utilise HSCP **Effective Communication, Consent and Information Sharing Procedure**.

Where agencies or individuals anticipate that prospective parents may need support services to care for their baby or that the baby may be at risk of significant harm, a referral to children's social care **Early Help and Safeguarding Hub (EHASH) should be made.**

7. Mental Capacity/Gillick Competence

Women and birthing people's consent is needed for every medical procedure, however minor, except in a life-threatening emergency when the individual is unable to make their wishes known, and in cases where a person has been deemed to lack capacity. If a woman or birthing person is deemed to lack capacity, decisions about their treatment must be made in their best interests. The **Mental Capacity Act** (2005) sets out the factors that should be taken into account in deciding someone's best interests.

Gillick competences is concerned with determining a child's capacity to consent.

Children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. If a child is considered 'Gillick competent' to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions.

Therefore, each individual decision requires assessment of Gillick competence.

If a child is deemed not Gillick competent, then the consent of a person with parental responsibility (or sometimes the courts) is needed to proceed with treatment.

Fraser Guidelines: are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. In the case of over 16's competency this is measured by the **Mental Capacity Act**.

8. Referral where Screening Indicates Vulnerability

Where vulnerability is identified, early referral to appropriate support services will promote positive working relationships between both parents and key professionals and can:

- Provide sufficient time to make adequate plans for the baby's arrival.
- Provide sufficient time for a full and informed assessment where appropriate.
- Avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time.
- Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome for the baby.
- Enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth.

The Hull Safeguarding Children Partnership Threshold guidance describes the local processes and appropriate routes of referral into Children and family services depending on the identified threshold of need and agreed consents.

9. Initial response from children's social care (EHASH) to an early referral

Any professional with a concern for an unborn child should follow the process for referral to EHASH having consulted the Threshold of Need Framework & Guidance.

Research and experience indicates that very young babies are extremely vulnerable, and that work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm. Evidence demonstrates that early intervention and effective intervention in childhood can lay the foundation for a healthy life. (DH,2009,P33).

Consequently, as soon as concerns have been identified referral's to EHASH should be made early in the pregnancy, which indicate that the unborn is at risk of significant harm.

If a referral is made to EHASH at an early gestation and this is not evidencing significant harm consent should be obtained to refer to Early Help Services, so they are able to undertake an early help assessment. This support may be able to mitigate the risks to the unborn child. Following this intervention and support and where there remain risks of harm, the early help practitioner will follow the step-up process for children's social care intervention.

When a referral for an Unborn Baby (or a family group which includes and Unborn) is made to EHASH this will be presented at the weekly **multi-agency vulnerability pre-birth panel** for decision making and allocation. If Threshold met for children's social care pre-birth assessment. **Pre-Birth C& F assessment allocated** to Assessment Teams or Locality Teams (dependant on the presenting concerns and level of risk). If threshold met for strategy discussion EHASH to arrange and Assessment Team or Locality Team to attend. Review panel date given **12 weeks** after initial panel. If threshold is not met for a pre-birth assessment however, it is acknowledged that the family would benefit from support and consent has been given then this will be allocated to Early Help. Where there are no identified concerns, the outcome will be no further action and the referrer will be notified of the decision within 2 working days.

In all cases identified as requiring a child and family pre-birth assessment, this should commence following the unborn being allocated to allow for purposeful interventions and support to commence.

A pre-birth assessment should be viewed as a preventative assessment, predicting any risks in advance of a child being born. The aim of which is to ensure a child's safety post-birth, including ensuring that parent(s) receive the kind of support and services that are required in order to be able to parent safely and effectively.

The primary aim of an assessment will always be to have the child remain in the parents' care where it is safe to do so, however it must be noted that should the child be deemed to be at risk of suffering significant harm, then consideration will need to be given to alternative outcomes.

Where the threshold is met for a Pre-Birth assessment the Pre-Birth Planning Meeting should take place within 15 – 20 working days of the open C&F Assessment. Children, Young People and Family Services should meet with any other professionals that the family are working with in order to gather a holistic picture of strengths and risks. Professionals will be required to share information with Children, Young People and Family Services.

Within 15-20 working days into assessment **family / friends network meeting** held to look at the family's support. Start **safety planning work** and identifying who can be part of this plan.

Families can access support in addressing any concerns prior to the Pre-Birth Assessment commencing. This can be achieved through utilising early help support.

Referrals should be made at point of disclosure of the pregnancy. There is no minimum gestation for a referral to EHASH.

Child and Family pre-birth assessment, outcomes, meetings, and monitoring

Please refer to Hull Children and Families Service **Pre-Birth Assessment Guidance**

Once a C&F pre-birth assessment has been completed there are a number of possible outcomes.

No further role for CSC – on going care provided through universal services including the Healthy Child Programme.

Letters confirming case closure to be sent to the family, along with a copy of the assessment. Letters should also be sent out to involved agencies and professionals to confirm closure.

Step down to Early Help – case to be presented at Early Help panel and a step-down meeting convened

Please refer to Early Help procedures.

Child in Need plan – an initial CIN meeting will be convened within 10 working days following the completion of the assessment

The initial child in need meeting, will also be the transfer point for any case transferring from the assessment service across to the locality teams.

The meeting should involve each agency involved or likely to have information relating to the family who may contribute to a support plan during pregnancy. Those unable to attend the meeting should be asked for their contribution in writing.

The meeting should be arranged at a time when parents and relevant professionals can attend. Within the Midwifery service, afternoon meetings are significantly easier to attend due to clinic commitments.

Invitations for attendance by a midwife at meetings should be sent to (and must include mother's details):

Community Midwives via the Community office (Hull University teaching Hospital NHS Trust) **hyp-tr.community.office@nhs.net**

The information that agencies should be prepared to bring to the meeting should include:

- Family composition.
- Agency involvement.
- What are you worried about? Including past harm, current worries, and complicated factors.
- What is working well? Safety and Strengths of the family, including extended family network.
- All agencies will be expected to provide a progress scale in regard to the level of safety, and rationale for this number (i.e. On a scale of 0 to 10 were 0 is that there is no safety identified for baby, and everyone is so worried that alternative plans for baby once born is needed, and 10 is where there are no worries, there is a clear plan in place and the case care be closed).
- All agencies will be expected to contribute to the development of the case trajectory and planning for the baby .

This will formulate the basis for a multi-agency plan, including the commencement and timeframes for any further assessments. An appropriate review point will need to be agreed at the meeting. The meeting should consider any referral to additional support services such as parenting programmes or specialist support. It should also ensure the delivery and oversight of important safety messages such as safer sleeping, crying baby and home safety.

In the event that any Professionals are unable to attend that a written report should be made available to the social worker prior to the meeting.

At this meeting everyone will be expected to contribute to the development of clear danger (or worry) statements, and safety (or wellbeing goal) with paired safety scaling. Every professional will be asked to scale how worried they are on a scale of 0-10 in the meeting and be able to provide a rationale. A clear case trajectory / plan will be developed to ensure that families are provided with the right support at the right time.

A review CIN meeting date will be set at the end of the initial meeting. The Social Worker should then provide minutes of the meeting to all professionals.

Initial Child Protection Conference

On occasions there may be sufficient, evidenced concerns regarding the risks posed to the unborn child, which may warrant the convening of an Initial Child Protection Conference, following a Strategy Discussion/Meeting. For more information see the HSCP Core Procedures.

The Child Protection Conference is the appropriate multi-agency arena to share the assessment to date and using the Signs of Safety model, will consider whether the unborn baby should become subject to a Child Protection Plan.

If a Child Protection Conference is assessed as necessary, the Team Manager and Social Worker must ensure that this is held well in advance of the estimated date of delivery. This should be held at approximately 20 – 24 weeks of pregnancy.

If it is agreed that the Unborn will be made subject of a child protection plan, there will be core group meetings held every 20 working days. A review child protection conference will be scheduled in within 12 weeks of the initial meeting.

Public Law Outline – pre-proceedings and Care Proceedings

Early planning should consider the need for legal action through the formal Children's Social Care process. Although not all referrals will go on to require legal proceedings, it is important to bear in mind the timescales laid out in the guidance as they will not be met unless referrals are made at an early stage in the pregnancy (see Statutory Guidance on Court Orders and Pre-Proceedings, DfE, 2014 and the Public Law Working Group amended guidance of pre-proceedings work 2021).

Where an Unborn is assessed to be at risk of significant harm due to the parental behaviours' consideration will be given to presenting the Unborn to legal gateway panel. This should take place between 24 and 26 weeks' gestation. This provides families with every opportunity to work with the plan and PLO agreement to support change prior to baby being born. Social workers will be expected as part of the PLO period to involve the family network, complete viability assessments of connected carers to inform planning for Unborn. Consultations with the adoption team regarding Early Permanence Placements should be considered were necessary.

10. The role of Early Help.

Where a need for additional support has been identified, it may be that this can be provided by one or more Universal Services providing a time limited intervention, such as promoting access to Children's Centre provision or providing a specialist referral to a single agency. It is important that agency responses are proportionate to the support needs of the parents and the unborn baby.

Should agencies working in Universal Services become concerned or 'stuck' at any point, the lead practitioner should consult with an Early Help Social Worker for a case discussion. If required, with the family's consent the situation can be discussed at an Early Help Action Meeting (EHAM) for allocation to a Targeted Pregnancy Support worker (TPS). The TPS worker would be responsible for completing the Early Help Assessment and co-ordinating the multi-agency support plan.

When EHASH management oversight has identified the need for a pre-birth assessment to be undertaken the case should be allocated to a social worker in order for an assessment to commence. If during the assessment it is identified that there is role for a TPS worker, then a request for support should be made to Early Help. A copy of the social care plan should be shared with a defined role. This will be the basis of the Early Help Plan.

In order to meet the needs of the parents and the unborn(s) where complex needs have been identified but threshold for a social care assessment has ***not*** been met, will involve a request for support to Early Help to be made. An Early Help Assessment should be started at the earliest opportunity. On completion or during the Early Help Assessment a multi-agency planning meeting will be convened with all stakeholders to facilitate the step-up process (see multi-agency planning

meeting below.) if it is felt that threshold is met. This meeting's evidence and the Early Help Assessment should be used to inform the 'step up' into Children's Social Care.

If consent cannot be obtained or is withdrawn at any point, then a decision will need to be made as to the impact of not receiving services and whether this would escalate concerns to meet the threshold of risk of significant harm. Or if there are enough strengths, support and monitoring in place to for it to remain at a universal level support.

Outcomes for referrals to Early Help

Once the case has been allocated to an Early Help worker, they should provide details including:

- Name and contact details to be sent to referrer via email or by telephone to referring midwife.
- If the service user withdraws consent, then the referrer should be informed.
- If threshold for stepping up to Children Social care is met outside of a Team Around the Family/professional meeting, then the referrer should be informed as above.

For HUTH (Hull University Teaching Hospital: NHS Trust) cases this should be via the generic Community Midwifery Email. **hyp-tr.community.office@nhs.net**

There are three Early Help Hubs throughout the city, these are listed below. The Early Help Hub that you should contact is the one which serves your local area. On contacting the Hub, please make them aware of this letter and the future requirement to undertake a Pre-Birth assessment.

- West Locality Early Help Hub – Priory Children Centre, Tel: 305770
- East Locality Early Help Hub – Acorns Children Centre, Tel: 708953
- North Locality Early Help Hub – Lemon Tree Children Centre, Tel: 828901

11. Role of Primary Care in antenatal/maternity care – 'Think GP'

Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services. GPs as well as all primary care staff, play a key role in safeguarding people of all ages by providing care throughout their lifetime including the antenatal period.

It is important that those caring for pregnant women are aware of any current or past medical or social issues that might place the mother or the baby at greater risk. It is therefore critical that relevant and proportionate information is shared across the health and care partnership to ensure safe, integrated care is delivered.

It is also important to reflect that the Primary Care team may hold information about other significant adults (father, partner or other) that may be relevant from a safeguarding perspective, and it may be appropriate to consider how this information is reciprocally shared.

12. Universal Health Visiting Service (Including Enhanced Family Support Pathway)

The Hull 0-19 IPHN Service is delivered and lead through the Healthy Child Programme. It offers a comprehensive programme of screening, developmental reviews, information, and guidance to support parenting and healthy choices which enhance a child or young person's life chances.

https://www.humber.nhs.uk/Services/hull-0-19-integrated-public-health-nursing-service-iphns.htm

The Enhanced Family Support Pathway offers an early intervention enhanced home visiting programme for families assessed as being vulnerable in their antenatal period. The programme is designed to support families through pregnancy, transition to parenthood and for the child's first three and half years of life through targeted intervention to improve parental confidence, to build parent/child relationships and to develop readiness for school. The four key areas within the pathway are:

- Preparation for Transition to Parenthood.
- Building parental confidence and skills.
- Building parent/infant relationships.
- Readiness to learn and readiness for school.

Pregnant women are included on the pathway if they fulfil the eligibility inclusion criteria which now are:

- Clients disclosing Domestic Abuse to the midwife or health visitor at antenatal contact.
- Parental Diagnosis of mental health disorder currently under the care of Let's Talk or secondary mental Health Services.
- Parental Diagnosis of a learning disorder.
- Current parental misuse of drugs and/or alcohol.
- Parents undergoing section17/47 assessment. Or have had children removed from their care.

Families are referred in on receipt of the antenatal notification form, following the pre-birth vulnerability meeting discussions or at any time during the antenatal period if assessed as being eligible for the pathway.

13. Domestic Abuse

The Hull DAP team are a group of professionals who work together in the same office to provide a support service for victims/survivors of domestic abuse and where possible, hold abusers accountable for their behaviour. The team consists of specialist practitioners who all have extensive knowledge and understanding of domestic abuse and include domestic abuse support workers, housing advisors, a social worker, a health practitioner, addictions workers and police domestic violence coordinators.

http://www.hulldap.com/support/support-available

14. Change, Grow, Live – ReNew

Where parental substance or alcohol misuse indicators have been identified, professionals should refer individuals at the earliest opportunity to ReNew for specialist support. Consent must be sought from the individual prior to referring.

Individuals are able to access services via self-referral however professionals are encouraged where such vulnerabilities exist to avoid signposting.

Professionals should consider completing Drug Assessment Tool (DAST) and Alcohol Audit (please see attached) to provide time-effective assessment of need at referral stage.

ReNew aims to assess pregnant service users within five days of referral. If pregnancy is confirmed, a 'Think Family' Recovery Co-ordinator will be allocated. 'Think Family' Recovery Co-ordinators will provide case management antenatal and post-natal.

Family Focused Clinics:

Women who require opiate replacement therapy will additionally be offered 2-4 weekly clinical consultation via our lead clinician. Medical reviews will be conducted to ensure safe and effective prescribing regimes and ensuring objectives and procedures are specifically aimed at achieving best outcomes for service users and their dependants. With client consent, any services involved in the care of the unborn should be invited to attend with the aim of optimising parenting ability and role of the individual.

Consideration should be given to significant others who may also benefit from a referral to specialist substance misuse support as part of adopted 'think family' approach.

How to refer:

- Alternatively, please visit **Hull ReNew - Referrals | Change Grow Live** and complete online professional referral. Individuals can also self-refer through the website.
- 01482 620013 – professionals can support individuals to complete a referral verbally.

15. Multi-Agency Planning Meeting/Team around the Family

The allocated Social Worker has responsibility for arranging this meeting. Unless there is a justifiable reason as to why parents should not be invited to this meeting, the parents and any advocate identified by them should be invited, as should any professional / service that is currently working with the family.

Prior to the Pre-Birth Multi-Agency Planning Meeting being held, the Social Worker should visit the family in order to explain the purpose of the meeting, including the commencement of the Pre-Birth Assessment. Parent(s) need to be fully informed of the purpose of the assessment, the process and how the findings of the assessment will be used. In addition, parents should be reminded of their right to seek independent legal advice and informed of the complaint's procedure.

The following is a list of other professionals / agencies who, if involved with the parent(s) / partner(s) should be invited to the Pre-Birth Multi-Agency Planning Meeting. This is not an exhaustive list:

- Midwife.
- Health Visitor.
- Children Centre Practitioner.
- Targeted Pregnancy Support.
- ReNew Drug/Alcohol Service.
- Probation.
- Housing.
- Hull Domestic Abuse Partnership.
- Sexual Exploitation Team; and
- Family Group Conferencing.

The Pre-Birth Multi-Agency Planning Meeting, whilst being respectful of parent(s) feelings, must be frank and honest. Attendees at the meeting must be prepared to share information openly and 'own' the information that they share.

As outlined in the Introduction, a Pre-Birth Assessment includes ensuring that parent(s) receive the kind of support and services that they require in order to be able to parent effectively at the earliest opportunity, the Pre-Birth Multi-Agency Planning Meeting is the starting point for this, and offers an opportunity to:

- Enable the early provision of support services to facilitate optimum home circumstances prior to the birth.
- Provide a multi-agency approach to supporting the family.
- Provide sufficient time for a full and informed assessment.

16. Assessment / Child's Plan for Health Professionals

Any assessment should be completed and shared with parents/partners by no later than 34 weeks gestation, and the birth plan completed and sent to the Safeguarding Children Team at **hyp-tr.safeguardingchildren@nhs.net** by 34 weeks gestation and shared with the Team Around the Family. Birth plans should be completed for all unborn's who are Child in Need (CiN), subject to a Child Protection Plan (CPP) or Public Law outline (PLO) and should include: planned duration of hospital stay, who to notify when baby is born, including contact telephone numbers, if supervision is required who is the agreed supervisor, details of any pending legal processes.

The assessment should identify:

- Risk factors.
- Strengths in the family environment.
- Factors likely to change and why.
- Factors that might change and how; and
- Factors that will not change and why.

Assessments should also:

- Consider what meaning this unborn has for the family.
- Consider family history and composition.
- Consider the role of wider family members and significant others.
- Consider the role of fathers and partners; and
- Be clear about recommendation regarding risk, need and support required.

When any assessment has concluded that an expected child may be at future risk of significant harm, the lead social worker should ensure that a copy of the child's plan for health professionals is also shared with the Emergency duty team.

Where vulnerability is identified late in the pregnancy it is essential that there is a clear plan regarding the birth of the baby. It is crucial that hospital discharge arrangements are clarified at the earliest opportunity. **NB In complex cases it is best practice to consider if a hospital birth planning meeting or discharge planning meeting is required**.

17. Pause

Consider Pause as part of early permanence planning.

Pause is a voluntary 18-month programme that works with women who have had children removed from their care. Pause provides an opportunity for women to take control over their lives, and working in partnership with their individual practitioner, and the wider Pause team, can find new ways to overcome the problems of the past, meet the challenges of the present, and build a better future.

To find out more about Pause as an organisation **https://www.pause.org.uk/**

To be eligible for Pause the woman must:

- Reside in Hull.
- Have no children in her care.
- Have had one or more children removed from their care.
- Be at risk of further pregnancy and subsequent removal.
- Consent to speaking to a Pause practitioner about the programme.

Pause are able to accept an early referral from professionals where a woman is pregnant, and there are plans for the removal of the child once born. The team will work sensitively and in collaboration with those agencies who know the woman best, to determine the right time to introduce an offer of Pause support.

This early introduction to Pause could provide an opportunity for building relationships with a woman, and, much needed support, should her baby be removed from her care.

The Pause team recognise that we cannot predict the outcome of any child protection proceedings. Where Pause have been communicating with a woman and the outcome of the proceedings is that the child remains in her care, she will then not be eligible for Pause, and alternative multi agency services will need to be put in place.

Each woman who is eligible and ready for Pause will be allocated a practitioner to discover her own goals and aims, independent of the child's plan. Pause do not assess parenting ability and do not provide a parenting course.

If you would like to make a referral or would like to speak to the team about a potential referral, please call: **01482 616056**.

Alternatively, you can e mail us here: **pause.admin@hullcc.gov.uk**

18. Additional considerations in working with unborn

Duala

The Goodwin Doula project can offer support to vulnerable or isolated women who would benefit from the extra support of a volunteer doula in their pregnancy, birth, and postnatal period.

The Goodwin Doula project can also support with antenatal and postnatal appointments, be a birth partner and offer help with emotional and practical aspects of adjusting to being a new parent.

Doula and Breastfeeding Peer Support – Goodwin Development Trust (goodwintrust.org)

Referrals include self-referral or via the midwife or health visitor:

Email doulaproject@goodwintrust.org

Telephone 01482 497 811

Coping with crying

All parents regardless of any known risk should receive information about coping with crying babies this is the responsibility of all professionals. Repeating this information will help to reinforce the message.

ICON

ICON is an evidenced-based National program aimed at preventing abusive head trauma injuries to babies caused by shaking. This program involves a public health campaign delivered to all pregnant women and their partners during pregnancy and postnatal period. Research points to persistent crying in babies being a potential trigger for some parents/care givers to lose control and shake a baby. ICON offers a series of brief 'touchpoint' interventions to parents offering coping with crying advice, comfort techniques and safe sleep information. Around 70 per cent of babies that are shaken are shaken by men and it is important that professionals delivering the information use the best opportunities to reach male care givers.

Safer sleeping

The purpose of this information is to minimise the risk of sudden infant death by promoting safer sleeping for babies to include:

- Awareness of temperature regulation.
- Babies sleeping in a safer environment.

- The risks of co-sleeping and bed sharing and parents falling asleep in unsafe areas whilst holding the baby.
- The increased risk of SIDs for babies of parents who smoke, take illicit drugs, medications with a sedative effect and alcohol.

The safest place for a baby to sleep in on their back with their feet to the foot of the crib, Moses basket or cot. The cot, crib or Moses basket should be a clear flat space free from pillows, quilts, duvets, bumpers, pods, nests or sleep positioners. This should be in the same room as their parents, in a smoke free environment day and night. For further detailed advise see the lullaby trust website". **www.lullabytrust.org.uk**

Definitions

Sudden infant death syndrome (SIDS): The sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring most commonly during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.

Co-sleeping: one or more person falling asleep with a baby in any environment (e.g., sofa, or bed at any time of the day). This may be a practice that occurs on a regular basis, or it may happen occasionally. A key feature is the baby is asleep.

Bed Sharing: babies sharing a parent's bed in hospital or home, to feed them or receive comfort. This maybe a practice that occurs on a regular basis or it may happen occasionally. There is a risk that the carer may fall asleep.

At the Hull University Teaching Hospitals NHS Trust, a Safer Sleeping Checklist is completed with all women in the ante-natal and post-natal period.

For up-to-date information please use the link below:

https://www.lullabytrust.org.uk/wp-content/uploads/Safer-sleep-saving-lives-a-guide-for-professionals-web.pdf

Responding to Concealed or Denied Pregnancy

The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and wellbeing of the unborn child and the mother.

- A concealed pregnancy is when a woman knows she is pregnant but does not tell any health professional; or when she tells another professional but conceals the fact that she is not accessing antenatal care; or when a pregnant woman tells another person or persons, and they conceal the fact from all health agencies.
- A denied pregnancy is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel, and behave as though they were not pregnant. In some cases, a woman may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children (Spinelli, 2005).

Through the nature of concealment or denial it may not be possible for anyone suspecting a woman is concealing or denying a pregnancy to be certain of the stage that the pregnancy is at.

Protection and Action to be taken by agencies in relation to concealed or denied pregnancy

Where there is a strong suspicion there is a concealed or denied pregnancy, then it is necessary to share this irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the unborn child will override the mother's right to confidentiality. A referral should be made to Children's Social Care (EHASH) about the unborn child. If the woman is aged less than 18 years, then consideration will be given to whether the mother is herself a Child in Need. If she is less than 16 years, then consideration needs to be given as to whether a criminal offence may have been committed and needs to be investigated.

If there is a denial of pregnancy, then consideration must be given at the earliest opportunity to a referral for Mental Health Services.

A full assessment will be needed in order to understand the circumstances in relation to the concealed or denied pregnancy.

The Midwife will consider referral into EHASH depending on level of the concern. A referral may not be required if the practitioner is satisfied that threshold has not been reached. It may be more appropriate to offer early help or direct access to single service or Health Visitor.

Bereavement Support

Where a pregnancy does not result in a live child.

All practitioners across agencies should be sensitive to and be aware of appropriate support services available to parents where a pregnancy does not result in a live child.

The impact on women and their families both physically and emotionally, following a pregnancy loss or early neonatal death cannot be underestimated. The care they receive from health care professionals can have a huge impact on their perceptions on what happened and their ability to cope in such difficult circumstances.

Hull University Teaching Hospital NHS Trust specialist bereavement midwife

The Bereavement Midwives are practising midwives who lead and work as a member of the multidisciplinary team within the maternity service. They will facilitate and provide individualised care to bereaved women and their families. The team offer emotional and practical support to grieving parents as well as advice and support to other professionals.

The team consists of two midwives covering 5 days. They can be contacted on The Bereavement Midwife, Hull University Teaching Hospitals NHS Trust. Tel; **01482 608962** mob; **0799080022** **hyp-tr.heybereavementmidwives@nhs.net**

Child Bereavement UK

Support families and educates professionals when a baby or child of any age dies or is dying, or when a child is facing bereavement. They provide confidential support, information and guidance to families and professionals.

- Professionally trained bereavement support workers are available to take calls 9am - 5pm Monday-Friday; Tel: **0800 02 888 40**
- The support team can also be contacted at: **support@childbereavementuk.org**.

The Miscarriage Association (National Charity)

Provides support and information to anyone affected by pregnancy loss, through:

- A staffed helpline Tel: **01924 200799** (helpline Mon-Fri 9am-4pm) and e-mail support **info@miscarriageassociation.org.uk**.
- Support network: a UK-wide network of support volunteers, who have been through the experience of pregnancy loss themselves and can offer real understanding and a listening ear.
- An online forum is a safe space for people to share thoughts, feelings and experiences about miscarriage, ectopic pregnancy and molar pregnancy.
- A range of leaflets that talk about the facts and feelings of miscarriage, ectopic and molar pregnancy. They are all available to download from this website.

Life Charity (National Charity)

Whatever the circumstances of your pregnancy loss, whether through miscarriage, ectopic pregnancy, hydatidiform mole, or stillbirth. Call counsellors on the National Helpline or text via the Text-to-Talk service.

Email: **sam@lifecharity.org.uk** Tel: **0808 802 5433** (National helpline 9am-3pm) Text: LIFECARE to 88020 (Text to Talk).

Child Death Helpline

A national free phone helpline, originated from Alder Hey and Great Ormond Street Hospitals provides a free phone service to anyone affected by the death of a child of any age – whether they are parents, grandparents, siblings, family members, friends or involved professionals.

The Child Death Helpline is staffed by volunteers, all of them bereaved parents and open every day of the year for anyone affected by the death of a child of any age, and offer a confidential, safe environment within which a caller can talk openly about the child's life and death.

Telephone: **0800 282 986** or mobile **0808 800 6019**

Monday to Friday - 10am to 1pm
Tuesday and Wednesday - 1pm to 4pm
Every evening - 7pm to 10pm

SANDS is the stillbirth and neonatal death charity. We operate throughout the UK, supporting anyone affected by the death of a baby, working to improve the care bereaved parents receive, and promoting research to reduce the loss of babies' lives.

Tel: **020 7436 5881**

BLISS Support, including after bereavement, for the family of a premature baby.

Helpline **0808 801 0322**

DAD PAD It's the essential guide for new dads, developed with the NHS.

19. Appendix

BIRTH PLAN TEMPLATE (LATEST) I

Pre-Birth Flowchart.pdf